

**Review of the State of New Hampshire's
Oversight and Monitoring of the Services
Provided by
Lakeview Neuro-Rehabilitative Center**

Prepared for Governor Hassan

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Section I. Introduction

Governor Hassan became increasingly concerned about the quality of services provided to individuals who are served by Lakeview Neuro-Rehabilitative Center (LNC) as the result of a report of a death of a resident that occurred in 2012 that was investigated by the Disabilities Rights Center (DRC) and reported in September 2014. The findings of this investigation highlighted numerous concerns regarding health care and assessment, programming, staff training and consistency, staff supervision, program monitoring and overall quality. The DRC made many substantive recommendations including closing the LNC program in New Hampshire.

In response the Governor stopped any further admissions to Lakeview from New Hampshire, required the health facilities licensing bureau to inform other states of this decision, and directed a three- phase review of services at LNC. The first phase was a licensing review completed by staff of the Department of Health and Human Services (DHHS) that were health facilities certification bureau staff not assigned to LNC, and an independent expert in quality assurance and program monitoring. This was completed in November 2014 and resulted in many findings of deficiencies and a requirement for LNC to develop and implement a Plan of Correction (POC). The second phase was an independent review of LNC and the third phase was an independent review of the state's monitoring and oversight efforts. This is a report of the third phase of the Governor's directive to review the services provided by LNC and the state's oversight of these services.

Governor Hassan has asked for an independent review of the quality of the monitoring and oversight of Lakeview Neuro-Rehabilitative Center (LNC) by state agencies. These include entities within the Department of Health and Human Services including The Bureau of Elderly and Adult Services (BEAS), Bureau of Developmental Services and its Office of Client Legal Services (OCLS), and the Health Facilities Licensing Bureau (HFLU). It also includes the Area Agencies that fund service providers and provide service coordination for individuals receiving supports and services from DHHS. Each of these entities has some responsibility for assuring the quality of services individuals receive and for protecting them from abuse, neglect and exploitation.

It was important for me to talk to the many stakeholders involved with oversight of Lakeview and review a number of relevant documents produced by various sources in order to have a comprehensive understanding of the requirements that are established for a facility such as Lakeview and how the state has tried to determine if Lakeview consistently meets these expectations. These include the rules governing the licensing of a residential treatment and rehabilitation facility (RTRF); the complaint process; the abuse and neglect investigation process; and the functions of the Area Agencies. I also reviewed the Licensing Inspection Report issued by DHHS in November 2014. I have interviewed administrative representatives from the New Hampshire Department of Health and Human Services (DHHS) including department leadership, complaint investigators, licensing inspectors, and abuse/neglect investigators, and the New York State Justice Center. I also interviewed two members of the survey team that conducted an inspection of LNC in November 2014 at the request of Governor Hassan as the first phase of this review.

I have talked with staff from the Disabilities Rights Center of NH, Community Support Network, Inc., (CSNI) and Area Agencies Directors. I also interviewed former employees of DHHS who reached out to me.

I want to thank everyone for his or her responsiveness and candor. I greatly appreciate the coordination that Frank Nachman, Legal Counsel provided and the numerous document he provided for me to complete a thorough review.

In general I find that the actual rules are adequate in many areas with the significant exception of the rules that establish the basic licensing requirements for Lakeview Neuro-Rehabilitation Center. The rules governing the abuse and neglect investigations conducted by both Adult Protective Services (APS) within BEAS and the complaint investigation process conducted by OCLS have inherent weaknesses that do not allow New Hampshire to have a comprehensive understanding of these overall concerns for a facility such as Lakeview or to consistently determine the underlying causes of abuse and neglect and address these systemic concerns.

Overall the rules provide reasonable standards for the development and implementation of a service delivery system that expects the protection and

suitable care of individuals with developmental disabilities within a community-based system of care. However these expectations are not always applied to Lakeview and the oversight and monitoring system has significantly failed the residents of Lakeview and their families by not assuring them even basic protection from abuse, neglect and exploitation. This is due to many systemic factors including a lack of sufficient resources to effectively monitor Lakeview; a lack of coordination, cooperation and communication among advocacy agencies, other states' monitoring divisions and New Hampshire's DHHS which is amplified by New Hampshire's lack of meaningful responsibility to protect out of state residents that reside at Lakeview; a lack of a contract with Lakeview specifying overall programmatic and financial accounting expectations; and a lack of administrative leadership setting high expectations for quality monitoring of all of its facilities.

Section II. The Responsibilities of the DHHS

The responsibilities of the Department of Health and Human Services (DHHS) are addressed in RSA 171-A, 126- A, 151, and their Implementation Rules. DHHS is responsible to ensure the health, safety and well- being of the individuals it serves. RSA171-A: 4 require DHHS to maintain a state service delivery system for the care, rehabilitation, treatment and training of persons with developmental disabilities. The Commissioner is required to contract with Area Agencies to carry out case management, service delivery and other responsibilities at the community level (RSA 171-A: 18).

The system is to be based on full participation in the community, sharing ordinary places, developing meaningful relationships, and learning things that are useful, as well as enhancing the social and economic status of persons served (RSA 171-A). Further, the state is to make service agreements based on the criteria of the least restrictive environment; promoting individual health and safety; promoting individual right to freedom from abuse, neglect and exploitation; promoting community participation; and ensuring the right to adequate and humane rehabilitation including psychological, medical and rehabilitation services.... to bring about improvement. The above is defined in He-M 505 and RSA 171- A: 1, VI.

The oversight of the system of services involves the Health Facilities Licensing Bureau, The Office of Client and Legal Services – Bureau of Developmental Services, Adult Protective Services of the Bureau of Elderly and Adult Services, and the Area Agencies. In the following sections I will briefly summarize the responsibilities of these entities as they relate to oversight, monitoring and investigation and note areas of shortcoming in assuring quality and protection from harm.

Section III. Licensing

RSA 151:2 establish the responsibilities of the Licensing Bureau of DHHS. The Licensing Bureau bears the responsibility to ensure facilities that provide medical, nursing and remedial care will ensure safe and adequate treatment of such persons in the facility. The Licensing Bureau conducts at least one annual unannounced clinical inspection to determine if the facility is in compliance and the facility and programs and services are appropriate to the needs of the residents (RSA 151:6-a I). It also conducts an annual Life Safety inspection. DHHS may suspend or revoke a facility's license.

The Rule governing Residential and Health Care Facilities are in Chapter He-P 800: Residential and Health Care Facility Rules Statutory Authority. He-P 807.01 states the purpose is to set forth the licensing requirements for all residential treatment and rehabilitation facilities (RTRF) pursuant to RSA 151:2,I (d). Lakeview is considered a Residential Treatment and Rehabilitation Facility (RTRF).

The rule covers a number of areas including: complaints; duties and responsibilities of the Licensee; client admission criteria, temporary absences, transfers and discharges; required services; medication services; personnel; client records; food services; infection control and physical environment. While some sections are adequate many do not include the basic expectations that the state should place on a facility providing intensive support and supervision to individuals with challenging needs.

The Personnel section (807.18) does not include sufficient expectations for staff training. Areas that should be included are abuse/neglect and exploitation including reporting requirements; restraints; person-centered

planning; positive behavioral programming; the concepts of most integrated setting and the Americans with Disability Act (ADA); CPR/First Aid; and incident reporting.

There are no standards for providing habilitative services; person-centered planning; assessments; review of restrictive programming including the use of psychotropic medication; or staffing expectation based on the acuity of individuals served.

The Compliant section (He-P 807.11) is a general description of the complaint process and does not specifically mention complaints of abuse, neglect or exploitation. Complaints are handled by OCLS and there are separate rules governing the review of complaints. The HFLU also investigates some complaints. However there should be specificity in the rule given the importance of this topic and the lack of reporting and follow up that has occurred at Lakeview.

Licensing conducts both Life Safety and Clinical Inspections of Lakeview on an annual basis. I was provided the Life Safety Inspections for 2011, 2013, and 2014. There was no Life Safety Inspection shared with me for 2012. The inspection completed in 2011 was not sent to the administrator for Lakeview until January 8, 2013. Areas of deficiency were not addressed for over a year as a result.

I requested the summaries of the clinical inspections. I was told that they had been completed each year but there was no report because there were no deficiencies. This is troubling for two reasons. It is virtually impossible to operate a program serving a multitude of individuals with hundreds of staff implementing programs and following procedures and not experience any deficiencies. Secondly, every inspection should result in a report even if it is a summary of the areas that were evaluated and the positive results that supported a finding of no deficient areas to demonstrate the validity and transparency of the process. This should be publically available so that participants, families and other stakeholders are fully aware of the state's expectation of a facility and its performance toward meeting its standards.

There are currently two Inspectors assigned in the Health Facilities Licensing Unit to complete clinical inspections and also handle complaints for Assisted Living Facilities and non-certified Nursing Facilities. They are also

responsible for RTRFs including Lakeview. There are 1,000 facilities that are licensed of which 400 receive annual inspections. HFLU also inspects new facilities. There were 3.5 position assigned to these functions within the unit. One position became vacant over the past few months and was unfunded in the Governor's proposed budget. The part time surveyor is on medical leave. This is not a sufficient number of positions to complete thorough annual inspections of over 400 facilities and address complaints on a timely basis. Clinical inspections should involve two inspectors who are onsite for 2-3 days at minimum. The team that conducted the inspection of Lakeview in November included 4-5 surveyors who spent a few days at the facility.

The training of the surveyors is minimal at best. The Director of the Unit reports that surveyors are trained by shadowing senior surveyors. The Unit does not provide any formal training. Surveyors have limited opportunity to attend workshops and have not been able to attend the National Association for Regulatory Administrators since 2003 because of a lack of funding. The Unit needs to develop formal training that is competency based and includes an orientation to the Department's mission and vision. It should also reflect best practices in the fields related to the areas of inspection that are being completed. Surveyors should have a basic understanding of quality improvement processes. Funding should be made available for surveyors to attend national conferences in their field so they remain current in the developments in regulatory practices and quality assurance.

I was able to interview three individuals who worked previously for DHHS in the Licensing Unit. They are credible individuals, two of whom remain actively involved in the human services field in New Hampshire. They noted differences in the organization; direction and philosophy of the different areas of licensing noting that the survey team that inspected facilities under Medicare was better resourced and trained than the surveyors who inspected the RTRFs. They reported that oversight was less diligent and the standards were less clear for the ALF's and non-certified NFs. They gave examples of administrative intrusion into regulatory findings and reports. At one facility there were 75 deficiencies noted and the surveyors were only allowed to cite 32. This was determined through a review by administrators not by the findings of the inspectors.

They reported that there have been previous times when inspections found egregious concerns about Lakeview that may have warranted closure and no

action was taken. They report that the Licensing Unit is not held in high regard in the community because it is not perceived to be diligent or rigorous. They worked for the agency several years prior to the appointment of the new Commissioner and find Commissioner Toumpas to be a "breath of fresh air." However their concern is that other staffs remain with the agency who had direct or indirect relationships with Licensing and the overall organizational approach to inspection has not changed.

I believe the administration needs to clarify its expectations of licensing and hold the staff directly involved accountable for a thorough and rigorous review of facilities that are trusted to serve vulnerable individuals. This vision must be set and articulated by the senior leadership if the agency is to achieve a cultural shift in its expectations for quality among its service providers and its expectation for comprehensive review and accountability among its quality review staff.

Previous and current staffs support my finding that the rules are inadequate. The ex-employees state that the last time the rules were updated the rule writing committee was comprised of many providers. Individuals who rewrote the rules did not have regulatory experience or expertise. The Team Lead for the team that inspected Lakeview in the fall of 2014 and the outside expert who joined the team shares the perspective that the rules are inadequate. Michael Fleming, Team Leader said he used his background and experience surveying MA qualified nursing facilities to determine the areas of services to inspect at Lakeview. He then anchored these expectations to the broad but less well defined 807 rule requirements. John Martin, the current Director of the HFLU agrees the rules are probably inadequate for a residential treatment facility.

The Office of the Legislative Budget Assistant completed an audit of the Health Facilities Licensing Unit for FY2012 and 2013. The report was issued on June 2014. It found the HFLU generally efficient and effective but found it did not complete all life safety inspections in 2012.

The OLBA made the following recommendations:

- Revise the rules
- Establish written policies and procedures
- Improve the handling of complaints and ensure deadlines are met
- Retain inspection information

- Notify complaints
- Collect data to measure overall performance and effectiveness
- Change the clinical inspection process so that site inspections are not done at predictable time

Findings: Lakeview has been able to operate its program at an unacceptable level in large part because the rules governing its functions are inadequate and the inspections have not been rigorous. Additionally there appears to be a lack of commitment to quality and thorough review of a facility such as Lakeview by DHHS' Licensing Unit. Lakeview had no clinical deficiencies for four years including early 2014.

During this time the Area Agencies were becoming increasingly concerned with services and Lakeview and began to take steps in late 2013 to address them. One parent in particular was making her concerns known to the Licensing Unit. The DRC of Maine conducted an investigation of Lakeview and its concerns were public knowledge. The DRC of New Hampshire had raised concerns prior to its report in September 2014. The NYS Justice Center (JC) conducted numerous investigations that were shared with the HFLU. The JC directed Lakeview to conduct its own investigations and improve its quality oversight because "New Hampshire's oversight of Lakeview is not sufficient to ensure the safety of service recipients placed from outside the state." OSHA cited Lakeview for numerous workplace concerns including workplace violence, due to insufficient staff and poor training.

None of these rather blatant signs of organizational dysfunction prompted any additional review by DHHS until the Governor's directive. The issues noted in the survey conducted in November 2014 reflect many serious and systemic concerns. Lakeview acknowledges in its Plan of Correction that many of these problems are chronic. They include poor incident reporting, inadequate staff training, and an inability to meet the levels of supervision the individuals need on a consistent basis. Individuals and staff have been hurt as a result. These issues were problematic for Lakeview long before they were cited in the 11/14 Licensing Report. They were not surfaced in any of the reviews conducted in the prior four years by the HFLU. If they had been noted Lakeview would have either

demonstrated its ability to correct its deficiencies and improve quality, or the state would have known long before now that the facility did not have the capacity to structurally improve, and been compelled to take action. Either outcome would have resulted in a safer environment for Lakeview residents.

Recommendations: The Rules need to be re-written to reflect the state's expectations for a residential treatment facility and its commitment to individualized services and the opportunity for community living as expressed in RSA 171. The Licensing Unit needs to add Surveyors and provide comprehensive competency based training. The leadership of this area needs to demonstrate its commitment to the changes DHHS expects.

Section IV. Investigations of Abuse, Neglect and Exploitation and Complaint Review

New Hampshire DHHS places the primary responsibility for the investigations of abuse, neglect and exploitation of adults with the Bureau of Elderly and Adult Services (BEAS) through the Adult Protective Services (APS) Unit. Chapter 161-F 42-57 details these responsibilities. It defines the responsibilities of individuals to report suspected acts of abuse, neglect, self-neglect and exploitation or for individuals who live in a hazardous situation. Investigations are to occur in a timely period and the findings are shared with the Commissioner. Individuals are placed on a Registry if the allegation of abuse, neglect or exploitation is substantiated. Providers are not allowed to hire a prospective employee if he is on the Registry unless a waiver is granted. APS often co-investigates with Complaint Reviewers from the Bureau of Developmental Services, Office of Client and Legal Services (OCLS). APS is limited in its investigatory role. It can only investigate where there is a named perpetrator. It can only substantiate a finding of abuse, neglect or exploitation against an individual(s). It does not have the authority to substantiate abuse, neglect or exploitation if there is not an identified perpetrator and cannot make systemic findings or recommendations. APS investigates all allegations of adults who reside at Lakeview regardless of their state of origin. Findings are shared with guardians and state agencies.

The Department of Children, Youth and Families (DCYF) does investigate allegations of abuse and neglect of children. While the law allows DCYF to investigate abuse and neglect its own definition of neglect is limiting in that it is defined as an act committed by a parent, guardian or custodian. DCYF does not investigate in the educational program but only in the residential service of a facility such as Lakeview. DCYF shares its results with Licensing although notes not all of its recommendations are made in writing. Lakeview receives a verbal report and does not have to respond in writing with its corrective strategy. Guardians are informed of the finding and can request the full report. Other states are not directly informed of the allegation or findings but may get access to the information with a release from the guardian.

The OCLS within the BDS is responsible to respond to complaints. These responsibilities are described in He-M 202: Rights Protection Procedures for Developmental Services. The Purpose of these rules is to define the procedures for protection of the rights of persons applying for eligible for, or receiving services from area agencies or developmental services or acquired brain disorder programs funded through the bureau of developmental services.

He-M 202.03 (b) states "a person wishing to make a complaint may make the complaint orally or in writing to the OCLS (Office of Client and Legal Services) or any employee of an area agency, a program, or the bureau. Any person receiving a complaint shall promptly forward the complaint to the OCLS. Under He-M 202.04 Responsibility to Complain (a) through (j) specifically details the responsibilities of the AA and subcontractor/program, i.e. Lakeview. To summarize: (a) employees of the department or an area agency or program shall promptly make a complaint on behalf of the individual whenever they have reason to suspect that an individual has been subjected to abuse, neglect, exploitation, or a rights violation by an employee of, or a contractor, or volunteer for an area agency or program. (b) The person making the complaint or filing complaint shall forward complaint to OCLS. (c) ASAP but not later than one business day following receipt, OCLS shall submit complaint to a Complaint Investigator and inform the Executive Director of the appropriate AA that complaint was filed. (f) Complaint Investigator shall report a complaint of abuse, neglect, or exploitation of an individual or other person to the bureau of elderly and adult services (BEAS) or division for children, youth and families (DCYF), as appropriate.

He-M 202.07(a) stipulates that OCLS will have three (3) persons designated as complaint investigators, or more if needed to carry out all the duties of the complaint investigator within the timelines required by He-M 202. Section (h) states the investigator shall attempt to resolve the complaint within fifteen (15) days.

Priority of complaints is covered in (g) "complaints involving abuse, neglect, or exploitation shall be investigated prior to any other complaints. Such other complaints shall be investigated in the order they were received.

Section (n) details the eight (8) categories that must be included in the investigators report for OCLS to review. Section (o) designates who gets the final report and the timelines. It states, "following OCLS review to determine that the elements in (n) (1)-(8) above have been addressed and within 15 days of the filing of the complaint, the complaint investigator shall forward the full report to the individual or his or her guardian, the area agency executive director, and the program involved, if any. Section (w) requires follow up when a complaint report is finalized and contains recommendations for resolution that require the AA, program, or bureau action. Such action shall be taken within 20 business days of the date of the final report, unless a shorter timeline is specified. The AA or program shall send written documentation of such actions to the complaint investigator and bureau upon completion. The bureau shall follow up as needed to ensure implementation of the actions. The rule allows an AA to conduct its own investigation but only after the complaint report by OCLS is final.

He-M 202.09 Complaint Investigator Training and Data collection is comprehensive. OCLS has developed a process for informal as well as formal reviews of complaints that creates a more efficient and responsive process.

BDS has the authority to make program and systemic recommendations as a result of its investigations of complaints, unlike APS. This allows for a broader review and potential systemic correction for allegations of incidents that may have a root cause that is in addition to the abusive or neglectful actions of an individual perpetrator. However BDS only accepts complaints that involve persons applying for, eligible for, or receiving services from area agencies or developmental services or acquired brain disorder programs funded through the bureau of developmental services.

Findings: New Hampshire has established processes to assure the reporting, investigation, and follow up of allegations of abuse, neglect, exploitation and other areas of complaints. The involved entities work together to share information and findings and relevant information is shared with the Area Agencies to assure follow up by providers. The coordination and sharing of information is positive. However, there appears to be some duplication of effort. The rules make both APS and OCLS responsible to investigate abuse, neglect and exploitation without any clear distinction. When I met with OCLS, APS and HFLU staff they told me that OCLS and APS often undertake an investigation together and are sometimes joined by a licensing inspector. There are limited staff resources in Licensing and OCLS. It is not an efficient use of resources.

The fact that there are three entities (and probably a fourth with the Department of Education needing to investigate abuse and neglect allegations within the school program) presents concerns for Lakeview and the quality oversight system. Lakeview has varied reporting and follow up requirements that are exacerbated by reporting requirements of other states.

Lakeview also only has to follow up on the systemic issues that cause or contribute to abuse and neglect for its New Hampshire residents. New Hampshire has no comprehensive picture of the systemic issues that are present at Lakeview or other facilities in the state that may serve out of state residents because the BDS OCLS does not assume responsibility for the complaints of issues involving these individuals. I recommend that the rules that prohibit OCLS from reviewing all complaints and providing feedback to Lakeview and similar facilities be revised so that all complaints are known to DHHS. If New Hampshire decides to become responsible to investigate all complaints and determine the systemic causes of allegations involving residents of Lakeview from other states, BDS will need additional staff resources to investigate and assure follow up or individuals from other states. The Area Agencies are only responsible to assure follow up for individuals who they fund.

The responsibility of the AAs to ensure follow up by providers in response to complaint findings is clear. However, each AA has no more than three individuals at Lakeview and some AAs have only one individual. The systemic findings are shared with AAs individually. No one is responsible to review all

of the New Hampshire complaints for the facility and determine what patterns of concern are evident.

I requested a summary of all complaints and allegations of abuse and neglect that involved residents of Lakeview since 2011. I was finally provided the summary on March 25th. There were 241 reports from 2011 through 2/9/15. Thirty- four of the allegations were founded and twenty- five remained opened. This is a substantiation rate of 16% of the completed investigations. This is approximately half of the national trend of 30-35% of allegations being substantiated. I believe that APS inability to substantiate an allegation without an identified perpetrator contributes to this low rate.

One example of this systemic weakness is portrayed in an investigation of an individual being bitten by another individual. There was no perpetrator identified, the individual was on 15-minute checks and had received medical attention and was healing. There did not seem to be a review of the other resident's level of supervision or whether either's supervision was appropriate. In another case an individual went without glasses for four months. APS could not specify if the nurse or the case manager was responsible so did not have an individual perpetrator. It also noted the staff were no longer at LNC. Individuals were harmed in both situations that may have resulted from systemic weaknesses at Lakeview. It is a failure of NH's oversight system that this cannot be identified and therefore goes unaddressed by the provider.

There are other examples of what appears to be a lack of thoroughness in the investigations, although I have not reviewed the entire investigations only the brief summaries shared with me. An incident was reported on 10/18/14 that involved two residents being found alone in one of the bedrooms. It was unfounded because individuals were on 15- minute checks and these were being performed. The investigation did not address that a minor was able to be in the bedroom of a person of majority. The investigation did not appear to suggest any future protections be put in place or training for staff.

Twenty-five of the investigations are still opened. The majority is from October 2014. The expectation is that OCLS will complete investigations within fifteen days. The fact that this many are opened may indicate that OCLS is not sufficiently resourced to meet the requirements of the agency's rules in this area.

Recommendations: New Hampshire needs to address two critical weaknesses in its rules or the interpretation of these rules. First, APS needs to expand its investigatory role to be able to identify abuse and neglect that is attributable to organizational failure to protect individuals and not be limited to substantiating allegations only when there is an identified perpetrator. If this is not possible all allegations without an identified perpetrator or that may have programmatic or systemic cause should be referred to OCLS that has the authority to make systemic findings.

Secondly the responsibility of OCLS needs to be expanded to include a review of complaints of all residents of Lakeview regardless of their state of origin, unless APS' responsibilities are broadened as I have suggested. The residents and families need to be assured that the state is monitoring and overseeing the safety and care for all individuals who reside at Lakeview; that it is aware of any and all systemic and organizational weaknesses that contribute to abuse, neglect, exploitation and poor care; and that it requires Lakeview to promptly implement corrective action. OCLS in coordination with HFLU should have the responsibility to review the findings and trends of all investigations and complaint reviews (including those performed by DCYF, DOE and other states' protective service agencies) to provide feedback to the administration of DHHS regarding the overall quality of care and to determine the facility's licensing status if Lakeview remains open. DCYF or another entity needs to investigate allegations of neglect of children by staff.

DHHS needs to complete a staffing analysis of OCLS and APS to determine if there is sufficient staffing to carry out their responsibilities. It should also more clearly delineate the roles of the two units in completing investigations and complaint reviews to use staff efficiently and to ensure the efforts of the two units are well coordinated. I saw efforts to begin to address this need for coordination when I met with DHHS staff.

Section V. The Role of the Area Agencies

Area Agencies have the overall responsibility to ensure the delivery of services for individuals with developmental disabilities within their region and to assure the quality of the service providers. They fulfill the service coordination responsibility for these individuals and are charged to develop

the capacity needed by their citizens. Their responsibilities are defined in their contract with DHHS and in rule.

He-M 301 defines the rights of persons receiving developmental services or acquired brain disorder services in the community. The purpose of these rules is to define the rights of applicants for service or persons who have been found eligible for services under RSA 171-A: 6 and who are being served in the community or in a state-operated designated receiving facility. Individuals have additional rights under RSA 151:21, patients' bill of rights for residents of health care facilities.

This rule is comprehensive and clear. He-M 310.06 (a) (3) asserts the right to receive services in such a manner as to promote the individual's full participation in his or her community and (a) (15) the right to have individuals of one's choosing at the service-planning meeting. He-M 310.09 (a) (1-3) assures the right to safe and sanitary and humane living conditions, to freely and privately communicate with others and the right to privacy.

He-M 503, Eligibility and the Process of Providing Services establish standards and procedures for the determination of eligibility, the development of service agreements, and the provision and monitoring of services which maximize the ability and decision making authority of persons with developmental disabilities and which promote the individual's personal development, independence and quality of life in a manner that is determined by the individual.

The requirements of He-M 503.08 (b) and (c) seem very pertinent to setting different expectations for the quality of care at Lakeview.

(b) All services shall be designed to:

1. Promote the individual's personal development and quality of life in a manner that is determined by the individual;
2. Meet the individual's needs in personal care, employment, adult education and leisure activities
3. Promote the individual's health and safety
4. Protect the individual's right to freedom from abuse, neglect and exploitation;
5. Increase the individual's participation in a variety of integrated activities and settings;

6. Provide opportunities for the individual to exercise personal choice, independence and autonomy within the bounds of reasonable risk;
7. Enhance the individual's ability to perform personally meaningful or functional activities;
8. Assist the individual to acquire and maintain life skills, such as, managing a personal budget, participating in meal preparation. Or traveling safely in the community; and
9. Be provided in such a way that the individual is seen as a valued, contributing member of his or her community.

(c) The environment or setting in which an individual receives services shall promote that individual's freedom of movement, ability to make informed decisions, self-determination, and participation on the community.

I cite these rules because they are an expression of New Hampshire's expectations for service delivery. These expectations should more clearly drive the planning and service delivery for the individuals placed at Lakeview by the Area Agencies and be reflected in the Individual Service Plans.

Service Coordination is an integral part of coordinating and assuring quality services. He-M 503.09 specifies the responsibilities of Service Coordination

- (a) The Service coordinator shall be a person chosen or approved by the individual or guardian and approved by the area agency, provided that the area agency shall retain the ultimate responsibility for service coordination.

The Service Coordinator is expected to act as an advocate for the individual, coordinate the service planning process, ensure continuity and quality of services, indicate actions to be taken when goals are not being addressed, and convene service planning meetings at least annually.

Service Planning expectations are outlined in He-M 503.10. They require that the individual or guardian may determine the following elements of the service planning process:

- 1) The number and length of meetings;
- 2) The location, date and time of meetings;
- 3) The meeting participants; and
- 4) Topics to be discussed

(h) Delineates the review of service agreements by the area agency with the individual or guardian at least once during first 6 months and that annual review is required.

(i) Delineates that the service coordinator is responsible for monitoring services identified in the service agreement and for assessing individual, guardian and family satisfaction at least annually for basic service agreements and quarterly for expanded service agreements.

The service coordination responsibility for the Area Agency is clearly to drive the system for the benefit of the individual and family. In essence, they are the frontline of the Area Agency to assure well coordinated planning and services for individuals. It does not appear that all of these responsibilities are being carried out consistently for individuals who reside at Lakeview. Families report that planning meetings are totally dictated by Lakeview and they have little control over the scheduling of the meetings or the agenda. Families do not report that their perception of service delivery or their satisfaction is always being asked by Service Coordinators.

Part He-M 506 outlines the staff qualifications and staff development requirements for developmental service agencies. The purpose for these rules is to outline the minimum qualifications of provider agency staff, and the training requirements for such staff. These are weak with little specificity in the areas of medication certification, safety, habilitation, nursing, restraint training, abuse and neglect, person-centered service delivery. There does not appear to be a qualification process for providers other than to meet basic licensing standards.

Part He-M 505 Establishment and Operation of Area Agencies defines the procedures and criteria for the establishment, designation, and re-designation of area agencies, and to define their role and responsibilities. The primary responsibility of the area agency shall be to plan, establish and maintain a comprehensive service delivery system for individuals who are residing in the area. The area agency shall plan and provide these services according to rules promulgated by the commissioner.

He-M505.08- Re-designation states the broad functions of an Area Agency including three responsibilities that are pertinent to Lakeview. These are the responsibilities in (e) to:

- 1) Demonstrates through multiple means, its commitment to individual rights, health promotion and safety; (e) (2)
- 2) Provides individuals and families with information and supports to design and direct their services in accordance with their needs and preferences and capacities and to decide who will provide them; (e) (3)
- 3) Continually assesses and improves the quality of its services, and ensures that the recipients of services are satisfied with the services they receive; (e) (5)

He-M 517 addresses Medicaid –Covered Home and Community –Based Care Services for Persons with Developmental Disabilities and Acquired Brain Injuries. The purpose of these rules is to define the requirements and procedures for Medicaid-covered home and community-based care waiver services for persons with developmental disabilities and acquired brain disorders where such services are provided pursuant to He-M 503, 507, 513, 518,521, 522, 525 and 10. A pertinent section to this review is in He-M 517.04 Provider Participation:

A residence funded under the home and community-based care waiver that provides services to persons with acquired brain disorders and is licensed as a supported residential care facility or a residential treatment and rehabilitation facility under RSA 151:2, I (e) shall **not be**

required to be certified as a community residence pursuant to He-M 1001. (Italics mine). This means that Lakeview is not being held to the same requirements as all other waiver providers that appear to be more extensive than the licensing requirements of a RTRF.

Area agencies are enrolled with the NH Medicaid program as providers in order to receive reimbursement for the provision of services under the home and community based waiver. Then when the services are to be provided by a subcontractor the area agency establishes a contract with the subcontractor specifying the roles of the area agency and subcontracting agency in the service planning, provision and oversight. New Hampshire recently underwent a quality review by CMS for the HCBS program. Richard Greal, Associate Regional Administrator, CMS wrote to Commissioner Toumpas on March 15, 2015 stating that New Hampshire's "quality assurance and improvement processes and procedures are implemented and in place for the HCBS waiver." New Hampshire uses HCBS waiver funding to pay for the individuals who receive services from Lakeview but exempt RTRFs from the normal waiver qualification and oversight process.

I had two opportunities to interview administrators from the Area Agencies and on one occasion from the Community Support Network, Inc. (CSNI), the group that represents all ten of the Area Agencies and coordinates some of their joint efforts. As has been noted in the Lakeview report and earlier in this report, the Area Agencies began having systemic concerns about Lakeview in 2013 and began meeting with Lakeview administrators in late 2013/early 2014. The Area Agencies report that they did not start to regularly make referrals to Lakeview until 2010/2011. At that time they found an increase in individuals with complex developmental and neuro-psychological needs who exhibited aggressive and violent behaviors. They were not finding providers with the capacity to serve this population.

Area Agency Service Coordinators completed a client survey for individuals who were served at LNC. The result of the survey highlighted concerns with incident reporting, communication among Lakeview employees, communication with the Area Agencies, an inability to meet deadlines, complaint reporting and follow up of

corrective action. The CSNI Quality Improvement Committee noted concerns with staff retention and a growing reliance on police intervention as a result of Lakeview's no restraint policy.

The Area Agencies held two meetings with the administration of Lakeview and submitted expectation for improvement to Lakeview on 2/3/14. The QI Committee then initiated monthly QI reviews at Lakeview and held quarterly meetings with the administration to review concerns. Regular onsite reviews were initiated in the spring and became daily in October 2014. These review efforts continue. The QI Committee of CSNI recently issued a letter to Lakeview (3/15) that expressed their concerns that Lakeview was regressing in its ability to meet the expectations outlined by the AAs in their letter of 2/14.

CSNI and the Area Agencies are also working with BDS to develop long-range community solutions and increase community provider capacity to address the needs of individuals who reside at Lakeview or individuals with similar needs that may be referred in the future. The AAs are working with START to develop transition plans for current NH citizens who are residents of Lakeview. At least four individuals have left Lakeview from NH. One individual was placed at FINR and the other three were able to transition to the community. The individual was placed at FINR through a private insurance company that is funding this man's placement.

Findings: I think the actions the Area Agencies are taking to monitor the services at Lakeview are reasonable and meet the responsibilities they have for assuring quality services for individuals in their areas. In addition to the overall monitoring that has taken place for almost a year, they regularly review the findings of APS and OCLS and require follow up by Lakeview. They also review any use of restraints and the PRN use of psychotropic medications. I recommend that all planned use of psychotropic medication at Lakeview undergo both a peer review and a human rights review.

The monitoring and oversight has been made a priority by the Area Agencies over the past year and significant resources have been devoted to the effort. However, there is no indication of an expectation that action will be taken against Lakeview if significant improvement is not

made. There is also no performance standards set for Lakeview to meet in each area of deficiency. The Area Agencies and the state need to determine for how long they will allow inadequate care of their citizens to go on without measurable improvement. A decision to revoke a license and stop funding a provider is always a difficult one and must be based on criteria, factual data and evaluation. It is more difficult for New Hampshire to make an objective decision about Lakeview's future while it does not have sufficient community resources to fully respond to the needs of Lakeview's current residents.

I am concerned that no entity has a contract with Lakeview. Lakeview is licensed by DHHS and each Area Agency funds and approves services for individuals through individual service authorizations. These authorizations specify the expectations for the services the individual will receive. However there is no contract that sets requirements for Lakeview as a service provider in terms of its policies, procedures, administrative practices, staff training and selection, clinical and health support services, quality assurance, etc. The Area Agency Directors indicate they have contracts with the other sub-contractors (providers) that operate within their jurisdiction. A contract is the normal mechanism to set program and administrative expectations that are above the basic requirements of licensing. The fact that there is no contract also means that there is no requirement for Lakeview to submit cost reports or certified audits. To my knowledge no entity in New Hampshire reviews or is knowledgeable of Lakeview's costs or budget.

It is difficult for any one Area Agency to focus significant attention on Lakeview. Each AA serves hundreds of individuals and contracts with numerous providers. No one AA appears to have more than three individuals at Lakeview. It is to the Area Agencies credit that they have used CSNI to coordinate their efforts to monitor and oversee services for Lakeview residents. CSNI sponsors a QI Committee giving all of the AAs a chance to share their findings.

It is troubling that the expectations set out in the rules of Section 505 are not made applicable to individuals at Lakeview. Lakeview serves over 60 individuals in an isolated setting that by its nature cannot meet all of the expectations for community inclusion and individualization. However, the Area Agencies should expect a program to provide

individuals with the ability to determine their services, involve their families in a meaningful way, meet their needs for employment and leisure, and engage in meaningful activities and acquire skills. Individuals and their families should have a much more significant role in the service planning process than they are afforded by Lakeview or the Area Agency Service Coordinators.

Recommendations: If Lakeview remains licensed by DHHS and utilized by New Hampshire residents it should have a contractual relationship with the state just as other providers of services to individuals with developmental disabilities have. Options to accomplish this would be to identify a lead AA or establish a contract with CSNI as the administrator for the Area Agencies.

Service coordination is at the heart of an effective service delivery system. Families who were interviewed report uneven responsiveness from their AA Service Coordinators. It may be difficult to achieve this consistency across ten AAs on a continual basis when each has service coordination responsibility for only one to three individuals. Families need this support and may rely on it more strongly when their children are placed far from home and the goal is to plan their transition back to the community. Area Agencies might be able to improve service coordination if they agreed to share one service coordinator who was assigned to support all of the NH Lakeview residents. This staff can become more of an expert on the services at Lakeview, the staff who provide them and note trends in service delivery and program planning.

VI. Summary

There are elements of New Hampshire's oversight and monitoring that are very workable and other areas that need significant re-structuring to meet the state's obligation to its citizens and those from other state's placed within its borders to be free from harm, safe and provided quality supports and services to experience a meaningful life within its communities.

New Hampshire appears to have a provider certification process for its HCBS waiver providers but does not have a similar process for an entity

wanting to operate as a RTRF. I recommend that New Hampshire determine if its existing provider qualification process is sufficient to ensure providers wanting to operate in the state can demonstrate the capabilities New Hampshire expects of its providers. The certification process should be an extensive review of a new provider and require documentation of policies and procedures, evidence of fiscal integrity, staff hiring and training requirements, protection of individual's rights including their finances, and administrative oversight and supervision. Providers should demonstrate an understanding of habilitative programming and person-centered planning. They should be required to submit relevant documentation and demonstrate basic proficiency in all areas before they are certified to become a provider in New Hampshire.

Throughout the report I have made recommendations for improvements in the rules; licensing process; abuse, neglect and exploitation investigatory process; the complaint process; and the provider oversight process.

New Hampshire has a structural problem in that these functions are not well integrated to insure similar expectations for the review of abuse, neglect and unusual incidents regardless of age or state resident status, and for the overall review and monitoring of the quality of services of providers such as Lakeview. New Hampshire needs to better align the responsibilities of the BEAS/APS, BDS/OCLS, and DCYF to investigate in these areas. It needs to strengthen its rules for RTRFs and develop quality service expectations in addition to the basic licensing requirements. It needs to assure its quality monitoring system protects all residents of facilities it licenses or certifies including individuals who are placed from other states.

New Hampshire needs an integrated service review process that is triggered by a program's inability to meet the standards over a set period of time and to consistently maintain its adherence to these standards. An effort needs to be made to regularly bring together the results of reviews by investigators, surveyors, Area Agency service coordinators and program quality review staff to review data in an integrated and coordinated manner. Such a review may be best described as a Program Integrity Review. It would consider incident

data, investigation data, progress toward meeting program measures, consumer and family satisfaction, use of restrictive programming, staffing and staff training and fiscal data. It would bring together experts in each of these areas to review the data and determine if the provider is meeting expectations, making progress or in need of corrective action. Such an effort can only be useful to consumers, families and funders if performance measures and criteria for changes to the provider's status when warranted are established by the State. A Program Integrity Review might lead to corrective action requirements, technical assistance, enhanced program monitoring, provisional licensure or certification, or revocation. It can provide the state with a coordinated quality assurance mechanism to support effective decision making about provider ability and capacity to provide quality services, safe environments and settings that keep individuals free from harm.