UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

Amanda D., et al., and others similarly situated, Plaintiffs, v. Chris Sununu, Governor, et al., Defendants.	)	
United States of America, Plaintiff-Intervenor, v. State of New Hampshire, Defendant.	)	Civ. No. 1:12-cv-53-SM

CMHA NOTICE OF NONCOMPLIANCE

I. Introduction

The Plaintiffs and the United States serve Notice of Noncompliance with the terms and obligations established under the 2014 Community Mental Health Agreement (CMHA). Class Action Settlement Agreement, ECF No. 105, Feb. 12, 2014.

The CMHA requires the State to provide institutionalized class members in Glencliff and in New Hampshire Hospital (NHH) with effective transition planning, an effective written transition plan, and a working in-reach system to identify and overcome barriers to community placement, to avoid trans-institutionalization, and to actively support their successful transition to integrated community settings. CMHA § VI.A. The State's failure to comply with required transition planning, in-reach, PASRR, and community capacity provisions of the CMHA demonstrates that it did not make reasonable efforts to avoid class members' trans-institutionalization, nor did it facilitate possible alternatives to nursing facility placement.

For these reasons, the Plaintiffs and the United States assert that the State is in noncompliance with the terms of the CMHA, necessitating further remedial action and a plan to cure identified violations.

Pursuant to Section X.C of the CMHA, Plaintiffs and the United States request that the State respond in writing to this Notice within 30 days, describing in detail what steps it will take, if any, to cure the alleged noncompliance. Should the State contest the violations identified in this Notice, we request a written response along with any additional information or evidence supporting the State's position.

This Notice addresses the State's failure to comply with these CMHA provisions:

1. Transition Planning from Glencliff and New Hampshire Hospital

CMHA Section VI.A.4 requires: "In developing the transition plans, the State will make all reasonable efforts to avoid placing individuals into nursing homes or other institutional settings. Before adopting a transition plan that places an individual in a nursing home or other institutional setting, the State must consider all possible alternatives and describe the steps it took to implement the alternatives. If the final transition plan results in placement of the individual in a nursing home or other institutional setting, the plan shall be used to identify the barriers to placement in a more integrated setting and describe steps the State will take to address the barriers."

Sections VI.A. 1-10 of the CMHA detail the State's obligations with regard to the transition planning process. The State is to provide each individual in New Hampshire Hospital (NHH) and Glencliff with "effective transition planning … developed through a person-centered planning process in which the individual has a primary role … [resulting in] an effective written transition plan that sets forth … the services and supports … each individual needs in order to *successfully transition to live in an integrated community setting* …" and to implement an in-reach system that includes meetings "between individuals in NHH and Glencliff and the community health program or provider from their respective regions to develop relationships of trust and to *actively support these individuals in transitioning to the community*." CMHA §§ VI.A.3(a) and 7 (emphasis added). Overall, the transition process is to provide all individuals at NHH and Glencliff with opportunities to consider, explore, and make informed decisions about integrated community living. These provisions also establish an affirmative State obligation to identify, and seek to resolve, specific barriers to community transition, through "individualized strategies" and engagement with the individuals, their guardians, if any, and utilization of the State's Central Team to address and overcome any barriers identified during transition planning or set out in the transition plans. Finally, the CMHA's transition planning process contemplates adherence to provisions of the Nursing Home Reform Act ("NHRA") related to the Preadmission Screening and Resident Review (PASRR) requirements set forth in 42 U.S.C. § 1396r(e)(7) and 42 C.F.R. § 483.120.

2. Residential Capacity for Glencliff Residents with Complex Health Care Needs

Sections V.E.2 and 3 of the CMHA require that the State develop residential capacity in the community sufficient to serve 16 Glencliff residents with "mental illness and complex health care needs who cannot be cost-effectively served in supported housing" by no later than June 30, 2017.

II. Background and Procedural Posture

As you know, earlier this year, the State encouraged trans-institutionalization by creating a new financial incentive program in which it paid nursing and assisted living facilities to accept transfers of individuals from NHH and Glencliff in exchange for an incentive payment of $45,000 per individual, plus an enhanced daily bed rate for the duration of the time the individual remains at the receiving facility. We believe that this program undermines the purpose and intent of the CMHA and directly conflicts with CMHA provisions requiring the State to actively support transitions to integrated community settings and to take all reasonable efforts to avoid transitioning class members to institutional settings.

On June 16, 2021, Plaintiffs' counsel requested, and later received, records from the State pertaining to those individuals transferred under the incentive program. Consistent with Section X.C.1 of the CMHA, Plaintiffs also notified the State, by letter dated June 16, 2021, that we believed the transfers violated the CMHA, and requested an opportunity to confer with the State about the violations at the July 1, 2021 all parties meeting. Consistent with CMHA Section X.C.1, at a videoconference on July 1, 2021, the parties and the Expert Reviewer conferred in good faith in an effort to cure outstanding issues. Unfortunately, the discussion at that meeting, as well as at the continuation of that meeting on August 16, 2021, did not result in any agreement or resolution regarding the scope of the alleged violations or remedial actions to cure.

Based on a review of NHH and Glencliff transition records produced by the State, ongoing monitoring efforts, and the findings reported by the Expert Reviewer in his latest report, the Plaintiffs and the United States, pursuant to CMHA Section X.C.2, provide the State with this Notice of Noncompliance.

III. Assertions of Noncompliance

A. In-Reach and Transition Planning Activities (CMHA § VI.A)

The State produced records from NHH for 14 individuals transferred from NHH to a nursing facility during the period from May 18, 2021 to June 18, 2021, and for 14 individuals transferred from Glencliff during the period from May 4, 2021 to June 22, 2021, eleven of which went to a nursing facility. The State confirmed that these individuals were transferred under its incentive program.[1] These class member records illustrate the following areas of noncompliance with the CMHA.

[1] Several other individuals transferred from Glencliff to a nursing facility since June 22, 2021. It is not known whether these transfers were part of the financial incentive program, as the records for those individuals have not

1. Glencliff In-Reach and Transition Planning Violations

The in-reach system at Glencliff has long been out of compliance with the provisions of the CMHA designed to ensure that class members and their guardians have the opportunity to make an informed choice between nursing facility or other non-community placement and integrated community services. At the urging of the Plaintiffs, the United States, and the Expert Reviewer, the State revised the Glencliff transition policy and developed a person-centered 'visioning' process in early 2020, in an effort to help address outstanding concerns, including the State's failure to provide sufficient in-reach and transition planning for Glencliff residents. Around that time, the State hired what it labeled an "In-Reach Liaison" to help implement these revised processes. Yet, despite these steps, the State still fails to comply with CMHA requirements on in-reach. For example, the State does not: (i) explain fully the benefits of community living; (ii) facilitate visits to community settings and accompany residents on these visits; and/or (iii) explore and work to address the concerns of any individuals who decline the opportunity to move to a community setting or who are ambivalent about moving to a community setting. CMHA §§ VI.A.2 and 7(a).

Our review of the produced records reveals that these failures are present in some form for all residents discharged from Glencliff in 2021, but they are particularly stark for the individuals who were transferred to nursing facilities under the State's financial incentive program. The records revealed inadequate or no discussions regarding the benefits of community living, or the prospect of visiting sites, or the possibility of accessing specific home and community-based services as alternatives to nursing or assisted living facility placement. Therefore, it appears that expressed preferences by individuals or guardians that are documented in the record were not the product of adherence to the requirements set out in the CMHA or to the State's visioning process, and were not in response to, or based on, an individualized discussion of potential integrated alternatives to nursing or assisted living facility placement.

Transition records indicate that the In-Reach Liaison was at least introduced to most of the individuals who left Glencliff in the first seven months of 2021. However, few Liaison records contained evidence of a sufficient in-reach and visioning process consistent with the CMHA or the State's revised transition planning policy. In many instances, a visioning script was cut and pasted into the transition record, accompanied by only cursory answers from the individual. Typically, next steps were not clearly identified. Record reviews completed by the Expert Reviewer in June of 2021, noted that the informed consent/visioning process had only been completed with 17 out of more than 100 Glencliff residents. Expert Reviewer Rep. No. 14, ECF No. 137-1, Oct. 4, 2021, at 37. The Expert Reviewer found poor documentation associated with use of the informed consent/visioning script and insufficient follow-up or next steps specifically described in the records. Id. As a result, the records revealed that information captured by the Liaison was typically a superficial, point-in-time assessment of the individual's interests and preferences and did not reflect the person's evolving goals or vision for community

been provided to us. It is not known whether any individuals have been transferred from NHH to a nursing facility pursuant to the incentive program since June 18, 2021.

living consistent with the CMHA or the State's policy. Additionally, there was inadequate or no evidence that the Liaison made reasonable accommodations to enable residents' active participation in the in-reach and visioning process, to comport with the specific communication strategies described in individual care plans.

With one exception, none of the individuals from Glencliff who moved to other institutional settings had the benefit of an adequate visioning process, consistent with the State's policy, as part of their transition planning, even where the resident and family had previously identified community living as a preference. For instance, there was no documented interaction between the Liaison and individual ES, despite the family's long-standing interest in community transition, and the facility's recommendation that ES transition to a medical model home in 2018. ES was discharged to a nursing facility on June 3, 2021. Instead, for many of these individuals, the Liaison's activities focused primarily, if not exclusively, on facilitating applications to other nursing facilities.[2]

Most transition records reveal no in-person or virtual visits to community settings as a way to explore integrated alternatives.[3] Nor was there evidence that the Liaison or other State officials had worked to address the concerns of individuals who were ambivalent about moving to a community setting or who expressed perceived barriers to community living as required by the CMHA. This was especially true for those individuals who transitioned to other nursing facilities.

Virtually all of the resident records lacked a detailed description of current barriers to discharge to an integrated setting and how to overcome them. Most reflected only the barriers identified at the time the individual was admitted to Glencliff, which in most circumstances, was years earlier. Very few records documented adequate efforts to provide additional services, skills development opportunities, or training during their tenure at Glencliff that would have helped to address and overcome barriers by preparing individuals for transition to an integrated community setting.

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[2] The ER similarly found that the Liaison:

> reports spending considerable time and effort assisting to effectuate nursing facility transfers for Glencliff residents … contacting and communicating with numerous nursing facilities, completing facility applications, sending requested medical records, and otherwise seeking to facilitate nursing facility transfers.

Expert Reviewer Rep. No. 14, ECF No. 137-1, Oct. 4, 2021, at 38.

[3] Only four individual transition records we reviewed documented in-person or virtual meetings with potential community service providers, including CMHCs, as is required in the CMHA. CMHA § VI.A.7 (a) and (b). Only two of those individual records had documented visits to a community program to which they might transition. After one resident's referral to a medical model home was denied, no other integrated community settings were explored, visited, or considered, as alternatives to nursing facility transfer.

The transition records we reviewed also included little, if any, documentation of solution-focused conversations with the individual/guardian designed to identify and resolve concerns with, or perceived barriers to, community transition. Even when specific barriers were identified, as reflected in some service denials, there was little or no evidence of meetings with the individual/guardian to try to resolve or overcome those barriers, or to consider other possible alternatives, as required by the CMHA. CMHA §§ VI.A.3(d), 4, and 7(a)(b). In one instance, the individual was found ineligible for a particular community waiver program because of a particular diagnosis. Another individual required diabetes medication by injection, leading to a denial by one residential provider. In both cases, there were no documented efforts to address identified issues or to identify other potential alternative community services/settings. Both individuals later transferred to other nursing facilities. These Glencliff in-reach and transition planning violations are consistent with findings of the Expert Reviewer, who concluded that he could find "no documentation … that residents transferred to nursing facilities had been offered information on integrated community alternatives or other optional settings," or provided with assistance in resolving barriers to transition to integrated community settings. Expert Reviewer Rep. No. 14, ECF No. 137-1, Oct. 4, 2021, at 38.

2. NHH In-Reach and Transition Planning Violations

For the 14 individuals transferred from NHH under the financial incentive program, the individual transition process did not "begin with the presumption that with sufficient services and supports, [these] individuals can live in an integrated community setting," as is required in the CMHA. CMHA § VI.A.2(a). Nor were the transition plans "developed and implemented" through a person-centered planning process "in which the individual has a primary role" or based on the principle of "self-determination." CMHA § VI.A.2(b). Finally, transition planning was not based on each individual's needs, but rather than on "the availability, perceived or actual, of current community resources and capacity." CMHA § VI.A.2(d).

For nearly all of the 14 individuals, transition planning began with a focus on placement in a non-integrated community setting, primarily an assisted living or nursing facility. The records typically revealed little or no evidence of any discussion with the individuals about their preferences. The records also revealed inadequate or no discussion of, or detailed plans about, specific community-based mental health and other supports and services the individuals would need to successfully transition to and live in an integrated community setting. CMHA § VI.A.3(a).[4] In addition, the records revealed that the State's transition planning process did not identify or attempt to resolve or overcome the specific barriers that exist to securing such

[4] These failures impacted people with serious mental illness (SMI), but also people with a dual diagnosis of SMI and intellectual disability. At least one individual had confirmed diagnoses of both mental illness and intellectual disability (described as "mild intellectual disability"), but there was no effective transition plan for that individual that outlined the services and supports she might need from both the State's developmental disability and mental health service-delivery systems to enable her to live in an integrated community setting. CMHA § VI.A.9.

supports and services and transitioning individuals to an integrated community setting. CMHA § VI.A.3(d).

For those individuals at NHH or their guardians who were concerned about transitioning out of NHH to an integrated community setting or expressed interest in transferring to another institutional setting, the records reflect insufficient or no in-reach efforts aimed at exploring community alternatives, or efforts that actively supported individuals in transitioning to the community, as is required in the CMHA. These efforts are to include explaining fully the benefits of community living, facilitating visits to community settings, and exploring and working to address individual concerns. CMHA § VI.7(a). The records also reveal inadequate State efforts to propose "individualized strategies" to address any concerns or perceived barriers to integrated community living, pursuant to the criteria set out in the CMHA. CMHA §§ VI.7(b) and VI.8. Instead, almost invariably, once an individual or guardian expressed interest in a trans-institutional transfer, the only efforts made were those focused on achieving the same through a placement at Glencliff or to a nursing or assisted living facility.

All of the violations set forth above with regard to NHH, apply to Glencliff as well.

B. Central Team Violations

The CMHA requires that the State create a "central team" to "assist in addressing and overcoming any of the barriers to discharge identified during transition planning and/or set forth in the transition plans." CMHA § VI.A.6. As noted above, the State's failure to engage in effective transition planning, and to identify and attempt to resolve barriers to integrated community extended to the Central Team process.

With the exception of one individual from Glencliff, it appears that none of the 25 individuals who were trans-institutionalized in 2021, were presented to the Central Team to assist in addressing and overcoming barriers to discharge to an integrated setting. For the one individual whose records referenced a referral to the Central Team, the results of that referral were not documented.

This reflects not only a failure to appropriately utilize Central Team resources, established to help resolve issues and overcome barriers to community living, but also reveals that the State failed to make all reasonable efforts to avoid placing individuals in nursing facilities or other institutional settings. CMHA § VI.A.4.

C. Failure to Take Steps to Avoid Trans-institutionalization of Class Members at NHH and Glencliff

Before adopting a transition plan that places an individual in a nursing facility or other institutional setting, the State must consider "all possible alternatives" and describe the steps it took to "implement the alternatives." CMHA § VI.A.4. If the final transition plan results in the placement of the individual in a nursing facility or other institutional setting, the plan shall be used to "identify the barriers to placement in a more integrated setting and describe steps the State will take to address the barriers." Id.

As detailed above, the NHH and Glencliff records produced by the State reflect a consistent failure to comply with this obligation. Instead, most of the efforts described in the 25 records were focused on securing placement in an assisted living or nursing facility. Few, if any, attempts were made to exhaust, seriously consider, or implement steps to secure possible alternatives to trans-institutionalization. Rather, once an individual or guardian expressed an openness to applying for a nursing or assisted living facility placement, often with the encouragement of NHH or Glencliff staff, this became the primary or exclusive focus of transition planning efforts. To the extent these records contained final transition plans, those plans did not attempt to describe the steps the State would need to take to address the barriers so that integrated community living might be achieved in the future. CMHA § VI.A.4.

As set out above, the State failed to: (1) adequately inform individuals of the benefits of, and opportunities for, community living; (2) provide appropriate in-reach and visioning processes, including interactions and meetings with potential community providers; and (3) identify and resolve or overcome perceived and/or real barriers to community living. As a result, individuals transferring from NHH and Glencliff to nursing or assisted living facilities were denied the transition planning process to which they were entitled under the CMHA and the State's revised transition planning policy and deprived of the opportunity to make an informed choice between nursing or assisted living facilities and integrated community-based services. The Expert Reviewer reached a similar conclusion as to the Glencliff transfers following his record review, finding "no documentation of informed consent that complies with Glencliff's own policies for individuals transferred to nursing facilities or other placements." Expert Reviewer Rep. No. 14, ECF No. 137-1, Oct. 4, 2021, at 39. In the absence of reasonable State efforts to avoid nursing facility placement and to exhaust all possible alternatives, individuals and guardians were effectively left with no choice other than to accept institutional placements as the only way to promptly leave NHH and Glencliff.

D. Development of Community Alternatives for Individuals with Mental Illness and Complex Medical Needs (CMHA § V.E.2-3)

The CMHA requires the State to develop residential capacity in the community to serve 16 Glencliff residents with mental illness and complex health care needs who cannot be cost-effectively served in supported housing. The CMHA requires the State to expand capacity so that there are 16 beds or settings capable of serving these individuals at any given time. To date, the State has only established such community capacity sufficient to serve nine individuals: four beds created at the medical model home administered by Harbor Homes in Nashua,[5] and five enhanced family care settings.

[5] The rotation of different individuals in and out of the four Harbor Homes beds does not satisfy the CMHA's community capacity requirement since the number of available beds remains the same. Moreover, it is not clear that all of the individuals transferred into the Harbor Homes apartments were individuals who could not be cost-effectively served in supported housing as contemplated under the CMHA. Indeed, some of these individuals were only transferred to Harbor Homes pending the availability of subsidized supported housing.

Despite CMHA provisions calling for additional, incremental increases in residential capacity in 2016 and 2017,[6] the Plaintiffs and the United States are aware of no additional community capacity that has been developed to satisfy the CMHA criteria. Nor are we aware of any ongoing or prospective efforts by the State to further expand such capacity, such as by targeting community-based housing development funds for individuals with complex health care needs transitioning from Glencliff.[7] As a consequence of this failure to expand community residential capacity, numerous Glencliff residents interested in, or identified as capable of benefitting from medical model homes, have either remained segregated at Glencliff or been forced to accept transfers to nursing facilities or other institutional settings.[8]

To the extent that the State might contend that the transfer over the last several years of other individuals to apartments or senior living apartments should be counted toward the capacity requirement, that contention should fail absent evidence that those individuals required and are receiving consistent medical care for complex medical needs, since this level of care would otherwise not be possible, or cost effective, in supported housing.

E. Violations of the CMHA's PASRR Provisions

The CMHA memorializes that the "Parties are committed to" compliance with the Americans with Disabilities Act (ADA), the Rehabilitation Act, and the Nursing Home Reform Act (NHRA), which requires compliance with the evaluation and service requirements of PASRR. CMHA § IV.A. The CMHA further reflects the parties' recognition that qualified individuals with disabilities shall receive services, programs, and activities in the most integrated setting appropriate to meet their needs. CMHA § IV.A.

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[6] The State was initially required to develop capacity to serve four such individuals in the community by June 30, 2015. It was required to further expand these community resources to achieve a total capacity of 16 by June 30, 2017, along with an effective plan to provide additional capacity in the future. CMHA § V.E.3.g-i. Over the last five years there have been some Glencliff residents who could be cost-effectively served in supported housing, and who were discharged to supported housing programs - either directly or indirectly – as part of Glencliff's transition planning process. However, the 16-community bed capacity addressed by this provision of the CMHA, was specifically intended to benefit those persons at Glencliff whose complex medical needs required 24-hour supervision and supports, making it inappropriate (and not cost-effective) for them to be discharged to an independent apartment with supports.

[7] In the past, and as set out in his most recent report to the Court, the Expert Reviewer has repeatedly urged the State to: "[m]ake it a very high priority to develop new small scale residential settings for residents with complex medical conditions as soon as possible," both as a way to restart movement of people to integrated community settings and because some "individuals have been waiting for transition for a long time." Expert Reviewer Rep. No. 14, ECF No. 137-1, Oct. 4, 2021, at 34. His most recent report notes that "[w]ith the exception of the enhanced family care setting for one resident, no new integrated community capacity has been developed on behalf of Glencliff residents in the past three years." Id. at 39.

[8] In the Expert Reviewer's March 23, 2020 memo to the parties concerning transition planning at Glencliff, he reported that "[o]f the 28 residents in active care planning at the time of the review 22 individuals "are candidates for integrated community settings, either independent housing or a Palm Street-type small scale integrated community residence."

Through specific provisions of the CMHA related to the transition planning process, the State has agreed to ensure that class members are provided with access to integrated community services, and that they are not transferred to congregate facilities that are unable to provide the mental health services they need. The CMHA incorporates the purpose and requirements of PASRR, for example, stressing the importance of evaluating if an individual's needs can be met in the community, and taking the necessary steps to avoid nursing facility placement if possible, including prompt referral to the appropriate Area Agency and/or Community Mental Health Center. CMHA § VI.A.10. As part of this commitment, the CMHA states that "[p]roviders of developmental and mental health services will discuss and develop community options with the individual and will offer the individual appropriate services and supports in an integrated community setting." Id. When the State fails to comply with these provisions, and with its obligations under federal law to evaluate individuals prior to placement in a nursing facility to determine if an alternative setting is appropriate, it is likewise failing to make reasonable efforts to avoid nursing facility placement. CMHA § VI.A.4.

IV. Conclusion

Pursuant to the CMHA, Plaintiffs and the United States request the State's prompt response to the violations described above and, in particular, the State's plan to remediate the effect of the violations on the individuals who were transferred to nursing facilities pursuant to its financial incentive plan. We also request that the State outline its plan to ensure that such violations do not reoccur. Finally, to the extent that the State contests any of the violations, we request a written response explaining its rationale and documents or other evidence to support the same.

Dated: November 22, 2021

Sincerely,

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