



Final Report

Evaluation of the Capacity of the New Hampshire Behavioral Health System

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About the Human Services Research Institute

The Human Services Research Institute (www.hsri.org) is a nonprofit, mission-driven organization that works with government agencies to improve human services and systems, enhance the quality of data to guide policy, and engage stakeholders to effect meaningful systems change.

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List of Acronyms

ACA	Affordable Care Act
ACT	Assertive Community Treatment
AHEDD	Automated Hospital Emergency Department Data
BBH	Bureau of Behavioral Health
BDAS	Bureau of Drug and Alcohol Services
BH	Behavioral Health
BHI	Behavioral Health Integration
CANS	Child and Adolescent Needs and Strengths
CBAT	Community-Based Acute Treatment
CBHA	New Hampshire Community Behavioral Health Association
CDC	Centers for Disease Control
CIT	Crisis Intervention Team
CMHA	Community Mental Health Agreement
CMHC	Community Mental Health Center
CoC	Continuum of Care
CoCM	Collaborative Care Model
CPRP	Certified Psychiatric Rehabilitation Practitioner
CSC	Coordinated Specialty Care
CSPECH	Community Support Program for Persons Experiencing Chronic Homelessness
DCYF	Division for Children, Youth and Families
DHHS	Department of Health and Human Services
DOC	Department of Corrections
DRF	Designated Receiving Facility
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-Based Practice
ED	Emergency Department
EMT	Emergency Medical Technician
ER	Emergency Room
FAST Forward	Families And Systems Together Forward
FEP	First Episode Psychosis
FQHC	Federally Qualified Health Center
HFA	Healthy Families America
HSRI	Human Services Research Institute
IDN	Integrated Delivery Network
IEA	Involuntary Emergency Admission

IRB	Institutional Review Board
ISO	Individual Service Option
LOA	Life of an Athlete
ME	Maine
MH	Mental Health
MOU	Memorandum of Understanding
NASMHPD	National Association of State Mental Health Program Directors
NGRI	not guilty by reason of insanity
NH	New Hampshire
NHH	New Hampshire Hospital
Project ECHO	Extension for Community Healthcare Outcomes
PRTF	Psychiatric Residential Treatment Facilities
PSA	Peer Support Agency
PSH	Permanent Supportive Housing
RAISE	Recovery After an Initial Schizophrenia Episode
REAP	Referral, Education, Assistance Program for Older Adults
RFP	Request for Proposals
RPHN	Regional Public Health Networks
SAMHSA	Substance Abuse and Mental Health Services Administration
SAP	Student Assistance Programs
SFY	State Fiscal Year
SUD	Substance Use Disorder
SW	Social Work
THS	Transitional Housing Services
UNH	University of New Hampshire
VA	Veterans Affairs

Executive Summary

Background

A number of reports and news articles in recent years have documented shortcomings in the New Hampshire behavioral health system, focusing in particular on the growing strains on hospital emergency departments (EDs) from mental health and substance abuse crises. To address these concerns, the Department of Health and Human Services issued a Request for Proposals for an “Independent Evaluation of the Capacity of the Current Health System.” Here, we detail our approach to that evaluation, including methods of data collection, analysis and reporting related to service capacity and gaps.

Methodology and Approach

To identify the behavioral health system needs, gaps, and recommendations in New Hampshire, HSRI used a mixed methods approach that consisted of three main elements: reviewing documents and reports, conducting interviews with a range of key informants, and analyzing data collected and provided by DHHS.

Behavioral Health Study Data Sources

Qualitative data was extracted through a review of 53 unique documents containing information about the NH behavioral health system and specifically issues of Emergency Room (ER) boarding and inpatient bed capacity. Interviews were conducted with 55 individuals, consisting of a core group identified by DHHS and expanded through snowball sampling. The following types of quantitative data were obtained for the analysis:

Community Mental Health Centers: Characteristics of service recipients from all 10 CMHCs for SFYs 2016 and 2017.

Psychiatric Inpatient Bed Capacity: Data on private and public general and specialty hospital beds.

New Hampshire Hospital: Data requested by HSRI on the characteristics of people served were not available in the timeframe for this project. In lieu of this, we utilized data from Community Mental Health Agreement quarterly reports.

Emergency Department: Limited data related to ED encounters available in the timeframe of the project was obtained for 26 hospitals from the Automated Hospital Emergency Department Data (AHEDD) dataset for SFY 2017, consisting of ED visits that did not result in hospital admission. More detailed information on ED discharges are contained in the state’s Discharge dataset, but the latest available data

are only through SFY 2015. Given that the emergency department data were not received until November 28, however, primary analysis was not feasible within the project timeframe.

Peer Support Services utilization data for SFY 2016.

Supported Housing data on service capacity, utilization, and characteristics of residents for SFY 2014 – 2018 Q1.

Community Mental Health Agreement Court Monitor Reports provided information on ACT services, mobile crisis, NHH readmission rates, supported employment penetration rates, and the Bridge Subsidy housing program.

Organization of This Report

Section 1 provides a discussion of the background and methodology for this project, focusing on issues related to inpatient bed capacity, ER boarding, and their relations to outpatient services, both nationally and in New Hampshire. The next three sections describe data sources, present an inventory of behavioral health services in the state, and present our analysis of system gaps. The final section consists of a set of recommendations with suggested action steps across the continuum of care, with a focus on how the continuum affects ER and inpatient utilization.

Key Findings

Bed Capacity and ER Boarding

There has been a steady increase in the number of individuals experiencing boarding in New Hampshire ERs. On September 24, 2017 there were 70 people waiting for admission. The greatest total number of individuals at one time was 72.

Trends in ER boarding, bed capacity and outpatient services indicate that the relationship among these factors is complex and not easily interpreted. While the number of inpatient beds available in New Hampshire has declined over the years, there has recently been an upward trend, with inpatient capacity increasing from 430 to 458 beds from 2016-2017 alone. Despite this increase, however, the wait-list for beds has continued to increase. While this suggests that adding beds would not in itself alleviate the problem of ER boarding, the upward trend in boarding occurred despite an increase in community-based services under the Community Mental Health Agreement during this period as well.

Key informants universally advocated for increased outpatient services for crisis prevention and diversion as a means of reducing the need for inpatient beds and the incidence of ER boarding. Opinion was divided, however, on whether an increase in the number of beds was also necessary, with a few individuals suggesting a modest increase would be beneficial. Key informants welcome the additional services provided under the Community Mental Health Agreement.

Community Mental Health Centers

New Hampshire's 10 Community Mental Health Centers (CMHCs) served 44,307 people in 2016, and slightly fewer (42,087) in 2017. Over a quarter of those served were youth. Just over half (55%) were female. Approximately 95% were White. The majority of those served had public insurance (Medicaid and/or Medicare), and roughly one quarter had private insurance. The percentage of people served who were uninsured was 17% in SFY 2016 and went down to 15% in 2017. The increased demand for inpatient beds, therefore, cannot be explained by an increase in the number of people in the system.

New Hampshire Hospital

Across SFY 2017, admissions decreased between quarter one (373) and quarter four (293). The median length of stay was 10 days. Individuals were primarily discharged from NHH back to their home as opposed to facilities and residential settings; a small number were discharged to non-permanent housing (including hotels/motels and homeless shelters/no permanent residence). Readmission rates were highest for the 180 days after discharge (32%), followed by 90 days (24%), and 30 days (15%).

Designated Receiving Facilities

In the final quarter of FY2017, there were a total of 804 admissions to DRFs—primarily to Portsmouth Regional Hospital (45.1%) and the Cypress Center (28.4%). In the third quarter of the SFY, involuntary admissions to Franklin Regional Hospital more than doubled, rising from 16 to 46—an increase that remained high through the end of SFY 2017.

DRFs had an average of 17.2 admissions each day in the final quarter of SFY 2017, with variation among facilities: Portsmouth Regional Hospital, for instance, received an average of 30.3 individuals whereas Franklin Regional Hospital received an average of 4.5 individuals. Adults in DRFs had a median length of stay of 5 days in the last quarter of SFY 2017. The longest length of stay was at the Elliot Geriatric Psychiatric Unit with 22 days in quarter four, whereas the four other DRFs had median lengths of stay that were less than 10 days. A total of 815 adults were discharged from DRFs in quarter four. Franklin Regional Hospital nearly doubled the number of persons discharged between quarter one (35) and quarter three (66).

Key Informant Comments on Service Gaps and Assets

Peer Supports: Many key informants recommended an increase in peer support services, but several recent plans for expansion were cancelled due to lack of funding.

ACT: Key informants generally endorsed the value of ACT teams, but there was some skepticism about their potential contribution to reducing hospitalization. Some suggested that ACT programs may have

reached the maximum number of consumers for whom ACT would serve to prevent hospitalization. A challenge to the expansion of ACT teams and the delivery of services with fidelity is the behavioral health workforce shortage.

Supported Employment: CMHCs, with some exceptions, are meeting the CMHA target for supported employment penetration. The programs are challenged, however, by the same workforce shortage issues that affect ACT teams.

Children’s Services: Community-based sub-acute services for children have some of the same gaps as those for adults, resulting in similar increased utilization of inpatient treatment according to many key informants. Among the gaps identified were availability of child psychiatrists and clinicians trained in evidence-based trauma-informed treatment models. On the other hand, several recent improvements were noted, in particular the FAST Forward (Families And Systems Together) program and the recent establishment of the Children’s Bureau of Behavioral Health.

Special populations: Some sub-groups were identified by key informants as being especially challenging. These included persons with co-occurring developmental disabilities, co-occurring substance use disorders, older adults and veterans.

Community Engagement: Many informants recommended increased efforts to engage the community in understanding and addressing behavioral health issues.

Criminal Justice: Numerous individuals called for increased partnerships between behavioral health and criminal justice agencies; informants also noted a number of successes—including re-entry programs in local jails, development of Integrated Delivery Networks (IDNs) as a result of the 1115 waiver, and Manchester Mobile Crisis Response Team as a model.

Mobile Crisis Units: Mobile crisis units beyond the major population centers was identified by many as a gap in the system.

Peer Respite Beds: Many endorsed the effectiveness of peer respite beds, though some suggested that a lack of awareness limited their use.

Law Enforcement Training: Increased training for law enforcement and other first responders was widely identified as a need. While some training is currently provided, it is not sufficient across the state.

Clinical Services in ERs: Key informants identified a need for several types of services for people while in the ER, such as peer navigators and increased clinical support such as psychiatric consultation.

NGRI: Multiple informants identified the number of patients with a not guilty by reason of insanity (NGRI) status in NHH as a major constraint on bed availability, and recommended alternatives such as forensic ACT teams.

Housing Options: The recent addition of a transitional housing program should help provide more options for discharge from inpatient beds in New Hampshire, but the consensus of the key informant interviews is that more housing is still needed, including additional transitional beds. The Bridge program was also noted by informants as a successful housing resource that should be expanded if possible.

Discharge Planning: Inpatient discharge planning and care coordination received mixed reviews. One asset is the involvement of a peer specialist in all discharge meetings at New Hampshire Hospital; peer specialists are very knowledgeable about community-based options and are skilled at facilitating connections with needed community services. On the other hand, a challenge is the overall lack of care coordination by community services when their client is hospitalized.

Resources: Key informants universally expressed the view that the behavioral health system in New Hampshire is drastically under-resourced, whether the topic was peer supports, mobile crisis rates, CMHC services, or any other service. One of the most common examples noted was that CMHC reimbursement rates have not seen an increase since the mid-2000s.

Workforce: Workforce capacity, combined with lack of funding, was frequently cited as a major barrier to the successful delivery of services. Lack of adequate reimbursement for services delivered forces providers to manage costs in other ways; wages and benefits are depressed, which in turn makes positions less attractive, or even financially feasible, for those interested in pursuing careers in human services.

Collaboration: Cross-system collaboration to break down silos was identified by many, though there was much optimism about the Delivery System Reform Incentive Payment (DSRIP) project as part of the 1115 waiver.

Planning: Systems planning through the 10 Year Plan was widely endorsed, though some expressed skepticism that the funding would be available to support the recommendations.

Data and Performance Metrics: The administrative burden of data collection on CMHCs, combined with a lack of coordination around its use or exchanges between the public health sector, hospitals, and CMHCs, was identified as a source of frustration.

Recommendations

The following tables present a summary of recommendations based on key informant interviews and analysis of qualitative and quantitative data. Recommendations are grouped according to three general divisions in the continuum of care: 1) outpatient services with a focus on their function in preventing crises and resulting ED and inpatient utilization; 2) crisis services with a focus on their function in diverting potential ED visits and hospital admissions; and 3) disposition of patients following inpatient and ED encounters. For each recommendation, several examples of suggested actions are provided along with the likely time frame (short term vs. long term) of strategies to address each recommendation (although the actual timeframes will depend on a variety of factors such as priorities set by stakeholders, available resources, feasibility of implementation and the like). It should be noted that the main body of the report spells out recommendations in much greater detail and presents numerous suggested actions for each recommendation.

Study Recommendations

Recommendations for Crisis Prevention	
RECOMMENDATION	STRATEGY TIMEFRAME
DHHS should restore and expand the capacity of community-based services that have been shown to decrease the need for hospitalization and to promote recovery (e.g., enhance ACT teams)	Short and long term
Increase peer support services that offer diversion or transition services (e.g., recruit and certify additional peer specialists)	Short term
Enhance the array of crisis services statewide (e.g., improve communication about available peer respite beds)	Short term
Establish a coordinating mechanism and a centralized data system that would track people waiting in ERs and available crisis and peer respite beds (e.g., provide for transfer to open beds)	Short term
Increase Permanent Supportive Housing (e.g., establish a housing registry, explore options for Medicaid reimbursement for PSH-related services)	Short term
Review adequacy of specialty services for children (e.g., telepsychiatry, increase family supports, expand school programs)	Short and long term
Explore feasibility and options for expanding the First Episode Psychosis programs currently funded by a Block Grant set-aside	Short term
Support and coordinate with efforts to enhance availability of behavioral health outpatient services in primary care	Short term
Partner with Federally Qualified Health Centers (FQHCs) and similar health centers as participants in the delivery of behavioral health	Short term

outpatient services (e.g., ensure full utilization of FQHC behavioral health)	
Enhance collaboration and communication between criminal justice and behavioral health service systems (e.g., use of Sequential Intercept Model)	Short and long term

Recommendations for ED Diversion	
RECOMMENDATION	STRATEGY TIMEFRAME
Develop and expand crisis alternatives (expand use of peer respite, establish alternative to ER for law enforcement)	Short and long term
Develop clinical consultation program to address gaps in specialty services (identify needed expertise, consider telepsychiatry)	Long term
Establish a centralized coordinating process and data system at the state level that would track people waiting in ERs and available beds, including peer respite and crisis stabilization (convene workgroup)	Long term
Require timely linkage to community-based services following inpatient or emergency department admission (policies for warm handoff, outpatient discharge follow-up)	Short term
Increase clinical support in ERs (e.g., consultation on complex cases)	Long term
Increase support and training for law enforcement and first responders (e.g., replicate Manchester model, increase consultation)	Long term

Recommendations for Disposition	
RECOMMENDATION	STRATEGY TIMEFRAME
Develop a formal protocol, criteria or communication process for allocating admissions to public vs. private hospitals to ensure the most appropriate level of care	Short term
Ensure the availability of re-entry programs from jails/prisons throughout the state	Long term
Establish community-based forensic services as a step-down for individuals in New Hampshire Hospital who are able to transition	Long term
Adopt advance discharge planning models that have been shown to reduce ED boarding by better management of inpatient capacity	Short term

System-Wide Recommendations

RECOMMENDATION	STRATEGY TIMEFRAME
DHHS should support the formation of local planning committees, where they do not already exist, to address various system issues, devise solutions, and monitor progress	Short term
Encourage communities to share responsibility with the state for promoting high quality behavioral health services (e.g., support public health approaches in 10 Year Plan, provide more communication about available services)	Long term
Workforce development (e.g., consider curriculum on best practices, develop peers in workforce throughout the system)	Short and long term
Improve workforce recruitment and retention (e.g., form a group to foster public-private provider partnerships for recruitment, establishing non-monetary incentives such as training, supervision)	Long term
Expand the use of remote health interventions (e.g., social media, psychiatry consultation to primary care)	Long term
Increase the use of performance metrics (e.g., service utilization, peer specialist employment, ER encounters)	Long term
Support current efforts to enhance and integrate data systems (e.g., training on data collection, supporting value-based care)	Short term

Notes About Language

In this report, “behavioral health” refers to both mental health and substance use. Those who receive services are typically referred to as “service users.” Those stakeholders who participated in key informant interviews as part of the study are referred to as “key informants.” Other individuals who gave informal feedback are referred to as stakeholders. The term “peer” is used to refer to individuals with personal experience with mental health or substance use issues, typically in the context of peer support.

1. Background and Approach

A number of reports and news articles in recent years have documented shortcomings in the New Hampshire behavioral health system, focusing in particular on the growing strains on hospital emergency departments (EDs) from mental health and substance abuse crises (Bender, Pande et al. 2008, Alakeson, Pande et al. 2010, Pearlmutter, Dwyer et al. 2017). Many of these publications have also tackled related issues such as inpatient bed capacity. In 2017, the NH state legislature authorized a broad-based initiative to expand the number of inpatient beds, crisis services, and community-based programs and to conduct a comprehensive review of the state's behavioral health system capacity and gaps. To that end, the Department of Health and Human Services commissioned an independent evaluation of the capacity of the current health system. The Human Services Research Institute (HSRI) was designated as the organization to carry out the evaluation over a period of 2 months. It is hoped the findings of this report will provide a rich foundation for the upcoming 10-year planning effort.

Methods

HSRI used a mixed methods approach to identify behavioral health system needs, gaps, and recommendations in New Hampshire. The project, which was reviewed and approved by the HSRI Institutional Review Board (IRB), consisted of three main elements:

- Gathering existing qualitative and quantitative data from available reports, presentations, and other documents identified by DHHS leadership and key informants that were interviewed.
- Semi-structured key informant interviews with stakeholders throughout New Hampshire. Key informants consisted of managers, practitioners, and other key stakeholders.
- Analysis of existing data being collected by DHHS, New Hampshire Hospital, and others. Specific reports were run at the request of HSRI, with de-identified aggregate summary data provided.

HSRI staff entered all qualitative data into qualitative analysis software, Dedoose, where analysts coded and organized content by topic to facilitate synthesis across sources. Summary quantitative data was imported into programs such as Excel and Tableau, which were then used to create quantitative data displays. For more detailed information on the specific sources used, please refer to Section 2 of this report.

Limitations

It must be noted that the following needs assessment was conducted in an extremely compressed timeframe, with 8 weeks between the kick-off meeting for the project and due date for the Final Report. While a significant amount of qualitative and quantitative data was still able to be gathered and

analyzed during this period, timeframe constraints prohibited us from obtaining and examining all of the existing data we had initially desired, or ensuring we were able to interview all possible key informants identified.

This report relies heavily on information provided by the 55 key informants interviewed. Given the extremely tight timeframe for the project, the interviews were conducted up until the final week. The key informant findings presented do not represent a comprehensive inventory of everything that was heard during the interviews. Rather, the findings present our analysis of the dominant themes across interviews which, combined with our other data sources, informed our recommendations. We greatly appreciate all of the information generously shared by all of our key informants.

Obtaining quantitative data to understand the ED boarding issue was the primary challenge to this project. Ultimately, the project timeframe was insufficient to obtain all the desired quantitative data. The best data to understand the characteristics of individuals boarding in emergency departments for a primary mental health diagnosis would be medical claims records from the New Hampshire Comprehensive Health Care Information System (CHIS) that would include claims from Medicaid, Medicare and commercial insurance. Primary analysis of these data was not within the scope of this project and aggregate reports for the time period needed were not available to be produced in the project timeframe. Additionally, the Uniform Healthcare Facility Discharge Data Set (UHFDDS) would provide valuable information on individuals discharged from emergency departments with a primary mental health diagnosis, including where they are going after discharge. This dataset has the disadvantage of a time-lag due to the data vetting process, with the most recent available data being from 2015.

The only ED quantitative data we were able to obtain within the project timeframe was from the Automated Hospital Emergency Department Data (AHEDD) dataset, maintained by the Division of Public Health. This real-time database was established for public health surveillance purposes and has limited use for this analysis. First, the data captures only ED encounters *not* resulting in hospital admission. Second, the dataset does not identify primary diagnosis among the diagnosis codes, therefore we could not distinguish individuals with a primary behavioral health diagnosis, only individuals with any behavioral health diagnosis. Two hospitals (Franklin Regional Hospital and Lakes Region General Hospital) had no information on diagnosis codes. Nevertheless, these data provide some insight into the volume of ED encounters involving behavioral health, and we appreciate the efforts by the Division of Public Health to prepare the data for this project.

Understanding the characteristics of individuals in New Hampshire Hospital was also key to this project, especially to shed light on where people are coming from and going to after discharge. Unfortunately, NHH was unable to fulfil our data request within the allotted timeframe. HSRI requested a draft of a

recent study of NHH patients conducted by the Institute on Disability at UNH in partnership with NHH, but clearance was not approved in time for this analysis.

In lieu of primary quantitative data, we referred to the publicly available Community Mental Health Agreement court monitor quarterly reports for information such as admissions to NHH and DRFs, discharge location for adults from NHH, readmission rates, utilization of the Housing Bridge Subsidy program, and numbers served by ACT. Data from the CMHA reports are limited to adult service users only.

Data from the 10 CMHCs were available, though have some limitations. Variation across CMHCs in service utilization could be due to differences in reporting, though time was insufficient to explore and understand all of these differences. We did not have time to vet the data presented in this report with the department or CMHCs, therefore there may be additional limitations of which we are not aware.

With respect to bed capacity for inpatient psychiatric care and supported housing, the data included in this report were compiled by the New Hampshire Hospital Association and the Bureau of Behavioral Health, respectively. We did not have time to vet or update these figures with each location individually. With respect to transitional housing capacity, this reflects the data compiled by the department. Housing options that are not state-funded might not be reflected in the inventory.

Estimating Bed Needs

An important consideration in estimating the need for inpatient psychiatric beds is ensuring that the calculation takes into account the capacity of the behavioral health service system overall, as we have done in this report.

This consideration is based on three points pertaining to mental health system reconfiguration:

- The diverse array of service providers in a given locale complicates efforts to view the mental health care delivery network as a “system.” In most areas, including New Hampshire, providers represent a variety of organizational and ownership types with differing incentives, constraints, and approaches to strategic planning. What is required for inpatient capacity—as well as any other service—depends on the complex interplay of a variety of factors.
- Within the context of a behavioral health system, there is no standard, universally applicable formula for “rightsizing,” or aligning a system’s structure with overarching goals and strategies. Because of the variability and complexity of the organizational characteristics across mental health systems and the nature of the relationships among their constituent parts, the appropriate allocation of resources differs from one system to another. This is particularly true with respect to the relationship between inpatient and community-based services, where it is

generally assumed that the latter may be substituted for the former to some degree at equal or better quality and cost. Precisely how this balance is to be achieved is difficult to determine, primarily due to the variability in the types, capacity, and effectiveness of available outpatient services across regions within a state. Additionally, population characteristics (including the prevalence of mental disorders, availability or lack of social supports, and barriers of race and poverty, among others) vary by locale.

- Bed shortages are frequently indicative of wider system shortcomings. In a sense, psychiatric hospitalization may be considered a treatment of last resort, to be invoked only when community-based services—which are less intensive, less restrictive, and less costly—have proven inadequate to address the needs of the individual. Before addressing a bed-shortage problem by simply allocating more resources to expand inpatient capacity, it is important first to ascertain whether the shortage might be alleviated by closing gaps, increasing efficiency, and improving the quality of outpatient services. The New Hampshire Legislature’s requirement for a comprehensive evaluation of system capacity to inform a longer term mental health system plan is therefore an appropriate response to the identified problem of bed shortages in the state.

Why Service Allocation Is Challenging

Policy makers, understandably, often wish to know how to allocate scarce resources to ensure adequate coverage of both inpatient and community-based services. Unfortunately, the research literature provides no definitive answer about the right number of inpatient beds. In fact, over the half century since the advent of deinstitutionalization, the issue has been hotly debated on a number of fronts. The reason why an appropriate balance is so difficult to calculate is that, despite years of research dedicated to the subject, the extent to which outpatient services can serve as an alternative to inpatient has yet to be determined with any degree of certainty. There are a number of reasons why this calculation is so difficult, if not impossible, but there are five that are particularly relevant to this report.

First, and most important, research has demonstrated that a good and modern behavioral health system—one with an adequate supply and variety of outpatient services—will reduce the need for inpatient care (SAMHSA 2011). Most people agree that all behavioral health systems must maintain some inpatient capacity, and the question is how many “avoidable admissions” can be prevented by an adequate supply of outpatient services. The problem is that the relationship between outpatient services and avoidable hospital admissions is so complex that it is, as of now, impossible to calculate precisely how the availability of outpatient services affects the ratio between avoidable and necessary admissions.

Second, most behavioral health systems offer a variety of services—psychotherapy, psychopharmacology, case management, peer support programs, etc.—all of which have a substantial

evidence base demonstrating their effectiveness at reducing psychiatric inpatient hospitalizations.¹ The problem is that research has not yet shown the comparative effectiveness of these various services, especially for different service user sub-groups and in various types of systems. For example, Assertive Community Treatment (ACT) has been shown to reduce hospitalization admissions, but mainly for patients with frequent admissions and in systems where admissions rates are relatively high. For another type of service user in another type of system, a different service such as Permanent Supportive Housing (PSH) may be more effective. In other words, the “right balance” issue arises not only with inpatient versus outpatient care but also with various modalities of outpatient care. Depending on the particular mix of services, therefore, the specifics of a bed shortage in one location may differ from that in another. For example, community services may be ample for adults but limited for children, with the result that the bed shortage affects only children. As another example, there may be an adequate supply of long-stay hospital beds, for example in a state hospital, but a shortage of beds for patients requiring only a brief acute-care stay.

Third, in a mental health system that is increasingly privatized, whether with for-profit or non-profit hospitals, the supply and demand equation is affected by economic and policy factors, quite apart from clinical necessity. For example, the rapid expansion of private for-profit psychiatric hospitals in the 1980s in response to expanded insurance coverage and various policy changes was followed by an equally large contraction in the 1990s, primarily in response to cost-containment initiatives (Hutchins et al. 2011). Economists call this dynamic “supplier induced demand,” meaning that an increased availability of a service will result in greater utilization, independent of clinical need. This phenomenon has been well documented in the literature for many services including psychiatric hospitalization (Watts et al. 2011).

Fourth, changes in clinical practice and philosophy, or—less frequent but more influential—the introduction of new treatment modalities, can rapidly alter the demand side of the hospital bed supply-and-demand equation. A dramatic example is the introduction of antipsychotic medications in the 1950s as a major facilitator of deinstitutionalization.

Fifth, every behavioral health system is different in many important respects. Most systems in the U.S. are, to varying degrees, county-based, and the county-level variation in numerous factors such as government structure and politics, illness prevalence, demographics, and social issues is even more extreme than state-level variation. It follows, therefore, that the variation in behavioral health systems, including the supply and demand of inpatient psychiatric care is equally great; therefore, no one formula can apply to every system.

¹ SAMHSA maintains a listing of such services in its National Registry of Evidence-Based Programs and Practices: <http://www.samhsa.gov/nrepp>

To further add to the challenge of determining inpatient bed need, there is mounting evidence that a variety of hospital alternatives result in reduced need for costly inpatient services, though this literature tells a complex story. A systematic review of literature involving 10 randomized controlled studies comparing inpatient and day hospitals concluded that, “Caring for people in acute day hospitals is as effective as inpatient care in treating acutely ill psychiatric patients” (Marshall et al. 2011). Another recent review of 13 randomized controlled trials published in the *Journal of the American Medical Association* last summer compared four interventions hypothesized to prevent involuntary hospital admissions: community treatment orders (such as assisted outpatient treatment or AOT), compliance enhancement techniques, augmentation of standard care, and advance statements, including advance directives and joint crisis plans. The review indicated that only advanced directives served to reduce compulsory admissions, and this reduction was considerable, at 23% (de Jong et al 2016). The review also concluded that the evidence base for Assisted Outpatient Treatment is lacking and called for more research into its impact.

In 2015, the Washington State Institute for Public Policy conducted a meta-analysis of community-based interventions that have been hypothesized to reduce psychiatric hospitalizations. In this review, three programs were identified as having a statistically significant effect on psychiatric hospitalization reduction: Assertive Community Treatment, Mobile Crisis Response, and Supported Housing for adults experiencing chronic homelessness. This same review found that Assisted Outpatient Treatment was significantly associated with a small increase in psychiatric hospitalization (Burley et al. 2015). A variety of services in addition to these, such as supported employment (Drake and Becker 2011), residential crisis alternatives (Lloyd et al. 2009), and specialized programs for treating PTSD (Grubaugh et al. 2011) have been shown by researchers to reduce hospital admissions.

In short, a variety of factors determine the need for inpatient beds. When there is a perceived shortage of inpatient beds in a community, it is therefore very important to determine on a local basis, in as fine-grained detail as available data allows, the particulars of that need. This includes identifying the characteristics of service users who are affected and determining whether the problem is in fact an inadequate supply of beds for that subgroup or a gap in the community service system that results in a demand for otherwise avoidable hospitalization. Numerous key informants in this report indicated severe shortages of community-based services, suggesting a need for careful review of those services before reaching a conclusion that a lack of inpatient services is at the root of New Hampshire’s behavioral health service needs.

Given all these variables, comparative data from other systems have limited utility and must be carefully weighed when applied to any particular case, such as that of New Hampshire. National trends in the supply and utilization of inpatient services and the factors that influence them, as discussed below, may provide a general gauge, but these must be considered in the context of New Hampshire’s circumstances. A report by the National Association of State Mental Health Program Directors

(NASMHPD) states that there is no standard formula to apply when seeking to project or estimate the number of inpatient beds that should exist in a system, and that the unique circumstances within the system should be taken into account when determining what the capacity should be (National Association of State Mental Health Program Directors Medical Directors Council 2014).

An additional challenge in determining appropriate bed capacity is a lack of standard terminology and baseline national data. What is often overlooked in recommendations for more psychiatric beds is the fact that there is no established definition of what constitutes a “bed” (Pinals and Fuller 2017). In an earlier era, a psychiatric bed was generally defined in reference to state hospitals, where most institutional care took place. Today, however, settings that provide around-the-clock psychiatric nursing and psychiatric care now also exist in university and community hospitals, charity and for-profit hospitals, private facilities dedicated entirely to mental health care, and other facilities.

The numbers of many sub-types of beds are not reported by any government agency. Sub-types include public and private child/adolescent, geriatric, acute-care, residential treatment (of various types), group living, supported housing, and psychiatric emergency room beds—each of which serves a different sub-group of the population (Pinals and Fuller 2017).

National Context

Public behavioral health systems play a vital role in ensuring access to a continuum of treatment and services designed to meet a range of needs. Safety-net services, such as psychiatric inpatient treatment and crisis intervention, are at one end of this continuum. Inpatient bed need and utilization, as well as interaction with other systems such as criminal justice and homeless service systems, are often contingent on the availability of quality community-based services, including an organized psychiatric crisis response and diversion system. Generally, stronger and more accessible community-based services and a well-developed psychiatric emergency response system will result in decreased reliance on costly inpatient care and overutilization of police intervention.

Viewing New Hampshire’s inpatient and systemic issues through the national lens helps to provide context for the current and future planning of inpatient capacity for the state. As previously stated, there is no valid or reliable standard formula to determine the number of beds needed in a particular system, but national context provides a general gauge. National trends in inpatient utilization and capacity have been driven by a variety of issues, including the strength of community services infrastructure, the U.S. Supreme Court’s 1999 Olmstead decision, reimbursement and payer issues, and the Affordable Care Act (ACA). Systems across the country are generally evolving in the context of three national trends: 1) decreases in overall psychiatric inpatient capacity; 2) a shift in the provision of inpatient treatment from public hospitals to general acute care hospitals; and 3) growth of community-based alternatives.

From a high point in the 1950s, the number of psychiatric beds in the United States has declined steadily over the years. In 1950, there were more than 500,000 state/county public psychiatric hospital beds in the United States. As of 2010, there were fewer than 44,000 (Treatment Advocacy Center 2012). In 1955, there were 340 public psychiatric beds per 100,000 people; by 2005, this figure was down to 17 beds per 100,000, a 95% reduction (Treatment Advocacy Center, Unpublished). At the same time, the number of psychiatric beds in general hospitals increased from virtually none in the late 1940s to more than 54,000 by 1998. (Note: This number has been reduced to about 40,000 today.) In the late 1940s, over 94% of psychiatric inpatient care was provided in public mental health facilities; by 1998, almost 50% of such care was provided in general hospital psychiatric units. In addition, the number of private psychiatric facility beds increased from fewer than 15,000 in 1970 to almost 45,000 in 1990, but dropped to 28,000 in 2004 (National Center for Health Statistics 2011).

Notably, the number of non-psychiatric, acute care beds has also dropped. In 1999, the nationwide average for hospital beds (all types) was 3.0 beds per 1,000 people; in 2009, the average was 2.6 per 1,000—a 13.3% drop.

The issue of emergency department (ED) overflow and bed shortages is not unique to New Hampshire. Approximately one in eight visits to EDs in the U.S. involve mental and substance use disorders. The rate of ED visits per 100,000 population related to behavioral health disorders increased by more than 50% for mental disorders and 37% for substance use between 2006 and 2013 (Owens, Mutter et al. 2016). Also, the percentage of behavioral health-related ED visits covered by private insurance decreased whereas the percentage covered by Medicaid increased. Because behavioral health-related ED visits are more than twice as likely to result in hospital admission compared with those involving other conditions, excess ED utilization has a ripple effect, placing strains on inpatient capacity and contributing to increased cost (Pearlmutter, Dwyer et al. 2017).

A key question addressed by this report, therefore, is whether a situation where demand for inpatient beds exceeds capacity represents a system gap in itself or is a result of gaps “upstream” in the continuum of care. ED visits by individuals with mental health and substance use disorders should be considered potentially avoidable, given adequate outpatient services in the community. Because ED visits frequently precipitate inpatient admissions, averting or managing crises in the community should have a ripple effect of reducing demand for inpatient treatment. In situations where demand for beds is driven by preventable ED visits resulting from gaps in the outpatient treatment system, given the high expense of inpatient treatment, the cost-effective solution is to enhance the outpatient system rather than increase inpatient capacity.

ED Boarding: A National Problem

The term “boarding” refers to time spent waiting in an emergency room for a hospital bed or for transfer to another inpatient facility. The problem is not limited to persons with psychiatric crises but is especially severe for that group—a 2008 survey of ED medical directors found that roughly 80% believed their facilities boarded psychiatric patients (American College of Emergency Physicians 2008).

A recent summary of literature of psychiatric ED boarding (Pearlmutter, Dwyer et al. 2017) cited a range of deleterious effects. Boarding has been shown to lead to ED crowding, poor patient experience and lower quality of care, including delays in treatment, with increased morbidity and mortality, increased medication errors, and adverse outcomes. Mental health boarding consumes scarce ED resources and worsens crowding so that other patients with undifferentiated, potentially life-threatening conditions wait longer to receive treatment. Additionally, mental health boarding has a negative effect on nursing and physician job satisfaction—not to mention the negative effects of being boarded on the individuals being boarded themselves.

New Hampshire Context

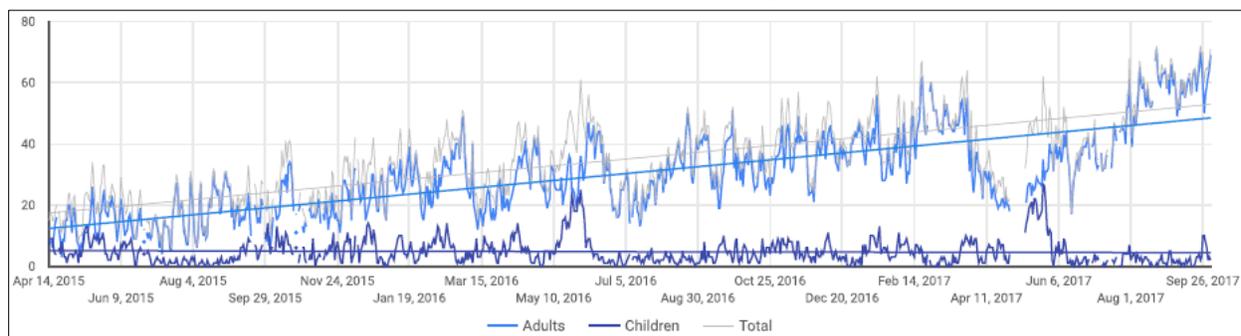
Many of our key informants, as well as the reports we reviewed for this study, commented on the decline in the New Hampshire behavioral health system since the 1990s when it was generally regarded as one of the best in the nation. Today, Mental Health America’s 2018 ranking of state adult mental health systems places New Hampshire in the bottom half, at number 29 (Mental Health America, 2017). Information from key informants and other reports makes it clear that there is no single cause of this decline, though most point to a general hollowing out of resources dedicated to the community mental health system. For example, numerous individuals have noted that the reimbursement rate for Community Mental Health Centers (CMHCs) has not increased since 2005, and according to some has actually decreased, while at the same time personnel benefit costs have increased significantly.

A 2017 white paper by the New Hampshire Community Behavioral Health Association (CBHA) details the challenges facing CMHCs in the face of diminished resources. Successive waves of funding cuts since the 1990s have resulted in the elimination of many services that had previously made New Hampshire a model for the nation. The white paper cites the example of Riverbend, which was forced to close a satellite site, a group home, and a crisis unit—all closures that could be expected to increase demand for inpatient care. Budget cuts, unreimbursed costs, and low Medicaid rates have had a direct impact on the workforce, as CMHCs are unable to compete with other employers such as Federally Qualified Health Centers (FQHCs), schools, managed care organizations, or private practices. According to the white paper, in July 2017 nine of the ten CMHCs reported open positions—for a total of 184 open positions—with 87% being clinical positions. Workforce shortages in turn impact the quality of outpatient

services—for example, making it difficult to maintain fidelity to evidence-based service delivery models such as Assertive Community Treatment (ACT).

Key informants indicated that because of gaps in the continuum of available community-based services, individuals find themselves heading toward crisis situations, at which point the only readily available option is presenting at an ED. Because of a general lack of diversionary services, and limited awareness of those that do exist, individuals find themselves unable to access key services that would help avert crisis or more intensive community services that would help them in the moment without requiring inpatient treatment, either voluntary or involuntary emergency admission (IEA) status. The result has been a steady increase in the number of individuals finding themselves “boarded” in local EDs as they await an inpatient bed. Exhibit 1, below, shows the steady increase in the number of adults awaiting beds at New Hampshire Hospital in emergency departments statewide. On September 24, 2017, there were 70 people waiting for admission. The greatest total number of individuals at one time was 72.

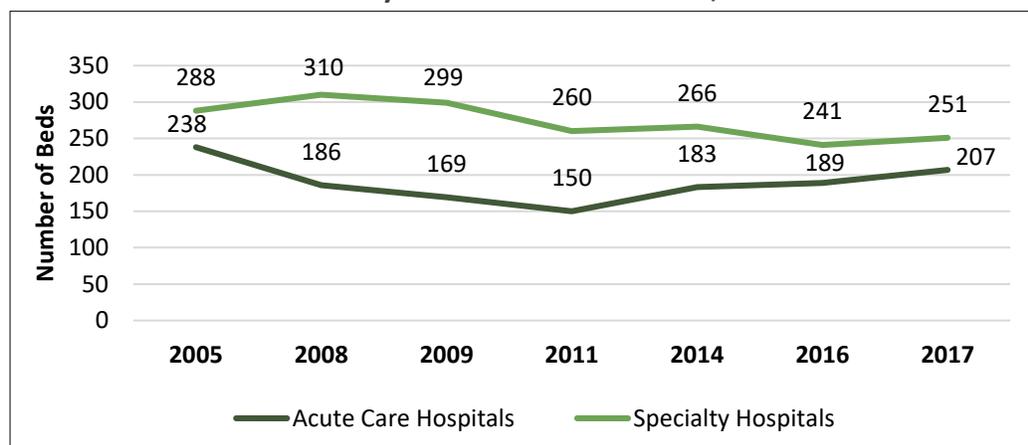
Exhibit 1. New Hampshire Hospital Admission Waiting List Count, Apr 2015 – Sep 2017



Source: NAMI New Hampshire

Interestingly, the number of inpatient beds available in New Hampshire has dropped since 2005 but is showing an upward trend, with inpatient capacity increasing from 430 to 458 from 2016-2017 alone (as shown in Exhibit 2). Yet the wait-list continues its upward trajectory despite the addition of beds.

Exhibit 2. Number of Psychiatric Care Beds in NH, 2005 – 2017



Source: NH Hospital Association / Foundation for Healthy Communities, updated as of 11/2/2017

Increasing Bed Capacity vs. More Funding for Community Services

This raises the question of whether the answers to addressing the ED boarding problem are focused on the community based support system or the funding of additional inpatient beds. Given the data displayed in Exhibits 1 and 2, simply increasing bed capacity did not alter the trend with the wait-list census; on the other hand, the early expansion of community-based services also occurring during this period as part of the Community Mental Health Agreement (Rockburn 2015) did not appear to change the trend in the short term either.

Stakeholders in New Hampshire may disagree as to whether the priority for any expansion should be an increase in inpatient beds or in outpatient services, given that any available funding will be limited. The 2014 Community Mental Health Agreement (CMHA) does provide for an expansion of mobile crisis response, crisis apartments, ACT, supported housing, community residence beds, and supported employment. While these are generally considered welcome and important improvements to the system, some question whether they will be adequate to address the problems of bed waiting times and ED boarding (New Hampshire Community Behavioral Health Association 2017). Those who believe that the CMHA in itself will not be sufficient are similarly divided between those who favor more inpatient beds versus those who advocate for even more greatly increased outpatient services. It is important to note that in our interviews with key informants for this report, nearly everyone viewed the solution to be rooted in enhanced community support services. Few individuals advocated for more inpatient beds; while some indicated that a modest increase in beds may help, simply adding beds would do nothing to address what they saw as the root cause of the current situation: the reduced continuum of care at the local levels.

The CBHA white paper extensively describes the shortcomings of the current outpatient system, and acknowledges that some stakeholders, such as the NH Disability Rights Center (which was party to the

class action suit resulting in the CMHA) believe that additional beds are not necessary. CBHA's position, in contrast, is that increases in outpatient capacity alone will not be sufficient; the white paper quotes the head of the organization as saying, "Part of the solution is more inpatient beds, whether people want to hear or not." However, the white paper authors also state that, "It is not just about beds at NH Hospital and there is truth in both points of view."

Estimates of Needed Beds for New Hampshire

As of 2016 New Hampshire had 11.9 beds per 100,000 population, slightly more than the national average of 11.7 beds per 100,000; however, this was before the 28-bed increase from 2016-2017 (see Exhibit 2). Around the nation, there is a wide range of number of psychiatric beds per 100,000 people; states range from 3.5 in Minnesota to 42 in the District of Columbia. It is noteworthy that these extremes are reversely correlated with NAMI's ranking of the quality of state mental health systems, with Minnesota ranked number 17 and the District of Columbia ranked 44. Though by no means conclusive, this relationship suggests that a system having relatively more beds does not in itself translate into a higher quality system. Based purely on population size, New Hampshire currently has an adequate number of inpatient beds available.

While the problems of bed shortages and ED boarding are widely documented, there is a lack of data regarding the underlying dimensions of these issues nationally as well as in New Hampshire. However, a 2014 survey conducted by the Foundation for Healthy Communities, provides some revealing information about the nature of the problem. The survey, which was conducted from Nov. 1, 2013 through Feb. 28, 2014 using data from all New Hampshire CMHCs and the 10 hospitals with inpatient behavioral health services in the state, found that:

- The most frequently cited barrier to discharge was a place to live or stay, which affected 71% of the survey sample.
- The average waiting time for a new adult patient to have an appointment with a mental health counselor or therapist was 26 days, while the average waiting time for a new child or adolescent patient was 42 days.
- The average number of psychiatric patients in hospital emergency departments awaiting placement in the New Hampshire State Hospital was 21 adults and five children, with spikes as high as 35 adults and 14 children; these figures have only increased since the time of the survey.
- The average operating cost for a day of inpatient care in an acute care community hospital is \$2,912, while the average operating cost for a day of supportive housing is \$297 per day (\$245 per day supportive care from CMHC care + \$52 per day housing room & board).

These data, combined with the fact that New Hampshire does not appear to be facing a significant shortage in the number of beds expected based on population size, strongly support the view that increasing capacity of outpatient services and supports, especially housing, is at least as important—and significantly more cost effective—as increasing the number of inpatient beds. In light of these findings, it should be expected that provisions of the Community Mental Health Agreement and the expansion of services under House Bill 517 will help partially ameliorate the problem of inpatient bed capacity and ED wait times. Given the depth of the challenges currently being faced by the behavioral health system in New Hampshire, however, these efforts represent more of a starting point than a final solution to the issue of excessive wait times for accessing inpatient care, especially for IEA individuals, resulting in ED boarding.

2. Data Sources

As noted earlier, our approach to this system needs analysis consisted of three main elements: 1) a review of data found in existing reports and presentations, 2) key informant interviews, and 3) an analysis of data provided by DHHS, New Hampshire Hospital, and others. Below, we further describe and identify these sources of data.

Existing Documents

DHHS staff and key informants we interviewed identified and sent us a total of 53 unique existing documents, presentations, summary reports, and spreadsheets containing information related to the NH behavioral health system in general, or specifically the issues of ED boarding and inpatient bed capacity. Appendix A lists the titles of the documents, as well as the year they were produced and who produced the documents (if known), that were shared with us and incorporated into our analysis and presentation of findings.

Key Informant Interviews

The second major source of data for this report consisted of interviews with key informants. These key informants were all identified through snowball sampling. DHHS leadership initially identified a cohort of nine “core” key informants; HSRI held introductory in-person and telephonic meetings with these individuals. These nine core key informants identified and sent many of the key documents listed in Appendix A. They also provided names and contact information for other key stakeholders whose perspectives they noted as important. As each key informant interview was subsequently conducted, each individual was asked to identify other potential informants whose perspectives were important to get. HSRI IRB approval, required before primary data collection could begin, was obtained on October 23, 2017. The scheduling and conducting of the key informant interviews began the following day, October 24, and continued through November 27, 2017. Please refer to Appendix B for a copy of the Key Informant Interview Guide used for these semi-structured interviews.

During the interviewing process, the research team attempted to contact and schedule interviews with a total of 74 individuals identified as possible key informants. Of those, 55 individuals were successfully reached and interviewed—representing a response rate of 74%. There were 17 individuals who either did not respond or were unable to schedule a time during the project timeframe; only 2 individuals declined to participate. Appendix C identifies the names and titles or roles within the New Hampshire system of all the individuals who completed a key informant interview, and demonstrates the range of roles and perspectives of those that informed our findings.

State Data Sources

A primary challenge of this project was identifying and obtaining, within the limited project timeframe, data on ED admissions for behavioral health, characteristics of individuals boarding in emergency departments, and mental health service capacity and utilization across the service continuum. HSRI attempted to obtain data from numerous sources and was successful in some, but not all, of these requests. The following is a description of the data availability for this report.

1. **Community Mental Health Centers.** The Bureau of Behavioral Health provided data on the characteristics of people served and CMHC service utilization from the 10 CMHCs for SFY 2016 and SFY 2017.
2. **Psychiatric Inpatient Bed Capacity.** New Hampshire Hospital Association provided data on inpatient psychiatric care bed capacity in acute care and specialty hospitals. The Bureau of Behavioral Health also provided bed capacity information by Designated Receiving Facility and voluntary bed status.
3. **New Hampshire Hospital.** HSRI requested data from NHH on the characteristics of people served including demographics, region of residence, referral source, criminal justice involvement, primary diagnosis, where discharged to, and frequency of readmission. The hospital was unable to fulfill the request within the project timeframe. In addition, through key informant interviews, we learned of a recent study conducted by the Institute on Disability at UNH in partnership with NHH that collected data on patient characteristics. HSRI made a request to the department to obtain a draft of this report, but as of the time of writing, clearance was not yet approved. In lieu of these data sources, we obtained data on NHH readmission rates and discharges from the Community Mental Health Agreement quarterly reports, described in #7, below.
4. **Emergency Department Data.** Limited data on ED encounters were available within the project timeframe. From the Division of Public Health Services, we obtained data from the Automated Hospital Emergency Department Data (AHEDD) dataset for SFY 2017. AHEDD is a real-time data surveillance system used for early detection. These data capture the number of ED encounters, and the number of unique (unduplicated) people served in emergency departments from 26 hospitals throughout the state in which a behavioral health diagnosis (mental health or SUD) was indicated on the ED encounter record. They are only for ED encounters that did not result in admission. More detailed information on ED discharges are contained in the state's Discharge dataset, but the latest available data are only through SFY 2015.
5. **Peer Support Services.** Data on peer support services utilization for SFY 2016 was provided by the Bureau of Mental Health.
6. **Supported Housing.** Data on supported housing came from three sources: 1) the Bureau of Mental Health shared a spreadsheet, 'BMHS SPMI BEDS SUMMARY,' of bed location and capacity for CMHC housing programs and supported housing; 2) NFI-North, which operates the Transitional Housing Services (THS) in Concord, provided data on service capacity, utilization, and characteristics of

residents for SFY 2014 – 2018 Q1; and 3) Information on the Bridge Subsidy program was available from the Community Mental Health Agreement quarterly reports, described in #7, below.

7. **Community Mental Health Agreement Court Monitor Reports.** Data collected and reported for the Community Mental Health Agreement were available online in the quarterly court monitor reports at: <https://www.dhhs.nh.gov/dcbcs/bbh/settlement.htm>. These data include information on ACT services, mobile crisis, NHH readmission rates, supported employment penetration rates, and the Bridge Subsidy housing program.

3. System Inventory

A goal of this project was to develop a system map that outlines and inventories existing services, including inpatient and outpatient services, housing supports, and peer and family supports available to individuals with mental illness or substance use disorders in New Hampshire. Whenever possible, we organized services by CMHC region so that the inventory of services and bed capacity can be compared to utilization patterns displayed by CMHC region in this report.

Exhibit 3 shows a summary of available resources by region, including inpatient psychiatric care beds, peer respite beds, mobile crisis services, safe stations, supported housing, ACT teams, and mental health and drug courts. The pages following, Exhibits 4 through 8, depict the inventory in geographical format on a map of the state.

Outpatient services provided by CMHCs include assessment and evaluation; case management; individual, group, and family therapy; community-based rehabilitative services; rehabilitation services; and emergency services. Data on these services are displayed in Appendix D, broken out by CMHC.

In addition to the services included in this inventory, there are many other local and statewide initiatives focused on prevention and health promotion, such as those noted below. This list is not exhaustive, as there are many local organizations and initiatives throughout the state.

- Regional Public Health Networks (RPHN): 13 RPHNs covering all regions of the state, providing a wide array of prevention and promotion services and collaboratives

Programs for Youth and Families:

- FAST Forward (wraparound services for youth and their families)
- Project LAUNCH (Manchester)
- Family Resource Centers (statewide)
- Healthy Families America (HFA) home visiting programs
- Student Assistance Programs (SAP)
- Juvenile Diversion Programs
- Raymond Coalition for Youth
- Connor's Climb - suicide prevention education to NH youth and the community
- Youth peer support (Youth M.O.V.E. NH)
- Life of an Athlete (LOA)
- The Davenport School (residential treatment for adolescent girls, located in Jefferson)
- Individual Service Option (ISO) services, intensive in-home foster care services

Other Statewide Prevention and Promotion Initiatives:

- Mental Health First Aid
- Narcotics Anonymous and Alcoholics Anonymous
- InSHAPE health and wellness programs embedded in CMHCs
- Change Direction Campaign; Anyone, Anytime Campaign
- Referral, Education, Assistance Program for Older Adults (REAP)
- Partnership for a Drug Free NH

Exhibit 3. Inventory of Services and Inpatient Psychiatric Bed Capacity by CMHC Region

CMHC Region	Num. of Voluntary Psych. Beds	Num. of DRF Beds	Total Psych. Beds (incl. NHH)	Num. Youth Psych. Beds	Num. Peer Respite Beds	Mobile Crisis Team	Mobile Crisis Beds	Safe Station	Num. CMHC Supported Housing Beds	ACT Team	Mental Health Court	Drug Court
01 - Northern	10	0	10	0	2				32	√	√	
02 - West Central	21	0	21	0	2				16	√	√	√
03 - Genesis	10	0	10	0	0				24	√	√	√*
04 - Riverbend	15	10	193	24	0	√	√		151	√	√	√*
05 - Monadnock	0	0	0	0	2				10	√	√	√
06 - Nashua	18	0	18	0	2	√		√	23	√	√	√*
07 - Manchester	33	30	63	0	0	√	√	√	12	√	√	
08 - Seacoast	30	12	42	0	0				8	√	√	√
09 - Comm. Partners	20	0	20	0	0				0	√	√	√
10 - Cntr Life Mgmt	81	0	81	20	0				0	√		
TOTAL	238	52	458	44	8				276			

* Denotes juvenile court; Source for mental health and drug court locations: <https://www.courts.state.nh.us/drugcourts/locations.htm>

Hospitals: **Region 01:** Cottage Hospital; Huggins Hospital; Memorial Hospital; Upper Connecticut Valley Hospital; Weeks Medical Center; **Region 02:** Alice Peck Day Memorial Hospital; Dartmouth Hitchcock Medical Center; **Region 03:** Lakes Region General Hospital; Spears Memorial Hospital; **Region 04:** Concord Hospital; Franklin Regional Hospital; New Hampshire Hospital; New London Hospital; **Region 05:** Cheshire Medical Center; **Region 06:** Southern New Hampshire Medical Center; St. Joseph Hospital; **Region 07:** Cypress Center; Elliot Hospital; **Region 08:** Exeter Hospital; Portsmouth Regional Hospital; **Region 09:** Frisbie Memorial Hospital; Wentworth-Douglass Hospital; **Region 10:** Hampstead Hospital; Parkland Medical Center.

Peer Support Agencies: **Region 01:** ALC – Berlin; ALC – Colebrook; ALC – Conway; ALC – Littleton; ALC - Wolfeboro Outreach; **Region 02:** The Stepping Stone Drop-In Center Association – Claremont; The Stepping Stone Drop-In Center Association – Lebanon; **Region 03:** Lakes Region Consumer Advisory Board – Laconia; Lakes Region Consumer Advisory Board – Plymouth Outreach; **Region 04:** Lakes Region Consumer Advisory Board – Concord; **Region 05:** Monadnock Area Peer Support Agency; **Region 06:** H.E.A.R.T.S. Peer Support Center of Greater Nashua; **Region 07:** On The Road To Recovery – Manchester; **Region 08:** Connections Peer Support Center – Portsmouth; **Region 09:** Tri-City Consumers' Action Co-operative – Rochester; **Region 10:** On The Road To Recovery – Derry.

Mental Health and Drug Courts: **Region 01:** Mental Health Court, Alternative Sentencing Solutions for Education, Recovery and Treatment (ASSERT) – Littleton; **Region 02:** Adult Felony Drug Court, Grafton Superior Court – North Haverhill; Mental Health Court, Halls of Hope – Lebanon; **Region 03:** Mental Health Court,

Circuit Court District Division – Plymouth; Adult Recovery Court, Circuit Court District Division – Laconia; Juvenile Drug Court, Circuit Court District Division – Laconia; **Region 04:** Mental Health Court, Circuit Court District Division – Concord; Juvenile Drug Court, Circuit Court District Division – Concord; **Region 05:** Mental Health Court, Circuit Court District Division – Keene; Adult Felony Drug Court, Cheshire Superior Court – Keene; **Region 06:** Mental Health Court, Circuit Court District Division – Nashua; Juvenile Drug Court, Circuit Court District Division – Nashua; **Region 07:** Mental Health Court, Circuit Court District Division – Manchester; **Region 08:** Mental Health Court, Circuit Court District Division – Brentwood; Mental Health Court, Circuit Court District Division – Portsmouth; Adult Felony Drug Court, Rockingham Superior Court – Brentwood; **Region 09:** Mental Health Court, Circuit Court District Division – Rochester; Adult Felony/Misdemeanor Drug Court, Strafford Superior Court – Dover.

Exhibit 4. Inpatient Psychiatric Bed Capacity by CMHC Region

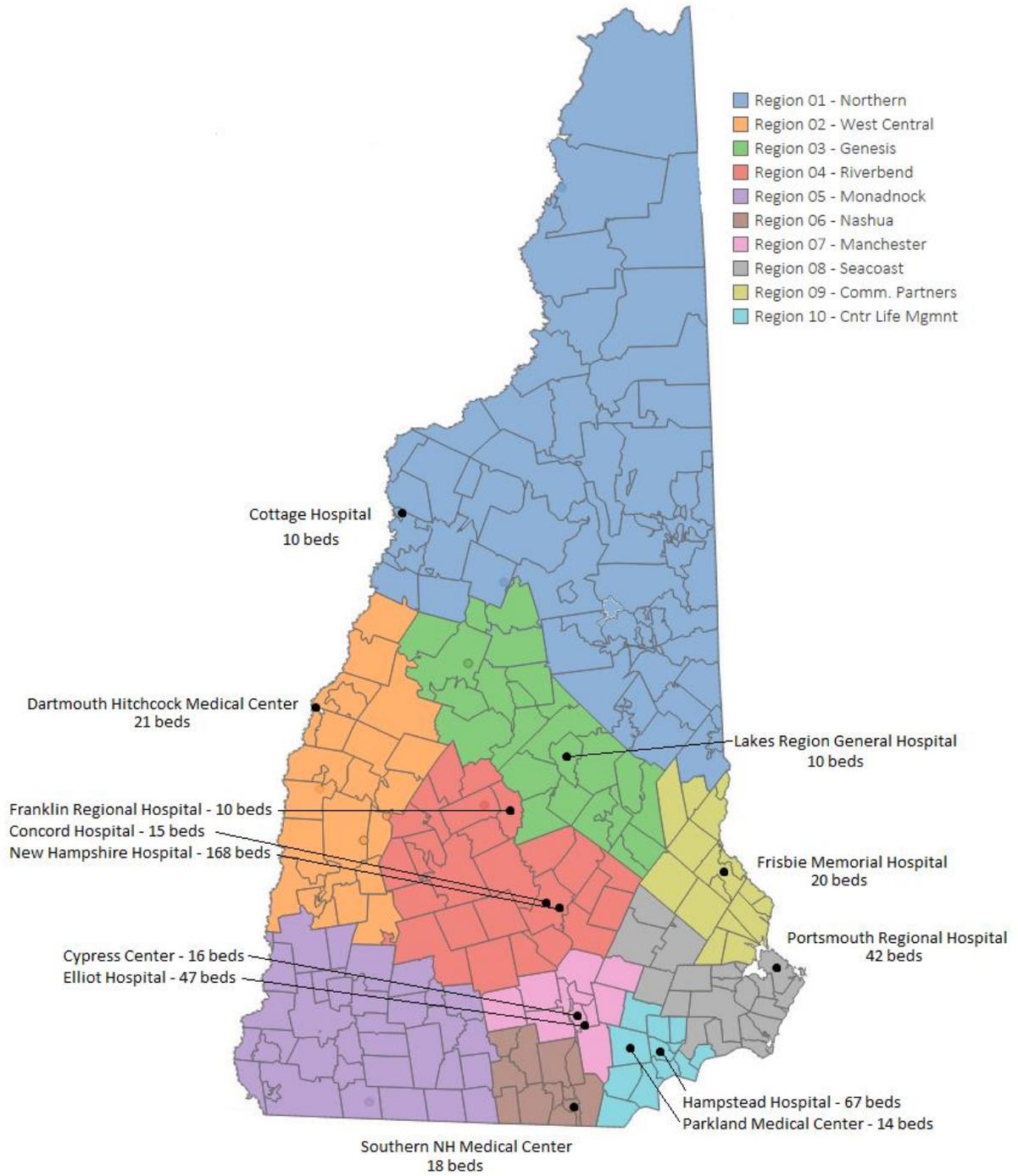


Exhibit 5. Peer Support Agencies and Peer-Run Crisis Respite Programs by CMHC Region

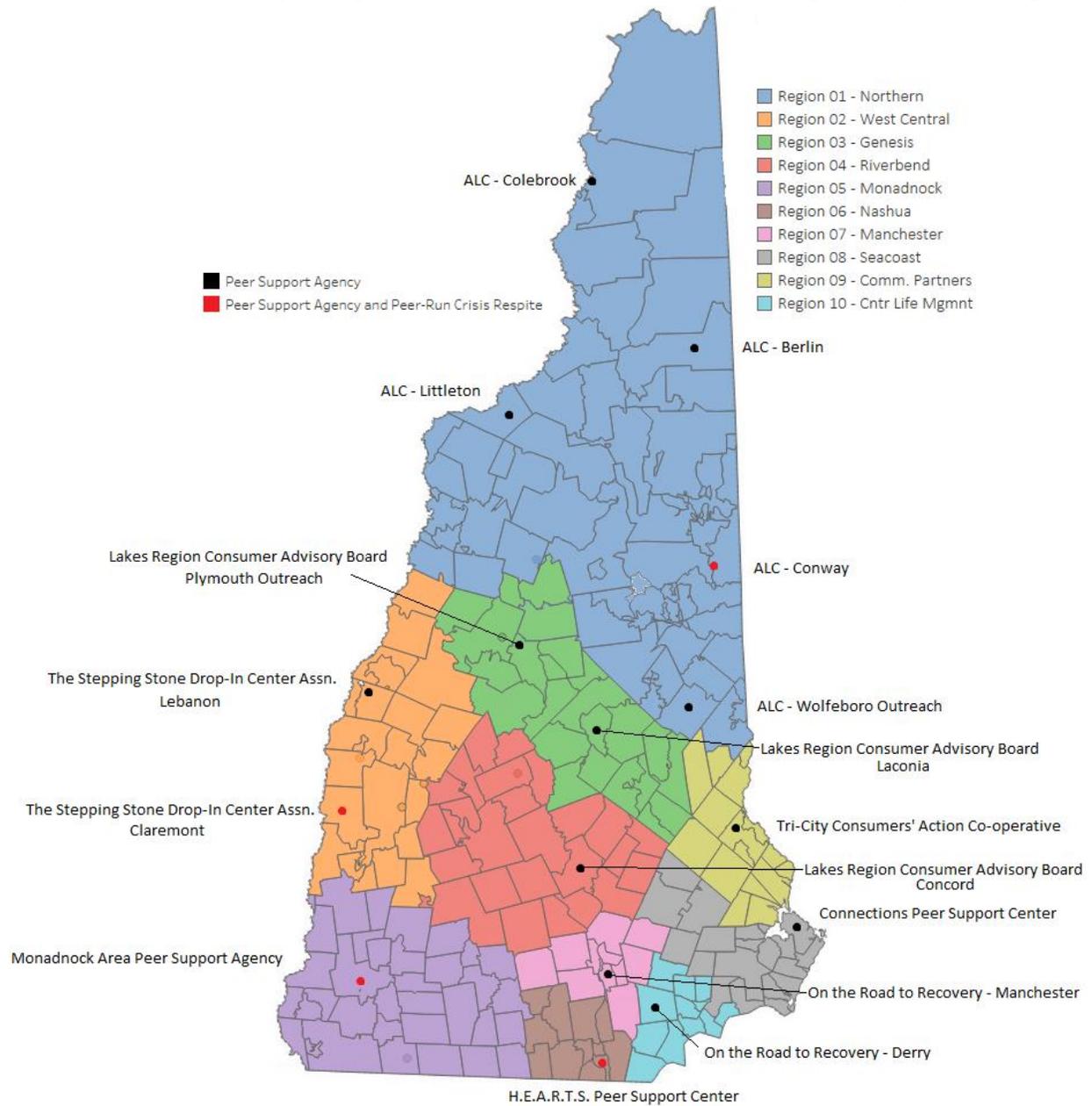


Exhibit 6. Mobile Crisis Response Teams by CMHC Region

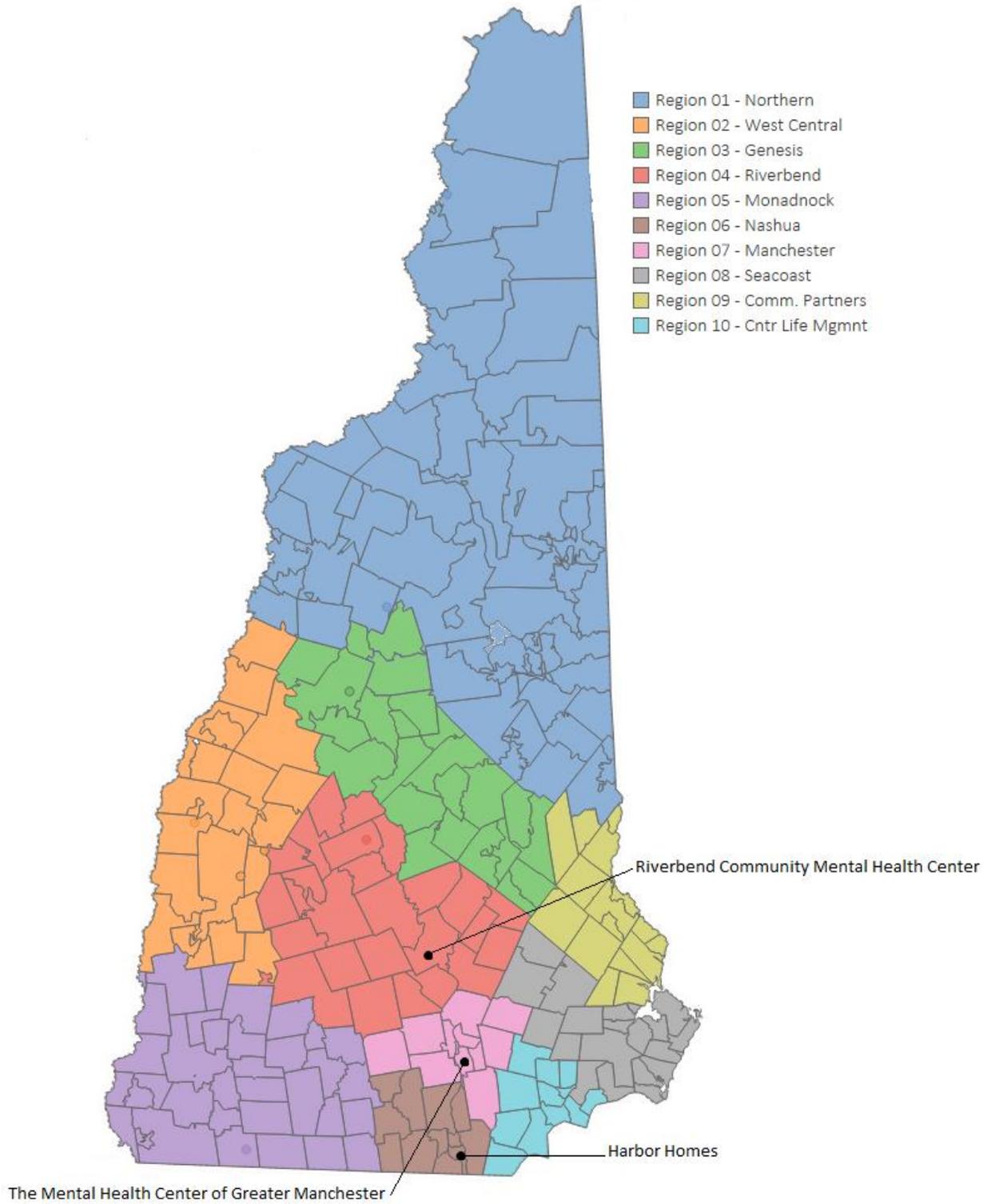


Exhibit 7. CMHC Housing Programs and Supported Housing by CMHC Region

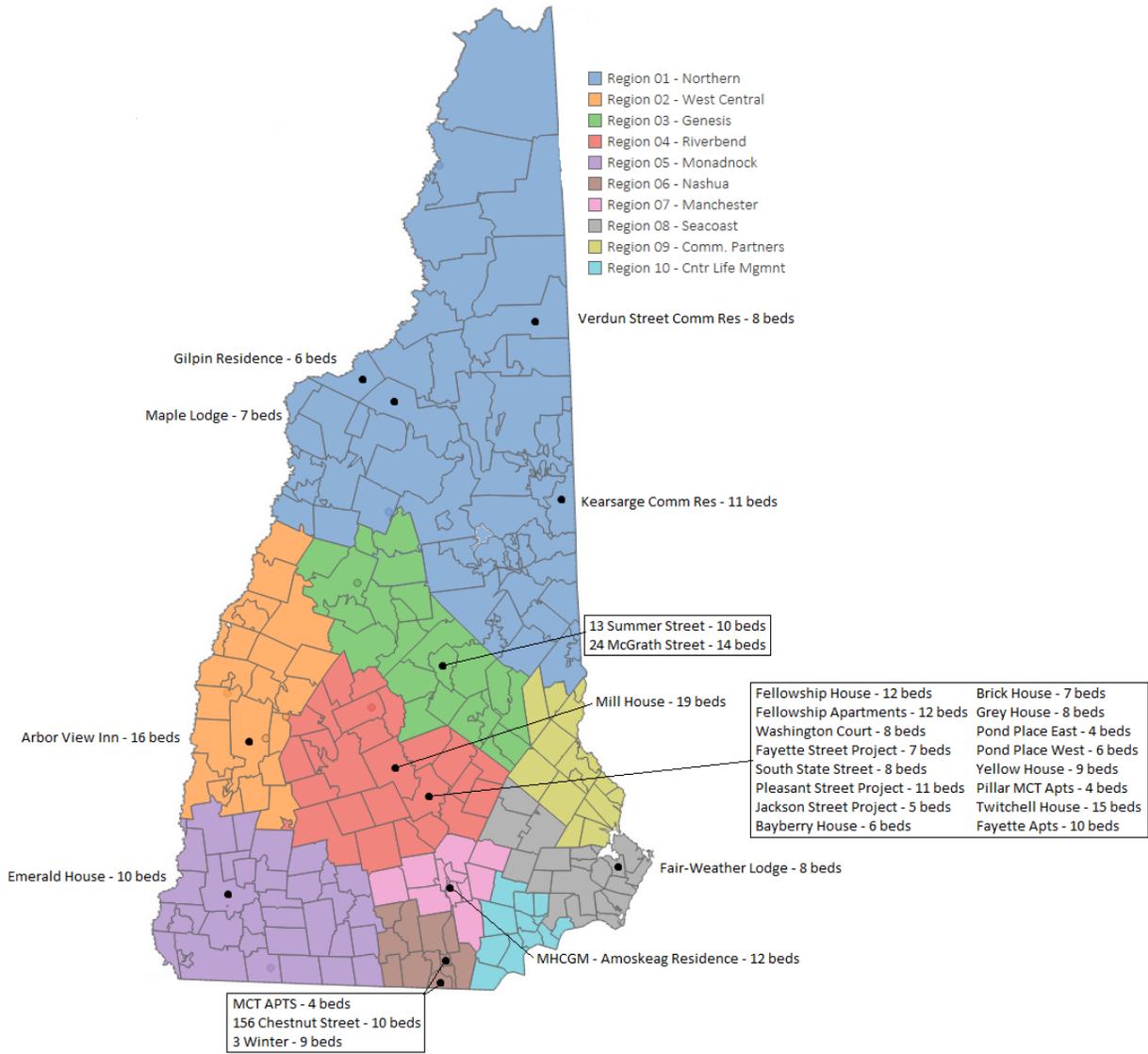
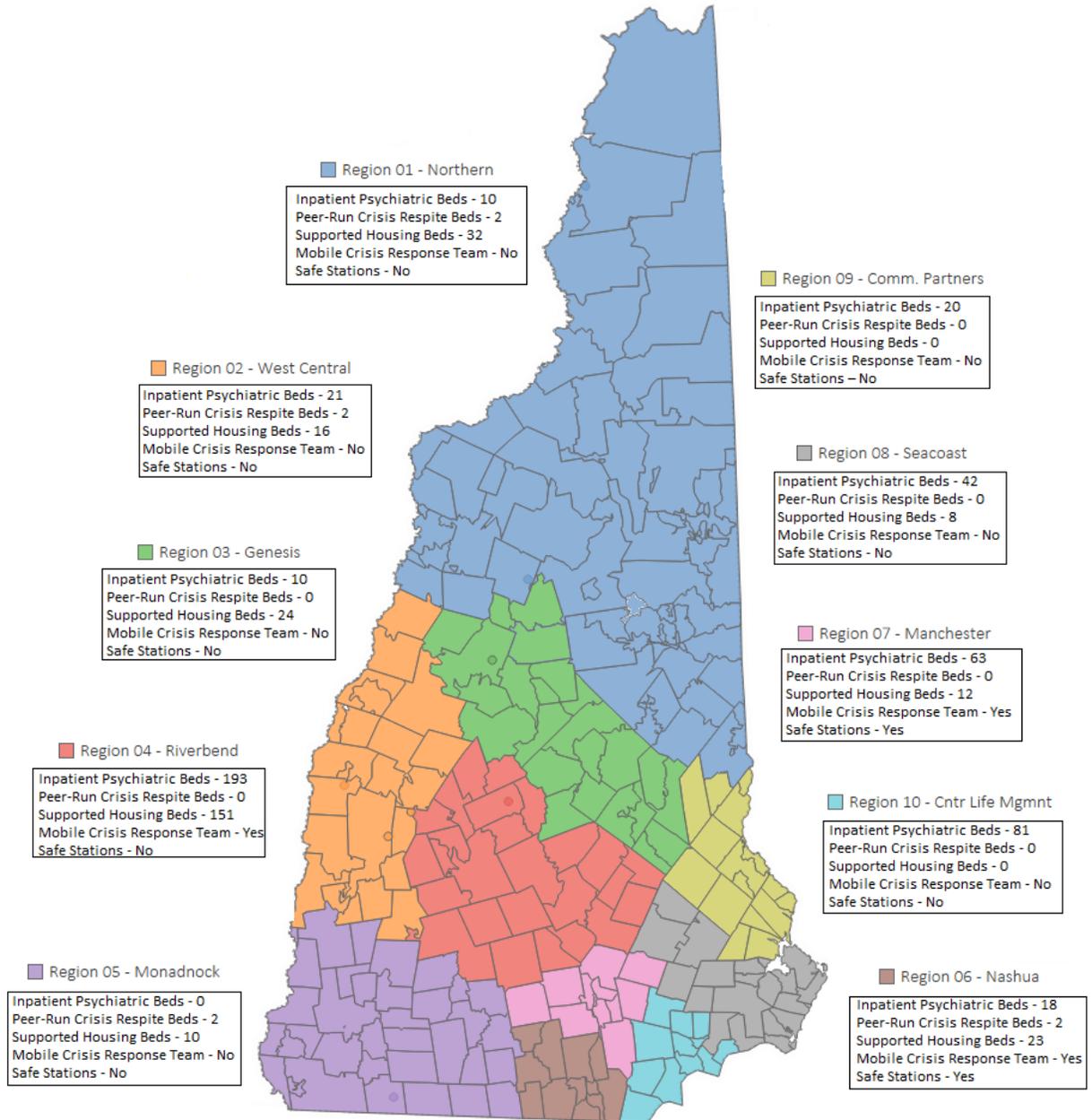


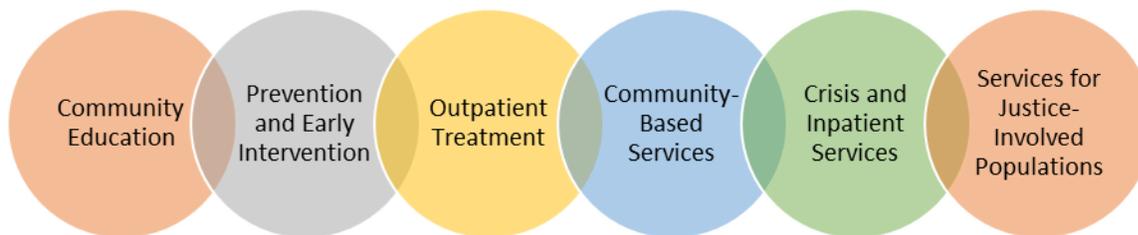
Exhibit 8. Services by CMHC Region



4. System of Care Gap Analysis

In this section, we discuss apparent gaps, based on available evidence, in what would be an optimal continuum of care, as diagrammed in Exhibit 9. The focus is on inpatient and outpatient service gaps that are likely to contribute to ED boarding times and which, if addressed, would likely reduce the extent of boarding. However, we also discuss some possible enhancements to the service system that would likely improve the quality of care and treatment outcomes regardless of any effect on ED boarding. Furthermore, we also discuss here, and in the Recommendations section that follows, what key informants have identified as bottlenecks or “choke points”: a discontinuity or inefficiency that blocks the progress of consumers through appropriate levels of care.

Exhibit 9. A Good and Modern Behavioral Health System



Emergency Room Boarding as Symptom

ED boarding is ipso facto evidence of shortcomings in the behavioral health system. It is, however, a complex, nationwide problem, determined by multiple factors that are not fully understood despite considerable attention from researchers and policy makers (Pearlmutter, Dwyer et al. 2017). Regardless of this complexity, inpatient capacity, if not the only explanation, is a contributing factor. The historic trend of deinstitutionalization has resulted in a decrease in the number of inpatient and residential psychiatric beds for state and county mental hospitals from approximately 400,000 nationwide in 1970 to 50,000 in 2006, a loss only partially offset by an increase of an additional 50,000 private and general hospital psychiatric beds (Tuttle 2008). It is widely recognized, however, that the decrease in the number of beds is only half the story of the problems with the mental health system today; the other half is the failure to fully implement the array of outpatient services and supports that were intended to supplant the need for inpatient care (Grob and Goldman 2007). As a consequence, psychiatric crises are more likely to occur, and because there is a lack of alternatives to ED use to address them when they do occur, the result is greater ED utilization, in turn leading to greater demand for a limited supply of finite beds and thereby to an increase in ED boarding. In that sense, ED boarding may be a symptom of shortcomings or limitations at any point in the continuum of care represented in Exhibit 9.

While data limitations prevent a precise quantification of the amount to which the shortcomings at any one stage in this progression contribute to the demand for inpatient beds and the consequent problem of ED boarding, the data we have analyzed, the documents we have reviewed, and the testimony of key informants all suggest there are opportunities to enhance and improve the system at every stage.

Our analysis of gaps and bottlenecks and our corresponding recommendations are organized into three broad areas of action reflecting the stages of progression through the continuum of care: prevention (reduction in the incidence of psychiatric crises), diversion (alternatives to ED and inpatient treatment when crises do occur) and disposition (outpatient capacity to provide for discharge from the ED to the community and inpatient capacity to accommodate appropriate admissions).

ED Utilization for Behavioral Health in New Hampshire

As mentioned, we were unable to obtain data on the characteristics of people boarding in EDs. Exhibit 10 shows the number of ED encounters (not resulting in hospital admission) and number of unique (unduplicated) persons presenting to the ED, overall, and with a behavioral health diagnosis in SFY 2017. These data are from the Automated Hospital Emergency Department Data (AHEDD) dataset, maintained by the Division of Public Health for real-time surveillance purposes. Statewide, there were nearly 80,000 ED encounters involving a behavioral health (mental health or SUD) diagnosis. At Concord Hospital, 8,546 individuals with a behavioral health diagnosis were seen in the ED, and nearly 8,000 were seen at Wentworth-Douglas Hospital. As mentioned previously, these data do not present a complete picture of ED visits or the issue of ED boarding, but provide a sense of the volume statewide where interventions such as crisis alternatives could help to reduce reliance on the ED for mental health issues. The graphs following the table present data by CMHC region.

Exhibit 10. Total Emergency Department Encounters, Not Resulting in Admission, By Hospital, SFY 2017

CMHC Region	Hospital Name	ED Encounters for Any Diagnosis		ED Encounters with Behavioral Health Diagnosis	
		Num. of Encounters	Num. of Individuals	Num. of Encounters	Num. of Individuals
01	Androscoggin Valley Hospital	7,875	4,542	610	439
01	Cottage Hospital	3,075	1,979	11	10
01	Huggins Hospital	9,817	6,187	1,193	940
01	Littleton Regional Hospital	7,783	4,851	1,370	948
01	Memorial Hospital	7,483	4,568	997	754
01	Upper Connecticut Valley Hospital	3,574	1,971	160	130
01	Weeks Medical Center	4,858	2,930	739	557
02	Alice Peck Day Memorial Hospital	4,006	2,695	865	672
02	Dartmouth Hitchcock Medical Center	16,352	11,803	763	612
02	Valley Regional Hospital	9,575	5,652	1,167	906

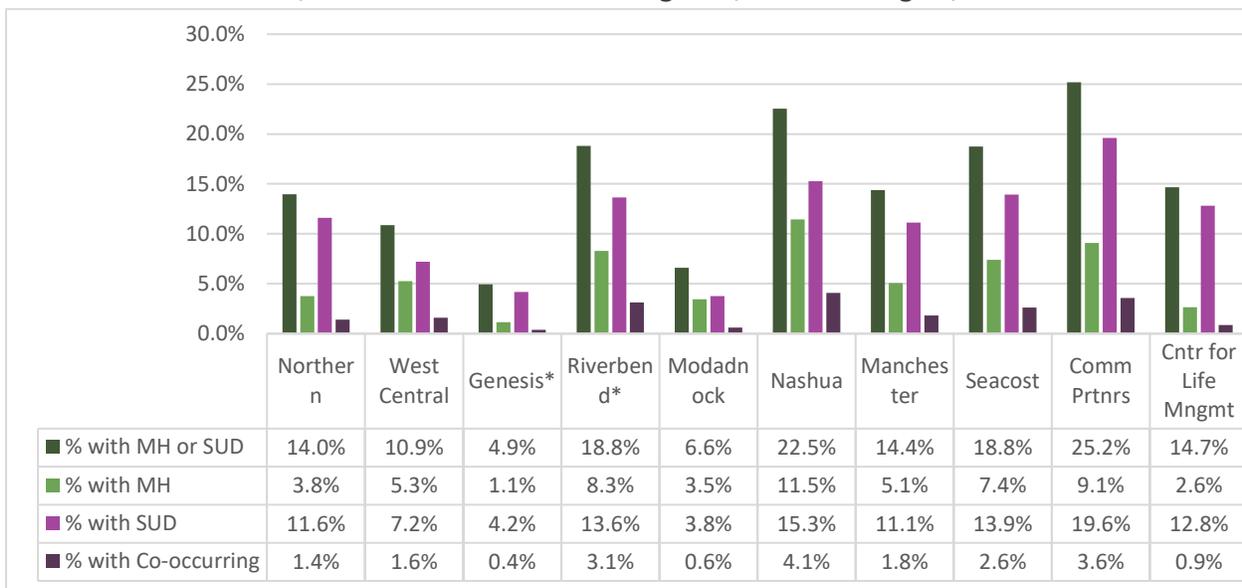
CMHC Region	Hospital Name	ED Encounters for Any Diagnosis		ED Encounters with Behavioral Health Diagnosis	
		Num. of Encounters	Num. of Individuals	Num. of Encounters	Num. of Individuals
03	Lakes Region General Hospital	18,194	11,127	N/A	N/A
03	Speare Memorial Hospital	9,740	6,398	1,065	867
04	Concord Hospital	63,790	37,279	12,668	8,546
04	Franklin Regional Hospital	7,735	4,761	N/A	N/A
04	New London Hospital	6,991	4,562	255	217
05	Cheshire Medical Center	21,349	12,674	1,072	810
05	Monadnock Community Hospital	11,833	7,519	621	521
06	Southern New Hampshire Medical Center	40,421	24,177	10,566	6,262
06	St. Joseph Hospital	22,784	14,616	3,411	2,479
07	Catholic Medical Center	34,350	23,052	7,659	5,466
07	Elliot Hospital	55,358	34,745	4,250	2,842
08	Exeter Hospital	28,651	18,573	6,080	4,297
08	Portsmouth Regional Hospital	20,647	13,362	2,263	1,694
09	Frisbie Memorial Hospital	24,336	16,487	6,267	4,301
09	Wentworth-Douglass Hospital	56,547	32,299	12,608	7,982
10	Parkland Medical Center	21,755	14,201	2,721	2,083

N/A: Franklin Regional Hospital and Lakes Region General Hospital did not submit ICD codes in their datasets.

Note: Franklin Regional Hospital, Lakes Region General Hospital and Speare Memorial Hospital did not submit ED data after April 2017, therefore, the total numbers may be undercounted.

Source: Automated Hospital Emergency Department Data (AHEDD), SFY 2017, Division of Public Health Services.

Exhibit 11. Percentage of Individuals Seen at Hospital Emergency Departments, Not Resulting in Admission, with a Behavioral Health Diagnosis, BY CMHC Region, SFY 2017

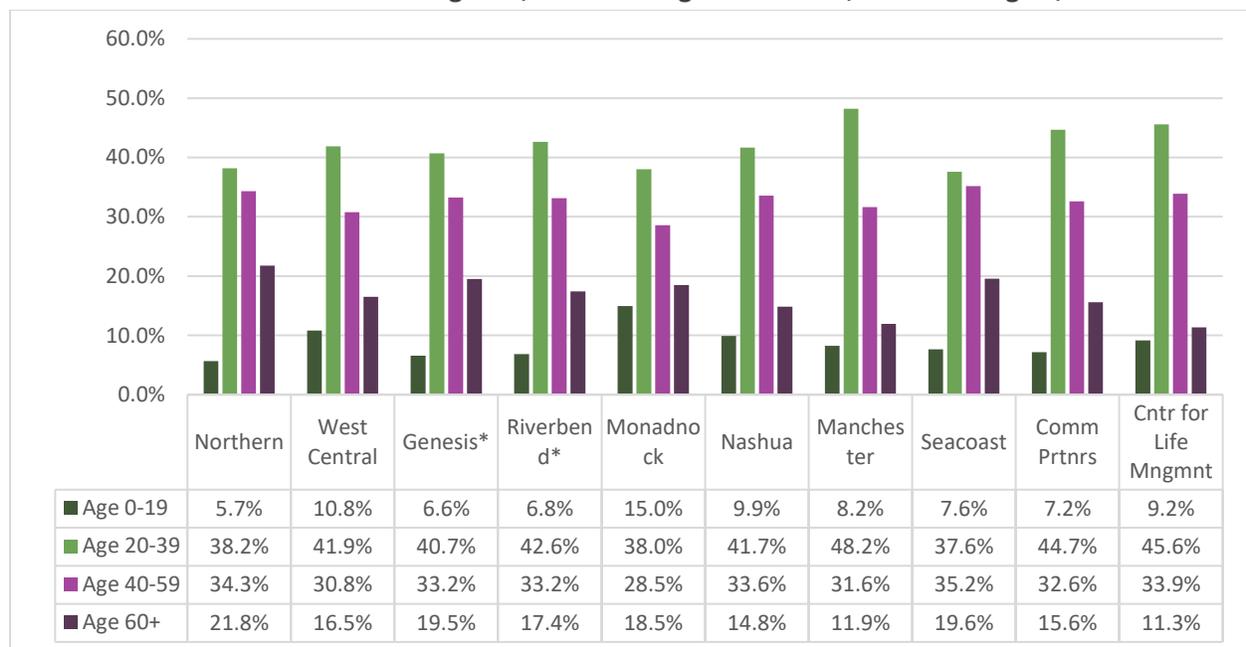


*Note: Franklin Regional Hospital (Riverbend) and Lakes Region General Hospital (Genesis) did not submit ICD-9 codes in their datasets and therefore are not included.

Source: Automated Hospital Emergency Department Data (AHEDD), SFY 2017, Division of Public Health Services.

One quarter of individuals seen at the two hospitals in CMHC Region 9-Community Partners (Frisbie Memorial and Wentworth-Douglas), not resulting in hospital admission, had a behavioral health diagnosis. Nearly one quarter (22.5%) in Region 6-Nashua (Southern New Hampshire Medical Center and St. Joseph’s) had a behavioral health diagnosis. SUD diagnoses were more common in most regions. Over 10% of individuals seen in Nashua hospitals had a mental health diagnosis. Exhibit 12, below, shows the age breakdown of individuals seen at EDs with a behavioral health diagnosis.

Exhibit 12. Percentage of Individuals by Age Group Presenting to Hospital Emergency Departments with a Behavioral Health Diagnosis, Not Resulting in Admission, BY CMHC Region, SFY 2017



*Note: Franklin Regional Hospital (Riverbend) and Lakes Region General Hospital (Genesis) did not submit ICD-9 codes in their datasets and therefore are not included.

Source: Automated Hospital Emergency Department Data (AHEDD), SFY 2017, Division of Public Health Services.

Crises Prevention

Numerous key informants remarked about the gradual dismantling of a once-robust continuum of care available within the community. Many spoke about the glory days of the mid to late 90s, when New Hampshire’s system was often held up as a model for other states. Since that time, services have steadily eroded. Many noted that reimbursement rates for CMHCs have not increased since the mid-2000s, with reimbursement actually dropping below those levels in some cases. Nearly all key informants interviewed saw the cause of the ED boarding being rooted in the lack of available community support services that help individuals function well in the community, avoiding many crises situations to begin with and providing options for more intensive services within the community rather than inpatient beds being the only resort. Some attributed the resource-starving to changes in the

political climate and increased emphasis on fiscal responsibility, others to general stigma and discrimination, noting that such cuts in funding and services would not be tolerated if occurring to individuals with other medical conditions such as cancer or heart disease.

People Served by CMHCs

Exhibit 13 provides an overview of the characteristics of people served by CMHCs across the state in SFY 2016 and SFY 2017. Overall, 44,307 unique (unduplicated) people were served in 2016, and slightly fewer, 42,087 in 2017. Over a quarter of those served were youth. Just over half (55%) were female. Approximately 95% were White. The majority of those served had public insurance (Medicaid and/or Medicare), and roughly one quarter had private insurance. The percentage of people served who were uninsured was 17% in SFY 2016 and went down to 15% in 2017.

Exhibit 13. Characteristics of Unduplicated People Served by CMHCs, SFY 2016 & 2017

	SFY 2016		SFY 2017	
	N	%	N	%
Total Served	44,307	-	42,087	-
Age				
0-17 years	11,709	26.4%	11,454	27.2%
18-24 years	4,942	11.2%	4,646	11.0%
25-64 years	24,565	55.4%	23,040	54.7%
65+ years	3,091	7.0%	2,947	7.0%
Gender				
Male	19,774	44.8%	18,842	44.9%
Female	24,371	55.2%	23,121	55.1%
Race				
American Indian or Alaska Native	194	0.5%	181	0.5%
Asian	196	0.5%	220	0.6%
Black or African American	628	1.6%	624	1.7%
Native Hawaiian or Pacific Islander	10	0.0%	18	0.0%
White	36,715	95.1%	34,954	94.7%
More Than One Race	884	2.3%	896	2.4%
Ethnicity				
Hispanic/Latino	1,614	4.7%	1,623	4.9%
Non-Hispanic/Latino	32,740	95.3%	31,586	95.1%
Insurance Status				
Public Insurance	19,717	54.8%	21,073	56.0%
Private Insurance	8,922	24.8%	9,575	25.4%
Combination Public and Private	1,111	3.1%	1,322	3.5%
Uninsured	6,205	17.3%	5,675	15.1%

Exhibits 14 through 16 display the regional variation in numbers served and demographics by CMHC.

Exhibit 14. Number Served by CMHC, SFY 2016 and 2017

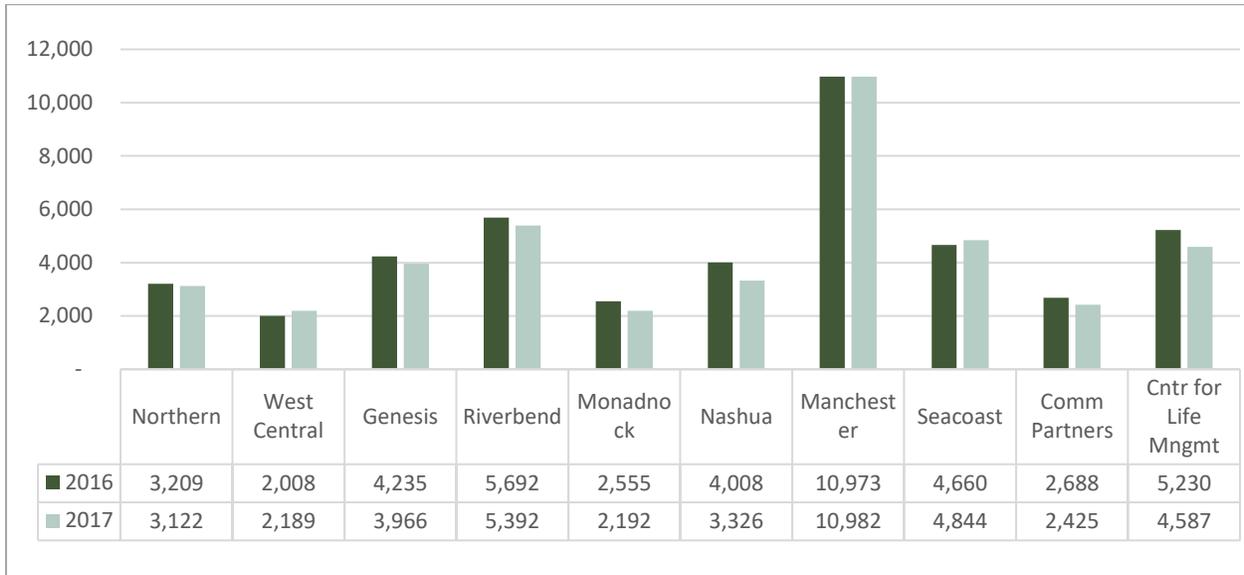


Exhibit 15. Percentage of Total Served by Age Group, SFY 2017

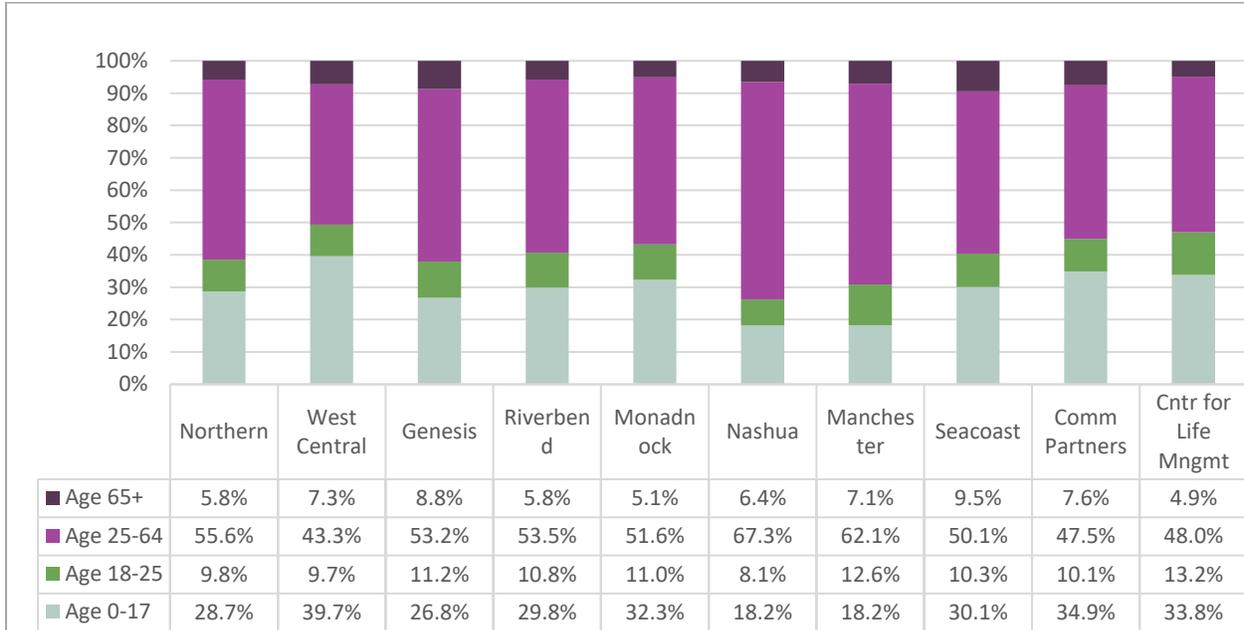
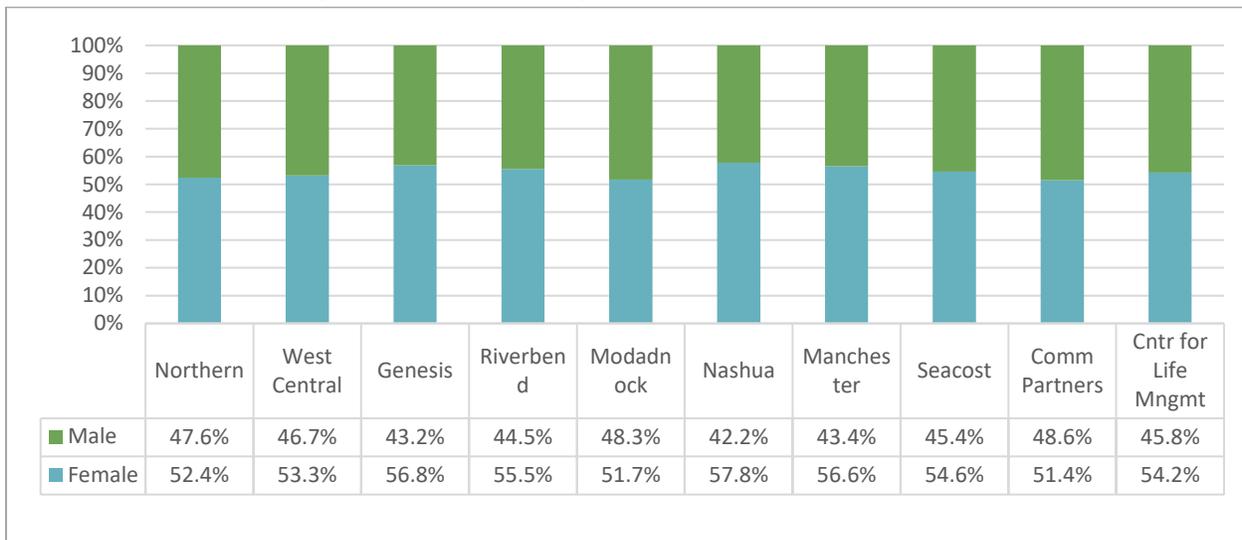


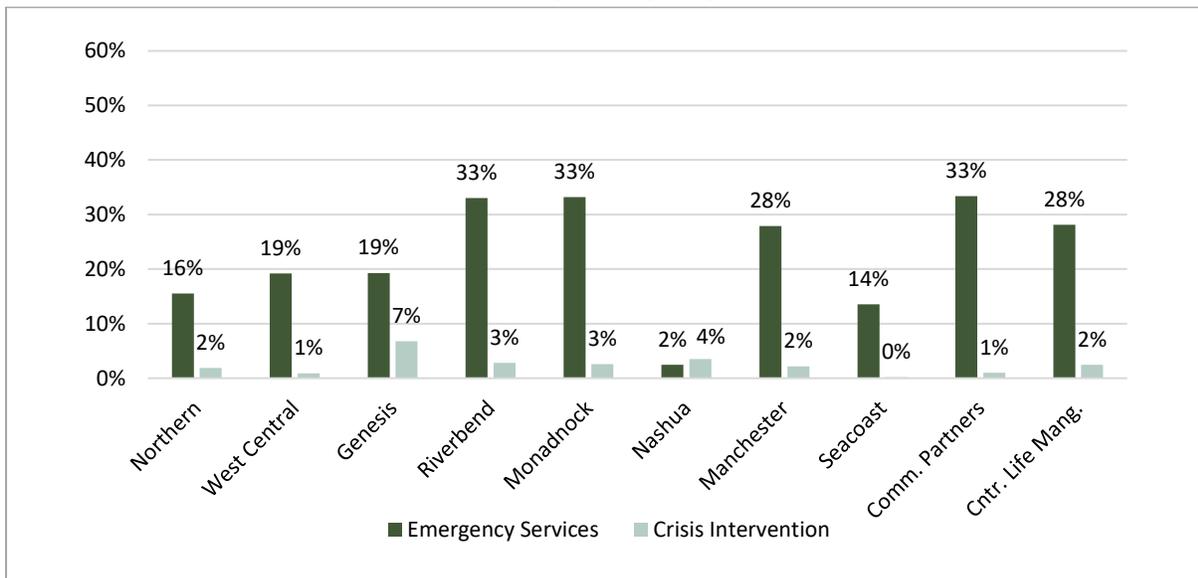
Exhibit 16. Percentage of Total Served by Gender, SFY 2017



As the above exhibits demonstrate, in most CMHCs the number of individuals served remained roughly the same from 2016 to 2017; a few even experienced a slight decrease. This indicates that the increase in demand for inpatient beds and usage of EDs is not simply the result of more individuals within the community mental health centers being served. Manchester and Riverbend serve the largest number of individuals, West Central, Monadnock, and Community Partners the fewest. Of note, West Central and the Center for Life Management serve a large proportion of transition-aged individuals and youth: youth aged 0-25 composed nearly 50% of those served in 2017. Consequently, any expansion of or piloting of youth-oriented interventions should begin with these centers, as their client population is most apt to benefit from such interventions.

Exhibit 17 shows the percentage of people served who received emergency services and crisis intervention by CMHC (shown are only billable emergency services). Notably, around one third of people served in regions 4 (Riverbend), 5 (Monadnock), 7 (Manchester), 9 (Community Partners) and 10 (Center for Life Management) received emergency services in SFY 2017. The proportion was much smaller at 2% in region 6 (Nashua). This could be due to a difference in reporting of services, which should be explored. The proportion of people served who received crisis intervention services was much smaller, totaling approximately 2% or 3% in most regions, and highest at 7% in region 3 (Genesis). Appendix D includes tables summarizing service utilization for each of the 10 CMHCs in SFY 2017.

Exhibit 17. Percent of Clients Served by Emergency Services & Crisis Intervention, SFY 2017



Identified Community-Based Service Gaps

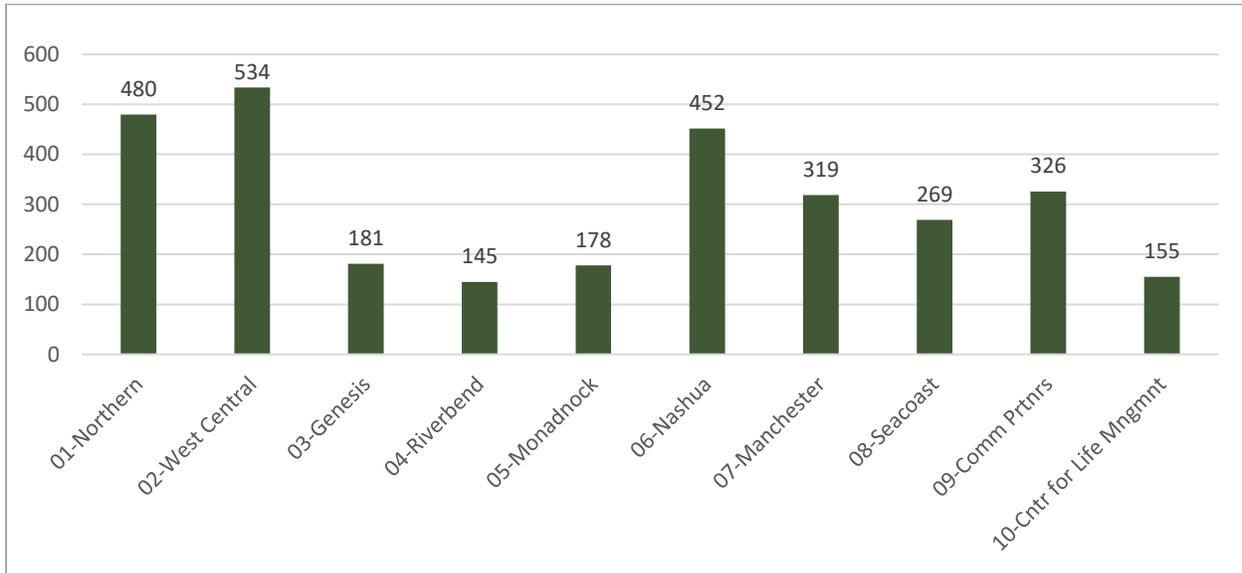
There were a number of specific services identified through our review of data and key informant interviews that were not currently being offered in sufficient amounts—or for which there appeared to be a general consensus that more of these types of services were needed to help individuals avoid crises and inpatient hospitalization. These services and the findings related to them are summarized below.

Peer Support

In 2016, New Hampshire BBH had contracts with eight non-profit Peer Support Agencies (PSAs) operating in 14 locations (New Hampshire Bureau of Behavioral Health Services 2017). Together the PSAs provided on-site support services, several mobile outreach teams, a transitional living program, and beginning in 2016, four peer-run Planned Respite Programs. Intentional Peer Support and Wellness Recovery and Action Plans are core practices, with staff trained in these approaches at all sites.

As Exhibit 18 shows, the PSAs had more than 3,000 peer members in 2016; of these, 1,900 were adults with serious mental illness in 2016. Almost two-thirds of those responding to a survey of those served by PSAs indicated they had been previously hospitalized for psychiatric reasons. Almost 14% of these respondents reported having been hospitalized five or more times. The same survey found that individuals overwhelmingly found peer support services in New Hampshire to be effective; 81% of 295 respondents agreed or strongly agreed with the statement “This peer support center helped prevent emotional difficulties from turning into psychiatric crises in the past 6 months.” (New Hampshire Bureau of Behavioral Health Services 2017).

Exhibit 18. Unduplicated Number of Peer Support Members, by Region, SFY 2016



Source: DHHS Statewide Peer Support Services, SFY 2016; 'Lakes Region Consumer Advisory Board - Plymouth Outreach' was counted as Region 03, and 'Lakes Region Consumer Advisory Board- Concord' as Region 04.

Key informants indicated that while there had been efforts to expand peer support services, such as the four peer respite beds, they also noted that recent efforts to expand services further were not successful, noting that funding for two additional peer respite programs in the most recent DHHS budget had been redirected at the last minute toward other purposes. The need was emphasized for ongoing education of both the behavioral health workforce and peer specialists themselves about what the role of a peer specialist is and the types of activities they can perform. Currently, some peer specialists are used as case aids, for transportation, or for medication delivery—and in some cases viewed as mini-clinicians, informally assessing mental status—rather than as individuals in a unique role. Individualized Peer Support (IPS) was emphasized as the model of peer support that more individuals should be trained in, with efforts to train more trainers in the model stressed as being key. Individuals also spoke of the need to make peer services Medicaid billable rather than relying largely on SAMHSA MH Block Grant funding, as is the current practice; adoption of the IPS model was viewed as facilitating the eventual shift to making the peer supports billable. Multiple individuals also spoke of the need to create a formal credentialing system for Mental Health peer supports, possibly using the Recovery Coach program of BDAS as an approach to follow. Currently the Office of Consumer Affairs is taking a leading role on peer certification in the state; however, the office consists of a single individual with a wealth of other responsibilities. Key informants also noted some novel ways that peer support was being used; one individual noted the use of Mental Health First Aid trained inmates to provide supports to individuals on suicide watch in a corrections setting. The involvement of a peer specialist in discharge planning meetings at New Hampshire Hospital was noted as a strength; however, there is a single peer specialist position for the entire hospital. Expanded availability of the peer support warm line was also

mentioned as a useful service; through this service, peer specialists had personally helped an individual avoid crises on numerous occasions, or helped de-escalate when they were in crisis to a point that ED visits were avoided. The peer support warm line is currently unavailable during the overnight hours, when individuals usually find it most helpful.

Intermediate Intensity/Step Up Options

Numerous key informants identified the lack of intermediate intensity or step-up service options as a glaring gap in the service system. It was noted that people generally only have two choices: either survive with the usual CMHC services, or, if that doesn't work, go to an ED or seek an inpatient bed, even though an inpatient bed might not be truly needed. Individuals noted the loss of intensive outpatient and partial hospitalization programs; while some partial hospitalization programs do still exist, transportation issues often bar individuals from accessing those programs if they are not in the immediate geographical area.

Housing/Supports in Housing

A lack of affordable housing units in general as well as of supported housing programs for individuals with behavioral health challenges were both strongly emphasized as gaps in the system. On the prevention side, individuals noted that there are not enough options for receiving in-home supports. Individuals frequently have to be able to get to and from the local CMHC to receive services, which can become more difficult the more one begins to struggle. Increased availability of mobile clinical and supportive services that could be provided in-home were viewed as helping individuals better stabilize within the community, thereby avoiding visits to EDs or decompensating to the point of requiring inpatient care.

Exhibit 19 shows the CMHC Housing programs and supported housing beds, as identified by DHHS in October 2017. It is notable that over half of the housing programs and supported housing beds are located in a single CMHC region, region 4. While a concentration of supported housing beds in populated and more service-rich areas is to be expected, it is striking that the Manchester area, whose CMHC serves twice the number of people as the Concord area CMHC, has only 12 contracted beds compared to Concord's 151. Though this list is CMHC contracted housing, meaning it may not represent all available housing in a given region, it clearly indicates there is a critical need for more availability of supported housing units across CMHC regions.

Exhibit 19. CMHC Housing Programs and Supported Housing

CMHC Region	CMHC Vendor	Program Name	Town/City	Number of Beds
1	NFI/THS	MAPLE LODGE	BETHLEHEM	7
1	NHS	GILPIN RESIDENCE	LITTLETON	6
1	NHS	KEARSARGE COMM RES	N. CONWAY	11
1	NHS	VERDUN STREET COMM RES	BERLIN	8
2	WCBH	ARBOR VIEW INN	NEWPORT	16
3	GBH	24 MCGRATH STREET	Laconia	14
3	GBH	13 SUMMER STREET	Laconia	10
4	FELLOWSHIP HOUSING	FELLOWSHIP HOUSE	CONCORD	12
4	FELLOWSHIP HOUSING	FELLOWSHIP APARTMENTS	CONCORD	12
4	FELLOWSHIP HOUSING	WASHINGTON COURT	CONCORD	8
4	FELLOWSHIP HOUSING	FAYETE STREET PROJECT	CONCORD	7
4	FELLOWSHIP HOUSING	SOUTH STATE STREET	CONCORD	8
4	FELLOWSHIP HOUSING	PLEASANT STREET PROJECT	CONCORD	11
4	FELLOWSHIP HOUSING	JACKSON STREET PROJECT	CONCORD	5
4	NFI/THS	BAYBERRY HOUSE	CONCORD	6
4	NFI/THS	BRICK HOUSE	CONCORD	7
4	NFI/THS	GREY HOUSE	CONCORD	8
4	NFI/THS	POND PLACE EAST	CONCORD	4
4	NFI/THS	POND PLACE WEST	CONCORD	6
4	NFI/THS	YELLOW HOUSE	CONCORD	9
4	RIVERBEND	PILLAR MCT APTS	CONCORD	4
4	RIVERBEND	TWITCHELL HOUSE	CONCORD	15
4	RIVERBEND	FAYETTE APTS	CONCORD	10
4	RIVERBEND	MILL HOUSE	BOSCAWEN	19
5	MFS	EMERALD HOUSE	KEENE	10
6	HARBOR HOMES	MCT APT 1	NASHUA	1
6	HARBOR HOMES	MCT APT 2	NASHUA	1
6	HARBOR HOMES	MCT APT 3	NASHUA	1
6	HARBOR HOMES	MCT APT 4	NASHUA	1
6	HARBOR HOMES	156 CHESTNUT ST	NASHUA	10
6	HARBOR HOMES	3 WINTER	NASHUA	9
7	MHCGM	MHCGM - AMOSKEAG RESIDENCE	MANCHESTER	12
8	SMH	FAIR-WEATHER LODGE	GREENLAND	8
TOTAL				276

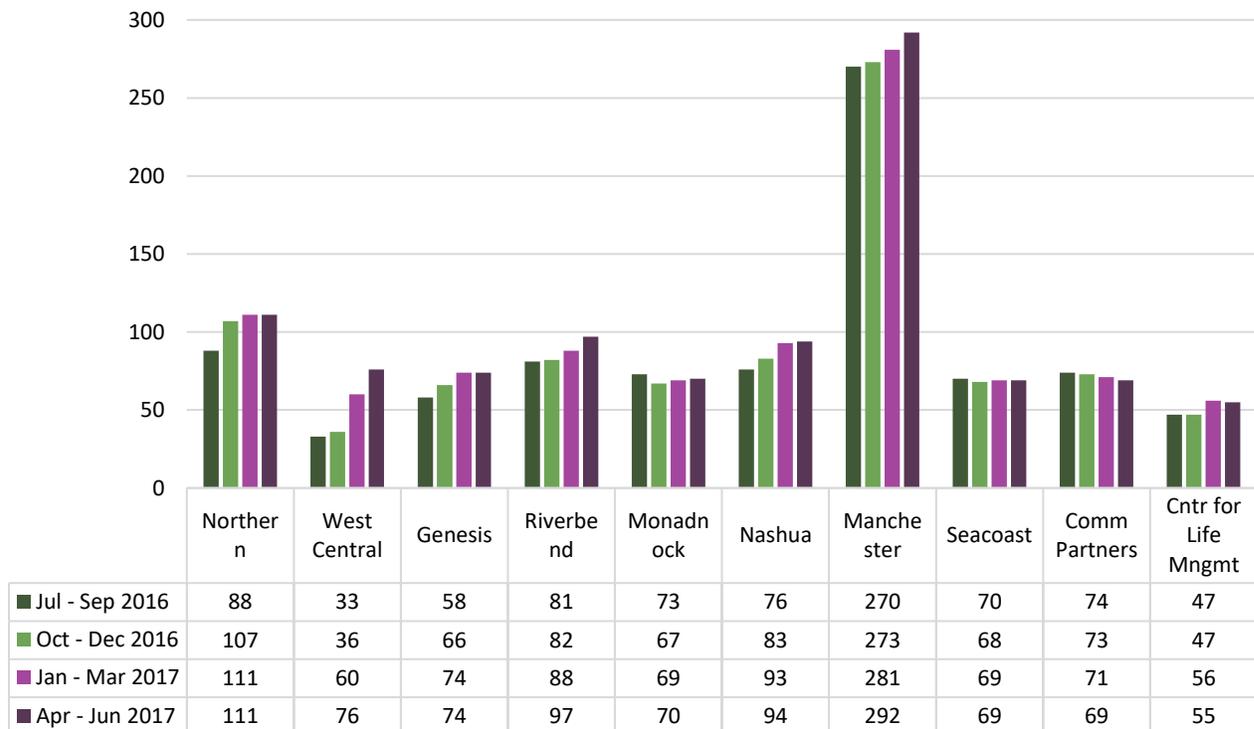
Source: NH DHHS, Bureau of Mental Health Services, Received October 18, 2017

Assertive Community Treatment (ACT)

As one of the core services emphasized in the Community Mental Health Agreement, the expansion of ACT services has been a recent point of focus in New Hampshire. As with other intensive community services, ACT in New Hampshire had once been a robust intervention with outstanding capability for serving individuals with dual diagnoses. But it had been cut back significantly prior to the CMHA. As Exhibit 20 displays, most CMHCs have seen a modest but steady increase in the number of unique individuals being served per quarter over the past year.

While overall positive about the impact of the ACT programs and recent expansion, key informants noted several challenges related to the provision of ACT services. Some expressed that the pool of individuals in need of ACT level services had been exhausted, and that the programs do not seem to be producing the expected outcomes. Many individuals noted that though the ACT programs have expanded, workforce capacity issues remain, and most programs are not operating with program fidelity (this data is routinely collected by the state) due in part to inflated caseloads caused by the workforce shortage. It was also noted that the larger caseloads keep the programs from doing the type of activities normally expected with this service, such as active participation in treatment team and discharge planning meetings when a client is hospitalized.

Exhibit 20. Unique Count of Adult Assertive Community Treatment Consumers, SFY 2017



Note: Consumers are counted only one time regardless of how many services they receive.

Source: Community Mental Health Agreement Quarterly Progress Reports, available at:

<https://www.dhhs.nh.gov/dcbcs/bbh/settlement.htm>

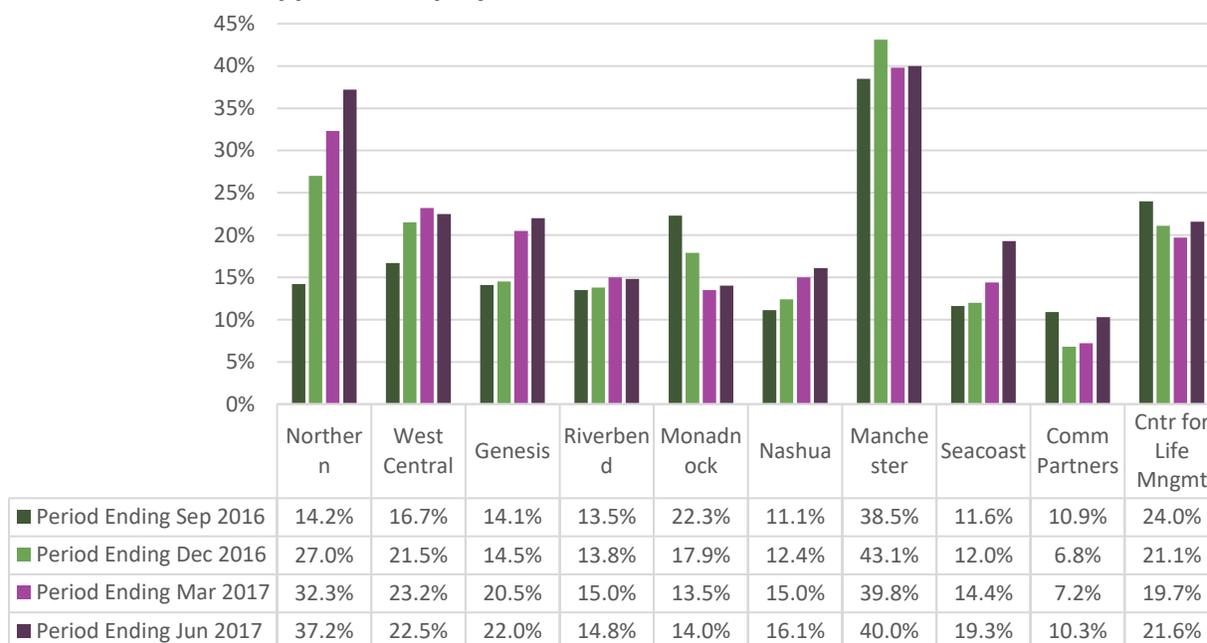
Mental Health Prevention and Promotion

Many key informants perceived there is not much of a statewide systemic focus on mental health promotion and prevention services, though there are pockets of such programs and some mentioned Spark NH as an example state-focused initiative. The state's 13 Regional Public Health Networks (RPHNs) are taking an increasing role in prevention and promotion services, and NFI-North provides an array of services including home visiting and family-focused programs. The youth-focused FAST Forward program (discussed later under Children's Services) is another of these initiatives. Generally, the perception was that the presence or absence of such services was largely dependent on the local communities themselves, with some seeking out Federal and other non-state funding to pursue such programs, such as Project LAUNCH in the Manchester area, or otherwise existing due to the force of will of key champions within the local community. While the effects of adoption of such programs are unlikely to be felt fully by communities for a number of years, expanding such offerings in childhood can lead to more resilient and well-functioning adults, thereby impacting incidence of crises and demand for high intensity services within a behavioral health system.

Employment and Other Rehabilitative Services

The expansion of supported employment services was also called for as part of the CMHA. As indicated in Exhibit 21, the majority of CMHCs have been increasing their penetration rates each quarter over the past fiscal year, and the penetration rates for most CMHCs are above the 18.6% benchmark specified in the CMHA. However, the data show some significant variation, with rates in 3 of the 10 centers remaining below the target benchmark. Key informants indicated that Supported Employment services have been adversely impacted by the same workforce capacity issues affecting the ACT programs, with caseload ratios making it difficult to deliver evidence based supported employment services. There remains much room for improvement in the delivery of employment services, especially in the more densely populated economic centers of the state, such as Riverbend, located in the Concord area.

Exhibit 21. Annual Supported Employment Penetration Rates for Prior 12 Months, SFY 2017



Source: Community Mental Health Agreement Quarterly Progress Reports, available at: <https://www.dhhs.nh.gov/dcbcs/bbh/settlement.htm>

Children’s Services

As with the continuum of care for adult services, multiple key informants noted that there are also missing rungs of care for children’s services. Individuals spoke of how there are very limited options for residential treatment and facilities that are not medical-model based (no prescribers), but staffed by clinicians able to provide individual and group psychotherapies. It was also noted that there are no subacute facilities (PRTF) or community-based acute treatment (CBAT) types of services. While some recent expansion of intensive outpatient and partial hospitalization programs were noted, still more are needed. Mobile crisis services for youth were also noted by multiple informants as a key area of need. One pressure point that was noted regarding children’s continuum of care is that residential services are sometimes viewed as solutions for a more permanent living situation, reducing the rate of turnover for the existing beds in the system and consequently limiting access to existing resources. Although options in the community are often limited, it was also noted that families are sometimes unaware of local options, leading some to seek treatment for their child out of state; more visible centralized service directories and public awareness efforts might help combat this.

The general lack of subacute and community-based treatment services has resulted in a heavier reliance on inpatient care for children, similar to the adult system. With a lack of availability of subacute step-down options in the community, certain populations, such as children with developmental disabilities and DCYF-involved children, can end up with longer inpatient stays.

Also noted were a number of challenges related to the children's workforce. As in the adult system, there is a shortage of psychiatrists, as well as across the behavioral health workforce in general. Professionals who move into New Hampshire from out of state can experience challenges obtaining licensure, demonstrating that the state requirements have been met. While recent efforts to increase the amount of trauma-informed children's services were noted, it was felt that trauma-informed services needed to be more consistently available. One example given was that of child-parent psychotherapy, a promising EBP that is available in certain CMHCs where there has been a therapist trained in it; however, such training is not widespread and therefore the service is regarded as hit or miss, depending on which clinician a family is working with, and completely unavailable in other centers. Workforce development efforts focused on such practices should help increase the efficacy of the services being provided.

One children's program that multiple informants identified as being helpful and, though currently undergoing expansion, still a service that should be replicated further, is FAST Forward (Families And Systems Together). FAST Forward focuses on the provision of high-fidelity wraparound services to children and transition-aged youth (6-21). Additionally, many also noted the establishment of the Children's Bureau of Behavioral Health a little over a year and half ago as a critical first step toward directing the attention needed to the children's behavioral health system in New Hampshire.

Specialty Populations

There were a number of populations identified as more challenging to reach in terms of crisis prevention services. Key informants noted that individuals with both mental health and developmental service needs were often difficult to find services for, as providers that serve individuals with developmental disabilities feel they don't know how to address the mental health needs, and the mental health providers feel unprepared to address any developmental disability-related needs. Other populations noted as challenging to effectively serve included individuals with co-occurring mental health and substance use disorders, homeless individuals, the elderly, and veterans. With veterans, it was noted that many individuals are not willing to receive services from the VA but feel that regular mental health service providers don't fully understand veteran's issues, and consequently avoid services. It was suggested that more non-VA affiliated community programs would be helpful in reaching this underserved population.

Community Engagement

Meaningfully engaging with communities and members of the public to collaboratively address behavioral health issues was identified as an area needing further improvement. While efforts are made to engage communities and the public, it was noted that the level of understanding of behavioral health in general is poor. Increasing this level of understanding and levels of engagement was viewed as a way

of making behavioral health a greater priority in the state, which would help enhance the willingness of the legislature to increase funding for the behavioral health system.

Criminal Justice Partnerships

Numerous key informants pointed to partnerships with criminal justice agencies as an area needing more emphasis. Greater coordination and collaboration would increase law enforcement officer knowledge of service options in the community, and would help connect individuals to needed services. One suggestion was for law enforcement to have the names of CMHC staff whom they could call when encountering a psychiatric patient in the community. It was noted that officers will often encounter individuals in obvious need of mental health services, yet there are no options available other than taking the individual to the ED or putting them in jail. Frustration rises when they are encountering the same individuals over and over again, with no place to connect them for help.

Various successes in partnerships and coordination between criminal justice and mental health agencies were also noted. Examples include re-entry programs taking root at local jails, and the development of IDNs as a result of the 1115 waiver. Manchester's Mobile Crisis Response Team was highlighted as a success in integrating law enforcement, and a community in ME where social workers ride along with police (a co-responder model) and provide on spot services, connection to resources, and have helped change the image of law enforcement in that community. Such programs deserve further exploration in New Hampshire.

Emergency Department Diversion

General Causes of ED Boarding, According to Key Informants

There was strong consensus among the key informants interviewed that the root cause of the current ED boarding problem was not a lack of inpatient beds but rather a lack of access and capacity within the full continuum of services that can help prevent and rapidly address issues before they escalate to the level of needing ED or inpatient care. While a handful of the 55 individuals interviewed did note that a small increase in the number of inpatient beds might be a key way to alleviate some of the pressure in the short term, they felt it would not solve the problem of ED boarding. The overall solution to the problem centered on creating or restoring options that helped keep individuals functioning well in the community and out of crisis, providing alternatives for individuals experiencing crisis other than going to their local ED (and more effectively serving those who are waiting in the EDs), and having a robust community service system with a continuum of options for discharge for those individuals who do require inpatient care, keeping individuals flowing through the inpatient beds that are currently available.

Crisis Alternatives

Key informants overwhelmingly noted that individuals often find themselves in the ED for care when in crisis because there are so few other options for them to turn to. While the CMHA has set in motion the process of expanding crisis alternatives, the key informants felt that the expansion of those efforts would prove useful for addressing the ED boarding issue.

Mobile Crisis Units

As the system mapping section (Section 3) indicates, the three current mobile crisis units in New Hampshire are all located in the southern third of the state. Given the population distribution within the state, this is not surprising, but it leaves nearly two thirds of the state with no ready access to these services. Not surprisingly, many key informants emphasized the need to increase the number of mobile crisis teams. For example, one key informant noted that the Concord mobile crisis team has helped avoid 100+ ED visits a month. Numerous individuals commented on the challenges of staffing and the resources to maintain 24/7 coverage in the more rural areas of the state, where the population base may not be enough to keep the mobile crisis team sufficiently busy. Some indicated that funding the teams more adequately and/or increasing the emergency services reimbursement rates might tip the cost balance in such situations and help promote the spread of the teams. Other suggestions included doing a feasibility study with rural providers to see what mobile crisis services might need to look like in their area and what levels of resources are needed to fully fund and support such teams in rural areas.

Peer Respite Beds

As shown in Exhibit 22, the four peer respite centers served a total of 85 unique individuals in 2016, offering a total of 852 bed days. Many key informants commented on the apparent effectiveness of the peer respite beds. However, key informants indicated the availability of such services is not widely known by the public as a resource, especially for the newest program in the Northern region (Conway). In Nashua, utilization of the peer respite is high, and an informant indicated there is a need for expanded capacity there if funding were available. In other regions, the beds are not often utilized. The peer respite programs have the resources to provide transportation for individuals seeking a bed if one is not available in their region.

Exhibit 22. Peer Services Crisis Respite Bed Capacity and Utilization, SFY 2016

CMHC Region	Peer Support Agency	Number of Beds	Number of Persons Served	Number of Admissions	Total Bed Days
01	Alternative Life Center - Conway	2	10	10	71
05	Monadnock Area Peer Support Agency	2	14	14	94
02	Stepping Stone Drop-In Center, Claremont	2	15	23	110
06	H.E.A.R.T.S. Peer Support Center, Nashua	2	46	51	577
	TOTAL	8	85	98	852

Source: DHHS Statewide Peer Support Services, SFY 2016

Coordination and Triaging of Crisis Alternatives

One refrain heard from the key informants was that while the mobile crisis units and peer respite beds are unequivocal strengths of the system, their potential is underutilized to avert ED visits for mental health crises due to lack of awareness at various levels, including that they can be used by individuals from all regions of the state. For example, even though transportation can be a barrier, there were still individuals themselves in the ED with no open beds at their local peer respite center that if they had been aware, could have possibly made it to an open respite bed in another region. As peer respite beds and mobile crisis units continue to expand, it was suggested that some sort of 24 hour coordinating hub/triaging center could be developed to help ensure efficient use of the available beds and to help maximize diversion of individuals from ED and inpatient facilities.

Law Enforcement Officer and First Responder Training

Training for law enforcement in mental health was another area that informants consistently identified as a need. Barriers to such training included the lack of funding to pay for certified trainers coming in, the need to schedule multiple trainings to reach all officers, and the difficulty of finding mental health workers with availability to speak with officers and keep them up to date on best practices and available services. While mental health training is part of the police academy training, the amount of ongoing or refresher training within community police departments remains limited, with one estimate of about 1 hour a year devoted to such training. Also emphasized was a need for officer trainings in available behavioral health resources in the community and how to de-escalate individuals in crisis. Individuals did note that while some CIT and Mental Health First Aid training is available, and there have been waves of trainings conducted in the past, it would be helpful to have it expanded and to have such training provided on an ongoing basis due to turnover in police departments. Training in the use of Naloxone was fairly widespread, and safe stations were mentioned by many as a valuable tool for increasing access to treatment services.

For non-law enforcement first responders, a challenge noted was the extremely limited amount of time spent on training in mental health and how to respond to people in crisis. While there is a module focused on working with individuals with mental illness, and a chapter in their training textbook, it was estimated that roughly 2 to 4 hours are spent on training in mental health, out of the 150 total hours of training for EMTs and the 18 to 24 months of training for paramedics. It was noted that though the state fire and EMS academy follows national standards, they do have the ability to make additions to the curriculum, as long as the fire training commission board approves, so there may be opportunities for enhancing the curriculum around mental health.

Services While in the Emergency Department

Key informants identified several services that were not being offered at all or not uniformly offered across hospitals while individuals were being boarded at the ED while awaiting inpatient psychiatric admission. These included peer navigator services and enhanced clinical services.

Peer Navigators

The incorporation of peer navigators in EDs was identified by a variety of key informants as a component that could improve the delivery and integration of services in the ED. Peer navigators could administer psychological first aid and perform informal mental health status exams, as well as promote services offered by the PSAs. One of the PSAs noted that they are actively involved in the IDN in their region, and that as part of that, they will be providing a number of peer support specialists in two of their area hospitals to improve integration. Several challenges were raised during our interviews with key informants, including what types of certification a person in this position would need and how the services they provide would be paid for.

Enhanced Clinical Services

Many of the key informants identified the need for enhanced clinical services for patients being boarded in the ED. These include an increased availability of clinical support and psychiatric consultation services for EDs. One key informant mentioned that at one of the hospitals, psychiatrists are able to provide treatment in the ED and discharge the patient after a few days once they are stabilized, while another informant noted that at other hospitals, they have Psychiatric Assessment Referral Services clinicians as part of the 24-hour ED staff who perform medical consults, direct admissions, and referrals. One barrier to increasing psychiatric services in the ED is the statewide psychiatrist shortage. Key informants noted a need for leveraging the knowledge of psychiatrists with personnel in the EDs, possibly through the use of e-consults. Another need that was identified was an emphasis on more frequent status reassessments of individuals being boarded in EDs. While some key informants specified that, depending on the facility, reassessments were completed every 12, 18, or 72 hours, another key informant indicated that reassessments at their facility were done every 4 hours at a minimum in an effort to move patients through the ED more quickly.

Public and Private Partnerships/Centralized Coordination of Inpatient Beds

Multiple key informants suggested the possibility of pursuing more public-private partnerships to enhance access to private inpatient beds. An example offered that could serve as a model for similar efforts was relayed by a key informant. Hampstead Hospital reached out to DHHS and wanted to assist with the ED boarding issue. They increased bed capacity up to their licensed amount. Historically, they had mainly provided services to children who had private insurance, not Medicaid; however, their

philosophy is changing, and DHHS worked with them on a contract around their increased capacity to take children with Medicaid, helping reduce the number of children waiting for a bed.

Disposition

Adequacy of Inpatient Beds, According to Key Informants

The consensus from the key informant interviews was that there was currently enough bed capacity in New Hampshire Hospital, and that the issue from the Hospital's perspective is a lack of discharge options. The lack of options for discharge results in individuals occupying beds longer than clinically necessary, creating bottlenecks in the flow through the system. Certain populations were highlighted as being more difficult to find appropriate community services for, resulting in longer stays. These populations were individuals with dual diagnosis of mental health and intellectual or developmental disability, dual diagnosis of mental health and substance use, the elderly, and individuals on some sort of legal hold, such as those found not guilty by reason of insanity (NGRI). Enhancing the flow of these populations through the inpatient beds currently available will greatly help to ease the backups currently being experienced; for example, a single NGRI individual occupying a bed for one month means three individuals were likely unable to access that bed during that time, given a median length of stay of roughly 10 days (see Exhibit 26).

Overview of Inpatient Bed Availability and Usage

In 2017, there were a total of 458 inpatient psychiatric care beds available in New Hampshire. As shown in Exhibits 23 through 25, Region 4 – Riverbend, which includes Concord Hospital, Franklin Regional Hospital, and New Hampshire Hospital, had the highest number of beds (193), followed by Region 10 – Center for Life Management which includes Hampstead Hospital and Parkland Medical Center (81), and Region 7 – Manchester which includes Cypress Center and Elliot Hospital (63). The only region that did not have psychiatric care beds was Region 5 – Monadnock.

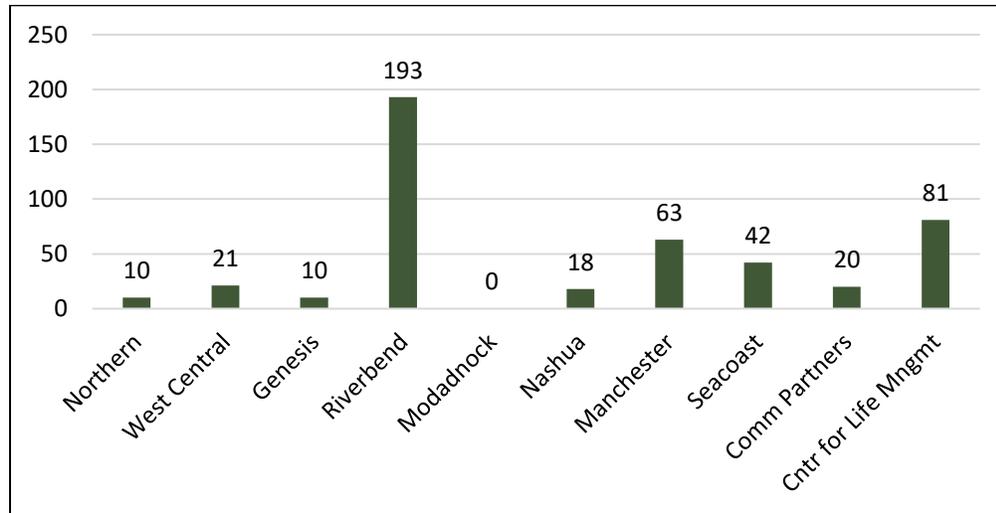
As shown in Exhibit 25 there were a total of 52 designated receiving facility (DRF) beds dispersed among three regions: Region 7 - Manchester (30), Region 8 - Seacoast (12), and Region 4 - Riverbend (10). New Hampshire Hospital's 168 beds are all involuntary. The remaining 238 inpatient psychiatric care beds were voluntary beds.

Exhibit 23. Psychiatric Care Bed Inventory, by Facility, 2017

CMHC Region	Hospital Name	Number of Beds
01- Northern	Cottage Hospital	10
02- West Central	Dartmouth Hitchcock	21
03- Genesis	Lakes Region General Hospital	10
04- Riverbend	Concord Hospital	15
04- Riverbend	Franklin Regional Hospital	10
04- Riverbend	New Hampshire Hospital	168
06- Nashua	Southern NH Medical Center	18
07- Manchester	Cypress Center	16
07- Manchester	Elliot Hospital	47
08- Seacoast	Portsmouth Regional Hospital	42
09- Comm. Partners	Frisbie Memorial Hospital	20
10- Cntr Life Mgmt	Hampstead Hospital	67
10- Cntr Life Mgmt	Parkland Medical Center	14
Total		458

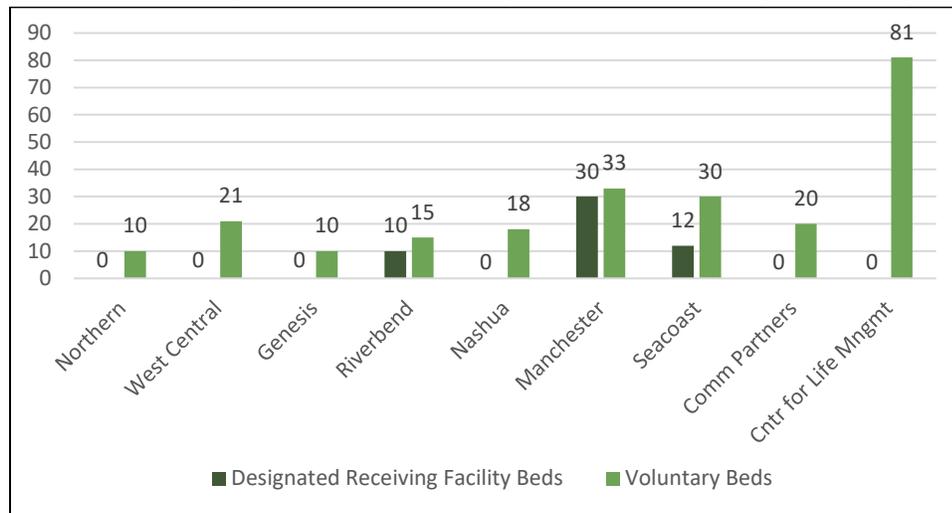
Source: NH Hospital Association / Foundation for Healthy Communities, updated as of 11/2/2017

Exhibit 24. Total Psychiatric Care Beds, By CMHC Region, 2017



Source: NH Hospital Association / Foundation for Healthy Communities, updated as of 11/2/2017

Exhibit 25. Psychiatric Care Beds by DRF and Voluntary Status, By CMHC Region, 2017



Source: NH Hospital Association / Foundation for Healthy Communities, updated as of 11/2/2017

Summary of New Hampshire Hospital Data

As mentioned, we were unable to obtain the desired data from the New Hampshire Hospital for this report within the project timeframe. The following data are from the CMHA court monitor quarterly reports, available publicly online. They provide information on admissions, length of stay, mean daily census, and discharge characteristics of adults receiving services at New Hampshire Hospital and Designated Receiving Facilities (DRFs). Data are reported by quarter within SFY 2017.

Exhibit 26 shows a similar number of admissions (293) and discharges (292) for New Hampshire Hospital in quarter four. There was a notable decrease in the number of admissions between quarter one (373) and quarter four (293). On average, persons had a median length of stay of 10 days before discharge, and an average of 156 persons per day were occupying beds within the latest quarter.

Exhibit 26. New Hampshire Hospital: Adult Census Summary, SFY 2017

Measure	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun
	2016	2016	2017	2017
Admissions	373	275	262	293
Mean Daily Census	134	137	156	156
Discharges	365	276	256	292
Median Length of Stay in Days for Discharges	8	10	12	10
Deaths	0	0	0	0

Note: Average Daily Census includes patients on leave and is rounded to the nearest whole number.

Source: Community Mental Health Agreement Quarterly Progress Reports, available at: <https://www.dhhs.nh.gov/dcbcs/bbh/settlement.htm>

Individuals were primarily discharged from New Hampshire Hospital back to their home as opposed to facilities and residential settings. As shown in Exhibit 27, a small number of individuals were discharged to non-permanent housing including hotels/motels and homeless shelters/no permanent residence.

Exhibit 27. New Hampshire Hospital: Discharge Location for Adults, SFY 2017

Discharge Location	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun
	2016	2016	2017	2017
Home - Lives with Others	194	141	142	138
Home - Lives Alone	124	94	76	107
Jail or Correctional Facility	5	8	2	3
Discharge/Transfer to IP Rehab Facility	2	7	1	6
Hotel-Motel	5	6	1	7
CMHC Group Home	12	5	6	3
Other Residence	5	5	3	5
DDS Supported Living	0	3	4	1
Nursing Home	3	3	4	5
Glenclyff Home for the Elderly	2	1	4	4
Homeless Shelter/ No Permanent Home	5	1	7	9
Individualized Service Option-ISO	0	1	0	0
Peer Support Housing	2	1	3	1
Private Group Home	4	0	5	3
Residential School	1	-	-	-
VA Housing	1	-	-	-

Source: Community Mental Health Agreement Quarterly Progress Reports, available at: <https://www.dhhs.nh.gov/dcbcs/bbh/settlement.htm>

As shown in Exhibit 28, the greatest rate of readmission to NHH in Q4 was in the 180 days after discharge (32%), followed by 90 days (24%), and 30 days (15%). There was a drop in quarter three readmission rates for all measures; yet, all increased by the final quarter of SFY 2017.

Exhibit 28. New Hampshire Hospital: Readmission Rates for Adults, SFY 2017

Measure	Jul - Sep 2016		Oct - Dec 2016		Jan - Mar 2017		Apr - Jun 2017	
	N	Rate	N	Rate	N	Rate	N	Rate
30 Days	62	16.2%	36	13.0%	21	7.9%	44	15.0%
90 Days	107	27.0%	78	28.3%	52	19.5%	71	24.2%
180 Days	128	34.2%	97	35.1%	73	27.4%	94	32.1%

Source: Community Mental Health Agreement Quarterly Progress Reports, available at: <https://www.dhhs.nh.gov/dcbcs/bbh/settlement.htm>

Note: Readmission rates are calculated by looking back in time from admissions in the study quarter. For example, the 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 for each readmission.

Exhibit 29 shows there were consistently more voluntary admissions than involuntary admissions to DRFs. In the final quarter, there were a total of 804 admissions to DRFs, primarily to Portsmouth Regional Hospital (45.1%) and the Cypress Center (28.4%). Notably, involuntary admissions to Franklin Regional Hospital more than doubled from the first quarter to the third quarter—rising from 16 to 46—and remained high through the end of SFY 2017.

Exhibit 29. Designated Receiving Facilities: Admissions for Adults, SFY 2017

	Jul - Sep 2016			Oct - Dec 2016			Jan - Mar 2017			Apr - Jun 2017		
	Invol.	Vol.	Total									
Franklin	16	21	37	21	18	39	46	19	65	35	25	60
Cypress Cnt.	61	146	207	62	155	217	72	134	206	49	179	228
Portsmouth	71	304	375	53	257	310	73	247	320	80	283	363
Elliot GPU	7	47	54	7	36	43	6	42	48	6	46	52
Elliot Path.	51	63	114	31	41	72	60	78	138	48	53	101
Total	206	581	787	174	507	681	257	520	777	218	586	804

Source: Community Mental Health Agreement Quarterly Progress Reports, available at: <https://www.dhhs.nh.gov/dcbcs/bbh/settlement.htm>

Among the DRFs, an average of 17.2 persons received care in DRFseach day in the final quarter of SFY 2017. There is variation in the number of persons receiving care in these facilities on any given day; for instance, Portsmouth Regional Hospital served an average of 30.3 individuals and Franklin Regional Hospital served an average of 4.5 individuals each day.

Exhibit 30. Designated Receiving Facilities: Mean Daily Census for Adults, SFY 2017

Designated Receiving Facility	Jul - Sep 2016	Oct - Dec 2016	Jan - Mar 2017	Apr - Jun 2017
Franklin	4.5	5.6	4.6	4.5
Manchester (Cypress Center)	13.6	12.4	14.6	12.0
Portsmouth	23.2	23.4	25.8	30.3
Elliot Geriatric Psychiatric Unit	25.6	24.8	28.1	29.3
Elliot Pathways	14.5	11.5	11.2	10.0
Average	16.3	15.6	16.9	17.2

Note: Portsmouth Regional Hospital has a total of 12 DRF beds and Elliot Hospital has a total of 14 DRF beds split between Pathways and the Geriatric Psychiatric Unit.

Source: Community Mental Health Agreement Quarterly Progress Reports, available at: <https://www.dhhs.nh.gov/dcbcs/bbh/settlement.htm>

Adults in DRFs had a median length of stay of 5 days in the last quarter of SFY 2017 (Exhibit 30). The longest median length of stay in quarter four was at the Elliot Geriatric Psychiatric Unit, 22 days, whereas the four other DRFs had median lengths of stay that were less than 10 days.

Exhibit 31. Designated Receiving Facilities: Median Length of Stay in Days for Discharges, SFY 2017

Designated Receiving Facility	Jul - Sep 2016	Oct - Dec 2016	Jan - Mar 2017	Apr - Jun 2017
Franklin	7	5	5	6
Manchester (Cypress Center)	5	5	4	4
Portsmouth	4	5	5	5
Elliot Geriatric Psychiatric Unit	24	24	28	22
Elliot Pathways	8	8	7	8
Total	5	5	6	5

Source: Community Mental Health Agreement Quarterly Progress Reports, available at: <https://www.dhhs.nh.gov/dcbcs/bbh/settlement.htm>

As shown in Exhibit 32, a total of 815 adults were discharged from DRFs in quarter four. Franklin Regional Hospital nearly doubled the number of persons discharged between quarter one (35) and quarter three (66), following a similar trend to involuntary admissions noted in Exhibit 29.

Exhibit 32. Designated Receiving Facilities: Discharges for Adults, SFY 2017

Designated Receiving Facility	Jul - Sep 2016	Oct - Dec 2016	Jan - Mar 2017	Apr - Jun 2017
Franklin	35	41	66	59
Manchester (Cypress Center)	213	213	211	232
Portsmouth	380	309	306	365
Elliot Geriatric Psychiatric Unit	64	46	49	54
Elliot Pathways	113	75	139	105
Total	805	684	771	815

Source: Community Mental Health Agreement Quarterly Progress Reports, available at: <https://www.dhhs.nh.gov/dcbcs/bbh/settlement.htm>

Forensic/NGRI Options

As noted earlier, one of the areas where flow of individuals through NHH bottlenecks is with individuals who are on some sort of legal hold or have NGRI status. For example, it was indicated that on any given day, there are roughly 10 to 12 individuals occupying beds long-term who clinically no longer require an inpatient level of care but that the DOC is unable or unwilling to discharge to the community. Multiple informants emphasized the need for other options besides NHH beds for these individuals, such as a

community based secure residential facility to start, with a possible step down to full integration within the community with high intensity supports provided by a Forensic ACT team along with other services like PSH.

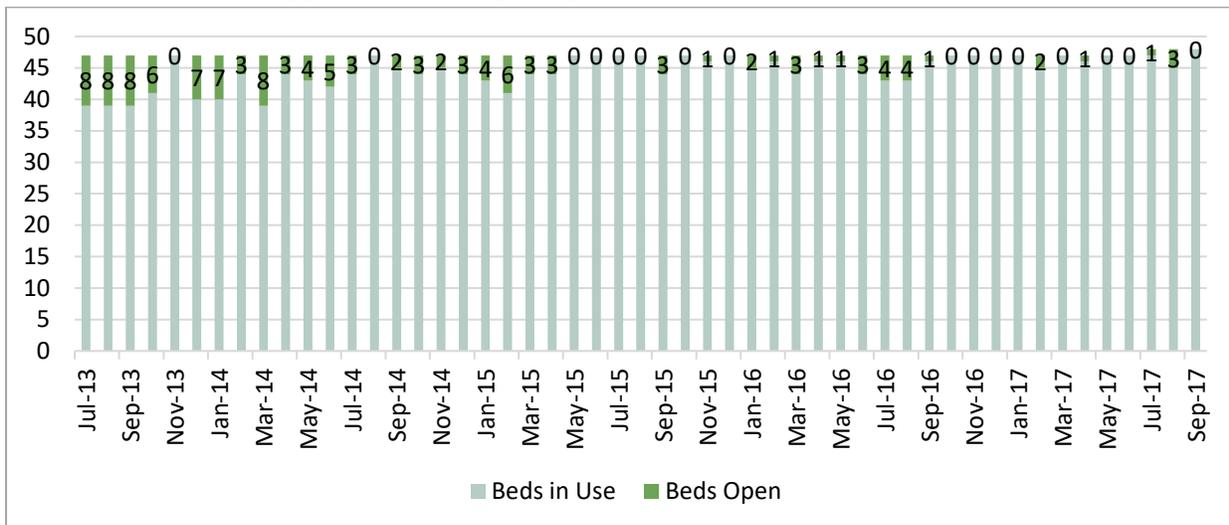
Housing/Housing Supports

The recent addition of a transitional housing program should help provide more options for discharge from inpatient beds in New Hampshire, but the consensus from the key informant interviews is that more housing is still needed, including additional transitional beds. The Bridge program was also noted by informants as a successful housing resource that should be expanded if possible.

Many individuals cited the need for more supportive services available in existing housing as well. They spoke of situations where an individual would be discharged back to a community apartment and receive a single weekly visit from a case manager as not enough to help the individual, who inevitably finds themselves being readmitted after a brief period due to lack of support. An enhanced continuum of services within the community would help provide more options, but individuals also noted a need for more in-house supports to help individuals as needed, and especially to provide added supports during times of transition. Individuals with criminal histories face even more challenges, as they are often disqualified from public housing and some of the supported housing programs that do exist.

Exhibits 33 and 34 outline the availability of beds in the only transitional housing program in the state, and display some of the utilization figures related to the Bridge program. As previously noted in the Crises Prevention housing findings section, the units that do exist tend to be clustered in limited regions; the same is true for transitional housing beds, available only through NFI in Region 4, where the bulk of housing resources are already located. As Exhibit 33 shows, there are usually no vacancies in the current TSH program. While the new RFP awarded will bring more beds online, there is still a critical need for additional transitional housing and other supported housing beds in other areas of the state.

Exhibit 33. THS Supported Housing Daily Bed Census, SFY 2014 – SFY 2018 Q1



Source: NFI North New Hampshire

Exhibit 34. Housing Bridge Subsidy Summary to Date, SFY 2017

Subsidy	Jul - Sep 2016	Oct - Dec 2016	Jan - Mar 2017	Apr - Jun 2017
Housing Bridge Subsidy	603	643	675	701
Section 8 Voucher	83	83	85	85

Source: Community Mental Health Agreement Quarterly Progress Reports, available at:

<https://www.dhhs.nh.gov/dcbcs/bbh/settlement.htm>

Exhibit 35. Housing Bridge Subsidy Current Census Summary, SFY 2017

Measure	As of Sep 30, 2016	As of Dec 31, 2016	As of Mar 31, 2017	As of Jun 30, 2017
Housing slots	479	513	553	591
Rents currently being paid	451	481	505	545
Individuals accepted but waiting to lease	28	32	48	46
Waiting list for slots	0	0	0	0

Note: All individuals currently on the Bridge Program are actively transitioning from the program (waiting for their Section 8 housing voucher).

Source: Community Mental Health Agreement Quarterly Progress Reports, available at:

<https://www.dhhs.nh.gov/dcbcs/bbh/settlement.htm>

Step-Down Options

As discussed in the Crises Prevention section, numerous key informants identified the lack of intermediate intensity or step-down service options as a glaring gap in the service system. If an individual is ready to be discharged from an inpatient bed, but needing more support than a return to an independent apartment in the community, there are few options available. One example of a helpful program that could be replicated is On the Road to Wellness, located in Manchester. On the Road to Wellness is a peer run housing program with capacity for 4-6 individuals. Referrals come primarily from New Hampshire Hospital. Individuals also noted the loss of intensive outpatient and partial hospitalization programs; while some partial hospitalization programs do still exist, transportation issues often bar individuals from accessing those programs if they are not in the immediate geographical area. More intermediate and high intensity supports in the community could allow NHH to discharge individuals more quickly once they have been acutely stabilized, leading to shorter and less disruptive hospital stays for the individuals and quicker pace of turnover of inpatient beds, allowing more individuals to be served with the current inpatient bed capacity.

Discharge Planning/Care Coordination

A strength that was identified by key informants related to the discharge planning and care coordination efforts from inpatient facilities was the involvement of a peer specialist in all discharge meetings at New Hampshire Hospital. This individual is very knowledgeable about the community based options available around the state, not just the Concord area, and is able to facilitate connections with needed community services. One challenge noted by key informants is the overall lack of care coordination by community services when their client is hospitalized. It sounded relatively common for even ACT case managers to not be involved in discharge planning and treatment planning meetings. This lack of participation is likely due to inability to directly bill for such services. Better care coordination while individuals are hospitalized can help ensure that connections with needed supports are in place before discharge. Mechanisms for funding coordination activities should be explored further.

Cross-Cutting

In addition to the findings relevant to crises prevention, diversion from EDs, and discharge/disposition from inpatient beds, there were a number of themes that cut across all three areas.

Funding of services

There was perfect consensus among the key informants interviewed who discussed funding that the behavioral health system in New Hampshire is drastically under-resourced. Whether the topic was peer supports, mobile crisis rates, CMHC services, or anything other type of service, key informants noted the general lack of adequate resources available. One of the most common examples noted was that of

CMHC reimbursement rates, which have not seen an increase since the mid-2000's while other costs, such as fringe benefits for employees, have exploded. Some noted that while community mental health positions have never paid well, the benefits packages used to make the wages tolerable enough to attract individuals inclined to the work, which is no longer the case. The chronic underfunding directly impacts the breadth of services that can be offered, the volume of services, and the quality of services. The lack of resources also negatively impacts reform efforts- EBP's cannot be delivered with fidelity when there are not staff available to provide them, or time and resources to train staff appropriately.

Workforce development- reciprocity and others

Workforce capacity was frequently cited in tandem with lack of funding of services as a major barrier to the successful delivery of services regardless of the point in the continuum of care. The two issues are closely intertwined. Lack of adequate reimbursement for services delivered forces providers to manage costs in other ways; wages and benefits are depressed which in turn makes positions less attractive, or even financially feasible, for those inclined or interested in pursuing careers in human services. Several informants noted that there are simply not enough people wanting to go into these fields- while increases in wages may help, creative solutions to attract people to this type of work are needed and should be further explored, such as student loan payoffs. Multiple people also brought up issues of reciprocity with the state licensing boards, indicating that the licensing boards had more stringent requirements and less flexibility around meeting those requirements than some other states, making it difficult for individuals moving to NH from other states to prove their education met NH's requirements. The challenges with seeking reciprocity were noted throughout the system- social workers, therapists, psychiatrists, etc., serving both children and adults.

Cross-system collaboration

Many key informants remarked that even though there have been efforts to collaborate, many services and systems in NH still operate largely in silos. There was much optimism about the DSRIP project as part of the 1115 waiver, with the Integrated Delivery Networks formed viewed as taking strides to help tackle the problem of fragmentation, but many felt that this initiative represented a good start but that much more was needed to address this challenge which impacts services across the continuum of care. Also noted was the need for better collaboration between DHHS's mental health and substance abuse bureaus.

Systems Planning

Multiple key informants mentioned the previous 10-year plan for mental health. While informants thought the plan was a good roadmap for their system, they also questioned the value of such efforts if the state was not going to provide the funding required to actually implement the plan. An informant

mentioned the development of the upcoming 10-year plan should be informed by lessons learned from the department's 3-year plan for substance abuse drafted in 2013. The system planning efforts from the two bureaus within the behavioral health division (MH and SUD) should be "talk the same language," or, this informant suggested, the real need is for one 10-year behavioral health plan, with a detailed financing strategy, that addresses both mental health and substance use disorder in the state, rather than having two separate plans.

Data and Performance Metrics

Many informants lamented about the administrative burden of data collection on CMHCs and the strain it has on resources. Also expressed was frustration that statewide data are not provided back to the centers, for example, from the Adults Needs and Strengths Assessment, and Children's Needs and Strength Assessment (CANS). In summary, a lot of clinical data are collected, but there is not coordination around its use, or exchanges between the public health sector, hospitals, and CMHCs. Several informants highlighted the valuable work collecting and tracking data on the side of Bureau of Drug and Alcohol Services, but there are not comparable efforts within the Mental Health Bureau.

5. Recommendations

As noted in the estimate for needed beds in New Hampshire section, the average operating cost for a day of inpatient care in an acute care community hospital is \$2,912, while the average operating cost for a day of supportive housing is \$297 (\$245 per day supportive care from CMHC care + \$52 per day housing room & board). These data, combined with the fact that New Hampshire does not appear to be facing a significant shortage in the number of beds expected based on population size, strongly support the view that increasing capacity of outpatient services and supports, especially housing, is at least as important—and significantly more cost effective—as increasing the number of inpatient beds. In light of these findings, it should be expected that provisions of the Community Mental Health Agreement and the expansion of services under House Bill 517 will help partially ameliorate the problem of inpatient bed capacity and ED wait times. Given the depth of the challenges currently being faced by the behavioral health system in New Hampshire, however, these efforts represent more of a starting point than a final solution to the issue of excessive wait times for accessing inpatient care, especially for IEA individuals, resulting in ED boarding.

Our overarching recommendation is to restore the continuum of community-based services that was once present in New Hampshire through a significant increase in resources devoted to the public mental health system. It was near unanimous amongst our key informants that the key to solving the ED boarding problem and current demand for inpatient beds was not to increase the number of inpatient beds but rather to expand services focused on community-based prevention, treatment and recovery supports—including housing, crisis diversion and intervention, peer support, employment services, and increased access to in-home and outpatient services. A stronger community-based system of care will help individuals avoid crises and the need for inpatient care on the front end, and increase options for discharge for those who do require hospitalization.

Our recommendations are organized into the three categories we used to present the results of the gap analysis. The categories are based on a conceptual model of levels of acuity and transitions through the behavioral health system. The first category is crisis prevention, which we use in a dual sense: first of health promotion and early intervention, and more specifically prevention of psychiatric crises. The second category is diversion, which promotes alternatives to both the ED and inpatient care for those who do experience crises. The third category is disposition, which refers both to provisions for discharge from the ED to the community as an alternative to inpatient care, and expedited discharge from inpatient beds for those who cannot be returned to the community from the ED.

Note: We acknowledge that a number of the recommendations offered here have been presented previously in various forums and documents such as the DHHS Lean Analysis of Community Mental Health Centers Emergency Services Process, the New Hampshire Community Behavioral Health

Association White Paper (2017), and the task force report entitled Addressing the Critical Mental Health Needs of NH's Citizens – A Strategy for Restoration (2008). One purpose of our document review was to consolidate recommendations from other sources that continue to be applicable as well as to generate new recommendations based on current data and pressure points identified by key informants. The fact that many of the recommendations from previous reports remain pertinent today demonstrates the extent of the challenges that New Hampshire's behavioral health system faces. On the other hand, the number of reports, as well as the many thoughtful recommendations from key informants, demonstrate not only an awareness of the system's shortcomings but also an ongoing commitment by a wide range of stakeholders to make improvements. Thus, while many of our recommendations echo those of previous reports, ours focus on the specific problem of ED boarding and the question of appropriate inpatient bed capacity.

Crisis Prevention

Alternative crisis services such as mobile crisis and crisis residential programs can provide resources to divert some individuals from acute inpatient and have been shown in many studies to reduce the need for inpatient care (Thomas & Rickwood, 2013). Other crisis alternative models, such as peer respites², are being adopted throughout the country and may serve as an additional resource for individuals in crisis (Ostrow & Croft, 2015). Peer respites are voluntary, short-term residential programs for individuals experiencing or at risk of experiencing a psychiatric crisis. Peer respites typically have a non-clinical orientation, are staffed and managed by peer specialists, and have a governing or oversight body with a majority of members having lived experience of the behavioral health system. In peer respites, "guests" are engaged by peer support staff using trauma-informed principles that emphasize building healing, trusting relationships. One recent study found that peer respite guests were significantly less likely to use inpatient and emergency services compared with a similar group who did not use the peer respite (Thomas & Rickwood, 2013). These and other alternative approaches to supporting individuals in crisis, and for providing support to individuals before they reach a crisis state, could reduce the need for inpatient and emergency services for many. Crisis alternative services will never fully replace inpatient care, but they can be helpful in some situations to reduce utilization and recidivism.

Recommendation: DHHS should restore and expand the capacity of community-based services that have been shown to decrease the need for hospitalization and to promote recovery

There is solid evidence to suggest that more available and accessible community-based services can decrease the demand for inpatient care. As key informants recounted in detail, New Hampshire's system

² <http://www.peerrespite.net/>

of outpatient services has been drastically reduced since the 1990s and many called for a restoration of lost funding. This included recommendations to take full advantage of Medicaid expansion and enforce parity in public and private insurance. The Community Mental Health Agreement has been a positive step toward this restoration for a targeted group of consumers, but has not been sufficient to address the larger system gaps. There need to be more resources dedicated to the community mental health system as a whole.

Suggested actions:

- Enhance the Capacity and Competencies for ACT Teams
 - The number of ACT teams should be increased to the level included as part of the CMHA and as part of the 10 Year Plan; consider whether any expansion beyond this number is needed.
 - Fidelity should be ensured especially in the areas of staffing (nursing, substance use disorder, and employment).
 - Consider financial incentives for key measures for ACT teams: specifically measures that require follow up within a certain timeframe after an individual is discharged from a hospital or an emergency department.

Recommendation: Increase peer support services that offer diversionary or transition services

Peer support services are delivered by individuals with personal experience as service users of behavioral health services. Peer support services are theorized to help service users to develop self-advocacy skills and build confidence to pursue their goals through establishing trust and rapport built on shared experiences. A recent review of 20 studies of peer support services concluded that peer support is associated with improved quality of life, hopefulness, activation³, and therapeutic relationships and reduced inpatient hospital use (Chinman et al., 2014).

Key informants and the research team identified a variety of ways in which peer support services can enhance the system. Identified here in the context of helping to better support individuals within the community and reduce the incidence of crisis, increased availability of effective peer support can also help divert individuals in crisis from EDs and inpatient beds and smooth their transitions back to the community when diversion is not possible. However, this will require additional peer specialists

³ “Patient Activation” is a widely recognized concept that describes the knowledge, skills and confidence a person has in managing their own health and health care

throughout the state performing strategic functions to assist with transitions or diversions from EDs and inpatient units. Additionally, this this will require providing information and education to current provider agencies to better understand the proper usage of peer support specialists.

Suggested actions:

- Recruit and certify additional peer specialists who are specifically trained to assist individuals who are diverted or transitioned from ED or inpatient units.
- Add peer support services and specialists to the Medicaid state plan to increase revenue and make it a sustainable service.
- Embed peer support specialists in programs other than ACT, like:
 - In mobile crisis intervention teams
 - In inpatient settings
 - EDs, as health navigators
- Educate providers on how peer specialists can be used effectively in the system.

Recommendation: Enhance the array of crisis services statewide

Alternative crisis services, such as mobile crisis, crisis residential programs and peer respites, can provide resources to divert some individuals from acute inpatient care and have been shown in many studies to reduce the need for inpatient care.

Suggested actions:

- Establish capacity for crisis residential and peer respites in all geographic regions of the state.
- Increase communication about the availability of existing crisis and peer respite beds not being fully utilized.
- Provide information to mobile crisis teams regarding the benefits of peer respite beds and educate them on the referral processes.
- Conduct a feasibility study with rural providers to see what mobile crisis services might need to look like in their area and what levels of resources are needed to fully fund and support.

Recommendation: Establish a coordinating mechanism and a centralized data system that would track people waiting in EDs and available crisis and peer respite beds

Suggested actions:

- Develop communication procedures to ensure that existing capacity is fully utilized.
- Establish a state policy that allows facilities to transfer a patient to a neighboring area with an open bed. This may involve regulatory change and development of protocols for consistent application across the system including development of MOUs to share this information with the state and among all EDs (replace the current blast fax methods).
- Establish a trigger that requires that the state be notified and take action after some threshold of time boarding.

Recommendation: Increase Permanent Supportive Housing (PSH)

PSH is an evidence-based practice involving the provision of support services alongside independent housing for individuals with serious mental health and substance use disorders. Numerous studies, including seven randomized controlled trials, have documented that PSH decreases homelessness, lengthens housing tenure, and reduces inpatient and emergency department utilization. Moreover, service users consistently rate PSH as preferable to other housing models (Rog et al., 2014).

Access to safe, adequate, and affordable housing is a critical element in supporting individuals with behavioral health needs to live independently in their communities. Key informants described significant unmet housing needs among people with behavioral health conditions. In part this is due to macro factors—notably a shortage of affordable housing in general—which increases the necessity of allocating behavioral health service resources to address the need. Permanent Supportive Housing can be a solution for addressing individuals boarded in EDs or awaiting discharge from inpatient units. States have used a Housing First model that rapidly rehuses individuals in PSH from inpatient psychiatric units or homeless shelters. Housing First was originally developed to help people with mental health problems who were living on the streets; many of whom experienced frequent stays in psychiatric hospitals. The target populations entering Housing First later grew to include people making long stays in homelessness shelters and those at risk of homelessness who were discharged from psychiatric hospitals, or released from prison.

Suggested actions:

- Develop a centralized/coordinated housing registry.
- Encourage collaboration of EDs and hospitals with the Continuums of Care (CoCs) and local Public Housing Authorities around their coordinated entry mechanisms, which can serve to identify existing housing stock that can be immediately used for individuals awaiting discharge from an ED or inpatient psychiatric unit.
- Create a state level BH housing coordinator (if not already existing).

- Explore Medicaid options for housing supports. Some examples from other states: In Illinois, Louisiana, New Jersey and Washington, DC, Medicaid reimburses Community Support Teams that provide ongoing housing supports to people with serious mental health conditions.
- Develop a program similar to the Community Support Program for Persons Experiencing Chronic Homelessness (CSPECH) in Massachusetts. The goal of CSPECH is to provide community-based support to increase housing stability and prevent avoidable hospitalizations. CSPECH serves individuals with a diagnosed mental health disorder who have been without stable housing for a significant period of time. The program provides non-clinical support services to adults who have experienced chronic homelessness and are now entering into a Housing First placement.
- Consider adoption of other payment models such as that of Illinois, which has incentive payments for housing stability to encourage health plans to invest in housing supports through a Medicaid bonus pool for persons with a mental health or substance use issue.

Recommendation: Review adequacy of specialty services for children

Comprehensive service options for children with behavioral health challenges are an important part of the good and modern behavioral health system. We recommend utilizing an existing coalition to review and report on behavioral health services for children as part of the 10-year planning process.

Suggested actions:

- Increase access to child psychiatry through the use of telemedicine or clinical support consultation to primary care practitioners through strategies such as Project ECHO. Project ECHO (Extension for Community Healthcare Outcomes) is a collaborative model of medical education and care management that empowers clinicians to provide better care to more people, right where they live. The ECHO model does not actually “provide” care to individuals. Instead, it increases access to specialty treatment in rural and underserved areas by clinicians with the knowledge and support they need to manage patients with complex conditions (including mental health conditions).
- Increase the number of child psychiatrists, including clinical consultation with child providers in areas with extreme shortages.
- Hospital diversion for children, including mobile crisis.
- Increase availability of intensive services, such as with current expansion of high fidelity wraparound services via Fast Forward.
- Stepdown programs for children, including short-term respite or treatment options.
- Promote family-driven care.

- Promote family-to-family supports.
- Promote the use of treatment models specifically for children and transitional age youth instead of adult models.
- Increase the use of child-parent psychotherapy, a trauma-informed EBP, around the state.
- Address administrative issues within the Board of Mental Health Practice.
- Expand evidence-based, age-appropriate school-based programs and interventions.

Recommendation: Explore feasibility and options for expanding the First Episode Psychosis programs currently funded by a Block Grant set-aside

The landmark Recovery After an Initial Schizophrenia Episode (RAISE) project, funded by the National Institute of Mental Health, has led to an increasing focus on identification and early intervention in first-episode psychosis.⁴ The interventions tested in the RAISE project, Coordinated Specialty Care programs, involve multidisciplinary team-based treatment that includes psychosocial supports and family education. Coordinated Specialty Care has been found to reduce symptoms and improve quality of life for people experiencing early psychosis (Kane et al. 2016). Such interventions alter the course of illness through outreach and engagement with individuals before years-long duration of untreated psychosis occurs (Addington et al. 2015) and through the early provision of comprehensive services. By providing low-dose medications and psychosocial and rehabilitative interventions, CSC programs can reduce impairment related to symptoms and increase skills and supports, enabling more effective functioning and a reduction of disability. Finally, by providing evidence-based practices such as supported employment and emerging practices such as supported education, CSC programs support individuals in pursuing desired roles such as student or worker that are interrupted by the emergence of psychosis during such a critical developmental time in individuals’ lives, helping to maximize recovery.

In 2014, SAMHSA directed states to use 5% of their mental health block grant dollars to address early episodes of serious mental health conditions, and in 2016, SAMHSA increased that set-aside to 10% with an added requirement that efforts focus specifically on first-episode psychosis using evidence-based approaches such as those tested in the RAISE project (Kane 2016). Suggested actions:

- Although the state has begun making progress in implementing FEP programs with block grant funding, we recommend making this a priority, given the availability of funding and the potential cost-effectiveness. In addition, the state should identify the components of FEP that could be

⁴ <http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml>

billed to third-party payers including Medicaid and blend other payment sources for services not able to be billed to commercial or public insurance (e.g., supported employment).

Recommendation: Support and coordinate efforts to enhance the availability of behavioral health outpatient services in primary care

The benefits of integrated care are well-established; individuals with behavioral health conditions experience high rates of serious health conditions such as diabetes, heart failure, and hypertension.

In addition, a high percentage of individuals presenting at EDs with acute medical symptoms often are suffering with undiagnosed and/or untreated anxiety, depression, substance use, and other behavioral health disorders. By providing treatment earlier in the progression of mental health and substance use disorders, individuals may be less likely to require specialty behavioral health services like psychiatry and case management.

New Hampshire has a great opportunity to use the Building Capacity for Transformation 1115 Waiver Program to improve care for persons in need of behavioral health services.

Suggested actions:

- Continue to work with New Hampshire’s Building Capacity for Transformation Waiver Program to prioritize persons with behavioral conditions and coordinate efforts.

Recommendation: Partner with Federally Qualified Health Centers and similar health centers as participants in the delivery of behavioral health outpatient services

In addition to efforts underway through the Building Capacity for Transformation Waiver Program, the state should enlist the support of Federally Qualified Health Centers (FQHCs) to expand the treatment capacity for individuals with behavioral health conditions. Under the Affordable Care Act, the FQHCs have received substantially increased funding to provide behavioral health services and to promote integrated care, with further increases to come. For example, effective January 1, 2018, FQHCs can receive payment for Behavioral Health Integration (BHI) services and psychiatric Collaborative Care Model (CoCM) services. Because this expansion of behavioral health capacity is relatively recent, and links between behavioral health systems and FQHCs have not been extensive in the past, many areas have yet to take advantage of this opportunity to increase the supply of innovative outpatient care.

Suggestion actions:

- Ensure that services that could be provided by FQHCs are being fully utilized.

- Provide regular outreach to FQHCs to coordinate system planning.

Recommendation: Enhance collaboration and communication between criminal justice and behavioral health service systems

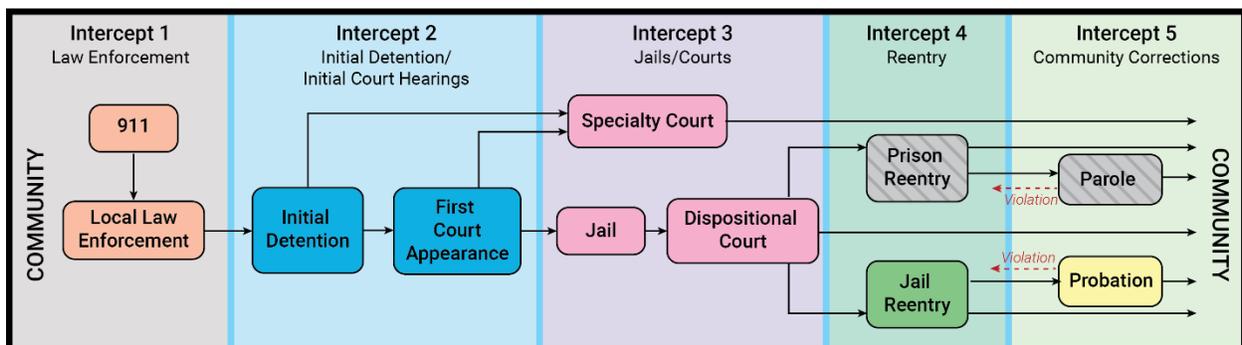
Nationwide, stakeholders have described the criminal justice system as the “de facto behavioral health system” for those with serious behavioral health conditions, referring to the overrepresentation of people with serious mental health conditions in jails and prisons.

The effectiveness of interventions designed to meet the behavioral health needs of those involved in the criminal justice system will hinge on the quality of the collaboration between the behavioral health and criminal justice systems. Key informants noted that this was one of the bottlenecks in the system and suggested community step-down programs specifically for individuals returning to the community from incarceration.

Suggested actions:

- The state should assist regions in local mapping using the Sequential Intercept Model. The Sequential Intercept Model (Exhibit 36) is used by many communities as a conceptual framework to understand and address behavioral health issues and the criminal justice system. The version of the model developed by the SAMHSA GAINS Center may be a tool for organizing and evaluating initiatives in New Hampshire. In a robust system, interventions are targeted at each point of intercept between the behavioral health and criminal justice systems to prevent individuals from entering (Intercept 1) or penetrating deeper into the criminal justice system. Ideally, most people are intercepted in the earlier stages, with decreasing numbers at each intercept.

Exhibit 36. Sequential Intercept Model



SAMHSA's GAINS Center. (2013). *Developing a comprehensive plan for behavioral health and criminal justice collaboration: The Sequential Intercept Model* (3rd ed.). Delmar, NY: Policy Research Associates, Inc.

Diversion

Recommendation: Develop and expand crisis alternatives

Alternative crisis services, such as crisis residential programs and peer respites, can provide resources to divert some individuals from acute inpatient care and have been shown in many studies to reduce the need for inpatient care.

Suggested actions:

- Communicate the availability of peer respite beds to maximize utilization.
- Encourage (when appropriate) mobile crisis teams to attempt peer respite referrals.
- Increase mobile crisis teams, especially for children.
- Establish an alternative to jail and EDs, such as a 24-hour psychiatric urgent care in CMHCs, where police could take people who are in crisis.
- Consider CMHCs operating 24-hour crisis services.
- Expand crisis stabilization beds as an alternative to inpatient care.

Recommendation: Develop a clinical consultation program to address gaps in specialty services

A clinical consultation program can be centralized and encompass different clinical specialties that are available to consult with emergency room doctors, mobile crisis teams, ACT and other teams, and individual psychiatrists and clinicians. This program can help facilitate quicker and more accurate crisis evaluations and be an important preventative service within the system.

Consultation models where psychiatrists provide consultation to primary care physicians about the use of psychiatric medications for “routine” cases have also been used successfully in states and counties across the country; these models free up psychiatrists for patients with more complex medication regimens. Strategies such as arranging for e-consults, scheduling psychiatry “office hours” so psychiatrists can provide consultation to primary care physicians, and increasing training for primary care physicians on the use of psychiatric medications have been used to help augment the shortage of available psychiatrists in rural areas.

Suggested actions:

- Assess the current capacity of the system to provide clinical consultation and expertise in core areas such as child and adolescents, co-occurring disorders, dual diagnoses, and traumatic brain injury.
- Explore feasibility of tele-health and some mobile capacity to perform on-site consultations as needed.

Recommendation: Establish a centralized coordinating process and data system at the state level that would track people waiting in EDs and available beds, including peer respite and crisis stabilization

The purpose of this recommendation is to ensure movement through the system and to minimize backups. Frequently, emergency departments experience boarding even when inpatient, respite, or crisis stabilization beds are available nearby elsewhere in the system. Disposition problems can be referred to the state as a last resort triage mechanism.

Suggested actions:

- The state should convene a workgroup to examine the feasibility of this approach. Considerations should include:
 - Develop communication procedures to ensure that existing capacity is fully utilized.
 - Provide for facilities to transfer a patient to neighboring area with open bed.
 - Enhance coordination and awareness of acceptance criteria, etc. Formulate MOUs to share this information with the state and among all EDs (replace the current blast fax methods).
 - Establish a time threshold by which EDs report to the state who is being boarded over a certain number of days,
 - Develop a dispute resolution process.

Recommendation: Require timely linkage to community-based services following inpatient or emergency department admission

Timely outpatient follow-up has been promoted as a key strategy to reduce emergency department and hospital readmissions. In general, one-half of patients readmitted within 30 days of hospital discharge do not have follow-up before the readmission. The state should consider steps to develop guidance for ED and hospital follow-up for patients with conditions of varying complexity.

Several key informants noted that, in the past, outpatient program staff would connect with inpatient patients and staff to coordinate discharge plans, but this practice no longer occurs, most likely due to staffing shortages. Restoration of this practice could shorten length of stay and reduce rapid readmissions.

Suggested actions:

- Establish a policy that providers are required to see referrals within a specified number of days of discharge from an inpatient or emergency department admission.
- Establish a process whereby hospitals and providers are required to establish a "warm handoff" so that an individual is engaged by a peer or provider (e.g., ACT, case manager) at discharge.
- Restore the practice of "inreach" whereby CMHC and ACT program staff meet with inpatient staff for case consultation and discharge planning.
- CMHC staff and ACT team members have regular meetings with staff of EDs to identify and problem-solve bottlenecks and communication/coordination issues.

Recommendation: Increase clinical support in EDs

Specialty psychiatric consultation can help stabilize and expedite discharge of ED admissions, given the clinical expertise of these individuals that is not generally available in EDs.

Suggested actions:

- Consider various models of Psychiatric Emergency Services that provide enhanced consultation for complex cases admitted to the ED, such as those described by Bender, Pande et al. (2008).
- Embed peer support specialists in EDs.
- Develop procedures for follow up on discharge from ED to the community to insure connection with outpatient services. (Peer support specialists might provide this function.)

Recommendation: Increase support and training for law enforcement and first responders

Crisis Intervention Team (CIT) training is a police-based model designed to improve police officers' interactions with individuals in mental health-related crisis. Through classroom-based and experiential training, officers learn how to deescalate crisis and redirect individuals to treatment rather than the criminal justice system. The model is used widely throughout the U.S., and research studies have documented effectiveness in diverting individuals to treatment, improving officers' attitudes toward and

knowledge about mental health issues, lowering arrest rates, and reducing criminal justice system costs (Compton et al., 2008).

Another alternative is what is known as a Co-Responder Program. For example, in Tacoma, Washington, the Mental Health Co-Responder Program employs mental health professionals, who are embedded within the police department and act as “go to” resources when police identify that an individual may have a mental health-related need. The mental health professionals provide support and consultation for officers and respond alongside officers to calls that appear to be mental health-related. Co-responders are Designated Mental Health Professionals who can aid in making a determination to involuntarily commit a person, though this is not a requirement of the position. The co-responders have a designated office within the police department and have their own cars.

Suggested actions:

- Increase training for first responders and police (e.g., Crisis Intervention Team).
- Replicate the model of the Manchester Police Department, working with local CMHC-mobile crisis team with a law enforcement component.
- Add social workers as part of police department, to ride with police for domestic situations, child issues, etc.
- Increase the availability of psychiatric consultation services to law enforcement and first responders.
- Establish protocols with police departments when it is appropriate to bring individuals to crisis diversion services, such as crisis residential, peer respite, or walk-in urgent clinics, as opposed to the ED.
- Consider a Co-Responder Program for New Hampshire.

Disposition

This section addresses issues related to disposition from ED and inpatient settings.

Recommendation: Develop a formal protocol, criteria or communication process for allocating admissions to public vs. private hospitals to ensure the most appropriate level of care

As in most areas of the country, New Hampshire’s inpatient behavioral health system includes both public and private provider organizations, which typically serve different population subgroups, though this distribution is not determined through any formal process. The two ownership types also respond

to different incentives and therefore adopt different strategic plans, which may affect bed availability in unpredictable ways. While the state does not have the authority to dictate the number or types of admissions for private hospitals, a cooperative agreement that provides detailed criteria for admission to New Hampshire Hospital versus private facilities, and procedures for transfer and discharge, would provide for a rational process for decision making and planning.

Suggested actions:

- New Hampshire Hospital should maximize collaboration with private hospitals to provide effective treatment and seamless discharge to the community for individuals with complex conditions. Some states have established agreements with private hospitals to serve individuals who otherwise would go to the public hospital. These agreements may have financial incentives and may include provisions that the private hospitals are able to refer to and access community-based services for individuals upon discharge.

Recommendation: Ensure the availability of re-entry programs throughout the state

The many challenges faced by every individual re-entering the community from correctional institutions are even greater for those with mental health problems, which are often complicated by co-occurring substance abuse disorders and physical health problems. During this transition period of increased vulnerability, connecting with needed behavioral health services, making appointments, getting prescriptions filled, etc. are critical for successful re-entry, yet are highly prone to failure without focused attention by the service system.

Suggested actions:

- Ensure that people with mental illness who are leaving jails are linked with mental health services prior to discharge through dedicated case managers who are assigned to or based at local jails.
- Ensure timely access to psychiatrists and clinicians, medications, related case management and support services, housing and employment post release from jails.

Recommendation: Establish community-based forensic services as a step-down for individuals in New Hampshire Hospital who no longer require that level of care and can transition

One of the areas where flow of individuals through NHH bottlenecks is with individuals who are on a legal hold or have NGRI status, but do not level an inpatient level of care. Multiple informants

emphasized the need for other options besides NHH beds for these individuals, such as a community based secure residential facility to start, with a possible step down to full integration within the community with high intensity supports provided by a Forensic ACT team along with other services like PSH.

Suggested actions:

- Explore the feasibility of establishing a secure residential facility to allow a step down from NHH intensity services while beginning the process of community integration.
- Establish criteria for when competency evaluations can be performed at a jail versus at NHH.
- Explore the feasibility of Forensic ACT or similar community-based, high intensity support services that could be used as a step-down from a secure residential facility.
- Increase mechanisms for case-level collaboration between DOC and NHH staff to ensure that NGRI individuals in need of acute inpatient levels of care are filling NHH beds; limit NHH stays to minimum length needed for stabilization.

Recommendations: Adopt advance discharge planning models that have been shown to reduce ED boarding by better management of inpatient capacity

Teams of utilization review staff, social workers and physicians can assess inpatient bed utilization and help plan more timely discharges across the system. Additionally, computerized bed management systems have been shown to improve hospital flow (Bender, Pande et al. 2008).

Suggested actions:

- Increase communication and develop strategies for more timely discharges.
- Develop an electronic bed management system.

System-Wide Recommendations

In the past, state and CMHCs served as coordinating bodies of services for people with serious mental illness, either through direct services or contract management. In the more complex behavioral health systems of today, this function no longer exists and has mostly been replaced. Gaps and limitations in behavioral health systems, such as those we documented in this study, are often due, in varying degrees, to fragmentation related to multiple funding sources and diverse organizations with differing missions that provide only certain services to a specific subpopulation of persons needing behavioral health care. These circumstances are the consequence of numerous historical factors and are not easily rectified; however, there are examples in some locales of various models of coalitions, steering

committees, task forces and the like that serve to enhance communication or coordination among the various parties involved in providing behavioral health care. Coalitions and related models may or may not have decision-making authority but can be effective at promoting consensus, limiting the negative consequences of competition, and advocating for addressing unmet needs.

Recommendations: DHHS should support the formation of local planning committees, where they do not already exist, to address various system issues, devise solutions, and monitor progress

Issues that such coalitions and task forces might address are:

- Strategies to prevent further reduction in inpatient capacity
- Increased system integration and continuity of care
- Coordination with the criminal justice system
- Closer integration of the mental health and substance use treatment systems
- Promotion of many of the other recommendations offered here

Recommendation: Encourage communities to share responsibility with the state for promoting high quality behavioral health services

Increasingly, behavioral health is being recognized as having a community-based public health dimension. The Centers for Disease Control (CDC) describes this multi-faceted issue as a need to identify risk factors, increase awareness about mental disorders and the effectiveness of treatment, remove the stigma associated with receiving treatment, eliminate health disparities, and improve access to mental health services for all persons, particularly among populations that are disproportionately affected.⁵

Addressing many of these needs involves activities at the community level, which has the additional potential to educate the public about the community-level benefits of increased funding of behavioral health.

Suggested actions:

- Consider public health approaches for the 10 Year Plan.
- Support anti-stigma efforts.

⁵ <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a1.htm>

- Create opportunities for engagement of youth, families, adults in the system.
- Involve families in general and in decision making for youth and adults.
- Conduct community focus groups about service needs.
- Provide more outreach and communication about available services.
- Support research and training for consumers, providers, state staff.
- Coordinate initiatives with public health agencies.

Recommendation: Workforce development

Enhancing workforce competencies through additional, focused trainings would have a positive impact on the quality of care throughout the system.

Suggested actions:

- Consider developing a training academy or curriculum to train providers in best practices, ACT or Permanent Supported Housing (PSH) for example, as a requirement to bill Medicaid (Louisiana is an example in this regard; it has such a policy in place for PSH providers).
- Work with universities/colleges to include additional education on behavioral health into the curriculums of social work and psychology degree programs.
- Encourage people in the field to get a Certified Psychiatric Rehabilitation Practitioner (CPRP) certification, especially paraprofessionals and peers, and recognize this as a credential for some services.
- Develop peers as part of the workforce throughout the system (e.g., Certified Peer Specialists, Peer Wellness Coaches, Health Specialists).

Recommendation: Improve workforce recruitment and retention

Behavioral health workforce shortages are a problem across the nation and especially in rural areas. These shortages occur in every job category (psychiatrists, nurses, psychologists, social workers, etc.) and are particularly severe for certain specialties such as child psychiatrists. Workforce shortages negatively impact the behavioral system in multiple ways: not only do they create barriers to access generally, but they may limit capacity to respond to crises and affect the quality of services, such as the fidelity of evidence-based practices. Many key informants identified staffing shortages as a core challenge to expanding the availability and improving the quality of outpatient behavioral health services in New Hampshire.

Suggested actions:

- Form a body or group to foster partnerships among public and private providers and assist them to identify human resource gaps, implement creative solutions for more effective recruitment and retention, advocate to the state legislature to increase reimbursement rates, and carry out an action plan for licensing, recruitment, and professional development to ensure a clinically competent workforce.
- The ability to attract and retain the behavioral health workforce is not only a matter of increasing pay but also a matter of improving morale. This can be accomplished in a variety of ways, including increased training, dedicated time for supervision, conference participation, and various forms of public recognition.
- Increase reimbursement rates for community mental health workers, psychiatrists, emergency services, non-NHH inpatient beds through formal discussions with Medicaid or other mechanisms like value-based purchasing and managed care type arrangements.
- Establish loan forgiveness/loan repayment programs.
- Increase non-monetary incentives for the workforce (trainings, quality supervision, recognition of high performance, foster a sense of community/responsibility etc.).
- Eliminate barriers to reciprocity of licensing.
- Provide consultation for clinicians seeking licensure from out of state.
- Leverage psychiatrist supply by doing e-consults with primary care, EDs.
- Provide additional training in the following areas:
 - Substance use, autism and mental health, children and mental health
 - Cross training across mental health and other providers of services
 - Substance use disorder (SUD) treatment providers need to be trained in mental health
 - Family-centered evidenced based practices
- Create internships programs – official training for students with promise of a job afterwards.

Recommendation: Expand the use of remote health interventions

Telemedicine is a nationally recognized approach to increasing access to care, including behavioral health care. A literature review was conducted, based on findings published from 60 scholarly sources within the past 12 years, to assess the use of telepsychiatry in the United States.⁶ The review concluded

⁶ <http://perspectives.ahima.org/telepsychiatry-in-the-21st-century-transforming-healthcare-with-technology/#.VczTOMd3vIU>

that telepsychiatry was effective in treating individuals with a variety of mental health conditions. The review determined that treatment delivered using telemedicine was comparable to face-to-face service delivery and that most people who received the service were satisfied with their level of care.

Other remote health interventions, including social media platforms and smartphone applications designed to equip service users and providers with tools for engagement, coaching, and collaboration have proliferated in recent years.⁷ As financing of behavioral health care shifts from fee-for-service to value-based payment models in coming years, there may be opportunities to incorporate such approaches into the provision of behavioral health care New Hampshire.

Recommendation: Increase the use of performance metrics

DHHS should establish performance metrics to evaluate whether the services that individuals are receiving are having a desired impact on reducing ED and inpatient utilization, as well as other recovery-oriented outcomes. Similarly, system-wide and hospital-specific metrics should be used when considering changes in inpatient bed capacity and considered in the context of the community-based performance indicators. Community-based performance indicators that demonstrate an expansion of services that produce desired outcomes—such as fewer crisis episodes, stable housing, and engagement in meaningful activities (employment and positive social relationships, among others)—will likely result in fewer hospital admissions. The ability of the system to correlate these metrics will provide a data-driven justification for additional decreases to inpatient bed capacity. Examples of metrics that other communities have used as part of routine reporting and dashboard systems include:

- Follow-up after discharge from an emergency department for individuals with a mental health condition
- Follow-up after discharge from an inpatient hospital for individuals with a mental health condition
- Provider collaboration measures around referrals and data sharing
- Number of inpatient bed days utilized by payer source and demographics
- Number of behavioral health emergency room encounters
- Number of new persons entering the system (could be defined as those completely new to the system or those who have not received a service for a specified amount of time)
- Number of persons entering the system via police or other criminal justice entry point

⁷ For a discussion of recent trends and tools, see <http://www.nimh.nih.gov/health/topics/technology-and-the-future-of-mental-health-treatment/index.shtml>

- When new services are added, the number of people utilizing the service by month
- Number receiving employment support services
- Number receiving housing support services
- Number of service users in competitive employment
- Number of service users who attain and maintain stable, integrated housing
- Number receiving housing vouchers
- Number of peer specialists employed
- Service user activation (Patient Activation Measure-Mental Health) and health and mental health-related functioning
- Substance use disorder treatment, retention and engagement

Recommendation: Support current efforts to enhance and integrate data systems

In today’s health care environment, comprehensive, integrated data systems are considered essential to effective planning, service coordination, and delivery. The inclusion of data system improvement in the Community Mental Health Agreement is an important step in this direction and should be vigorously supported.

Suggested actions:

- Training for behavioral health providers to routinely collect and use data to inform clinical decision-making and demonstrate improved individual-level outcomes.
- Sufficient capacity across all providers to collect data in formats that allow for assessment of the core functions that are essential to integrated or coordinated care (e.g., referral tracking, follow-up, care planning, and cross provider/system communication).
- Efforts to ensure that the goal of required data collection and reporting moves beyond documenting the number and type of services delivered to tracking whether the services are making a difference in the lives of individuals and improving overall population health (i.e., moving from volume-based care to value-based care).

Summary

The recommendations in this report, based on utilization data and key informant interviews, provide a partial picture of existing and needed outpatient services and suggest a need for outpatient and community-based service enhancements that may provide a better return on investment than inpatient

services. However, behavioral health systems are constantly changing, and continued monitoring of outpatient need and capacity will be essential to ensuring a high-quality behavioral health system in the long term.

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Appendix A List of Documents Reviewed

Title of Document Shared (Date; Author/s)
Access New Hampshire Highlight: The changing dynamics of hospital care for mental illness & substance use in New Hampshire – implications for supporting continuums of care (2008; UNH Institute on Disability)
Access New Hampshire Policy Brief: The changing dynamics of hospital care for mental illness & substance use in New Hampshire – implications for supporting continuums of care (2008; UNH Institute on Disability)
Addressing the Critical Mental Health Needs of NH’s Citizens: A Strategy for Restoration aka “10-year plan” (2008; DHHS and NHCBHA)
An Act to Implement a System of Care for Children’s Behavioral Health in New Hampshire- Year 2 Draft Report (2017; DHHS)
Barriers to People Receiving the Right Care (2017; Foundation for Healthy Communities)
Bed Capacity Study: Where are we now?, Presentation (2004?; DHHS)
Behavioral Health Barometer: New Hampshire (2015; SAMHSA)
Billing Issues for Mental Health Patients Boarding in Acute Care Hospital Emergency Departments (2017; NHCBHA and NH Hospital Association)
Building Capacity for Transformation: New Hampshire’s DSRIP Waiver Program, Presentation (2016; DHHS)
Children's Mental Health in New Hampshire: Evidence Based Practice (2007; NH Center for Public Policy Studies)
Class Action Settlement Agreement aka “Community Mental Health Agreement” (2013; Court Document)
Clinical Services Provided to Mental Health Patients Boarding in Hospital Emergency Departments- June 2017, Presentation (2017; NH CBHA and NH Hospital Association)
CLM Year in Review FY 2017 (2017; CLM)
CMHC EBP services ACT and Supported Employment (Unknown, unknown)
Community Mental Health Agreement and 2018/2019 System Improvements- July 2017, Presentation (2017; DHHS)
Community Well-Being in the Monadnock Region (2012; NH Center for Public Policy Studies)
DHHS Behavioral Health Presentation to Senate Finance Committee 4-28-17 (2017; DHHS)
Falling behind in early childhood education (2015; Business New Hampshire)
FAST Forward Community Readiness Assessment (2014; NH Children’s Behavioral Health Collaborative and Antioch University)
Gap Analysis of New Hampshire Family and Youth Engagement Practices (2016; Human Service Collaborative)
Greater Monadnock Region Community Health Improvement Plan, Presentation (2015; Greater Monadnock Public Health Network)
Improving Child & Community Health: Addressing Workforce Challenges in Our Community Mental Health Centers (2016; Antal for various)
List and Map of CMHC Regions (unknown; DHHS)
List of NH mental health reports -links 2008 – 2014 (Unknown; unknown)

Title of Document Shared (Date; Author/s)
Mental Health Services for New Hampshire's Young Children and Their Families: Planning to Improve Access and Outcomes (2009; NH Association for Infant Mental Health)
Mission Statement (2017; CLM)
Mobile Crisis Response Teams (Unknown; unknown)
New Hampshire Children's Behavioral Health Strategic Plan Summary (2012; DHHS)
New Hampshire Children's Behavioral Health Strategic Plan (2013; DHHS?)
New Hampshire Code of Administrative Rules, Rule He-M 426 (2017; DHHS)
New Hampshire Community Mental Health Agreement Expert Reviewer Report Number 6 (2017; CMHA Expert Reviewer)
New Hampshire Drug Monitoring Initiative December 2016 Report (2016; DMI)
New Hampshire Drug Monitoring Initiative September 2017 Report (2017; DMI)
New Hampshire Hospital Admission Waiting List Count 10.1.17 (2017; NAMI)
New Hampshire Public Mental Health Consumer Satisfaction Survey Report (2016; JSI and DHHS)
New Hampshire's Community Mental Health System: A Way Forward (2017; NHCBA)
NH Community Behavioral Health Association Workforce Trends, Impacts and Solutions; Presentation (2016; NHCBA)
NH DHHS Adult Consumer Satisfaction Survey Adult and Family Response Report 9-20-16 (2016; DHHS)
NH DHHS Adult Consumer Satisfaction Survey Adult and Family Response Report 9.1.2017 (2017, DHHS)
NH DSRIP Demonstration Program Behavioral Health Workforce Capacity Strategic Plan (2017; DHHS and statewide IDNs)
NH Involuntary Emergency Assessment Admit to Discharge Flowchart 10-4-2017 (2017; NHH)
NH Regulatory Oversight Summary and Chart 2017 (2017; Institute for Health Policy and Practice at NH School of Law)
NH System of Care Community Readiness Assessment Executive Summary (2016; Unknown)
Position Paper on Ten-Year Plan Funding in the SFY 2014-15 Budget (2013; NHCBA)
Psychiatric Units Chart (Unknown; DHHS)
Psychiatric Units Chart- DRF & Non-DRF (2017; DHHS)
Single Audit of Federal Financial Assistance Programs for the Year Ended June 30 2016 (2016; Department of Administrative Services)
Spreadsheet Showing Voluntary and DRF Bed Capacity in NH as of November 2nd, 2017 (2017; NH Hospital Association)
Spreadsheet Summarizing BMHS Housing Beds for Individuals with SPMI (2017; DHHS)
Spreadsheet Summarizing Psychiatric and Substance Abuse Beds from 1990 to November 2 nd , 2017 (2017; NH Hospital Association)
State Level System of Care Work Handout (Unknown; DHHS?)
Systems of Care Issue Brief (2015; NH Children's Behavioral Health Collaborative)
Wraparound Brief (2016; NH Children's Behavioral Health Collaborative)

Appendix B Key Informant Interview Guide

Human Services Research Institute
IRB Approved Until
October 23, 2018



Comprehensive Behavioral Health Systems Analysis for New Hampshire: Key Informant Interview Questions

October 19, 2017

Background Information

1. Tell me about yourself/your organization.
 - Populations served? Explore if any of following served:
 - i. Early childhood
 - ii. Transition-age youth and young adults (ages 18-25)
 - iii. New Americans
 - iv. Military service members and family
 - v. Older New Hampshirians
 - vi. Persons with non-behavioral health related disabilities
 - vii. Justice-involved populations
 - viii. Nursing facility residents
 - ix. People without insurance
 - x. People with co-occurring mental health and substance use issues
 - Services provided or issue you work on?
 - Mission and values?
 - How long in the area?
 - Involvement in any state or local behavioral health-related initiatives or workgroups?
 - Any previous relevant work experience?
 - [If a service user or family member] How long have you or your family member been receiving services through the New Hampshire behavioral health system?

Promotion, Prevention, and Services and Populations in Need of Services

2. What behavioral health promotion and/or prevention activities are taking place in your region or New Hampshire in general? Promotion activities may include strategies to promote mental health and wellbeing for all residents of the state, whether or not they are experiencing a mental health or substance use problem. Prevention activities may also be targeted interventions to prevent the development of more serious problems for people who are at risk of developing or already have mental health or substance use issues.
 - What data are available for us to understand more about these activities? [probes for expenditures, numbers reached/numbers targeted, impact]
 - In your view, are these prevention activities adequate in regard to quality and quantity?
 - Are there any prevention activities that should be added or expanded? Please describe any particularly innovative and/or successful initiatives related to prevention or promotion?
 - Are there any prevention activities that are not useful or should be curtailed?
 - Are prevention activities culturally and linguistically appropriate?
 - Are there any populations that you feel aren't being reached by prevention activities? Why has there been difficulty reaching them?
 - What specific drug and alcohol prevention services are available? What are the barriers to providing these services?
 - Are you aware of safe stations or similarly trained first responders in your area?

3. In your view, are the services and supports provided by the publicly funded behavioral health system (CMHCs) sufficient to meet the behavioral health-related needs of people who rely on publicly funded services in New Hampshire?
 - What services are missing or available in insufficient quantities? Probe specifically for availability of crisis response services, alternatives to hospitalization?
 - Also probe for: evidence-based practices (**including peer support, peer mentoring, supported employment, supported housing**), community-based services (including skills training, ACT, **mobile crisis services and crisis supports including child crisis services and help lines, trauma informed care training, and CIT or de-escalation training for first responders**, behavioral health within schools), outpatient treatment, **emergency room and inpatient, hospital discharge planning and transition support**, corrections-based care and community reintegration services, **mental health and drug courts**, and uninsured/unreimbursed care
 - Are there services that should be preserved or expanded? Please describe any particularly innovative and/or successful services and supports in your area.
 - Are there services or supports that you think are not useful or should be curtailed?
 - Are services and supports culturally and linguistically appropriate?

- Are there any populations that you feel aren't being reached or served adequately? What do you think is getting in the way of adequately serving this/these population(s)?
 - Are there sufficient numbers of qualified service provider agencies and individual practitioners to meet the demand for services?
 - [if services are not Medicaid-reimbursable or tracked through CMHCs] What data are available for us to understand more about these services? [probes for expenditures, numbers reached/numbers targeted, impact]
 - What is the availability of housing and housing support services for those you serve? What are the barriers to obtaining housing? What are the barriers to maintaining housing?
 - What housing related resources are you aware of? Please describe any particularly innovative and/or successful housing supports in your area.
 - Do you feel there is adequate inpatient capacity at New Hampshire Hospital? What challenges have you encountered when seeking inpatient services for someone? Has there been anything that facilitated access to inpatient services?
 - What do you feel is the number one contributor to individuals experiencing long wait times in ERs when accessing inpatient services?
 - What is the availability of services and supports for individuals with intensive/acute service needs?
 - What types of services and supports are available to individuals after receiving intensive/acute services such as inpatient? Probes for discharge plans, bridging and coordination, referrals and follow-up
 - What types of services and supports are available to individuals to avert the need for an inpatient stay? Probes for mobile crisis response, warm lines, crisis residential
 - What are the barriers to meeting the needs of individuals with intensive and/or acute service needs?
 - Are there any particularly innovative and/or successful programs, services, or supports for individuals with intensive/acute service needs?
4. Where do you think people in New Hampshire first go for help with a mental health or substance use problem?
- How is the experience different – if at all – for:
 - People who are brand new to the system?
 - People with no health insurance?
 - Parents of children and adolescents with potential behavioral health issues?
 - Military service members and their families?
 - New Americans?
5. Are there population groups that are being served particularly well? If so, please describe.

System and Financial Issues

6. How are the formal and informal policies or practices of providers, the CMHCs, or other funders affecting the delivery of mental health and/or substance use services?
 - Are there any policies that are impeding the delivery of mental health and/or substance use services?
 - Are there any policies that are helping to ensure adequate services are available?
7. Are the rates being paid to providers adequate for them to provide high-quality versus “medically necessary” services? Are any rates too high?
8. Are there any licensing or certification issues that you are aware of affecting the supply of individuals to provide services?
9. What mechanisms for coordination among and between provider organizations exist? In what ways might coordination of services be improved?
10. What mechanisms for coordination among and between relevant state and local agencies exist? In what ways might inter-agency coordination be improved? Probes for education, early intervention, vocational rehabilitation, justice systems (law enforcement, prisons, jails, courts), physical health systems including federally qualified health centers (FQHCs), aging and disability systems, child welfare, public health
11. Are telehealth systems readily available? What barriers exist for accessing telehealth services? Please describe any particularly innovative or successful telehealth initiatives.
12. What sorts of data does your organization collect? As part of regular program administration (e.g., units of service provided)? Service user experience?
 - How frequently are these types of data collection?
 - How are these data used? Are these data reported to any other parties? Does your organization coordinate its data collection and analysis efforts with other organizations or report data in a centralized way (e.g., participate in some sort of larger, system-wide data initiative at the state or local level)?
 - Are there any types of data that your organization should be collecting?
13. Do you believe providers, the CMHCs, and/or funders are conducting adequate oversight processes to assure that services are of high quality? If not, what do you think they should be doing differently?
14. What has been the impact of Medicaid expansion on the behavioral health service system?

Community and Service User Involvement

15. Is there sufficient public input into decisions that impact the behavioral health system?

- Are there forums and avenues for the public to have a voice in the behavioral health systems (e.g., town halls on opioid epidemic)?
 - Are the forums and avenues provided for individuals with limited English proficiency?
 - Are the forums and avenues provided for all major groups represented in the community, including racial and ethnic minorities?
- Do entities within the behavioral health system reach out to the public to seek their views? If so, how effective are these processes?
- Are they receptive to feedback from the community?
- Are there specific groups in the community that are given fewer opportunities to provide feedback, or whose feedback is overlooked?

16. Is there sufficient service user and family member input into decisions that impact the behavioral health system?

- Are there forums and avenues for service users and their families to have a voice in the behavioral health systems?
 - Are there forums and avenues for service users and family members with limited English proficiency to have input into service delivery decisions?
 - Are there forums and avenues for service users and their families in all major groups represented in the community, including racial and ethnic minorities, to have input into service delivery decisions?
- Do entities within the behavioral health system reach out to service users and family members to seek their views? Do they make use of bilingual staff, interpreter services, and translated materials?
- Are entities within the behavioral health system receptive to service user and family member feedback?

17. Is there sufficient provider input into service delivery decisions?

- Are there forums and avenues for providers to have a voice in the behavioral health service delivery systems?
- Do entities within the behavioral health system reach out to providers to seek their views?
- Are entities within the behavioral health system receptive to provider feedback?

Sources of Information

18. Are there documents, needs assessments, or data that you believe would be helpful to this project?

- If so, what are they, and where can we get them?

19. Are there other people or groups you believe we should be talking to about the needs in your area?
- Who are they, and how do we contact them?

General Questions

20. Any other ideas for changes that would make the system work better?
21. Is there anything else that you think is important to know about the behavioral health service system in New Hampshire that we did not get to today?
22. Of all of the things we discussed today, please highlight the most important points. What are the key takeaways from this conversation?

Appendix C Key Informants Interviewed

Name	Title or Role
Adams, Eric	Laconia Police Officer
Ahmen, Steve	President, New Hampshire Hospital Association
Amoth, Craig	Region VI CMHC CEO- Greater Nashua Mental Health Center at Community Council
Antal, Peter	UNH Institute on Disability
Bizarro-Thunberg, Kathy	Exec V.P. of federal relations, New Hampshire Hospital Association
Brunette, Mary	Medical Director, Bureau of Mental Health Services; Dept of Behavioral Health; NH DHHS; Associate Professor of Psychiatry; Geisel School of Medicine at Dartmouth; Department of Psychiatry, Dartmouth-Hitchcock
Calcutt, Dennis	Children's Program Director for Monadnock SOC
Collins, Brian	Region IX CMHC CEO- Community Partners of Strafford County
Conley, Jennifer	Cypress Center, Unit Coordinator
Conte, Russ	New Hampshire State Police, NAMI board member
Couture, Geraldine	Region VIII CMHC CEO- Seacoast Mental Health Center, Inc.
Cunningham, Ross	Superintendent, Merrimack County Department of Corrections
Cusano, Karen	NFI-North
Denesnera, Alexander	Medical Director, NHH
Dixon, John	Family member
Drown, Susan	Administrator, Office of Quality Assurance and Improvement; NH DHHS
Escalante, Annette	Director, Bureau of Drug & Alcohol Services; Division for Behavioral Health; NH DHHS
Evangelista, O.J.	Director, BH Outpatient services for Riverbend
Evers, Peter	Region IV CMHC CEO- Riverbend Community Mental Health
Griffin, Suellen	Region II CMHC CEO- West Central Behavioral Health
Grinley, Thomas	Director; Office of Consumer & Family Affairs; Bureau of Mental Health Services; Division for Behavioral Health; NH Department of Health and Human Services
Guinen, Heidi	Runs Secure Psychiatric Unit/Residential Treatment Unit, NH Department of Corrections (in place of Debbie Robinson)
Harding, Joe	Former addictions chief at DHHS
Hewitt, Martha	Chair of peer support agencies meeting; Director, Tri-City Consumers' Action Co-operative (Region IX PSA)
Hodder, Lucy	UNH Director, Center for Health Law and Policy at UNH
Johnson, Eric	Region I CMHC CEO- Northern Human Services
Keaveney, David	Sergeant, Portsmouth Police Department
Kelleher, Peter	Region VI Residential Services CEO- Harbor Homes, Inc.
Kelly, Michael	DHHS; Works with peer support agencies & NAMI NH
LaCroix, David	Peer specialist, NHH

Name	Title or Role
Lamy, Roland	Executive Director of NHCBHA
Lewis, Ken	Region VI PSA Exec Director- HEARTS Peer Support Center of Greater Nashua
Looser, Justin	Portsmouth Regional Hospital, Behavioral Health Market Director
Morris, Polly	Region V PSA Exec Director- Monadnock Area Peer Support Agency
Norton, Ken	Executive Director, NAMI
Pendergast, Deborah	Director NH Fire Academy and EMS
Pritchard, Margaret	Region III CMHC CEO- Genesis Behavioral Health
Prive, Karen	NAMI board member, consumer and family member
Putnam, Lucy	Children's director Region IV - Concord
Rider, William	Region VII CMHC CEO- The Mental Health Center of Greater Manchester
Rourke, Tym	Chair of the Governor's Commission on Drug and Alcohol Abuse
Scheetz, Deb	Deputy Medicaid Director; Department of Health & Human Services
Seidler, Susan	Region II PSA Exec Director- Multiple programs
Shibinette, Lori	CEO, NHH
Shumway, Don	Former Interim CEO, NHH
Skibbie, Mike	Policy Director, Disability Rights Center of New Hampshire
Tenney, Daryll	Program Specialist; Bureau for Children's Behavioral Health DBH/Main Building
Tenny, Claire	Chief of Mental Health at Manchester VA Medical Center
Tilley, Trisha	Deputy Director, DPH
Topo, Victor	Region X CMHC CEO- CLM Center for Life Management
Torrey, Will	Psychiatrist and clinical leader at Dartmouth-Hitchcock
Trudel, Karen	NAMI board member, consumer
Ungarelli, Erica	Director, Children's Bureau, DHHS
Willard, Nick	Manchester Chief of Police
Wyzik, Philip	Region V CMCH CEO- Monadnock Family Services

Appendix D CMHC Services Provided by Region

Region 1

Exhibit D1. Services provided by Northern Human Services, SFY 2017

	Count of Unique Clients		Count of Services	
	N	%	N	%
TOTAL	3,122	-	95,649	-
ACT Screening Eligible	1	0.0%	1	0.0%
Case Management - Direct (Face-To-Face)	1,599	51.2%	10,495	11.0%
Case Management - Direct Non-Billable	885	28.3%	4,255	4.4%
Clozaril Management	18	0.6%	178	0.2%
Court Ordered DWI Assessment	3	0.1%	3	0.0%
Crisis Intervention MH Service (IROS/FSS)	58	1.9%	247	0.3%
Emergency Services	485	15.5%	653	0.7%
Emergency Services - Non-Billable	442	14.2%	985	1.0%
Evaluation & Management	1,115	35.7%	4,613	4.8%
Evaluation & Management Non-Billable	16	0.5%	28	0.0%
Evidence Based Supported Employment	116	3.7%	1,300	1.4%
Family Therapy with The Client	316	10.1%	1,386	1.4%
Family Therapy Without the Client	107	3.4%	200	0.2%
Family Training and Counseling (IROS/FSS)	301	9.6%	1,281	1.3%
Group Therapy	57	1.8%	441	0.5%
Group Therapy - Non-Billable	2	0.1%	4	0.0%
Illness Mgmt. & Recovery (EBP) - Individual	29	0.9%	247	0.3%
Illness Mgmt. And Recovery (EBP) - Group	14	0.4%	256	0.3%
Individual Psychotherapy	2,005	64.2%	14,335	15.0%
Individual Psychotherapy - Non-Billable	24	0.8%	39	0.0%
Intake	1,089	34.9%	1,118	1.2%
Med Training & Support / 15 Min. (IROS/FSS)	82	2.6%	2,915	3.0%
Non-Billable Evidence Based Supported Employment	446	14.3%	727	0.8%
Nursing Assessment	4	0.1%	46	0.0%
Psychotherapy for Crisis	18	0.6%	21	0.0%
RPH - Full Day	23	0.7%	2,589	2.7%
RPH - Half Day	22	0.7%	222	0.2%
Therapeutic Behavioral Service-Individual	899	28.8%	28,177	29.5%
Therapeutic Behavioral Service-Per Diem	43	1.4%	15,486	16.2%
Therapeutic Behavioral Services-Group	9	0.3%	30	0.0%

Source: DHHS, Office of Quality Assurance and Improvement

Exhibit D2. Characteristics of People Served by Northern Human Services, SFY 2016 and 2017

	SFY 2016		SFY 2017	
	N	%	N	%
Total Served	3,209	-	3,122	-
Age				
0-17 years	894	27.9	897	28.7
18-24 years	363	11.3	307	9.8
25-64 years	1,759	54.8	1,736	55.6
65+ years	193	6.0	182	5.8
Gender				
Male	1,537	47.9	1,486	47.6
Female	1,671	52.1	1,635	52.4
Race				
American Indian or Alaska Native	12	0.4	11	0.4
Asian	10	0.3	8	0.3
Black or African American	10	0.3	8	0.3
Native Hawaiian or Pacific Islander	0	0.0	1	0.0
White	2,860	97.7	2,872	97.7
More Than One Race	34	1.2	41	1.4
Ethnicity				
Hispanic/Latino	40	1.4	48	1.7
Non-Hispanic/Latino	2,796	98.6	2,788	98.3
Insurance Status				
Public Insurance	1,948	70.2	2,092	67.1
Private Insurance	489	17.6	572	18.3
Combination Public and Private	0	0.0	0	0.0
Uninsured	339	12.2	456	14.6
CMHC Eligible	2,032	63.3	2,069	66.3
Non-CMHC Eligible	1,177	36.7	1,053	33.7

Source: DHHS, Office of Quality Assurance and Improvement

Region 2

Exhibit D3. Services provided by West Central Behavioral Health, SFY 2017

	Count of Unique Clients		Count of Services	
	N	%	N	%
TOTAL	2,189	-	71,987	-
ACT Screening Eligible	12	0.5%	14	0.0%
Case Management - Direct (Face-To-Face)	1,207	55.1%	7,807	10.8%
Case Management - Indirect	455	20.8%	1,529	2.1%
Clozaril Management	98	4.5%	764	1.1%
Completion of a 920 Form	1	0.0%	1	0.0%
Consultation to Another on Their Case	1	0.0%	1	0.0%
Coordination of admission from outpatient ACT to hospital DRF nursing home or residential service	3	0.1%	5	0.0%
Coordination of discharge from hospital DRF nursing home or residential service to outpatient ACT	1	0.0%	2	0.0%
Crisis Intervention MH Service (IROS/FSS)	20	0.9%	27	0.0%
Emergency Services	420	19.2%	645	0.9%
Evaluation & Management	1,420	64.9%	5,483	7.6%
Evidence Based Supported Employment	114	5.2%	930	1.3%
Family Therapy with The Client	601	27.5%	3,225	4.5%
Family Therapy Without the Client	299	13.7%	876	1.2%
Family Training and Counseling (IROS/FSS)	304	13.9%	1,935	2.7%
Group Therapy	189	8.6%	2,795	3.9%
Illness Mgmt. & Recovery (EBP) - Individual	164	7.5%	1,376	1.9%
Illness Mgmt. And Recovery (EBP) - Group	51	2.3%	682	0.9%
Individual Psychotherapy	1,678	76.7%	17,102	23.8%
Injection	66	3.0%	601	0.8%
Intake	516	23.6%	523	0.7%
Med Training & Support / 15 Min. (IROS/FSS)	102	4.7%	796	1.1%
Non-Billable Evidence Based Supported Employment	100	4.6%	134	0.2%
Nursing Assessment	165	7.5%	1,524	2.1%
Outreach without face to face contact	35	1.6%	139	0.2%
Psychological and Neuropsych. Testing	23	1.1%	40	0.1%
Psychotherapy for Crisis	10	0.5%	10	0.0%
RPH - Full Day	8	0.4%	8	0.0%
RPH - Half Day	25	1.1%	3,052	4.2%
Therapeutic Behavioral Service-Individual	756	34.5%	12,442	17.3%
Therapeutic Behavioral Service-Per Diem	25	1.1%	5,667	7.9%
Therapeutic Behavioral Services-Group	235	10.7%	1,843	2.6%

Source: DHHS, Office of Quality Assurance and Improvement

Exhibit D4. Characteristics of People Served by West Central Behavioral Health, SFY 2016 and 2017

	SFY 2016		SFY 2017	
	N	%	N	%
Total Served	2,008	-	2,189	-
Age				
0-17 years	846	42.1	868	39.7
18-24 years	169	8.4	213	9.7
25-64 years	861	42.9	948	43.3
65+ years	132	6.6	160	7.3
Gender				
Male	947	47.2	1,010	46.7
Female	1,059	52.8	1,151	53.3
Race				
American Indian or Alaska Native	41	2.1	34	1.7
Asian	12	0.6	14	0.7
Black or African American	20	1.0	25	1.3
Native Hawaiian or Pacific Islander	0	0.0	0	0.0
White	1,813	94.4	1,844	94.8
More Than One Race	34	1.8	28	1.4
Ethnicity				
Hispanic/Latino	57	3.6	54	3.3
Non-Hispanic/Latino	1,518	96.4	1,591	96.7
Insurance Status				
Public Insurance	517	25.7	1,061	48.5
Private Insurance	1,275	63.5	835	38.2
Combination Public and Private	30	1.5	92	4.2
Uninsured	186	9.3	199	9.1
CMHC Eligible	1,207	60.1	1,274	58.2
Non-CMHC Eligible	801	39.9	915	41.8

Source: DHHS, Office of Quality Assurance and Improvement

Region 3

Exhibit D5. Services provided by Genesis Behavioral Health, SFY 2017

	Count of Unique Clients		Count of Services	
	N	%	N	%
TOTAL	3,966	-	121,778	-
ACT Screening Eligible	3	0.1%	3	0.0%
ACT Screening Non-Eligible	1	0.0%	1	0.0%
Case Management - Direct (Face-To-Face)	2,111	53.2%	11,917	9.8%
Case Management - Direct Non-Billable	338	8.5%	481	0.4%
Case Management - Indirect	1,532	38.6%	4,240	3.5%
Consultation to Another on Their Case	88	2.2%	133	0.1%
Crisis Intervention MH Service (IROS/FSS)	269	6.8%	398	0.3%
Eligibility Determination	1,952	49.2%	2,502	2.1%
Emergency Services	764	19.3%	2,058	1.7%
Evaluation & Management	2,231	56.3%	8,281	6.8%
Evaluation & Management Non-Billable	143	3.6%	416	0.3%
Evidence Based Supported Employment	220	5.5%	2,497	2.1%
Family Therapy with The Client	591	14.9%	1,947	1.6%
Family Therapy Without the Client	114	2.9%	662	0.5%
Family Training and Counseling (IROS/FSS)	219	5.5%	422	0.3%
Group Therapy	95	2.4%	883	0.7%
Group Therapy - Non-Billable	6	0.2%	6	0.0%
Illness Mgmt. & Recovery (EBP) - Individual	39	1.0%	109	0.1%
Illness Mgmt. And Recovery (EBP) - Group	81	2.0%	455	0.4%
Individual Psychotherapy	2,631	66.3%	20,875	17.1%
Injection	39	1.0%	338	0.3%
Inshape - Grant-Funded	6	0.2%	6	0.0%
Intake	1,292	32.6%	1,327	1.1%
Medication Related Non-Billable Services	48	1.2%	57	0.0%
Non-Billable Client Specific Paperwork	3,323	83.8%	12,322	10.1%
Non-Billable Evidence Based Supported Employment	426	10.7%	1,715	1.4%
Non-Mental Health Services	1,138	28.7%	5,905	4.8%
Nursing Assessment	235	5.9%	640	0.5%
Paperwork	1,686	42.5%	3,408	2.8%
Therapeutic Behavioral Service-Individual	1,043	26.3%	22,736	18.7%
Therapeutic Behavioral Services-Group	100	2.5%	1,367	1.1%

Source: DHHS, Office of Quality Assurance and Improvement

Exhibit D6. Characteristics of People Served by Genesis Behavioral Health, SFY 2016 and 2017

	SFY 2016		SFY 2017	
	N	%	N	%
Total Served	4,235	-	3,966	-
Age				
0-17 years	1,152	27.2	1,062	26.8
18-24 years	501	11.8	445	11.2
25-64 years	2,201	52.0	2,111	53.2
65+ years	381	9.0	348	8.8
Gender				
Male	1,816	42.9	1,712	43.2
Female	2,417	57.1	2,253	56.8
Race				
American Indian or Alaska Native	3	0.1	2	0.1
Asian	4	0.1	3	0.1
Black or African American	29	1.1	21	0.9
Native Hawaiian or Pacific Islander	0	0.0	3	0.1
White	2,680	97.6	2,385	97.7
More Than One Race	30	1.1	27	1.1
Ethnicity				
Hispanic/Latino	50	1.9	45	2.0
Non-Hispanic/Latino	2,586	98.1	2,215	98.0
Insurance Status				
Public Insurance	2,772	65.7	2,569	65.1
Private Insurance	1,084	25.7	1,057	26.8
Combination Public and Private	0	0.0	0	0.0
Uninsured	364	8.6	323	8.2
CMHC Eligible	1,086	25.6	1,052	26.5
Non-CMHC Eligible	3,149	74.4	2,914	73.5

Source: DHHS, Office of Quality Assurance and Improvement

Region 4

Exhibit D7. Services provided by Riverbend Community Mental Health Center, SFY 2017

	Count of Unique Clients		Count of Services	
	N	%	N	%
TOTAL	5,392	-	183,419	-
ACT Screening Eligible	3	0.1%	6	0.0%
ACT Screening Non-Eligible	434	8.0%	892	0.5%
Case Management - Direct (Face-To-Face)	2,649	49.1%	18,581	10.1%
Case Management - Direct Non-Billable	2	0.0%	2	0.0%
Case Management - Indirect	173	3.2%	334	0.2%
Client Centered Conference	1	0.0%	1	0.0%
Clozaril Management	1	0.0%	1	0.0%
Crisis Intervention MH Service (IROS/FSS)	153	2.8%	370	0.2%
Electro Convulsive Therapy	22	0.4%	296	0.2%
Emergency Services	1,782	33.0%	4,512	2.5%
Evaluation & Management	2,727	50.6%	11,515	6.3%
Evaluation for Medicaid	21	0.4%	21	0.0%
Evidence Based Supported Employment	261	4.8%	2,353	1.3%
Family Therapy with The Client	940	17.4%	4,264	2.3%
Family Therapy Without the Client	567	10.5%	1,941	1.1%
Family Training and Counseling (IROS/FSS)	512	9.5%	4,118	2.2%
Group Therapy	306	5.7%	3,258	1.8%
Illness Mgmt. & Recovery (EBP) - Individual	44	0.8%	224	0.1%
Illness Mgmt. And Recovery (EBP) - Group	42	0.8%	348	0.2%
Individual Psychotherapy	3,139	58.2%	32,564	17.8%
Injection	114	2.1%	1,366	0.7%
Inshape - Not Grant-Funded Position	159	2.9%	3,020	1.6%
Intake	1,557	28.9%	1,604	0.9%
Med Training & Support / 15 Min. (IROS/FSS)	125	2.3%	29,946	16.3%
Non-Billable Client Specific Paperwork	1	0.0%	1	0.0%
Nursing Assessment	857	15.9%	2,945	1.6%
Outreach without face to face contact	42	0.8%	77	0.0%
Psychological and Neuropsych Testing	5	0.1%	16	0.0%
Public Prevention and Education	3	0.1%	3	0.0%
Respite	75	1.4%	1,566	0.9%
RPH - Full Day	140	2.6%	5,556	3.0%
RPH - Half Day	62	1.1%	673	0.4%
Therapeutic Behavioral Service-Individual	1,933	35.8%	40,023	21.8%
Therapeutic Behavioral Service-Per Diem	229	4.2%	10,101	5.5%
Therapeutic Behavioral Services-Group	56	1.0%	903	0.5%
VOC	1	0.0%	1	0.0%

Source: DHHS, Office of Quality Assurance and Improvement

Exhibit D8. Characteristics of People Served by Riverbend Community Mental Health Center, SFY 2016 and 2017

	SFY 2016		SFY 2017	
	N	%	N	%
Total Served	5,692	-	5,392	-
Age				
0-17 years	1,684	29.6	1,609	29.8
18-24 years	574	10.1	584	10.8
25-64 years	3,022	53.1	2,887	53.5
65+ years	412	7.2	312	5.8
Gender				
Male	2,488	43.8	2,397	44.5
Female	3,196	56.2	2,986	55.5
Race				
American Indian or Alaska Native	9	0.2	9	0.2
Asian	17	0.4	24	0.5
Black or African American	47	1.1	59	1.3
Native Hawaiian or Pacific Islander	1	0.0	2	0.0
White	4,337	98.0	4,258	96.8
More Than One Race	16	0.4	47	1.1
Ethnicity				
Hispanic/Latino	196	5.0	276	6.9
Non-Hispanic/Latino	3,761	95.0	3,743	93.1
Insurance Status				
Public Insurance	759	40.5	2,605	56.5
Private Insurance	767	41.0	1,326	28.8
Combination Public and Private	185	9.9	379	8.2
Uninsured	162	8.6	299	6.5
CMHC Eligible	3,045	53.5	2,933	54.4
Non-CMHC Eligible	2,647	46.5	2,459	45.6

Source: DHHS, Office of Quality Assurance and Improvement

Region 5

Exhibit D9. Services provided by Monadnock Family Services, SFY 2017

	Count of Unique Clients		Count of Services	
	N	%	N	%
TOTAL	2,192	-	64,766	-
Case Management - Direct (Face-To-Face)	1,068	48.7%	6,925	10.7%
Case Management - Direct Non-Billable	589	26.9%	1,315	2.0%
Client Centered Conference	107	4.9%	196	0.3%
Coordination of admission from outpatient ACT to hospital DRF nursing home or residential service	13	0.6%	32	0.0%
Coordination of discharge from hospital DRF nursing home or residential service to outpatient ACT	11	0.5%	27	0.0%
Crisis Intervention MH Service (IROS/FSS)	57	2.6%	98	0.2%
Emergency Services	728	33.2%	1,223	1.9%
Emergency Services - Non-Billable	3	0.1%	3	0.0%
Evaluation & Management	838	38.2%	2,724	4.2%
Evidence Based Supported Employment	123	5.6%	1,581	2.4%
Family Therapy with The Client	425	19.4%	2,483	3.8%
Family Therapy Without the Client	171	7.8%	326	0.5%
Family Training and Counseling (IROS/FSS)	214	9.8%	1,603	2.5%
Group Therapy	90	4.1%	1,356	2.1%
Illness Mgmt. & Recovery (EBP) - Individual	53	2.4%	226	0.3%
Illness Mgmt. And Recovery (EBP) - Group	20	0.9%	166	0.3%
Individual Psychotherapy	1,438	65.6%	12,965	20.0%
Injection	53	2.4%	726	1.1%
Intake	635	29.0%	638	1.0%
Med Check - Comprehensive	182	8.3%	182	0.3%
Med Training & Support / 15 Min. (IROS/FSS)	58	2.6%	925	1.4%
Non-Billable Client Specific Paperwork	26	1.2%	26	0.0%
Non-Billable Evidence Based Supported Employment	133	6.1%	531	0.8%
Nursing Assessment	330	15.1%	2,199	3.4%
Outreach without face to face contact	61	2.8%	201	0.3%
Psychotherapy for Crisis	15	0.7%	20	0.0%
RPH - Full Day	16	0.7%	572	0.9%
RPH - Half Day	7	0.3%	10	0.0%
Therapeutic Behavioral Service-Individual	728	33.2%	15,514	24.0%
Therapeutic Behavioral Service-Per Diem	17	0.8%	3,159	4.9%
Therapeutic Behavioral Services-Group	166	7.6%	1,607	2.5%
Transportation to activity or service the facilitates treatment plan goals	22	1.0%	78	0.1%

Source: DHHS, Office of Quality Assurance and Improvement

Exhibit D10. Characteristics of People Served by Monadnock Family Services, SFY 2016 and 2017

	SFY 2016		SFY 2017	
	N	%	N	%
Total Served	2,555	-	2,192	-
Age				
0-17 years	802	31.4	708	32.3
18-24 years	278	10.9	241	11.0
25-64 years	1,310	51.3	1,131	51.6
65+ years	165	6.5	112	5.1
Gender				
Male	1,223	47.9	1,058	48.3
Female	1,331	52.1	1,133	51.7
Race				
American Indian or Alaska Native	16	0.7	21	1.0
Asian	8	0.3	8	0.4
Black or African American	25	1.1	22	1.1
Native Hawaiian or Pacific Islander	0	0.0	0	0.0
White	2,231	96.7	1,953	96.0
More Than One Race	26	1.1	31	1.5
Ethnicity				
Hispanic/Latino	27	2.2	35	3.0
Non-Hispanic/Latino	1,225	97.8	1,142	97.0
Insurance Status				
Public Insurance	N/A	-	N/A	--
Private Insurance	N/A	-	N/A	--
Combination Public and Private	N/A	-	N/A	--
Uninsured	N/A	-	N/A	--
CMHC Eligible	1,644	64.3	1,562	71.3
Non-CMHC Eligible	911	35.7	630	28.7

Source: DHHS, Office of Quality Assurance and Improvement

Region 6

Exhibit D11. Services provided by Community Council of Nashua, SFY 2017

	Count of Unique Clients		Count of Services	
	N	%	N	%
TOTAL	3,326	-	115,402	-
Case Management - Direct (Face-To-Face)	1,929	58.0%	14,233	12.3%
Case Management - Indirect	1,403	42.2%	9,127	7.9%
Case Related Travel	106	3.2%	1,298	1.1%
Client Centered Conference	42	1.3%	64	0.1%
Consultation to Another on Their Case	26	0.8%	45	0.0%
Court Ordered DWI Assessment	4	0.1%	4	0.0%
Crisis Intervention MH Service (IROS/FSS)	117	3.5%	201	0.2%
Emergency Services	82	2.5%	223	0.2%
Emergency Services - Non-Billable	342	10.3%	830	0.7%
Evaluation & Management	2,633	79.2%	9,785	8.5%
Evidence Based Supported Employment	188	5.7%	2,215	1.9%
Family Therapy with The Client	431	13.0%	1,880	1.6%
Family Therapy Without the Client	191	5.7%	776	0.7%
Family Training and Counseling (IROS/FSS)	93	2.8%	296	0.3%
Group Therapy	267	8.0%	2,560	2.2%
Group Therapy - Non-Billable	73	2.2%	2,078	1.8%
Illness Mgmt. & Recovery (EBP) - Individual	30	0.9%	210	0.2%
Illness Mgmt. And Recovery (EBP) - Group	14	0.4%	165	0.1%
Individual Psychotherapy	1,967	59.1%	17,948	15.6%
Injection	151	4.5%	1,553	1.3%
Intake	552	16.6%	563	0.5%
Med Training & Support / 15 Min. (IROS/FSS)	103	3.1%	9,551	8.3%
Medication Related Non-Billable Services	402	12.1%	864	0.7%
Non-Billable Client Specific Paperwork	727	21.9%	2,955	2.6%
Non-Billable Evidence Based Supported Employment	216	6.5%	526	0.5%
Non-Mental Health Services	58	1.7%	133	0.1%
Nursing Assessment	183	5.5%	1,594	1.4%
Outreach	34	1.0%	37	0.0%
Psychological and Neuropsych Testing	6	0.2%	10	0.0%
Psychotherapy for Crisis	155	4.7%	193	0.2%
Public Prevention and Education	98	2.9%	288	0.2%
Substance Abuse Evaluation	42	1.3%	45	0.0%
Therapeutic Behavioral Service-Individual	1,225	36.8%	23,947	20.8%
Therapeutic Behavioral Services-Group	113	3.4%	1,941	1.7%

Source: DHHS, Office of Quality Assurance and Improvement

Exhibit D12. Characteristics of People Served by Community Council of Nashua, SFY 2016 and 2017

	SFY 2016		SFY 2017	
	N	%	N	%
Total Served	4,008	-	3,326	-
Age				
0-17 years	796	19.9	604	18.2
18-24 years	352	8.8	268	8.1
25-64 years	2,629	65.6	2,240	67.3
65+ years	231	5.8	214	6.4
Gender				
Male	1,713	42.7	1,405	42.2
Female	2,295	57.3	1,921	57.8
Race				
American Indian or Alaska Native	6	0.2	7	0.2
Asian	23	0.6	21	0.7
Black or African American	92	2.4	76	2.4
Native Hawaiian or Pacific Islander	0	0.0	0	0.0
White	3,387	90.1	2,790	89.7
More Than One Race	252	6.7	218	7.0
Ethnicity				
Hispanic/Latino	366	9.5	304	9.5
Non-Hispanic/Latino	3,505	90.5	2,905	90.5
Insurance Status				
Public Insurance	3,082	100.0	2,635	100.0
Private Insurance	0	0.0	0	0.0
Combination Public and Private	0	0.0	0	0.0
Uninsured	0	0.0	0	0.0
CMHC Eligible	2,245	56.0	2,035	61.2
Non-CMHC Eligible	1,763	44.0	1,291	38.8

Source: DHHS, Office of Quality Assurance and Improvement

Region 7

Exhibit D13. Services provided by Mental Health Center of Greater Manchester, SFY 2017

	Count of Unique Clients		Count of Services	
	N	%	N	%
TOTAL	10,982	-	331,165	-
ACT Screening Eligible	2	0.0%	3	0.0%
ACT Screening Non-Eligible	4	0.0%	8	0.0%
APRTP	777	7.1%	16,175	4.9%
Cancelled Appointment	7,760	70.7%	32,329	9.8%
Case Management - Direct (Face-To-Face)	3,579	32.6%	23,144	7.0%
Case Management - Direct Non-Billable	7,298	66.5%	29,231	8.8%
Case Management - Indirect	2,029	18.5%	4,253	1.3%
Clozaril Management	103	0.9%	1,207	0.4%
Community Based Assessment	30	0.3%	35	0.0%
Coordination of admission from outpatient ACT to hospital DRF nursing home or residential service	54	0.5%	112	0.0%
Coordination of discharge from hospital DRF nursing home or residential service to outpatient ACT	57	0.5%	193	0.1%
Crisis Intervention MH Service (IROS/FSS)	239	2.2%	2,254	0.7%
Emergency Medical Service Evaluation	3	0.0%	3	0.0%
Emergency Services	3,064	27.9%	6,361	1.9%
Emergency Services - Non-Billable	723	6.6%	1,973	0.6%
Evaluation & Management	6,576	59.9%	20,141	6.1%
Evaluation for Medicaid	6	0.1%	6	0.0%
Evidence Based Supported Employment	346	3.2%	5,880	1.8%
Family Therapy with The Client	1,431	13.0%	8,560	2.6%
Family Therapy Without the Client	550	5.0%	1,704	0.5%
Family Training and Counseling (IROS/FSS)	105	1.0%	777	0.2%
Follow Up Telephone Support	328	3.0%	787	0.2%
Group Therapy	190	1.7%	1,899	0.6%
Group Therapy - Non-Billable	25	0.2%	4,264	1.3%
Illness Mgmt. & Recovery (EBP) - Individual	50	0.5%	316	0.1%
Illness Mgmt. And Recovery (EBP) - Group	14	0.1%	140	0.0%
Individual Psychotherapy	5,930	54.0%	41,092	12.4%
Individual Psychotherapy - Non-Billable	541	4.9%	1,219	0.4%
Injection	231	2.1%	2,268	0.7%
Intake	1,510	13.7%	1,527	0.5%
Interactive Complexity	52	0.5%	109	0.0%
MCR Notification Community Based Assessment Hospitalization	61	0.6%	64	0.0%
MCR Notification Community Based Assessment No Hospitalization	261	2.4%	325	0.1%
MCR Notification Office Based Assessment Hospitalization	6	0.1%	6	0.0%

MCR Notification Office Based Assessment No Hospitalization	6	0.1%	6	0.0%
MCR Notification Phone Support	668	6.1%	1,069	0.3%
Med Training & Support / 15 Min. (IROS/FSS)	239	2.2%	45,599	13.8%
Medication Related Non-Billable Services	14	0.1%	36	0.0%
Mobile Crisis Disposition	672	6.1%	1,115	0.3%
Non-Billable Client Specific Paperwork	5	0.0%	5	0.0%
Non-Billable Evidence Based Supported Employment	1,534	14.0%	6,466	2.0%
Nursing Assessment	874	8.0%	10,209	3.1%
Office Based Urgent Assessment	71	0.6%	111	0.0%
Other Community Referral	4	0.0%	9	0.0%
Other Internal Referral	4	0.0%	5	0.0%
Outreach	2,103	19.1%	6,081	1.8%
Outreach with No Contact	132	1.2%	179	0.1%
Outreach without face to face contact	189	1.7%	646	0.2%
Peer Support Contacts	175	1.6%	251	0.1%
Psychotherapy Add On	1	0.0%	1	0.0%
Psychotherapy for Crisis	61	0.6%	70	0.0%
Services Provided While in Crisis Apartment	7	0.1%	148	0.0%
Therapeutic Behavioral Service-Individual	897	8.2%	42,732	12.9%
Therapeutic Behavioral Service-Per Diem	13	0.1%	3,412	1.0%
Therapeutic Behavioral Services-Group	115	1.0%	4,644	1.4%
Transportation to activity or service that facilitates treatment plan goals	2	0.0%	3	0.0%

Source: DHHS, Office of Quality Assurance and Improvement

Exhibit D14. Characteristics of People Served by Mental Health Center of Greater Manchester, SFY 2016 and 2017

	SFY 2016		SFY 2017	
	N	%	N	%
Total Served	10,973	-	10,982	-
Age				
0-17 years	2,000	18.2	2,004	18.2
18-24 years	1,424	13.0	1,382	12.6
25-64 years	6,838	62.3	6,820	62.1
65+ years	711	6.5	776	7.1
Gender				
Male	4,825	44.0	4,768	43.4
Female	6,148	56.0	6,211	56.6
Race				
American Indian or Alaska Native	90	0.9	80	0.8
Asian	76	0.8	82	0.8
Black or African American	296	3.0	295	3.0
Native Hawaiian or Pacific Islander	8	0.1	12	0.1
White	9,035	91.4	8,881	91.3
More Than One Race	381	3.9	382	3.9
Ethnicity				
Hispanic/Latino	746	8.1	730	8.1
Non-Hispanic/Latino	8,418	91.9	8,262	91.9
Insurance Status				
Public Insurance	5,591	51.0	5,459	49.9
Private Insurance	3,733	34.1	3,885	35.5
Combination Public and Private	679	6.2	688	6.3
Uninsured	953	8.7	917	8.4
CMHC Eligible	4,660	42.5	4,691	42.7
Non-CMHC Eligible	6,313	57.5	6,291	57.3

Source: DHHS, Office of Quality Assurance and Improvement

Region 8

Exhibit D15. Services provided by Seacoast Mental Health Center, SFY 2017

	Count of Unique Clients		Count of Services	
	N	%	N	%
TOTAL	4,844	-	120,237	-
ACT Screening Eligible	7	0.1%	7	0.0%
ACT Screening Non-Eligible	288	5.9%	497	0.4%
Case Management - Direct (Face-To-Face)	1,453	30.0%	8,969	7.5%
Case Management - Indirect	982	20.3%	3,599	3.0%
Client Centered Conference	18	0.4%	19	0.0%
Crisis Intervention MH Service (IROS/FSS)	10	0.2%	11	0.0%
Emergency Services	657	13.6%	1,197	1.0%
Emergency Services - Non-Billable	707	14.6%	2,167	1.8%
Evaluation & Management	3,378	69.7%	16,042	13.3%
Evaluation for Medicaid	2	0.0%	2	0.0%
Evidence Based Supported Employment	118	2.4%	1,243	1.0%
Family Therapy with The Client	910	18.8%	4,428	3.7%
Family Therapy Without the Client	375	7.7%	833	0.7%
Family Training and Counseling (IROS/FSS)	285	5.9%	2,011	1.7%
Group Therapy	94	1.9%	873	0.7%
Illness Mgmt. & Recovery (EBP) - Individual	12	0.2%	41	0.0%
Illness Mgmt. And Recovery (EBP) - Group	28	0.6%	355	0.3%
Individual Psychotherapy	2,472	51.0%	23,505	19.5%
Injection	3	0.1%	13	0.0%
Intake	1,512	31.2%	1,531	1.3%
Med Training & Support / 15 Min. (IROS/FSS)	92	1.9%	1,827	1.5%
Non-Billable Evidence Based Supported Employment	219	4.5%	287	0.2%
Non-Mental Health Services	28	0.6%	504	0.4%
Nursing Assessment	62	1.3%	814	0.7%
Psychological and Neuropsych Testing	111	2.3%	116	0.1%
Substance Abuse Evaluation	162	3.3%	1,237	1.0%
Therapeutic Behavioral Service-Individual	693	14.3%	16,196	13.5%
Therapeutic Behavioral Service-Per Diem	8	0.2%	5,999	5.0%
Therapeutic Behavioral Services-Group	10	0.2%	183	0.2%

Source: DHHS, Office of Quality Assurance and Improvement

Exhibit D16. Characteristics of People Served by Seacoast Mental Health Center, SFY 2016 and 2017

	SFY 2016		SFY 2017	
	N	%	N	%
Total Served	4,660	-	4,844	-
Age				
0-17 years	1,283	27.5	1,458	30.1
18-24 years	471	10.1	501	10.3
25-64 years	2,510	53.9	2,427	50.1
65+ years	396	8.5	458	9.5
Gender				
Male	2,124	45.6	2,198	45.4
Female	2,535	54.4	2,645	54.6
Race				
American Indian or Alaska Native	17	0.4	15	0.3
Asian	20	0.5	27	0.6
Black or African American	58	1.3	66	1.4
Native Hawaiian or Pacific Islander	0.0	0	1.0	0.0
White	4,124	95.9	4,591	96.0
More Than One Race	80	1.9	80	1.7
Ethnicity				
Hispanic/Latino	65	1.5	72	1.5
Non-Hispanic/Latino	4,161	98.5	4,665	98.5
Insurance Status				
Public Insurance	2,635	66.6	2,706	62.4
Private Insurance	1,324	33.4	1,634	37.6
Combination Public and Private	0	0.0	0	0.0
Uninsured	0	0.0	0	0.0
CMHC Eligible	2,352	50.5	2,598	53.6
Non-CMHC Eligible	2,308	49.5	2,246	46.4

Source: DHHS, Office of Quality Assurance and Improvement

Region 9

Exhibit D17. Services provided by Community Partners, SFY 2017

	Count of Unique Clients		Count of Services	
	N	%	N	%
TOTAL	2,425	-	65,874	-
Case Management - Direct (Face-To-Face)	1,096	45.2%	7,729	11.7%
Case Management - Direct Non-Billable	1,595	65.8%	17,079	25.9%
Completion of A 920 Form	2	0.1%	2	0.0%
Crisis Intervention MH Service (IROS/FSS)	25	1.0%	34	0.1%
Eligibility Determination	1	0.0%	1	0.0%
Emergency Services	809	33.4%	1,129	1.7%
Emergency Services - Non-Billable	1	0.0%	1	0.0%
Evaluation & Management	200	8.2%	200	0.3%
Evidence Based Supported Employment	42	1.7%	231	0.4%
Family Functional Therapy (URS - EBP)	282	11.6%	3,365	5.1%
Family Therapy with The Client	617	25.4%	6,397	9.7%
Family Therapy Without the Client	175	7.2%	349	0.5%
Group Therapy	45	1.9%	466	0.7%
Illness Mgmt. & Recovery (EBP) - Individual	15	0.6%	64	0.1%
Illness Mgmt. And Recovery (EBP) - Group	13	0.5%	106	0.2%
Individual Psychotherapy	755	31.1%	7,671	11.6%
Injection	103	4.2%	1,241	1.9%
Inshape - Grant-Funded	1	0.0%	1	0.0%
Intake	399	16.5%	399	0.6%
Med Check - Comprehensive	1,254	51.7%	3,669	5.6%
Med Training & Support / 15 Min. (IROS/FSS)	24	1.0%	3,058	4.6%
Non-Billable Evidence Based Supported Employment	64	2.6%	320	0.5%
Nursing Assessment	103	4.2%	1,243	1.9%
Outreach without face to face contact	36	1.5%	163	0.2%
Therapeutic Behavioral Service-Individual	705	29.1%	10,735	16.3%
Therapeutic Behavioral Services-Group	23	0.9%	218	0.3%
Transportation to activity or service the facilitates treatment plan goals	3	0.1%	3	0.0%

Source: DHHS, Office of Quality Assurance and Improvement

Exhibit D18. Characteristics of People Served by Community Partners, SFY 2016 and 2017

	SFY 2016		SFY 2017	
	N	%	N	%
Total Served	2,688	-	2,425	-
Age				
0-17 years	920	34.2	846	34.9
18-24 years	242	9.0	244	10.1
25-64 years	1,315	48.9	1,151	47.5
65+ years	211	7.8	184	7.6
Gender				
Male	1,241	48.8	1,139	48.6
Female	1,301	51.2	1,207	51.4
Race				
American Indian or Alaska Native	2	0.1	2	0.1
Asian	11	0.5	15	0.8
Black or African American	44	2.0	43	2.2
Native Hawaiian or Pacific Islander	1	0.0	0	0.0
White	2,090	97.3	1,873	96.9
More Than One Race	0	0.0	0	0.0
Ethnicity				
Hispanic/Latino	23	6.8	37	8.0
Non-Hispanic/Latino	316	93.2	428	92.0
Insurance Status				
Public Insurance	1,917	71.3	1,604	66.1
Private Insurance	398	14.8	448	18.5
Combination Public and Private	233	8.7	182	7.5
Uninsured	140	5.2	191	7.9
CMHC Eligible	1,609	59.9	1,431	59.0
Non-CMHC Eligible	1,079	40.1	994	41.0

Source: DHHS, Office of Quality Assurance and Improvement

Region 10

Exhibit D19. Services provided by Center for Life Management, SFY 2017

	Count of Unique Clients		Count of Services	
	N	%	N	%
TOTAL	4,587	-	131,671	-
ACT Screening Eligible	102	2.2%	102	0.1%
ACT Screening Non-Eligible	2,272	49.5%	2,414	1.8%
Case Management - Direct (Face-To-Face)	1,426	31.1%	11,795	9.0%
Case Management - Direct Non-Billable	2,752	60.0%	19,246	14.6%
Case Management - Indirect	1,576	34.4%	13,094	9.9%
Case Related Travel	255	5.6%	1,405	1.1%
Client Benefits Specialist	177	3.9%	470	0.4%
Coordination of admission from outpatient ACT to hospital DRF nursing home or residential service	4	0.1%	7	0.0%
Court Ordered DWI Assessment	11	0.2%	11	0.0%
Crisis Intervention MH Service (IROS/FSS)	112	2.4%	238	0.2%
Emergency Services	1,290	28.1%	2,571	2.0%
Emergency Services - Non-Billable	1,072	23.4%	2,266	1.7%
Evaluation & Management	2,451	53.4%	9,858	7.5%
Evaluation for Medicaid	5	0.1%	5	0.0%
Evidence Based Supported Employment	147	3.2%	1,570	1.2%
Family Therapy with The Client	470	10.2%	1,744	1.3%
Family Therapy Without the Client	212	4.6%	417	0.3%
Family Training and Counseling (IROS/FSS)	267	5.8%	1,678	1.3%
Group Therapy	213	4.6%	1,477	1.1%
Illness Mgmt. & Recovery (EBP) - Individual	59	1.3%	413	0.3%
Illness Mgmt. And Recovery (EBP) - Group	26	0.6%	262	0.2%
Individual Psychotherapy	3,094	67.5%	27,560	20.9%
Individual Psychotherapy - Non-Billable	20	0.4%	36	0.0%
Injection	73	1.6%	717	0.5%
Intake	1,134	24.7%	1,137	0.9%
Med Training & Support / 15 Min. (IROS/FSS)	70	1.5%	5,862	4.5%
Medication Related Non-Billable Services	526	11.5%	527	0.4%
Non-Billable Client Specific Paperwork	1,367	29.8%	2,397	1.8%
Non-Billable Evidence Based Supported Employment	188	4.1%	757	0.6%
Non-Mental Health Services	1	0.0%	1	0.0%
Paperwork	26	0.6%	34	0.0%
Psychotherapy Add On	257	5.6%	890	0.7%
Public Prevention and Education	1	0.0%	1	0.0%
Therapeutic Behavioral Service-Individual	794	17.3%	19,876	15.1%
Therapeutic Behavioral Services-Group	47	1.0%	334	0.3%
Therapeutic Repetitive Transcranial Magnetic Stimulation	4	0.1%	4	0.0%
Transcranial Magnetic Stimulation - Subsequent	22	0.5%	335	0.3%

Source: DHHS, Office of Quality Assurance and Improvement

Exhibit D20. Characteristics of People Served by Center for Life Management, SFY 2016 and 2017

	SFY 2016		SFY 2017	
	N	%	N	%
Total Served	5,230	-	4,587	-
Age				
0-17 years	1,486	28.4	1,552	33.8
18-24 years	718	13.7	604	13.2
25-64 years	2,740	52.4	2,204	48.0
65+ years	286	5.5	227	4.9
Gender				
Male	2,283	43.7	2,100	45.8
Female	2,946	56.3	2,486	54.2
Race				
American Indian or Alaska Native	2	0.0	2	0.0
Asian	18	0.4	19	0.4
Black or African American	20	0.4	19	0.4
Native Hawaiian or Pacific Islander	0	0.0	0	0.0
White	4,940	98.2	4,309	97.9
More Than One Race	49	1.0	52	1.2
Ethnicity				
Hispanic/Latino	63	1.2	54	1.2
Non-Hispanic/Latino	5,167	98.8	4,533	98.8
Insurance Status				
Public Insurance	958	18.4	817	19.1
Private Insurance	0	0.0	0	0.0
Combination Public and Private	0	0.0	0	0.0
Uninsured	4,237	81.6	3,450	80.9
CMHC Eligible	1,785	34.1	1,722	37.5
Non-CMHC Eligible	3,445	65.9	2,865	62.5

Source: DHHS, Office of Quality Assurance and Improvement