New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Five

January 6, 2017

I. Introduction

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

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

In this six-month period (July 1, 2016 through December 31, 2016), the ER has continued to observe the State's work to implement certain key service elements of the CMHA, and has continued to have discussions with relevant parties related to implementation efforts and the documentation of progress and performance consistent with the standards and requirements of the CMHA. During this period, the ER:

- Conducted on-site reviews of Assertive Community Treatment (ACT) teams/services and Supported Employment (SE) services at West Central Behavioral Health, Greater Nashua Mental Health, and Northern Human Services: a non-random sample of ACT and SE records was reviewed at each of these sites;
- Conducted an on-site visit related to implementation of the Mobile Crisis Program in Manchester;
- Met with the New Hampshire Consumer Council;
- Met with Ken Norton, Executive Director of NAMI New Hampshire;
- Met with the State's Central Team to review progress and discuss barriers to transition from both New Hampshire Hospital (NHH) and Glencliff Home (Glencliff);
- Met with senior management and with a clinical team at NHH to review transition planning processes and issues;
- Met with Glencliff leadership, clinical staff, and residents to discuss transition planning processes and issues;

- Met with New Hampshire Department of Health and Human Services (DHHS) Commissioner Jeffrey Meyers;
- Met with DHHS staff involved with the PASRR program to discuss the new contract for PASRR services and to identify data reporting issues;
- Participated in several meetings with representatives of the Plaintiffs and the United States (hereinafter "Plaintiffs");
- Met twice with DHHS Quality Management/Quality Service Review (QM/QSR) staff to discuss refinements to the QSR process; and
- Convened two all parties meetings to discuss general progress and implementation issues related to the CMHA.

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

II. Data

The New Hampshire DHHS continues to make progress in developing and delivering data reports addressing performance in some domains of the CMHA. Appendix A contains the most recent DHHS Quarterly Data Report (November 2016), incorporating standardized report formats with clear labeling and date ranges for several important areas of CMHA performance. The ability to conduct and report longitudinal analyses of trends in certain key indicators of CMHA performance continues to improve. Specific data from the quarterly reports are included in the discussion of individual CMHA services below.

In addition to the standardized reporting of certain types of data, DHHS continues to collect and report on other data necessary to monitor performance related to the CMHA. These include reports from the new mobile crisis services in the Concord and Manchester Regions; data on discharge destinations from NHH and Glencliff; reports of wait list numbers for Emergency Department (ED) boarding; and utilization of the Bridge Housing Subsidy Program.

As noted in previous ER reports, there continue to be important categories of data that are needed, but not routinely collected and reported, and which will need to be reported in order to accurately evaluate ongoing implementation of the CMHA. For example, there continues to be no reported or analyzed data on the degree to which participants in SE are engaged in competitive employment in integrated community settings consistent with their individual treatment plans. These data are important in assessing the fidelity with which SE services are provided. DHHS's efforts related to assuring the fidelity of SE services is discussed in the SE section of this report.

Another gap in data is related to people receiving Supported Housing (SH) under the Bridge Housing Subsidy Program. These participants are not yet clearly identified in the Phoenix II system, and thus it is difficult to document the degree to which these individuals are: (a) connected to local CMHA services and supports; or (b) actually receiving services and supports to meet their individualized needs on a regular basis in the community. As noted in the January 2016 ER Report, DHHS has identified a strategy to link data from the Bridge Subsidy Program to the Phoenix II system. However, such data has not been produced to date, leaving a significant gap in the ER's ability to evaluate compliance with SH provisions of the CMHA. Other gaps in data are referenced later in this report.

Although the soon-to-be-initiated QM/QSR process will provide additional information related to the quality, effectiveness, and (where applicable) the fidelity of the services delivered, the data identified above is an essential complement to those client reviews and necessary in order for the ER and the parties to effectively measure ongoing implementation, and for the State to demonstrate compliance with the terms of the CMHA. The QM/QSR process is discussed later in this report.

III. CMHA Services

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

Mobile/Crisis Services and Crisis Apartments

The CMHA calls for the establishment of mobile crisis capacity and crisis apartments in the Concord Region by June 30, 2015 (Section V.C.3(a)). DHHS conducted a procurement process for this program, and the contract was awarded on June 24, 2015. Riverbend CMHC is the vendor selected to implement the mobile team and crisis apartments in the Concord Region.

Table I below includes the most recent available information on activities of its new crisis program.

Table I

Concord Region Self-Reported Mobile Crisis Services: April-June 2016 and July-September 2016

	April – June 2016	July - September 2016
Total unduplicated people served	532	549
Services provided in response to immediate crisis:		
• Phone support/triage	735	927
• Mobile assessments	142	157
• Crisis stabilization appointments	63	64
• Emergency services medication appointments	33	69
• Office based urgent assessments	36	46
Services provided after the immediate crisis:		
• Phone support/triage	226	427
• Mobile assessments	18	27
• Crisis stabilization appointments	63	64
• Emergency services medication appointments	27	33
• Office based Urgent Assessments	36	46
Referral source:		
• Self	282	310
• Family	111	101
• Guardian	23	0
• Mental health provider	18	28
• Primary care physician	16	18
• Hospital emergency department	24	64
• Police	23	25
• CMHC Internal	94	63
Crisis apartment admissions:		
• Bed days	120	289
• Average length of stay	3.0	3.9
Law enforcement involvement	46	46
Total hospital diversions*	288	263

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

These data indicate a growth in the number of people accessing crisis services, and in the number of crisis response services delivered. There has also been substantial growth in utilization of the crisis apartments. These data also suggest that there are hundreds of triage callers each quarter

who receive neither a mobile crisis assessment nor an office-based appointment. In order to measure whether and to what extent class members have appropriate access to community-based MCI, a further examination and analysis of MCI triage and dispatch decisions is needed.

In mid-June 2016, DHHS awarded a contract to the Mental Health Center of Greater Manchester to establish the second Mobile Crisis Team and Crisis Apartments. Given the timing of the contract award, mobile crisis services were not operational in the Manchester Region by June 30, 2016, as specified in the CMHA. However, as of December 2016 the Manchester Mobile Team is staffed and operational; the separate Mobile Crisis telephone system is in place; an interim crisis apartment has been identified and is in use; and outreach has begun to the Manchester police and other first responders in the community. Data from the Manchester Mobile Crisis program will be incorporated in the June 30, 2017 ER report. At that time, the ER hopes to include an analysis of whether the new crisis services are having a positive impact on reducing the number of ED presentations and the number of readmissions to NHH/DRFs in the Concord and Manchester regions.

DHHS reports that it will be incorporating Mobile Crisis and Crisis Apartment data in the Phoenix system, which will support routine collection and reporting of these data in the Quarterly Data Reports. DHHS also reports that the RFP for the new Mobile Team and Crisis Apartments to be developed in the Nashua region by July 1, 2017, was issued on December 19, 2016, and is expected to be approved in March 2017. In order to comply with the terms of the CMHA, and to avoid extended delays in implementation, like those seen in the Concord and Manchester Regions, DHHS must make every effort to ensure this procurement process proceeds rapidly enough to assure the selected vendor is ready to operate the program and begin serving class members by July 1, 2017.

Assertive Community Treatment (ACT)

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

1. By October 1, 2014, the State will ensure that all of its 11 existing adult ACT teams operate in accordance with the standards set forth in Section V.D.2;
2. By June 30, 2014, the State will ensure that each mental health region has at least one adult ACT team; and
3. By June 30, 2016, the State will provide ACT team services consistent with the standards set forth above in Section V.D.2 with the capacity to serve at least 1,500 individuals in the Target Population at any given time.

The CMHA requires a robust and effective system of ACT services to be in place throughout the state as of June 30, 2015 (18 months ago). Further, as of June 30, 2016, the State is required to have the capacity to provide ACT to 1,500 priority Target Population individuals.

As displayed in Table II below, the staff capacity of the 12 adult ACT teams in New Hampshire has increased by only two FTEs in the three months between June 2016 and September 2016. During the same time, the total active caseload has increased by only 26 individuals. As of the date of this report, the State is providing ACT services to 865 unique consumers and as a result is delivering only 58 percent of the ACT capacity required by the CMHA, and is out of compliance on this key CMHA service.

Table II

Self-Reported ACT Staffing (excluding psychiatry): May 2015 through September 2016

Region	FTE May-15	FTE Sep-15	FTE Dec-15	FTE March 2016	FTE June	FTE September 2016	% change June – Sept
Northern	14.80	11.29	11.15	11.15	11.15	10.25	-8.78%
West Central	3.00	3.83	2.64	4.37	4.44	5.44	18.38%
Genesis	7.10	7.5	6.4	7.4	7.60	7.00	-8.57%
Riverbend	7.00	7.3	6.7	7	7.50	7.50	0.00%
Monadnock	8.20	8.5	7.75	7.75	7.75	7.25	-6.90%
Nashua 1					5.75	6.25	8.00%
Nashua 2					3.75	5.25	28.57%
Manchester 1					14.61	15.46	5.50%
Manchester 2					18.81	20.24	7.07%
Seacoast	12.80	11.77	11.77	11.53	10.73	8.73	-22.91%
Community Partners	8.20	8.7	7.9	5.9	7.90	8.03	1.62%
Center for Life Man.	7.80	6.36	8.16	8.16	7.91	7.91	0.00%
Total	68.90	65.25	62.47	63.26	107.90	109.31	1.29%

It is clear from this table that overall ACT staffing has remained at best static, and in some regions has decreased over the past four reporting periods. This is true despite previous ER findings that New Hampshire was out of compliance with the standards of the CMHA. Based on staffing shortages alone, more than 500 individuals potentially would not be able to receive such services due to the lack of capacity. This current pace of staff recruitment and capacity development is not sufficient to satisfy the State's outstanding obligations under the CMHA; nor will it allow for a prompt, statewide response to the needs of individuals eligible for ACT and identified through ongoing outreach efforts.

Table III below displays trends in active caseloads for ACT services by Region.

Table III

Self-Reported ACT Caseload (Unique Adult Consumers) by Region per Quarter: May 2015 through September 2016

	Cases May-15	Cases Sep-15	Cases Dec-15	Cases Mar-16	Cases Sep-16	% Change Mar. to Sep
Northern	60	72	74	79	88	10.23%
West Central	16	19	21	26	33	21.21%
Genesis	22	30	34	39	58	32.76%
Riverbend	79	60	56	70	81	13.58%
Monadnock	47	54	61	68	73	6.85%
Greater Nashua	63	74	72	72	76	5.26%
Manchester	254	265	270	293	270	-8.52%
Seacoast	73	65	65	72	70	-2.86%
Community Partners	16	70	76	73	74	1.35%
Center for Life Man.	39	37	40	49	47	-4.26%
Total*	669	746	766	839	865	3.10%

Based on self-reported staffing data, the Regions appear to have made some gains in enhancing staff capacity within certain ACT teams between June and September, 2016. Seven ACT Teams (including the two teams in Manchester and the two teams in Nashua) reported increases in ACT staffing from March through September, 2016, while five teams reported reductions in ACT staffing during that period. All ACT teams continue to report substance use disorder (SUD) staff competency. Four of the teams continue to report less than one FTE SE competency.

Three of the 12 adult ACT teams still have fewer than the 7 - 10 professionals specified for ACT teams in the CMHA, and four teams continue to report having no peer specialist on the ACT Team. As with the previous report, only three teams report having at least one FTE peer specialist. Five teams continue to report having less than .5 FTE combined psychiatry/nurse practitioner time available to their ACT teams. Three teams report having less than 50% FTE Nursing on the Team (Note: this is a substantial improvement from the previous ER report, in which seven ACT Teams were noted to report less than 50% FTE nursing staffing).

Despite the progress noted above, remaining deficiencies in ACT team staffing and composition, leave the State out of compliance with the foundational service standards described in Section V.D.2 of the CMHA, and threaten its ability to provide a robust and effective system of ACT services throughout the State.

As noted in the previous ER Report, the New Hampshire DHHS has begun to take more aggressive action to work with CMHCs in certain Regions to increase their ACT staffing and caseloads. These actions include: (a) monthly ACT monitoring and technical assistance with DHHS leadership and staff; (b) implementation of a firm schedule for ACT self-assessments and DHHS fidelity reviews; (c) a small increase in ACT funding incorporated into the Medicaid rates for CMHCs; (d) active on-site monitoring and technical assistance for CMHCs not yet meeting CMHA ACT standards; and (e) substantial and coordinated efforts to address workforce recruitment and retention. Compliance letters and performance improvements plans (PIPs) have been initiated in three of the 10 Regions. Also, as noted in the previous ER report, the new QSR being implemented by DHHS will examine the provision of ACT services, and the QSR findings are expected to prompt additional PIPs where necessary.

DHHS and representatives of the Plaintiffs have been working collaboratively on new regulations defining ACT service eligibility and access standards over the past year. The ER understands that the revised ACT regulations were approved on December 15, 2016. The ER applauds the mutual efforts and spirit of open communication and compromise that have taken place to ensure that these new regulations were developed and promulgated in a positive fashion.

Based on continuing non-compliance with the ACT staffing and capacity standards in the CMHA, in the previous report the ER recommended that DHHS adopt several management initiatives to facilitate and speed up progress towards meeting the CMHA ACT requirements. Progress related to these suggested actions is summarized in the conclusion to this report.

Supported Employment

Pursuant to the CMHA's SE requirements, the State must accomplish three things: 1) provide SE services in the amount, duration, and intensity to allow individuals the opportunity to work the maximum number of hours in integrated community settings consistent with their individual treatment plans (V.F.1); 2) meet Dartmouth fidelity standards for SE (V.F.1); and 3) meet penetration rate mandates set out in the CMHA. For example, the CMHA states: "By June 30, 2016, the State will increase its penetration rate of individuals with SMI receiving supported employment …to 18.1% of eligible individuals with SMI." (Section V.F.2(d)).

For this reporting period, the State reports that it has achieved a statewide SE penetration rate of 20.4%, 2.3 points higher than the 18.1% penetration rate specified for June 30, 2016 in the CMHA. Table IV below shows the SE penetration rates for each of the 10 Regional CMHCs in New Hampshire.

Table IV

Self-Reported CMHC SE Penetration Rates: March 2015 through October 2016

	Penetration Mar-15	Penetration Sep-15	Penetration Dec-15	Penetration Mar-16	Penetration Oct-16	% Change Mar-Oct
Northern	7.10%	8.20%	9.50%	10.60%	14.00%	32.08%
West Central	13.50%	12.90%	14.30%	15.30%	17.50%	14.38%
Genesis	9.40%	9.30%	9.60%	9.60%	14.10%	46.88%
Riverbend	14.90%	14.20%	14.60%	14.10%	13.70%	-2.84%
Monadnock	8.00%	16.40%	19.40%	20.50%	20.40%	-0.49%
Greater Nashua	6.10%	7.70%	8.60%	9.00%	11.90%	32.22%
Manchester	14.60%	26.10%	31.70%	36.70%	37.10%	1.09%
Seacoast	10.50%	13.10%	12.70%	11.00%	12.00%	9.09%
Community Part.	8.10%	11.60%	13.00%	12.60%	10.40%	-17.46%
Center for Life Man.	16.30%	15.70%	13.00%	24.70%	23.00%	-6.88%
CMHA Target	14.10%	16.10%	16.10%	16.10%	18.10%	0.00%
Statewide Average	11.30%	15.70%	17.90%	19.30%	20.40%	5.70%

As noted in Table IV, the State has exceeded the statewide CMHA penetration rate in the last two reporting periods. In addition, the New Hampshire DHHS is commended for continuing its efforts to: (a) measure the fidelity of SE services on a statewide basis; and (b) work with the seven Regions with penetration rates below CMHA criteria to increase access to and delivery of SE services to target population members in their Regions. As can be seen in Table IV, five of the seven Regions with less than 18.1% SE penetration rates have improved their performance in the most recent reporting period. And, as with ACT services, the DHHS has implemented a combination of contract compliance, technical assistance, workforce recruitment and retention, and internal and external fidelity reviews to assure the quality and accessibility of SE services statewide. The ER expects the QSR process to measure whether and to what extent SE services are delivered in the amount, duration, and intensity to allow individuals the opportunity to work the maximum number of hours in integrated community settings consistent with their individual treatment plans and the fidelity requirements of the CMHA. To that end, the ER expects to review employment data from each region during the next reporting period.

Supported Housing

The CMHA requires the State to achieve a target capacity of 450 SH units funded through the Bridge Subsidy Program by June 30, 2016. As of the September 30, 2016, DHHS reports having 451 individuals in leased SH apartments, and 28 people approved for a subsidy but not yet

leased. The State is in compliance with the CMHA numerical standards for SH effective June 30, 2016.

Table V below summarizes recent data supplied by DHHS related to the Bridge Subsidy Program.

Table V

New Hampshire DHHS Self-Reported Data on the Bridge Subsidy Program: September 2015 through September 2016

Bridge Subsidy Program Information	September 2015	March 2016	September 2016
Total housing slots (subsidies) available	450	450	479
Total people for whom rents are being subsidized	376	415	451
Individuals accepted but waiting to lease	23	22	28
Individuals currently on the wait list for a bridge subsidy	0	0	0
Total number served since the inception of the Bridge Subsidy Program	466	518	603
Total number receiving a Housing Choice (Section 8) Voucher	70	71	83

The CMHA stipulates that "…all new supported housing …will be scattered-site supported housing, with no more than two units or 10 percent of the units in a multi-unit building with 10 or more units, whichever is greater, and no more than two units in any building with fewer than 10 units known by the State to be occupied by individuals in the Target Population." (V.E.1(b)). Table VI below displays the reported number of units leased at the same address.

Table VI

Self-Reported Bridge Subsidy Housing Concentration (Density)

	September 2015	March 2016	June 2016	November 2016
Number of properties with one leased SH unit at the same address	290	317	325	339
Number of properties with two SH units at the same address	27	22	35	24
Number of properties with three SH units at the same address	2	13	8	13
Number of properties with four SH units at the same address	4	1	1	3
Number of properties with five SH units at the same address	1	2	2	0
Number of properties with six SH units at the same address	1	0	1	1

As noted in the previous report, almost 90% of the leased units are at a unique address or with one additional unit at that address. This supports a conclusion that the Bridge Subsidy Program, to a large degree, is operating as a scattered-site program. For the 24% of the units shown in Table VI at the same address, it is not known at this time whether the unit density standards included in the CMHA are being met. DHHS is collecting information on the total units in each property where there are two or more Bridge units at the same address, and this data will be reported in the next ER report.

It should be noted that these data do not indicate whether any of the leased units are roommate situations, and if so, whether such arrangements meet the requirements of the CMHA (V.E.1(c)). DHHS reports, and anecdotal information seems to support, that there are very few, if any, roommate situations among the currently leased Bridge Subsidy Program leased units.[1]

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

As noted in the Data section of this report, current data is not available on the degree to which Bridge Subsidy Program participants access and utilize support services and whether or not the services are effective and meet individualized needs. Receipt of services is not a condition of eligibility for a subsidy under the Bridge Program, but the CMHA does specify that "…supported housing includes support services to enable individuals to attain and maintain integrated affordable housing, and includes support services that are flexible and available as needed and desired….". (V.E.1(a)). As noted in the January and June 2016 ER Reports, DHHS has been working on a method to cross-match the Bridge Subsidy Program participant list with the Phoenix II and Medicaid claims data. This will allow documentation of the degree to which Bridge Subsidy Program participants are actually receiving certain mental health or other services and supports.

In previous reports the ER has identified a number of important and needed data elements associated with the SH eligibility criteria and lack of a waitlist, as well as monitoring implementation of the SH program in the context of the CMHA. These include:

- Total number of Bridge Subsidy Program applicants per quarter;
- Referral sources for Bridge Subsidy Program applicants;
- Number and percent approved for the Bridge Subsidy Program;
- Number and percent rejected for the Bridge Subsidy Program;
    - Reasons for rejection of completed applications, separately documenting those who are rejected because they do not meet federal HCV/Section 8 eligibility requirements;
- Number and disposition of appeals related to rejections of applications;
- Elapsed time between application, approval, and lease-up;
- Number of new individuals leased-up during the quarter;
- Number of terminations from Bridge subsidies;
- Reasons for termination:
    - Attained permanent subsidized housing (Section 8, public housing, etc.);
    - Chose other living arrangement or housing resource;
    - Moved out of state;
    - Deceased;
    - Long term hospitalization;
    - Incarceration;
    - Landlord termination or eviction; or
    - Other;
- Number of Bridge Subsidy Program participants in a roommate situation; and
- Lease density in properties with multiple Bridge Subsidy Program leases.

This information is important in assessing whether eligibility is properly determined, whether a waitlist is properly maintained and in assessing whether or not support services are adequate to

enable the individual to "attain and maintain integrated affordable housing" and whether services are "flexible and available as needed and desired." Most rental assistance programs collect and report such information, given its intrinsic value in monitoring program operations. Further, such data enhances DHHS' ability to demonstrate the timeliness and effectiveness of access of the priority target population to this essential CMHA program component. Most importantly, this data is necessary to help the ER determine compliance with CMHA Sections IV.B, IV.C, and VII.A. The ER will continue to work collaboratively with DHHS to identify sources and methods for such data collection and reporting.

As described in the previous ER report, DHHS was in the process of drafting Bridge Housing Subsidy Program rules, in consultation with representatives of the Plaintiffs. These revised SH rules have been successfully promulgated, and, as with the ACT rules noted above, represent evidence of positive collaboration among the parties related to CMHA implementation.

Transitions from Institutional to Community Settings

During the past 18 months, the ER has visited both Glencliff and NHH on at least four separate occasions to meet with staff engaged in transition planning under the new policies and procedures adopted by both facilities late last year. Transition planning activities related to specific current residents in both facilities were observed, and most recently, a small non-random sample of resident transition records has been reviewed. Additional discussions have also been held with both line staff and senior clinicians/administrators regarding potential barriers to effective discharge to the most appropriate community settings for residents at both facilities.

The ER has participated in three meetings of the Central Team. The Central Team has now had about 12 months of operational experience, and has started reporting data on its activities. To date, 21 individuals have been submitted to the Central Team, 14 from Glencliff and seven from NHH. Table VII below summarizes the discharge barriers that have been identified by the Central Team with regard to these individuals. Note that most individuals encounter multiple discharge barriers, resulting in a total substantially higher than the number of individuals reviewed by the Central Team.

Table VII

Discharge Barriers Identified by the Central Team: September 2015

Through November 2016

Discharge Barriers	NHH	Glencliff
Legal	2	2
Residential	3	7
Financial	1	5
Clinical	3	4
Family/Guardian	1	0
Other	2	0

Glencliff

In the time period from April to September 2016, Glencliff reports that it has admitted nine individuals, and has had only two discharges. There have been no readmissions during this time frame. One of these two discharges is reported to have been to an independent apartment in the community. The wait list for admission has remained relatively constant: averaging 15 people during this time frame. The lengths of stay for the two persons discharged were 481 days and 2,871 days.

Section V.E.3(g) of the CMHA requires the State by June 30, 2015 to: "…have the capacity to serve in the community four individuals with mental illness and complex health care needs residing at Glencliff…." The CMHA defines these as: "individuals …who could not be cost-effectively served in supported housing."[2] This target increases to a total capacity for ten such individuals to be discharged to the community by June 30, 2016. The CMHA includes several options for attaining that goal, including the issuance of an RFP to secure new residential services beds and/or to access existing community capacity in the residential services system. The CMHA also anticipates collaboration with the DHHS Elderly and Adult Services component to assist with implementing transition plans for this population.

[2] CMHA V.E.2(a)

As noted in the June 30, 2015 and January 5, 2016 ER reports, DHHS has been endeavoring to access the Enhanced Family Care service modality included in New Hampshire's Home and Community-Based Services waiver for people who are elderly or have disabilities. DHHS has also been exploring other Medicaid waiver and in-plan service authorities to piece together an array of services for each of the individuals at Glencliff for whom this type of transition planning is being conducted. As of the date of this report, DHHS has: (a) identified a vendor to serve four individuals with complex health care needs in the community; and (b) has developed a funding mechanism through which the vendor can invoice for specialized individualized supports for these individuals. Four individuals have visited the new program site and have accepted transfers to this new program. The first individuals are expected to move to the program in January, and the remaining individual(s) are expected to transition in January. It is hoped that this program model and funding mechanism will provided a template and positive experience to accelerate transitions of individuals with mental illness and complex medical conditions from Glencliff into integrated community settings.

The ER notes that Glencliff continues to support and effectuate transitions of individuals to integrated community settings under a variety of other funding and living arrangements. DHHS reports that six individuals have transitioned from Glencliff to integrated community settings since the inception of the CMHA. This activity is to be commended, and hopefully will accelerate in parallel with facilitated transitions of individuals with complex health care needs into small program sites as noted above.

The ER continues to find that the State is not in compliance with Section V.E.3(g) and (h) of the CMHA, as well as a number of provisions throughout Section VI. Despite the commendable progress identified above, the ER continues to find that the progress in creating capacity for individuals with mental illness and complex health care needs who cannot be cost-effectively served in supportive housing does not yet meet the requirements of the CMHA.

After this report was drafted, the State provided some information on six individuals that it believes have been discharged from Glencliff consistent with this provision of the CMHA. However, neither the Plaintiffs nor the ER have been able within the time frame of this report to assess the information provided by the State. The ER will request input from the Plaintiffs, and may request additional information from the State. Any changes resulting from these discussions and information analyses will be reflected in future ER reports.

PASRR

In October 2016, the ER met with program staff of DHHS to discuss data reporting related to the State's PASRR Program. At that time the State was engaged in re-procuring the PASRR contract, a new vendor was in the process of being selected, and it was not possible to obtain detailed information about how the new vendor will collect and report data. The ER expects

DHHS will provide the requested data, and will facilitate a meeting between the ER and the new vendor, as soon as possible. The ER needs to be satisfied that PASRR reviews are being conducted as described under VI A.10, and that individuals whose needs could be met in the community are promptly referred to the appropriate area agency or CMHC in order to find that there is compliance with this CMHA requirement.

New Hampshire Hospital

For the time period July through September 2016, DHHS reported that NHH effectuated 373 admissions and 365 discharges. The mean daily census was 134, and the median length of stay for discharges was 8 days.

Table VIII below compares NHH discharge destination information for the three most recent reporting periods. The numbers are expressed as percentages because the length of the reporting periods had not previously been consistent, although the type of discharge destination data reported has been consistent throughout.

Table VIII

New Hampshire Hospital Self-Reported Data on Discharge Destination

Discharge Destination	Percent January 2014 through May 2015	Percent July 1 2015 through September 18, 2015	Percent September 19, 2015 through April 20, 2016	Percent October and November 2016
Home – live alone or with others	74.4%	67.3%	80.2%	84.86%
Glencliff	0.4%	0.20%	0.60%	0.54%
Homeless Shelter/motel	3.8%	2.4%	2.7%	0.54%
Group home 5+/DDS supported living, etc.	3.4%	9.02%	3.2%	1.62%
Jail/corrections	1.5%	0.40%	1.4%	3.64%
Nursing home/rehab facility	1.9%	3.0%	0.80%	3.78%
Unknown	12.6%	17.64%	6.8%	1.62%

The most recent Quarterly Data Report contains new, consistently reported information on the hospital-based DRFs/APRTP in New Hampshire. It is important to capture the DRF/APRTP data and combine it with NHH and Glencliff data to get a total institutional census across the state for the SMI population. The ER appreciates the State gathering this information. Table IX summarizes this data.

Table IX

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

	Franklin	Cypress	Portsmouth	Elliot Geriatric	Elliot Pathways	Total
Admissions						
Jan - March 2016	69	257	NA	65	121	512
April - June 2016	79	205	378	49	92	803
July - Sept 2016	37	207	375	54	114	787
Percent involuntary						
Jan - March 2016	53.70%	18.70%	NA	18.50%	30.60%	26.20%*
April - June 2016	55.70%	24.40%	20.40%	4.10%	48.90%	25.50%
July - Sept 2016	43.20%	29.50%	18.90%	13.00%	44.70%	26.20%
Average Census						
Jan - March 2016	7.9	14.7	NA	19.7	18.1	60.1*
April - June 2016	7.8	13.2	21.4	22.5	16.9	81.8
July - Sept 2016	4.5	13.6	23.2	25.6	14.5	81.4
Discharges						
Jan - March 2016	76	261	NA	57	122	516*
April - June 2016	78	206	363	51	90	788
July - Sept 2016	35	213	380	64	113	805
Mean LOS for Discharges						
Jan - March 2016	8.6	4.2	NA	15	7.4	8.8*
April - June 2016	6	4	4	28	7	5
July - Sept 2016	7	5	4	24	8	5

*Totals do not include Portsmouth for Jan – March 2016.

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

Table X

Self-Reported Discharge Dispositions for DRFs in New Hampshire

July 2016 through September 2016

Disposition	Cypress	Elliot GPU	Elliott Pathways	Franklin	Portsmouth Regional	Total
Home	188	16	102	27	245	578
NHH	0	0	0	2	12	14
Nursing Home	0	17	0	0	0	17
Residential Facility	4	16	1	2	0	23
Other DRF	3	2	2	3	0	10
Death	0	2	0	0	0	2
Other or Unknown	18	10	8	0	123*	159

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

It should be noted that the above represents the first DHHS report of discharge disposition data to be included in this report. Thus, there is no reporting or analyses of trends in such discharge dispositions at this point. DHHS is to be commended for producing and sharing this data with the Parties to the CMHA.

In the previous two reports, the ER has identified the waiting list (hospital ED boarding) for admission to NHH to be an important indicator of overall system performance. Based on recent information reported by DHHS, the average number of adults waiting for a NHH inpatient psychiatric bed was 24 per day in FY 2014; 25 per day in FY 2015; and through June of FY 2016 was 28 per day. For the period July 1 through September 30, 2016 the average weekly wait list for admission to NHH was 31.5. The constant and increasing number of adults awaiting inpatient admission to NHH is of concern to DHHS and many other parties in New Hampshire. In most mental health systems, a high number of adults waiting for inpatient admissions is indicative of a need for enhanced crisis response (e.g., mobile crisis) and high intensity community supports (e.g., ACT).

As noted earlier in this report, DHHS is analyzing data related to adults boarding in EDs who may have some connection to the mental health system. DHHS is making these data available to CMHCs on a monthly basis, and expects the CMHCs to use these data to identify potential participants for ACT or related services to reduce the risk of hospitalization and support integrated community living. In future months, DHHS will be receiving information on the degree to which CMHCs have increased ACT (or other services') participation as a result of these analyses. The ER plans to include summaries of this information in future reports.

Summary of Transition Issues

Over the past three reports, the ER has consistently noted that the transitions process at Glencliff is moving very slowly. This appears to be true both at the individual consumer level, and at the system level. Although information at this point is anecdotal, interviews with both line staff and administrators, plus some selective record reviews, indicate that it is taking substantial amounts of time to overcome the many and varied barriers to discharge to the community. Although the Central Team is now fully operational, it has been concentrating on a small number of cases, and referrals to the Central Team from Glencliff and NHH seems to have declined in the past two months for which data is available (N=1 total referrals to the Central Team in October and November). This centralized resource is expected to play a larger role in addressing, overcoming and reporting on continued barriers to transition planning from both Glencliff and NHH, in keeping with the requirements of the CMHA. (VI.A.6)

The ER will continue to follow up with Glencliff, NHH, and the Central Team to monitor improvements in transitions processes and successes, and to document continued barriers to transitions to the community from these facilities.

Finally, as noted earlier in this report, re-admission data for NHH remains incomplete. A single data point from November 2016 shows 17 readmissions over the previous 90 day period. Readmission rates are one important measure of the quality of discharge planning and community-based service provision. Without more complete information, the ER is unable to fully gauge the adequacy of transition planning for individuals in the target population or measure their resulting stability in the community. The ER renews outstanding requests for regular reporting of this data, as collected at 30/90/180 day intervals, and recommends that this population of individuals be a focus of the State's continued outreach efforts.

Family and Peer Supports

Family Supports

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

Peer Support Agencies

As noted in the June 30, 2015 ER report, New Hampshire reported having a total of 16 peer support agency program sites, with at least one program site in each of the ten regions. The State reported that all peer support centers meet the CMHA requirement to be open 44 hours per week. At the time of that report, the State reported that those sites had a cumulative total of 2,924 members, with an active daily participation rate of 169 people statewide. As can be seen from the most recent quarterly data report included in Appendix A, the State currently reports total membership to be 3051, with active daily visits averaging 147 people. In the June 2016 data

report, the total membership was reported to be 2,978 people, with average daily statewide visits of 148.

The CMHA requires the peer support programs to be "effective" in helping individuals in managing and coping with the symptoms of their illness, self-advocacy, and identifying and using natural supports. As noted in previous reports, enhanced efforts to increase active daily participation appear to be warranted for the peer support agency programs.

Anecdotally, the ER believes that in many regions of the state, relationships and communications among the CMHCs and the Peer Support Programs have improved. Peer support programs are generally reported by CMHCs to be useful sources of employees for ACT and Mobile Crisis and Crisis Apartment services. In addition, CMHCs report that the peer operated crisis beds available in several regions are a useful intervention for some CMHC clients at risk of hospitalization.

IV. Quality Assurance Systems

In the past 18 months, DHHS has made considerable progress in the design of the QSR process required by the CMHA. Three QSR pilot test site visits were conducted in this reporting period. Based on the experiences of those QSR site visits, the QSR team determined that substantial revisions to the protocol and instruments were necessary. These changes have been made and are now under review by the ER (in the role of providing technical assistance on QSR to DHHS). A QSR site visit using the new instruments and process (as may be amended based on input from representatives of the Plaintiffs and the ER) is scheduled for mid-January 2017. Lyn Rucker, who has been providing technical assistance to DHHS under the aegis of the ER, will participate as an observer in that site visit, and offer additional feedback and written recommendations based on her observations.

Given the importance of completing the QSR design process, the ER expects the parties to accomplish the following activities over the next 60 days:

(a) On or before February10, 2017, DHHS will review and respond to Plaintiffs' written comments of December 13, 2016;

(b) On or before February 10, 2017, DHHS will incorporate proposed recommendations from Lyn Rucker, the ER and Plaintiffs into a set of revised QSR documents and recirculate those documents to the ER and Plaintiffs;

(c) On or before February 24, 2017, DHHS will convene a face to face meeting of the QSR leadership and representatives of the Plaintiffs to discuss the findings of the pilot, the Plaintiffs' comments, and further proposed revisions to the QSR instrument; and

(d) Depending on the nature and extent of the revisions, an additional pilot of the revised instrument may be necessary. As soon as practicable thereafter, a final set of QSR documents (protocol and instruments) will be developed.

It is essential that the QSR process produce information that is accurate, verifiable, and actionable. It is similarly essential that all parties, as well as the ER, have confidence in, and are able to rely upon, the QSR as a measure of compliance with the CMHA. Although the QSR process is part of broader DHHS quality management efforts, it must be directly responsive to the quality and performance expectations of the CMHA. This is why all Parties to the agreement have invested so much time and effort into the design and implementation of the QSR process. For the remaining time period covered by the CMHA, the QSR will produce essential core information by which all Parties assess compliance with all quality and performance standards and requirements of the CMHA. Thus, the ER expects that the action steps outlined above will be successfully completed on time, and the final version of the QSR can be implemented in a consistent fashion across the CMHC system.

As noted earlier in this report, DHHS has been conducting on-site ACT and SE fidelity reviews to supplement and validate the ACT and SE fidelity self-assessments conducted on an annual basis by the CMHCs. Three DHHS SE fidelity reviews have been completed and published, and two ACT on-site fidelity reviews have been completed, but the reports have not yet been published. DHHS has also engaged the Dartmouth/Hitchcock Center on Evidence Based practices to assist in attaining and assuring fidelity to the evidence based models of ACT and SE. The Dartmouth/Hitchcock team will also assist on workforce development and training for these and other evidence based practices under the aegis of DHHS and the CMHCs. This partnership with the nationally respected Dartmouth/Hitchcock Center adds valuable expertise and experienced personnel to facilitate further development and operations of fidelity model ACT and SE in conformance with the CMHA.

Effective and validated fidelity reviews and consequent training and workforce development activities are essential to DHHS' overall quality management efforts for the community mental health system. The QSR and the fidelity reviews mutually support but do not supplant or replace each other. The QSR, in particular, examines outcomes from a personal as opposed to an organizational perspective. It assesses the quality, appropriateness and effectiveness of specific ACT and SE services at the individual participant level. Implementation of fidelity-based models of delivery does not necessarily mean that specific service interventions are working well or being delivered with the frequency or intensity required by a participant's individual treatment plan. That is why quality measures for ACT and SE are necessary aspects of the QSR, and essential tools for measuring the effectiveness of services under the CMHA.

V. Summary of Expert Reviewer Observations and Priorities

The CMHA and ER have now been in place for 30 months. At the last three All Parties meetings, the ER has expressed increasing concern related to: (a) continued lack of compliance with at least two major requirements of the CMHA; and (b) long elapsed times and/or delays related to implementation of system improvements or capacities related to the CMHA. The ER has emphasized the need for the State to be more aggressive, assertive, planful, and timely in its implementation and oversight efforts to assure compliance with the CMHA.

DHHS continues to implement more aggressive measures to both remove potential barriers to CMHA implementation, and to assure effective action on the part of the ten CMHAs to achieve compliance. The ER believes these management initiatives are positive and have the potential to improve performance vis-à-vis the CMHA. However, lack of measurable progress to date makes an assessment of the adequacy of these actions, or their ability to remedy ongoing implementation challenges and non-compliance, premature.

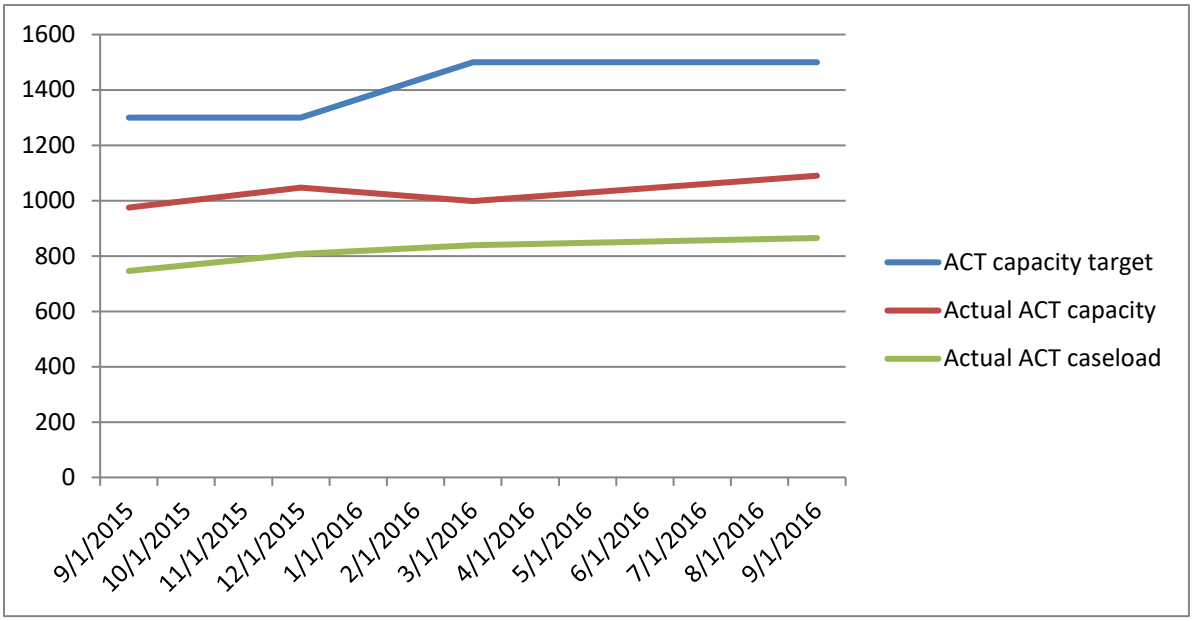
Specifically, the State has been and currently remains out of compliance with the CMHA. Two key examples of the State's non-compliance are:

1. **Sections V.D.3(a, b, d, and e), which together require that all ACT teams meet the standards of the CMHA; that each mental health region have at least one adult ACT Team; and that by June 30, 2016, the State provide ACT services that conform to CMHA requirements and have the capacity to serve at least 1,500 people in the Target Population at any given time; and**
2. **Sections V.E.2(b) and V.E.3(g)(h) which together require that by now the State "have the capacity to serve in the community [ten] individuals with mental illness and complex health care needs residing at Glencliff…."**

With regard to ACT services, aggressive actions by DHHS and the CMHCs have resulted in a net increase in capacity (ACT staffing) of 9.2 staff, thereby increasing capacity by 92 – a 1.3% increase in staff capacity since last June. In the same time period, active ACT caseload has increased by 26 participants - a 3% increase since last March. The direction of change in ACT services continues to be positive, but the pace of change remains exceedingly slow. Chart I below illustrates the relatively slow progress of the CMHC system with regard to ACT capacity and active caseloads.

Chart I

ACT Capacity and Active Caseloads Compared to the CMHA ACT Capacity Target



With regard to placements into integrated community settings of people with complex medical conditions from Glencliff, potential progress has been made. As described earlier in this report, a vendor and program space have been identified, and a payment mechanism has been implemented to support the necessary services and supports to maintain people in the community. However, to date no identified resident of Glencliff with complex medical conditions has moved into the new program or into any other qualifying integrated community setting. It is expected that four such individuals will be living in the new program by the end of January, 2017, but it is not possible for the ER to state for this report that compliance with the CMHA has been attained, as 10 people with complex medical conditions should have been transitioned at this time.

With regard to SE, DHHS is to be commended for exceeding the SE penetration rate target on a statewide basis. DHHS is also to be commended for continuing efforts to increase SE penetration in the seven regions of the state that do not meet the CMHA penetration rate standard.

It should be noted that the State continues to meet the SH capacity standards of the CMHA. This continues to be a positive aspect of the State's overall CMHA implementation efforts.

In the June 30, 2016 report, the ER recommended that the State carry out a number of action steps to increase access to key services for CMHA target population members and thereby to

increase compliance with the CMHA. The State agreed to voluntarily adopt the recommended action steps. The following is a brief summary of the ER's assessment of the degree to which the State has implemented these recommended action steps.

1. By August 1, 2016, circulate to all parties a detailed plan with implementation steps and time lines to achieve compliance with the CMHA requirements for ACT services;

   ER Finding: The State has implemented this recommendation and continues to track and report progress on the plan.

2. By August 1, 2016, circulate to all parties a detailed plan with implementation steps and timelines to achieve CMHA penetration rates and fidelity standards for SE throughout New Hampshire;

   ER Finding: The State has implemented this recommendation and continues to track and report progress in the context of on the plan.

3. By August 1, 2016 circulate to all parties a detailed plan with implementation steps and timelines to achieve CMHA requirements to assist 10 residents of Glencliff with complex medical needs to move into integrated settings as soon as possible;

   ER Finding: The State has implemented this recommendation and continues to track and report on four individuals with pending discharge plans. Progress towards fulfillment of the remaining obligations for capacity development and transition remains unclear under the plan.

4. Starting September 1, 2016, and each month following, submit to all parties a monthly progress report of the steps taken and completed under these respective plans to assure compliance with CMHA requirements as identified in this report;

   ER Finding: The State has implemented this recommendation and continues to track and report on its progress, which varies depending on the sections of the plan.

5. By October 1, 2016, complete the field tests and technical assistance related to the QSR, convene a meeting with Plaintiffs and the United States to discuss any recommended design or process changes, and publish a final set of QSR documents governing the process for future QSR activities;

   ER Finding: By agreement with the ER and representatives of the Plaintiffs, this action step has been delayed in order to develop and field test new QSR protocols and instrumentation.

6. Complete at least one QSR site review per month between October 2016 and June 2017, with the exception of the month of December, and circulate to all parties the action items,

plans of correction (if applicable), and updates on implementation of needed remedial measures (if applicable) resulting from each of these visits;

ER Finding: Three QSR site visits were conducted, resulting in QSR team recommendations for substantial changes in the QSR protocols and instruments. The ER and representatives of the Plaintiffs agreed to postpone further site visits until these changes were made. The QSR site visits will begin again in 2017.

7. Starting July 1, 2016, circulate to all parties on a monthly basis the most recent data reports of the Central Team;

   ER Finding: The State has implemented this recommendation and continues to track and report progress on the plan.

8. No later than October 1, 2016, assure that final rules for supportive housing and ACT services are promulgated in accordance with the draft rules developed with input from all parties;

   ER Finding: The Supported Housing rules have been promulgated, and incorporate positive elements resulting from discussions among DHHS staff and representatives of the Plaintiffs. The ACT rulemaking has been filed, and is reported to have been approved and promulgated as of this date. The State and representatives of the Plaintiffs are to be commended for their collaborative work developing these two regulations.

9. By October 1, 2016, augment the quarterly data report to include:
   - ACT staffing and utilization data for each ACT team, not just for each region. ***ER Finding: The State has implemented this recommendation.***
   - Discharge destination data and readmission data (at 30, 90, and 180, days) for people discharged from NHH and the other DRFs; ***ER Finding: Readmission data are not yet available for the DRF and readmission data for NHH are currently reported only for the 90 day interval.***
   - Reporting from the two Mobile Crisis programs, including hospital and ED diversions. ***ER Finding: DHHS has determined a method for collecting and reporting Mobile Crisis data through the Phoenix system, and DHHS reports that these data will be incorporated in the next Quarterly Data Report. The most recent past Quarterly Data Report included information submitted by the Riverbend CMHC, but did not include data from the new Mobile Crisis Program in Manchester. The ER understands that Manchester data will be included in the next Quarterly Report***. and;
   - Supportive housing data on applications, time until eligibility determination, reason for ineligibility determination, and utilization of supportive services for those

receiving supportive housing. ***ER Finding: DHHS has not agreed to supply these types of data at this point.***

10. By October 1, 2016, (immediately prior to the next All Parties meeting) and then by December 1, 2016 (the time just before the next ER report), factually demonstrate that significant and substantial progress has been made towards meeting the standards and requirements of the CMHA with regard to the ACT, SE and placement of individuals with complex medical conditions from Glencliff into integrated community settings.

    ER Finding: As noted in the introduction to this section, the State has made limited progress towards compliance with the ACT and Glencliff requirements in the CMHA. Even this limited progress towards compliance remains slow, and the State remains out of compliance on these requirements. The State has achieved compliance with the statewide penetration rate standard for SE, due in part to high penetration rates in one region. The ER encourages ongoing efforts by the State to elevate SE penetration rates in all regions to ensure appropriate access to SE services across all regions of New Hampshire. The ER also encourages continued independent assessments to ensure ACT and SE fidelity to CMHA standards.

11. By October 1, 2016 demonstrate that aggressive executive action has been taken to address the pace and quality of transition planning from NHH and Glencliff through the development of a specific plan to increase the speed and effectiveness of transitions from these facilities.

    ER Finding: The Central Team has now been functioning for almost a year, and appears to have become more efficient in facilitating transitions from both NHH and Glencliff. The ER believes that both NHH and Glencliff have evidenced, at a leadership and a staff level, increased efforts and commitment to facilitating timely transitions to integrated community settings, albeit with modest result to dates. As noted above, transitions from Glencliff remain exceedingly slow. It is expected that after the first four transitions of medically complex individuals from Glencliff have been successfully accomplished, the pace of further transitions will be substantially increased.

Conclusion

The ER concludes that the State has increased its level of effort and organizational commitment to achieving compliance with the CMHA. The State has committed additional staffing and leadership resources to CMHA compliance, and has begun to implement management tools and initiatives to facilitate and support compliance efforts. In addition, the State has created a more clear accountability structure that is designed to hold DHHS and the CMHCs to measurable and accountable action steps to attain increased compliance. The ER believes the State is better

positioned today than it has been in the past two years to oversee and effectuate positive steps towards implementing high quality and fidelity model community services to members of the CMHA target population.

Nonetheless, as emphasized above, progress towards compliance over the past six months has been relatively minor and therefore far short of the significant and substantial progress identified as necessary for meeting the standards and requirements of the CMHA. The State remains out of compliance on ACT, and the current pace of change in ACT capacity and active caseloads is not sufficient to attain compliance in the near future. To date, there have been very few transitions from Glencliff, and it remains to be seen whether the pace of transitions to integrated community settings will improve.

The initiatives and administrative actions taken by the State in the past six months have the potential to significantly improve access to CMHA services for CMHA target population members. It is hoped that with the continued effort of DHHS, and the support and commitment of the new Governor, there will begin to be significant and measureable progress towards achieving compliance with the CMHA, as well as evidence of beneficial outcomes for adults with serious mental illness in New Hampshire. To achieve this end, the pace of change must rapidly increase over the next 3-6 months, or non-compliance with the CMHA will become an even more critical issue than it is now.

The ER has stated previously that the time for patience has come and gone, and that the ER continues to be concerned and dissatisfied with the current status of compliance with the CMHA. The State also evidences concern with the current status of compliance with the CMHA. The action steps noted above must produce results, and accountability for attaining necessary service expansions and improvements must be measured and enforced. With a new Administration, there is a significant opportunity for new actions and efforts to reverse this longstanding pattern of noncompliance with several key provisions of the CMHA. If substantial progress is not clearly evident and well documents by the time of the next six month report, the ER will have to consider what other compliance enforcement mechanisms may be necessary, including possible involvement by the Court.

Appendix A

New Hampshire Community Mental Health Agreement

State's Quarterly Data Report

July to September 2016