A REPORT BY THE NEW YORK STATE OFFICE OF THE STATE COMPTROLLER

Alan G. Hevesi
COMPTROLLER

OFFICE OF MENTAL HEALTH

OVERSIGHT OF AFTERCARE SERVICES

2002-S-53

DIVISION OF STATE SERVICES

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Report 2002-S-53

Sharon E. Carpinello, RN, Ph.D.
Acting Commissioner
New York State Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Dear Dr. Carpinello:

The following is our report on the Office of Mental Health's oversight of aftercare services.

We performed this audit pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law. We list major contributors to this report in Appendix A.

Office of the State Comptroller
Division of State Services

February 6, 2004

EXECUTIVE SUMMARY

OFFICE OF MENTAL HEALTH
OVERSIGHT OF AFTERCARE SERVICES

SCOPE OF AUDIT

The Office of Mental Health (OMH) operates 28 facilities that provide inpatient psychiatric care. OMH reports that, during the 2002 calendar year, about 6,500 inpatients were discharged from these facilities. Most of the individuals discharged from these facilities require assistance obtaining housing, employment, financial support, social support, education and ongoing mental health services if they are to make a successful return to the community. These various aftercare services may be provided by OMH or contractors overseen by OMH. According to OMH's Discharge Policy, the aftercare services to be provided to each patient should be specified in the patient's discharge plan, and the services themselves should be verified after discharge.

Our audit addressed the following questions about OMH's oversight of aftercare services for the period January 1, 2001 through December 31, 2002:

- Were the actions taken by OMH sufficient to provide reasonable assurance that aftercare services were provided as planned?
- Were aftercare services evaluated to determine whether they were effective in helping patients return to their communities?

AUDIT OBSERVATIONS AND CONCLUSIONS

OMH needs to verify that aftercare services were provided to discharged patients because, if they are not actually provided, the patient may be less likely to make a successful transition to the community and may have to be returned to the costlier and more restrictive environment of an inpatient facility. However, we found that many of the aftercare services planned for discharged inpatients are not verified. We further found that, even when the services are verified, they are often verified only once within 30 days of discharge, which may not be sufficient to cover the period needed for a patient's successful transition to the community. The facilities' verification practices are not closely monitored by the OMH Central Office. We recommend the Central Office increase its oversight. We also found that the effectiveness of aftercare services is addressed to some extent by an OMH performance measure, but the measure is

not complete and needs to be supplemented by additional performance indicators.

Aftercare services are to be verified in accordance with general guidelines contained in OMH's Discharge Policy. The facilities are required to develop specific verification procedures that are consistent with these guidelines. We examined these procedures and found they generally do not meet all the requirements contained in the guidelines. As a result, aftercare services are less likely to be properly verified. In the past, written procedures developed by the facilities had to be approved by OMH regional offices. Since OMH no longer has regional offices, we recommend that the procedures be reviewed and approved by the Central Office. (See pp. 5-8)

We examined the specific aftercare verification practices at the facilities. We found that many of the services planned for discharged patients routinely are not verified. Moreover, when we reviewed the actions taken in verifying the services planned for a random sample of 475 discharged patients, we found that the ongoing mental health services planned for 86 of the patients (18 percent) were not verified. We also found that the verification practices of different facilities varied considerably. At some facilities these practices were thorough and provided assurance that services were provided as planned. However, at other facilities, the practices were not as thorough and, as a result, provided little such assurance. We recommend that standard detailed procedures be developed for the verification process, and facility compliance with these procedures be verified by the Central Office through periodic site visits. (See pp. 8-12)

OMH has developed a performance measurement system for its services. In one of its performance measures, OMH identifies inpatients that are readmitted, within 30 days of discharge, to the same facility from which they were discharged. This measure is relevant to the effectiveness of aftercare services, as such readmissions may indicate that improvements are needed in the aftercare services provided to the readmitted patients. However, the measure is incomplete in that it does not include readmissions after 30 days or readmissions to a different facility. We recommend the measure be expanded to include these other readmissions and be supplemented by other measures, such as measures indicating the extent to which the aftercare services on discharge plans are actually provided. The development of such measures could encourage facilities to improve their verification processes and thus provide additional assurance that aftercare services are provided as planned. (See pp. 12-15)

COMMENTS OF OFFICIALS

OMH officials generally agreed with the report's recommendations and indicated actions planned to implement them. A complete copy of OMH's response is included as Appendix B. Appendix C contains State Comptroller's Notes, which address matters of disagreement contained in OMH's response.

CONTENTS

INTRODUCTION

Background

The Office of Mental Health's (OMH's) mission is to provide hope and recovery for people with psychiatric disabilities. OMH is responsible for planning and operating an integrated system of mental health care that serves adults with serious and persistent mental illness and children with serious emotional disturbances. OMH directly operates 28 facilities that provide both inpatient and outpatient psychiatric services, including 17 psychiatric centers for adults, six psychiatric centers for children and adolescents, three forensic facilities for individuals with severe mental illness who are involved in the criminal justice system and two research facilities. OMH reports that adult admissions and discharges approximated 5,000 and 4,700 in calendar years 2001 and 2002, respectively, while child and adolescent admissions and discharges approximated 1,600 and 1,500 in calendar years 2001 and 2002, respectively.

When a patient is discharged from an OMH inpatient facility, the patient usually requires services after discharge (aftercare services) to help with the transition back into the community. If this transition is to be successful, inpatient and aftercare services must be coordinated. According to OMH, the discharge planning process is a critical aspect of patient care that begins upon admission to a facility. The discharge planning process should anticipate a patient's needs after discharge and identify services available in the community to meet those needs. These services include assistance in obtaining housing, employment, financial support, education, health care, clinical services and social services.

A patient may be discharged to an outpatient program, a day treatment program, a residential treatment program (such as an adult home or nursing home), the patient's own residence, or the custody of the court. The various programs may be operated by OMH or contractors overseen by OMH.

The discharge planning process and the provision of aftercare services should be consistent with guidelines contained in OMH's Discharge Policy, which was developed by OMH in 1982 and updated in May 2002. According to OMH's Discharge

Policy, a treatment plan should be developed for each patient and this treatment plan should contain a discharge plan. In these plans, facility officials should specify the patient's diagnosis, the treatment services to be provided while the patient is in the facility, and the aftercare services to be provided after the patient is discharged from the facility. Facility officials are further expected to verify whether aftercare services are provided as planned. OMH's Central Office is responsible for monitoring facility discharge planning and verification activities and developing performance measurements relating to the effectiveness of these activities.

Audit Scope, Objective and Methodology

We audited OMH's oversight of aftercare services for the period January 1, 2001 through December 31, 2002. The objective of our performance audit was to evaluate the actions taken by OMH in determining whether aftercare services were provided as planned and were effective in helping patients return to their communities.

To accomplish our objective, we reviewed surveys of OMH facilities that were conducted by external accrediting and oversight entities, such as the Joint Commission on Accreditation of Healthcare Organizations, the Centers for Medicare and Medicaid Services, and Behavioral and Organizational Consulting Associates. In addition, we interviewed officials at the OMH Central Office and at 23 of the 28 OMH facilities (we excluded the three forensic facilities because of ongoing litigation involving these facilities and we also excluded the two research facilities). From these 23 facilities, we obtained and reviewed written discharge policies and procedures for verifying that patients received aftercare services.

We also visited 9 of the 23 facilities, as follows: Bronx Psychiatric Center, Bronx Children's Psychiatric Center, Hudson River Psychiatric Center, Kingsboro Psychiatric Center, Mohawk Valley Psychiatric Center, Rockland Psychiatric Center, Rockland Children's Psychiatric Center, Sagamore Children's Psychiatric Center and South Beach Psychiatric Center. We selected these nine facilities because they discharged a relatively high number of patients and/or were cited for discharge planning deficiencies by the external accrediting and oversight entities. We randomly selected 475 patients from the

6,492 patients who were discharged from these nine facilities between January 1, 2001 and December 31, 2002, and reviewed the patient files to identify the actions taken by the facilities in verifying whether the patients received the aftercare services specified in their discharge plans. We did not determine whether the treatment and discharge plans were properly prepared, because such determinations are made by the accrediting and oversight entities in their reviews. We also reviewed written agreements between the nine facilities and local government agencies, and performance information maintained by the OMH Central Office.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations of OMH that are within our audit scope. Further, these standards require that we understand OMH's internal control structure and its compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that we have identified through a preliminary survey as having the greatest probability of needing improvement. Consequently, by design, we use our finite audit resources to identify where and how improvements can be made. Thus, we devote little audit effort to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's

financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under Generally Accepted Government Auditing Standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

Response of OMH Officials to Audit

Draft copies of this report were provided to OMH officials for their review and comment. Their comments were considered in preparing this report and are included as Appendix B. Appendix C contains State Comptroller's Notes, which address matters of disagreement contained in OMH's response.

Within 90 days of final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office of Mental Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

AFTERCARE SERVICES

The patients discharged from OMH facilities are to receive certain aftercare services. These services are intended to help the patient make a successful transition to the community. If this transition is not successful, the patient may have to be readmitted to the costlier and more restrictive environment of an OMH inpatient facility.

Despite the importance of aftercare services, we found OMH facilities often do not verify whether the services are actually provided. We further found that, even when the services are verified, they are often verified only once within 30 days of discharge, which may not be sufficient to cover the period needed for a patient's successful transition to the community. The facilities' verification practices are not closely monitored by the OMH Central Office, and this lack of oversight may be partly responsible for the lack of verification. We recommend that the Central Office increase its oversight of facility verification practices. To facilitate this increased oversight, we recommend the Central Office develop better performance measurements for use in evaluating aftercare services.

Oversight of Facilities

OMH's Discharge Policy contains a number of general guidelines that are to be followed by the facilities when they plan a patient's aftercare services and verify that the services were provided as planned. For example, according to these guidelines, the patient's need for social services should be assessed and the various aftercare services specified in the written discharge plan should be verified within 30 days of discharge. The Discharge Policy also requires that each facility develop its own written discharge planning and aftercare verification procedures (discharge procedures) to specify how these processes will be implemented at that particular facility.

We examined the written discharge procedures developed by 23 of OMH's 28 facilities. We found that, at 22 of the 23 facilities (all except Buffalo Psychiatric Center), the procedures did not comply with the Discharge Policy, because they did not

meet, or did not fully meet, one or more of the guidelines contained in the Discharge Policy.

For example, the Discharge Policy requires that the written discharge procedures include certain guidelines. One of these guidelines is verifying that the patient discharged is receiving services specified in the written service plan. The services, which are provided by OMH or a contractor, may be verified by the facility, the contractor or a local government agency (either the local mental health department or the local social services department). However, when we examined the written discharge procedures developed by the 23 facilities, we found that this guideline was not contained in the written discharge procedures developed by 11 of the facilities.

In response to our preliminary audit findings, OMH officials stated that the requirements contained in the Discharge Policy could be met in other written procedures developed by the facilities, even if they were not fully met by the facility's discharge procedures. They stated that the Discharge Policy affects the operations of many different departments, disciplines and divisions within each facility, and asked that we review the written policies and procedures of these various units when we visited the facilities to determine whether requirements not met in a facility's discharge procedures were met in any of these other procedures.

We agree that many different facility operations are affected by the Discharge Policy. However, the Policy specifically requires that a complete, stand-alone set of discharge procedures be developed by each facility. It is possible that certain of these procedures may also be included in other written procedures used by the facility, but if the facility lacks a complete, stand-alone set of discharge procedures, it fails to comply with the requirement for such procedures. Moreover, if discharge procedures are not contained in a single document, but are scattered piecemeal in different documents, there is a greater risk that the procedures will not be followed.

Nonetheless, to determine the extent to which requirements not met by a facility's discharge procedures may be met by other written procedures at the facility, we did as OMH officials requested and reviewed these other written procedures at the five facilities we had yet to visit (we had already visited four of the nine facilities we planned to visit). However, at only one of

the five facilities (Rockland Psychiatric Center) did we find that other written procedures met requirements not met by the facility's discharge procedures.

We therefore conclude that, generally, the discharge procedures developed by OMH facilities do not comply with OMH's Discharge Policy. As a result, aftercare services are less likely to be planned and verified in accordance with the requirements contained in the Discharge Policy.

All nine of the facilities that we visited are required by the Discharge Policy to have written agreements with their local mental health departments and local social services departments. These written agreements also must meet certain requirements described in the Discharge Policy. We requested copies of these written agreements at all nine facilities. At only one of the facilities (Mohawk Valley Psychiatric Center) did all the written agreements comply with the Discharge Policy's requirements. At the other eight facilities, either the facility had no written agreement with its local mental health department and/or local social services department or the facility's agreements did not comply with the Discharge Policy because they were missing one or more of the required elements, as follows:

- Agreements with local mental health departments - Two facilities (Hudson River and Mohawk Valley) had agreements that complied with the Discharge Policy. Three facilities (Rockland, Rockland Children's and Sagamore) had agreements but these agreements were missing one or more of the elements required by the Discharge Policy. Four facilities (Bronx, Bronx Children's, South Beach and Kingsboro) did not have written agreements with their local mental health departments.

- Agreements with local social services departments - One facility (Mohawk Valley) had agreements that complied with the Discharge Policy. Two facilities (Hudson River and Rockland Children's) had agreements but these agreements were missing one or more of the elements required by the Discharge Policy. Six facilities (Bronx, Bronx Children's, Kingsboro, Rockland, Sagamore and South Beach) did not have written agreements with their local social services departments.

In response to our preliminary audit findings, OMH officials stated that they have concluded that the Discharge Policy needs to be revised so that it is consistent with clinically appropriate discharge practices and the Mental Hygiene Law. OMH officials also stated they will revise the Discharge Policy and eliminate the requirement for written agreements regarding discharge planning with local governments and local departments of social service.

When the Discharge Policy was originally issued in 1982, the OMH regional offices were required to review and approve all written procedures and written agreements developed by the facilities. However, OMH no longer has regional offices, and when the Discharge Policy was updated in May 2002, the Central Office was not required to review the facilities' compliance with the requirements in the Policy. Moreover, Central Office officials told us they do not have the resources to visit the facilities and perform such reviews. In the absence of such reviews, OMH officials have no assurance the facilities have implemented the Discharge Policy as required. To provide some assurance, we recommend that the Central Office review the facilities' discharge procedures to ensure compliance with OMH policy.

In response to our preliminary audit findings, OMH officials stated they would instruct the facilities to redraft their own discharge planning policies and procedures in accordance with OMH's revised Discharge Policy. OMH will also direct each facility to present its policies and procedures at quarterly meetings between the facility and Central Office officials. At that time the facility will have to demonstrate that it is in full compliance with the revised Discharge Policy.

Verification of Aftercare Services

The aftercare services to be provided to a patient are specified in the patient's discharge plan. According to the Discharge Policy, these services are to be verified within 30 days of the patient's discharge. In our interviews with officials of the 23 facilities, we were told that aftercare services are verified by all the facilities. However, an official at one facility (St. Lawrence Psychiatric Center) said he did not begin verifying these services until February 2003, when the OMH Central Office informed them of this audit. An official at another facility (Mohawk Valley Psychiatric Center) said that, prior to March

2003, he did not verify the aftercare services provided to all patients; rather, they verified the aftercare services provided to about 10 percent of the adult patients discharged to contractors and all adult patients discharged to OMH facilities, and did not verify the aftercare services provided to children. They stated that they now verify the aftercare services provided to all patients.

During our visits to the nine facilities, we reviewed the discharge plans and other documentation in the patient files for a random sample of 475 patients from the 6,492 patients who were discharged from these facilities during the two years ended December 31, 2002. The purpose of our review was to determine whether facility officials verified that the aftercare services specified in the discharge plans were actually provided to the patients.

We found that all nine facilities verified only certain kinds of aftercare services (mental health services), even though the discharge plans also contained other types of services relating to the patients' living arrangements, social support, financial support, employment, education and health care. These other types of services are important in helping patients make a successful return to the community and, accordingly, should be verified.

We further found that, in many instances, the mental health services to be provided to the patients also were not verified. In some instances, the mental health services were verified, but not within 30 days. We also found that the verification practices of the nine facilities varied considerably. At some facilities these practices were thorough and provided assurance that mental health aftercare services were provided as planned. However, at other facilities, the practices were not thorough and, as a result, provided little such assurance. We recommend that standard detailed procedures be developed for the verification process, and facility compliance with these procedures be verified by the Central Office through periodic site visits. The details of our review follow.

We determined that the mental health services on the discharge plan were not verified for 86 of the 475 patients in our sample (18 percent). These 86 patients related to three of the nine facilities (Mohawk Valley, Rockland and Rockland Children's). We also determined that, for 26 of the 475 patients (5.5

percent), the mental health services were verified, but not within 30 days. Rather, these services were verified between 31 and 255 days of discharge (between 1 and 225 days late), and on average were verified about 13 days late. These 26 patients related to six of the nine facilities (Bronx Children's, Hudson River, Mohawk Valley, Rockland, Rockland Children's and Sagamore Children's).

The verification practices of the nine facilities varied as follows:

- mental health services were verified for all patients at some facilities, but not for all patients at other facilities;

- services were verified only once at some facilities, but more than once over a period of several months at other facilities; and

- verification activities were thoroughly documented at some facilities, but poorly documented at others.

For example, three facilities (Rockland Children's Psychiatric Center, Kingsboro Psychiatric Center, and South Beach Psychiatric Center) routinely verify the mental health services of all discharged patients, while the other six facilities routinely do not verify these services for all patients. Moreover, the practices at these six facilities vary, as some of the facilities do not verify services for patients discharged to courts, others do not verify services for patients discharged directly to facility-operated outpatient programs, others do not verify services for patients discharged to residential outpatient programs, and one of the facilities only verifies services for 10 percent of the patients discharged to outside-operated outpatient programs. Officials at some facilities stated that, in their opinion, it is not necessary to verify the mental health services of patients discharged to facility-operated outpatient programs and residential outpatient programs, because the patients will either be supervised by facility staff or reside in a supervised residence. However, verification of such services is required by OMH's Discharge Policy, and in the absence of this verification, there is less assurance that the services were actually provided. If the services are not provided, the patient may be less likely to make a successful transition to community living and may have to be readmitted to inpatient care.

In addition, four of the nine facilities we visited routinely verify discharged patients' mental health services only once, within 30 days of discharge. In comparison, the other five facilities verify these services more than once over a period of at least 90 days and as long as one year after discharge. OMH's Discharge Policy does not specify how many times aftercare services should be verified or how long verification should continue. Rather, the Policy simply requires verification within 30 days. However, aftercare services are intended to help patients return successfully to the community; we therefore question whether a single verification within a month of discharge is sufficient to monitor an aftercare process that may last several months. We note that, when we interviewed officials at the 23 facilities, we found that 12 of the facilities routinely verify services only once within 30 days of discharge, while 11 of the facilities routinely verify these services more than once over a period of at least 90 days and as long as one year after discharge.

Documentation practices also varied, as six of the nine facilities routinely document who verified the services, the date the services were verified, the names of the service providers, and a description of the patient's status. In comparison, the other three facilities do not document the date the services were verified and the names of the service providers, and only rarely record any notes about the patient's condition. As a result, OMH officials cannot determine whether the services were verified in a timely manner, cannot determine which particular mental health services were verified, and cannot ascertain the patient's condition.

As was previously noted, the nine facilities we visited verify only mental health aftercare services, even though other types of services are included in patients' discharge plans and are important in helping patients make a successful return to the community. When we interviewed officials at the 23 facilities, we found that only three of the facilities (Binghamton, Bronx Children's and Pilgrim) routinely verify all types of aftercare services. At 11 of the facilities (including the nine we visited), only mental health services are verified, and at the other nine facilities, officials stated that they verify some, but not all, types of services. If discharged patients are to make a successful return to the community, it is crucial that every type of aftercare service be verified.

In response to our preliminary audit findings, OMH officials stated the majority of our exceptions involved follow-up on the discharge of children. Furthermore, OMH officials stated that we were not incorrect to characterize these situations as exceptions because they did not comply with certain elements of the Discharge Policy. OMH officials stated the Discharge Policy was designed for adult patients and needs to be modified to reflect the inherent differences between appropriate aftercare follow-up for children and adults. OMH officials also stated that facilities have procedures in place to address discharge planning practices and verification and believe that a standardized approach for verifying aftercare services is unnecessary. However, OMH is revising its Discharge Policy to require that facilities discharge patients to programs that can provide the necessary aftercare support to the patient. In addition, OMH agrees that facilities should be documenting when verification took place, the person conducting the verification and the patient's status. OMH officials report that this requirement will be included in the revised Discharge Policy. OMH officials do not agree that they should periodically visit the facilities to determine whether aftercare services are being verified in accordance with requirements. Rather, OMH officials stated that they could achieve this assurance through periodic reviews of data provided at quarterly facility-Central Office meetings. However, such a general review will not provide OMH with the assurance that facilities are verifying aftercare services in accordance with the Discharge Policy.

Evaluating the Effectiveness of Aftercare Services

According to OMH's *2002-2006 Statewide Comprehensive Plan for Mental Health Services*, OMH's approach to the management and oversight of New York State's public mental health system emphasizes the measurement of outcomes to document service effectiveness. OMH has thus developed a performance measurement system for its services. This system produces quarterly reports indicating the number of admissions to facilities, the number of discharges, the median length of inpatient stays, the percent of patients discharged within 90 days and the percent of patients re-admitted within 30 days of discharge. OMH also maintains other performance information.

We examined OMH's performance measurements and performance information to determine whether any of the measurements or information relates to aftercare services.

Since OMH indicates that it emphasizes the measurement of outcomes to document service effectiveness, we were particularly interested in measurements relating to the intended outcome of aftercare services: the patient's successful return to the community.

We found that none of OMH's performance information relates directly to aftercare services, and one measurement relates to the outcome of aftercare services. In this measurement (the 30-day readmission rate), OMH identifies patients who are readmitted, within 30 days of discharge, to the same facility from which they were discharged. This measurement is relevant to the effectiveness of aftercare services, as such readmissions may indicate that improvements are needed in the aftercare services provided to the readmitted patients. However, the measurement is incomplete in that it does not include readmissions after 30 days or readmissions to a different facility. In addition, discharged patients who do not make a successful return to the community could be arrested or admitted to general psychiatric hospitals for treatment. Such patients could also attempt to harm themselves or others. Such incidences are not accounted for by the 30-day readmission rate and are not tracked through any other OMH performance information.

OMH's 30-day readmission rate also does not address the specific factors that may be responsible for a patient's successful, or unsuccessful, return to the community. If follow-up of discharged patients was conducted over some period of time by facility officials or outside entities and provided to OMH, OMH officials might be able to identify those factors and modify aftercare services accordingly.

Such a follow-up study is in progress at Mohawk Valley Psychiatric Center, as facility officials stated they were in the process of implementing a performance measurement system that will include information about discharged patients. The officials stated they are tracking and examining the reasons for readmission to the facility. Each patient discharged from the Mohawk Valley Psychiatric Center adult admission ward is contacted by an administrative aide on a monthly basis to determine the patient's status. This follow-up is documented on a computer-aided spreadsheet. Facility officials stated they began this process because patients often regress shortly after discharge from the facility. They noted that some patients stop taking their medication and some patients begin using drugs or

alcohol. The officials stated they want to study those patients who remain in the community for at least a year, and try to identify the factors responsible for such extended returns to the community.

We recommend that the efforts initiated by Mohawk Valley Psychiatric Center be extended statewide, and be used to evaluate the effectiveness of the facilities' aftercare services. To assist in such evaluations, we recommend that OMH's performance measurement for readmissions be expanded to include readmissions to different facilities and readmissions after 30 days. We also recommend that OMH develop performance measurements directly related to aftercare services, such as measurements indicating the extent to which aftercare services are provided as planned. The development of such measurements could encourage facilities to improve their verification processes and thus provide additional assurance that aftercare services are provided as planned.

In response to our preliminary audit findings, OMH officials agreed that a common indicator, or set of indicators, that reflects the success of discharge activities should be considered for implementation by all OMH facilities.

According to OMH data, on average, daily inpatient care costs about $482 for adults and $843 for children, while daily outpatient care costs about $195 for adults and $168 for children. Thus, readmissions are more costly to the State as well as more restrictive for the patient. Improvements in aftercare services could help to reduce readmissions, and the development of performance measurements for aftercare services could lead to such improvements.

Recommendations

1. Review all facilities' written discharge procedures to ensure their compliance with OMH policy.

2. Develop standard detailed procedures for the verification of aftercare services. In these procedures, specify which services should be verified, how many times the services should be verified, how long the verification process should continue after discharge, and the manner in which verification activities should be documented.

Recommendations (Cont'd)

3. Require the facilities to track the verification of aftercare services.

4. Periodically visit the facilities to determine whether aftercare services are being verified in accordance with requirements.

5. Develop performance measurements related to aftercare services and the intended outcome of aftercare services (discharged patients' successful return to the community).

6. Extend statewide the discharge follow-up studies initiated by Mohawk Valley Psychiatric Center, and use the results of the studies to evaluate and modify the facilities' aftercare services.

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New York State
Office of Mental Health

Sharon E. Carpinello, RN, Ph.D.
Acting Commissioner

44 Holland Avenue
Albany, New York 12229

November 18, 2003

Kevin McClune
Audit Director
State Audit Bureau, 11th Floor
Office of the State Comptroller
110 State Street
Albany, NY 12236

Dear Mr. McClune:

The Office of Mental Health has reviewed the draft audit report entitled, Oversight of Aftercare Services (2002-S-53). Our comments to the findings and recommendations contained in the report are enclosed.

The Office of Mental Health appreciates the Office of the State Comptroller's efforts to recommend improvements in our operations.

Many thanks for your continued help and cooperation.

Sincerely yours,

Sharon E. Carpinello, RN, Ph.D.
Acting Commissioner

Enclosure

OFFICE OF MENTAL HEALTH
RESPONSE TO OFFICE OF THE STATE COMPTROLLER'S
DRAFT AUDIT REPORT 2002-S-53
OVERSIGHT OF AFTERCARE SERVICES

Overall OMH Comments

The Office of the State Comptroller has issued its draft audit report based on their review of OMH discharge planning efforts in comparison with OMH Policy PC-400 and facility policies and procedures developed to comply with the policy. OSC's draft report observations, conclusions and recommendations were developed after their visits to nine OMH psychiatric centers, where they reviewed 475 randomly selected discharge records (275 adults and 200 children). OSC reported that 86 of the 475 cases reviewed did not meet certain of the requirements of OMH's PC-400 or (if they were more stringent) the facility's own policies and procedures for discharge planning and follow up.

* Note 1

In reviewing the OSC report, we determined that OMH practices were appropriate in the vast majority of the situations which were noted as "exceptions." Most of those exceptions involved follow up on the discharge of children. OSC was not incorrect in characterizing these situations as exceptions to OMH policy, because they did not comply with certain elements of PC-400. However, our review has led us to conclude that PC-400 needs to be modified to reflect the inherent differences between appropriate post-discharge follow up for children and for adults. PC-400 was written with a primary focus on ensuring that adult patients received proper care following discharge. Children, on the other hand, are discharged into the custody of specific adults or entities who are responsible for ensuring that care continues, and PC-400 will be modified to reflect that reality.

Of the 86 exceptions cited by OSC, 80 involved the discharge of children. As we will explain in detail in the section of this response entitled, "Verification of Aftercare Services, Cases Identified as Not Having Follow Up," unlike adults, children are <u>always</u> discharged into the custody of some responsible person or entity. They never leave an OMH facility on their own, nor are they ever responsible for managing their own outpatient care and follow-up services. Children are regularly discharged: into the custody of their family (or sometimes foster family); into an all-inclusive, 24-hour per day residential care facility; or back into the custody of the court. Many children have been remanded by the court to OMH facilities for evaluation, under Section 251 of the Family Court Act, and the court is responsible for oversight of the children after the evaluation has been completed.

* Note 2

In every case where a child was discharged into the custody of a responsible person or entity, OMH's response to OSC's exceptions is that Policy PC-400 needs to be clarified to comply with clinically appropriate discharge practices. Since OMH, in most of these cases, has discharged a minor patient into an appropriate full-time setting or returned the patient to court oversight, there is no need for follow up. Once the discharge has been completed and custody has been appropriately transferred, responsibility for the child's care and treatment passes on to the residential program or court, each

* Note 2

* See State Comptroller's Notes, page 29

of which arranges for all of the care and services needed by the child. The responsible person or entity is free to follow or to modify any discharge recommendations which have been made by the OMH facility. In the case of discharge of a child to their family, good clinical practice dictates that the clinician remain in contact with the family and, when appropriate, with the aftercare provider, to assure that agreed upon services are accessed and provided to the child, and that the services are sufficient to ensure the child's well-being in the community.

OMH's review has shown that for over half of the 80 exceptions which OSC noted for children, the children were discharged into a setting for which no follow up was required after assuring that custody of the child was appropriately transferred. However, for those children discharged back to their family, good clinical practice includes continued contact with the family to ensure that the services identified in the discharge plan are being accessed, and that these services meet the needs of the child and the family. Where this level of follow up was not provided for those children, a plan of remediation has been developed. OMH concludes that, of the 475 cases which OSC selected for review, follow up was appropriate for most of the 200 children and for 98 percent of the 275 adults.

In the ordinary course of business, OMH has procedures in place to monitor its facility discharge planning processes. OMH continuously evaluates the performance of its inpatient, outpatient and residential programs for adults, children and forensic patients. Evaluation is based on data collected continuously from the 27 psychiatric centers and analyzed quarterly. Over 50 indicators address the areas of patient care, admissions and length of stay, missing patients and discharge rates, utilization of atypical antipsychotic medications, residential services, fiscal conditions, and inpatient and outpatient costs of care. Of these performance indicators, several address the success of individuals discharged from the inpatient service of OMH hospitals. These include the median length of stay, percent of patients discharged within 90 days of admission, percent of long-stay (greater than one year) patients successfully discharged, readmission rates, and number of inpatient discharges placed in State-operated and voluntary congregate care settings.

A very important outside review is the triennial Joint Commission on the Accreditation of Health Care Organizations (JCAHO) survey, which is based on detailed standards for treatment and discharge planning and includes the review of records of discharged patients. OMH facilities perform extremely well on these surveys in comparison with national benchmarks. Overall, the OMH system of psychiatric hospitals has achieved a score of 96.3 on recent JCAHO surveys compared with the national average score of 90.0.

OMH facilities are also the subject of periodic reviews by the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA. CMS conducts their own reviews of OMH facilities against standards for: admission; treatment planning; discharge planning; and discharge practices. There have been no significant deficiencies noted in any CMS survey over the past several years.

In addition, the annual Inspection of Care Surveys (IOC), which are completed by an independent private contractor using Federal Medicare and Medicaid standards, include a review of discharge planning elements for open records. OMH facilities' ratings document an outstanding level of

performance on these surveys, with few or no deficiencies being noted over a period of many years. OMH facilities also participate in JCAHO's ORYX performance measurement system. Among other indicators, our facilities use the JCAHO indicator of rate of readmission within 30 days of discharge. Data on this indicator are collected monthly and transmitted to JCAHO's ORYX vendor quarterly. Performance can be compared with the facility's historical level, to all other OMH facilities, or benchmarked against data from psychiatric hospitals throughout the United States. For example, in 2002, the OMH systemwide score on this indicator showed that 4.15 percent of all admissions were readmissions within 30 days of discharge. The national benchmark for the same period was 6.22 percent.

The reviews described above provide an extensive base of quality management data that is used to monitor performance in the area of discharge and release of patients. Based on these continuous reviews, OMH management is confident that discharge planning, discharges, and follow up of discharged patients is being done well at its 27 psychiatric centers. In contrast to the conclusions in OSC's draft report, all OMH facilities have achieved outstanding results on outside surveys and reviews that address discharge planning and follow up.

Moreover, OMH licenses and inspects the outpatient and residential programs to which individuals are discharged from our facilities to ensure that they provide adequate and appropriate care.

Lastly, OMH has concluded that Policy PC-400 needs to be modified so that it is more consistent with clinically appropriate discharge practices and the Mental Hygiene Law. It is OMH's intention to revise the policy as described above, taking the findings of this audit into account. Some anticipated changes include: the requirement for written agreements regarding discharge planning with local governments and with local departments of social service will, for most situations, be eliminated; discharge planning requirements for children and youth will be clarified; and requirements for discharge to OMH's own outpatient programs, to courts, to the Office of Children and Family Services (OCFS) and to the patient's own home or family will be delineated.

Having addressed the issues regarding children, the other exceptions involve the 6 adult patients who comprise 2 percent of the OSC sample of 275 adults. The following sections of this response include the remainder of OMH's comments pertaining to the draft report. Those sections provide our detailed comments on specific OSC statements and report segments and respond to the audit recommendations.

OMH Comments to Specific OSC Statements and Report Sections

Verification of Aftercare Services

- *OSC Telephone Contacts (Page 8)*

OMH believes that OSC's use of telephone interviews on this review made it difficult for facility staff to clearly explain, and for OSC to understand, the actual discharge planning follow-up process and practice. This is demonstrated by comments about St. Lawrence PC which indicated that the facility did not begin verifying aftercare services until February 2003 or after the audit had begun. However, St. Lawrence had an informal, ward-based process in place prior to February 2003 that was driven by clinical need. Social work staff routinely followed up on their discharges as a part of clinical care. Additionally, approximately 50 percent of discharges from St. Lawrence were to facility-operated programs.

- *Cases Identified as Not Having Any Follow Up (Page 9)*

The OSC audit results, which were based on their visits to nine OMH psychiatric centers, are skewed for a number of reasons. Approximately half of all OMH inpatients are discharged either to State-operated outpatient programs operated by the same facility, to residential facilities which offer a complete range of outpatient services, or are court-ordered discharges over which OMH has no control (see table on next page). For those discharged to a facility's own outpatient programs, follow up is a given by the facility's own staff. For those persons discharged to residential facilities offering a full complement of outpatient services, OMH's discharging facility only needs to ensure that the patient is admitted to the residential provider. In the case of the court-ordered discharges, follow up is not practical since it is outside of OMH's realm of control. Our analysis of how these factors should modify OSC's conclusions appears below.

* **Note 3**

OSC reviewed 475 discharge records (275 adults, 200 children and youth), selected at random, at nine OMH facilities for this audit. On a case-by-case basis, OSC determined that 86 of the 475 cases they reviewed did not comply with one or more requirements of OMH's PC-400 or, if they were more stringent, the facility's own discharge planning and follow-up policies and procedures. Of the 86 exceptions, 6 were from the OSC sample of adult patients. These 6 represented only 2.2 percent of the 275 adult discharges sampled by OSC.

* **Note 1**

Eighty exceptions involved children and youth. As previously commented in the Overall Comments portion of this response, OMH would like to further clarify some factors that may not have been apparent to OSC regarding the discharge and follow up of patients who are minors.

Unlike with an adult, a child is <u>always</u> discharged into the custody of some person or entity. They never leave an OMH facility on their own, nor are they ever responsible for managing their own outpatient care and follow-up services. Children are usually discharged into the custody of their family (or sometimes foster family); to an all-inclusive, 24-hour per day residential care facility; or back to the custody of the court (many children are remanded to OMH facilities by the court under Section 251

* See State Comptroller's Notes, page 29

of the Family Court Act for evaluation purposes only; the disposition of their case remains with the court once the evaluation has been completed).

In all of the situations described above, once the initial contact is made, responsibility for the child's care and treatment passes to the residential program or the court, each of which arranges for all of the care and services needed by the child. These entities are free to follow or to modify the discharge recommendations of the OMH facility. Therefore, once a child has been placed into one of the above situations, the OMH facility has, in fact, fulfilled its responsibility for follow up after discharge. In cases when a child is discharged to the custodial family, good clinical practice dictates that the clinician remain in contact with the family and, where appropriate, with the aftercare provider to assure that agreed upon follow-up care is accessed and provided to the child.

* Note 4

With this background, we revisited OSC's 80 exceptions, all of which were from Mohawk Valley or Rockland Children's Psychiatric Center. The following table shows the status of the 80 children who were discharged from these two facilities and cited by OSC for not having been followed up upon discharge.

Rockland Children's Psychiatric Center and Mohawk Valley Children & Adolescent Unit
Status of Discharges for Records Selected
Where OSC Noted No Follow Up

	RETURNED TO HOME	PLACED	RETURNED TO COURT	TOTALS
Rockland Children's PC	10	13	7	30
Mohawk Valley C&A Unit	28	9	13	50
TOTALS	38	22	20	80

As can be seen, 48 percent of these cases were discharged home, where follow up by psychiatric center staff should be provided to ensure that the agreed upon services in the discharge plan are accessed, and that those services meet the needs of the child and the family. Twenty-five percent of cases were returned to the court following evaluation, where no further follow up is necessary. Finally, 22 children or 27 percent were placed to various other care settings. The specific settings to which children were placed included: Residential Treatment Facilities; OCFS facilities; Children's Homes; and specialized residential schools.

* Note 4

Therefore, for 42 of the 80 cases of children discharged from Mohawk Valley and Rockland Children's Psychiatric Centers which were noted as exceptions by OSC, no formal follow up was required after the initial transfer of the child.

* Note 5

* See State Comptroller's Notes, page 29

- *Verification of Other Types of Services (Page 11)*

OSC concluded that OMH should follow up on more than just mental health services. However, such follow up by OMH psychiatric centers would be duplicative, and is unnecessary, because outpatient programs are required by regulations to provide services designed to reduce symptoms, improve functioning and provide support (e.g., case management and health screening and referral).

* Note 6

Evaluating the Effectiveness of Aftercare Services

Of OMH's performance indicators, several speak to the success of individuals discharged from the inpatient service of OMH hospitals. These include the median length-of-stay, percent of patients discharged within 90 days of admission, percent of long-stay (greater than one year) patients successfully discharged, and number of inpatient discharges placed in State-operated and voluntary congregate care settings.

OMH has also been interested in developing a more direct and accurate indicator of connection to outpatient services following inpatient discharge. OMH has begun work with a nationwide inter-state indicator project regarding efforts to measure the percentage of individuals who connect with an outpatient provider within a specified period of time (5, 7 and 30 days have been used). Because of the difficulty in collecting data that fairly represents the State-operated and local mental health systems, this indicator has not reached a practical implementation stage as yet. Recently, newly available data warehouse techniques have made Medicaid data more easily available. OMH staff are presently working on using this source of data to identify the first outpatient service following an inpatient stay for use as a performance measure.

As previously noted, OMH facilities also all participate in the JCAHO ORYX performance measurement system. Among other indicators, OMH facilities use the JCAHO indicator of rate of readmission within 30 days of discharge. Data on this indicator are collected monthly and transmitted to JCAHO's ORYX vendor quarterly. Performance can be compared with the facility's historical level, to all other OMH facilities, or benchmarked against national data from psychiatric hospitals throughout the United States.

Untoward events are assiduously tracked, monitored, investigated and reported to Central Office. Here, they are reviewed and discussed at a weekly rounds meeting where patterns and trends are identified for potential management actions.

Finally, individual psychiatric centers have their own performance measures which are analyzed and reported quarterly at Governing Body meetings. The process at Mohawk Valley PC (noted by OSC) is typical of these facility performance measurement practices. Another example is the quarterly report on Organizational Performance Indicators that is routinely prepared by Hudson River Psychiatric Center. This report contains a table in which data are reported by month throughout the year on the *Provision of Aftercare Services*. Each month, the number of: patients placed out of the inpatient service; post-discharge patient appointments needed; and 72 hour follow-up appointments made, kept, and missed; are recorded. This data is presented and discussed with Central Office management each

* See State Comptroller's Notes, page 30

quarter at Governing Body meetings. Although not all OMH facilities use these exact indicators, many do track the success of their discharged inpatients. OMH agrees that a common indicator, or set of indicators. that reflects the success of discharge activities should be considered for implementation by all OMH facilities. However, we also believe that this should, at least initially, be a local measure discussed quarterly at Governing Body meetings rather than a centrally operated system.

OMH Responses to OSC Recommendations

OSC Recommendation No. 1

Review all facilities' written discharge procedures to ensure their compliance with OMH policy.

OSC Recommendation No. 2

Develop standard detailed procedures for the verification of aftercare services. In these procedures, specify which services should be verified, how many times the services should be verified, how long the verification process should continue after discharge, and the manner in which verification activities should be documented.

OSC Recommendation No. 3

Require facilities to track the verification of aftercare services.

OSC Recommendation No. 4

Periodically visit the facilities to determine whether aftercare services are being verified in accordance with requirements

OMH Response to OSC Recommendation Nos. 1 through 4

OMH facilities have procedures in place to address discharge planning practices and follow up, and we believe that a standardized approach is unnecessary. Moreover, OMH does not agree that site visits are necessary.

* Note 7

However, OMH will review PC-400 and amend it, as necessary, to reflect clinically appropriate discharge practices and the Mental Hygiene Law. OMH will direct its facilities to redraft their own discharge planning policies and procedures in accordance with a revised PC-400. OMH will also direct each facility to present its policies and procedures at a facility Governing Body meeting. At that time, the facility will have to demonstrate to the satisfaction of the Governing Body that it is in

* See State Comptroller's Notes, page 30

full compliance with PC-400. Additional requirements that go beyond PC-400 will have to be justified by the facility and approved by the Governing Body before implementation. Thereafter, discharge planning policies, procedures, and outcome data will become a standing agenda item for discussion at quarterly Governing Body meetings.

Regarding documentation of follow up, OMH agrees that facilities should be documenting when follow up took place, who made the follow up and the patient's status. The requirement to do this has been reiterated verbally at the facility level, and will be emphasized (in writing) in the updating of PC-400. OMH policy will require facilities to document follow-up procedures, as clinically appropriate.

The requirement for written agreements with local governments and departments of social services will, in most situations, be eliminated.

OSC Recommendation No. 5

Develop performance measurements related to aftercare services and the intended outcome of aftercare services (discharged patients' successful return to the community).

OMH Response

OMH agrees that performance measures are important and believes it has made enhancements in this area over the past several years as previously discussed in this response. OMH will continue to use best practices and benchmarking to improve its measurement of performance in all areas, including discharge planning and follow-up activities.

OSC Recommendation No. 6

Extend statewide the discharge follow-up studies initiated by Mohawk Valley Psychiatric Center and use the results of the study to evaluate and modify the facilities' aftercare services.

OMH Response

OMH concurs that the discharge follow-up study being done at Mohawk Valley is an important project with the potential for enhancing the discharge planning and follow-up process at that facility. Upon completion of the study and evaluation of the results, OMH will disseminate such results to the other adult facilities. However, since the study is not complete, OMH cannot commit to replicating this study statewide.

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State Comptroller's Notes

1. OMH's Discharge Policy, PC-400, requires each facility to develop its own written discharge planning and aftercare verification procedures to specify how these processes will be implemented at that facility. When we conducted our review of discharge records at the facilities, we assessed whether the records complied with the Discharge Policy and the facilities' own written discharge planning and aftercare verification procedures.

2. According to OMH's Discharge Policy, facilities are expected to verify whether aftercare services are provided as planned for all patients. The Discharge Policy does not distinguish between adults and children. During our review, if the facility's written discharge procedures required follow-up for all discharged patients, including children, and facility officials confirmed that they performed follow-up for all discharged patients, including children, then we assessed the children's records according to the facility's criteria.

3. We disagree with OMH's statement that our audit results are skewed. As stated in the Audit Scope, Objective and Methodology section of our report, we used statistical sampling techniques to randomly select 475 patients discharged from nine facilities during our audit period. We selected these nine facilities because they discharged a relatively high number of patients and/or were cited for discharge planning deficiencies by external accrediting and oversight entities. Furthermore, OMH's Discharge Policy requires facility officials to verify whether aftercare services are provided as planned for all patients, and we assessed facility compliance with this requirement during our audit.

4. OMH officials state that in cases where a child is discharged to the custodial family, good clinical practice dictates that the facility staff should remain in contact with the child's family and aftercare provider to assure that the services are provided to the child. However, we determined that the aftercare services were not verified for the 38 cases (48 percent of the 80 discharges from Mohawk Valley and Rockland Children's Psychiatric Centers cited by our audit) where children were discharged to their homes.

5. We disagree that no formal follow-up was required for 42 of the 80 cases discharged from Mohawk Valley and Rockland Children's Psychiatric Centers. These facilities' own written discharge planning and aftercare verification procedures (prepared in compliance with OMH's Discharge Policy) specify that these facilities should have verified the provision of aftercare services for all discharged cases, including children who are discharged to the court system or other care settings, such as specialized residential schools. We assessed the children's records according to these facilities' written discharge procedures.

6. If discharged patients are to make a successful return to the community, it is crucial that every type of aftercare service be verified. As stated in our report, OMH's Discharge Policy requires that a patient's discharge plan specify the aftercare services to be provided after the patient is discharged from the facility and that facility officials are to verify whether aftercare services are provided as planned. In addition to mental health services, and as we noted in our report, discharge plans contain other types of services relating to the patients' living arrangements, social support, financial support, employment, education and health care. These other types of services are important in helping patients make a successful return to the community and, accordingly, should be verified.

7. Our findings demonstrate that OMH needs to develop standard detailed procedures for verifying aftercare services and perform periodic site visits to verify facility compliance with these procedures. From our review of facilities' compliance with OMH's Discharge Policy, and as stated in our report, we found the verification practices varied considerably among the facilities. At some facilities these practices were thorough and provided assurance that aftercare services were provided as planned. However, at other facilities, the practices were not as thorough and, as a result, provided little such assurance. Further, while OMH officials stated they could achieve this assurance through periodic reviews of data provided at quarterly facility-Central Office meetings, we maintain that such a general review will not provide OMH with assurance that facilities are verifying aftercare services in accordance with the Discharge Policy.