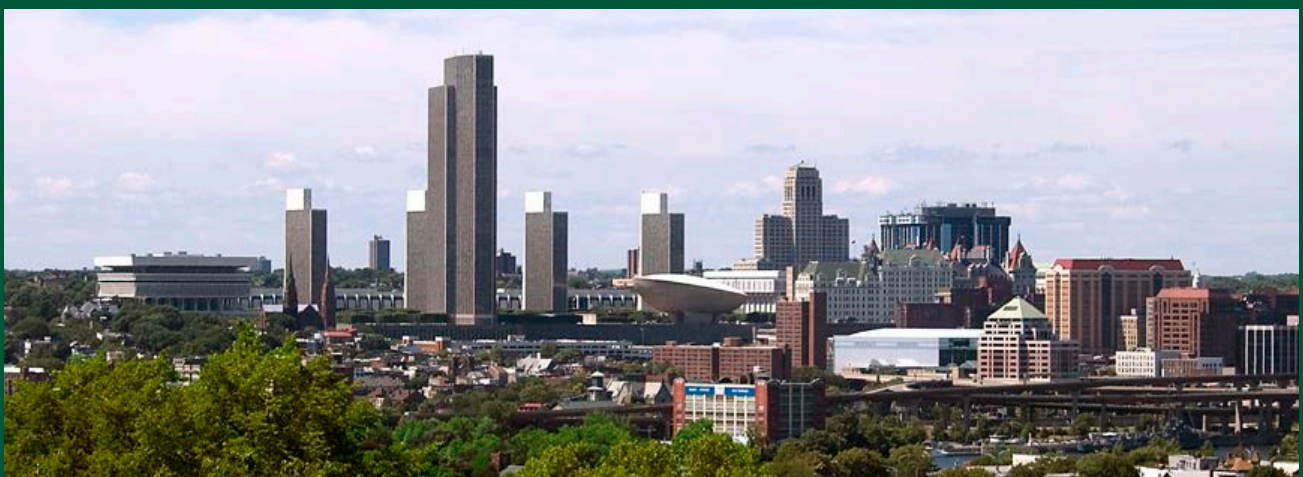


New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Assertive Community Treatment Program

Office of Mental Health



Report 2014-S-25

May 2015

Executive Summary

Purpose

To determine whether the Office of Mental Health (Office) is effectively overseeing the Assertive Community Treatment (ACT) program to ensure that ACT provider teams are complying with requirements and that program goals are achieved. The audit covers the period April 1, 2012 through October 31, 2014.

Background

The Office promotes the mental health and well-being of all New Yorkers. Its mission is to facilitate recovery for adults receiving treatment for serious mental illness; to support children and families in their social and emotional development and in the early identification and treatment of children's serious emotional disturbances; and to improve the capacity of communities across New York to achieve these goals. One way the Office accomplishes its mission is through the ACT program, which uses evidence-based practices to provide treatment, rehabilitation, and support services to individuals diagnosed with severe mental illness whose needs have not been well met by more traditional mental health services. Currently, 78 ACT provider teams are licensed by the Office and operate throughout the State to provide services for up to 5,000 recipients. ACT provider teams are required to conduct recipient assessments every six months, develop treatment plans based on assessment outcomes, and track progress. The Office uses its Child and Adult Integrated Reporting System (CAIRS) to collect, analyze, trend, and report recipient data and outcomes. To ensure effectiveness in delivering services, ACT provider teams are required to complete mandatory training. ACT program teams received over \$74 million in 2014, most of which (89 percent) came through the Department of Health for services provided to Medicaid recipients, with the remainder being funded directly by the State.

Key Findings

- The Office is not effectively overseeing the ACT program to ensure that provider teams are complying with certain important program requirements. Provider teams are not recertified timely; program data in the CAIRS system is not complete or accurate; some program staff do not receive required training; and program recipients' treatment plans are not completed on time, with required team leaders' approvals. As a result, program recipients' service needs may not be adequately addressed.
- The Office has also not established methods to assess the extent to which it is achieving overall program goals. Of 457 recipients who were discharged from the program during the audit period, 24 percent (110) met program objectives. Absent criteria to measure performance against expectations, it is unclear to what extent, if any, the other 76 percent of discharged recipients, including 10 percent who were eventually jailed and another 12 percent who required hospitalization, should be considered program successes.

Key Recommendations

- Establish controls to effectively oversee the ACT program to ensure provider teams are complying with program requirements and recipients are receiving needed services. Improve monitoring to ensure:

- Provider teams are recertified timely.
- Program data is complete and accurate.
- All program staff complete required training.
- Program recipients' treatment plans are completed on time, with required clinical approvals.
- Establish measurements to assess achievement of overall program goals.

State of New York
Office of the State Comptroller

Division of State Government Accountability

May 6, 2015

Ann Marie T. Sullivan, M.D.
Commissioner
Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Dear Dr. Sullivan:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Office of Mental Health entitled *Assertive Community Treatment Program*. The audit was performed 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.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

The Office of Mental Health (Office) promotes the mental health and well-being of all New Yorkers. Its mission is to facilitate recovery for adults receiving treatment for serious mental illness; to support children and families in their social and emotional development and in the early identification and treatment of serious emotional disturbances; and to improve the capacity of communities across New York to achieve these goals. One way the Office accomplishes its mission is through the Assertive Community Treatment (ACT) Program, which provides treatment, rehabilitation, and support services to individuals diagnosed with severe mental illness whose needs have not been well met by more traditional mental health services.

The ACT program employs evidence-based practices to provide services using a team-based approach, including members from various fields (e.g., psychiatry, nursing, and vocational rehabilitation). Currently, 78 ACT provider teams are licensed by the Office and operate throughout New York State to provide services for up to 5,000 recipients. Based on their respective areas of expertise, ACT provider team members collaborate to deliver integrated services. The Office has established certain requirements to ensure effective delivery of those services. Among those requirements, for example:

- ACT provider teams are licensed by the Office and therefore must be recertified at least every three years.
- Staff must complete specific training courses (e.g., Person-Centered Treatment Planning, Motivational Interviewing) within certain time frames.
- ACT provider teams must conduct recipient assessments and develop comprehensive individualized treatment plans at least every six months, including goals and intervention strategies, based on assessment outcomes.
- All treatment plans must be approved and signed by provider team leaders.

ACT program teams received over \$74 million in 2014, most of which (89 percent) came through the Department of Health for services provided to Medicaid recipients, with the remainder being funded directly by the State.

Audit Findings and Recommendations

We found the Office is not effectively overseeing the ACT program to ensure that provider teams are complying with certain important program requirements. We found ACT provider teams are not recertified timely; program data entered in the Child and Adult Integrated Reporting System (CAIRS) is not complete or accurate; some program staff do not receive required training; and program recipients' treatment plans are not completed on time, with required team leaders' approvals. As a result, program recipients' service needs may not be adequately addressed.

Further, the Office has not established a formal method to assess the extent to which it is achieving overall ACT program goals. Of the 457 recipients who were discharged from the program during the audit period, 110 (24 percent) met their program objectives. Absent criteria for such evaluation, it is unclear to what extent, if any, the other 76 percent of discharged recipients, including 10 percent who were eventually jailed and another 12 percent who required hospitalization, should be considered program successes.

Assertive Community Treatment Program Oversight

The Office relies heavily on its certification process to ensure ACT provider teams fulfill program requirements. The Office also uses its CAIRS, as well as Medicaid data, to analyze, trend, and report aggregate recipient data and program outcomes. Additional monitoring processes are also in place, including provider team visits conducted by field office representatives, monthly regional meetings between the field office ACT liaison and the ACT team leaders, and monthly communication between the central and field offices. In addition, through its contract with the Research Foundation for Mental Health, the Office relies on the Center for Practice Innovations/ACT Institute (hereafter referred to as "vendor") to manage staff training, so that the Office can ensure ACT provider teams are meeting program training requirements.

Assertive Community Treatment Provider Team Recertification

Although the Office monitors ACT processes – for example, through performance reports and vendor training updates – the recertification process is the Office's primary method for monitoring ACT provider teams' compliance with program requirements (e.g., recipient assessments, treatment plans, and training). The Office requires recertification visits to be conducted at least every three years, and in some cases as often as every three months if certain risks were identified during prior visits. Certification staff conduct unannounced field visits and, guided by the Office's Certification Manual, evaluate a checklist of items, including an assessment of CAIRS data, for a sample of recipients to determine compliance with program requirements. ACT provider teams that do not meet all requirements receive a Monitoring Outcome Report and must submit a Performance Improvement Plan detailing corrective actions. Despite this formal process, ACT provider teams do not always take corrective actions and implement their Performance Improvement Plan. In fact, we found provider teams can receive repeated citations for noncompliance with the same program requirement.

An inspection schedule that allows up to three years between visits makes it difficult to ensure that program requirements are met in critical areas (e.g., maintenance of accurate CAIRS data), and delays in inspections can pose even greater risk. Based on our analysis, we determined the Office isn't able to adhere to its existing inspection schedule. Of 74 ACT provider teams that were due for recertification during our audit scope period, 61 current teams had been inspected – some more than once, for a total of 66 visits – while 13 (18 percent) had not and were overdue anywhere from 3 to 18 months. Office staff attributed these delays primarily to staffing shortages in New York City.

Incomplete and Inaccurate Child and Adult Integrated Reporting System Data

The Office's guidelines state that: each ACT provider team is responsible for developing and maintaining a procedure to ensure assessment data is entered in CAIRS; baseline assessment data should be entered in CAIRS within 30 days of a recipient's admission in the ACT program; and assessment data should be completed in CAIRS every six months from the date of admission, although Office staff informed us this six-month interval is being extended to one year.

The Office relies on ACT provider teams to update CAIRS timely, with complete and accurate data, including the number of incarcerations and level of substance abuse activity. Accurate reporting is critical to ensure not only that the reported number of recipients in the ACT program is correct, but also that meaningful data exists to track recipient progress and identify areas for improvement. Complete and reliable data can also allow management to measure the effectiveness of services based on trends between assessments, and ensure treatment plans adequately support recipients' current needs. We reviewed certain CAIRS data to assess accuracy. In total, we judgmentally selected 1,008 data elements recorded for 84 recipients. We were able to assess the accuracy of 831 of these data elements and found 688 (83 percent) were accurate, while 143 (17 percent) were not. For example, for one recipient, CAIRS data showed two incarcerations within six months of admission, while source data in the recipient's files showed none. The remaining 177 elements either had no data (100) or no source documentation (77) with which to compare the data.

According to the program's Certification Manual, ACT provider teams are also required to update CAIRS whenever recipients are admitted to and discharged from the ACT program. This ensures an accurate representation of the number of recipients in the program at any given point. However, we found the total number of recipients in CAIRS did not match actual ACT provider team records. In fact, of the 66 ACT provider teams that provided census data to us, only 15 (23 percent) had census numbers in CAIRS that matched their own records as of July 7, 2014. For example, one provider team had not updated CAIRS with assessment data for any of its 63 recipients. Further, for one region with 10 ACT provider teams, only 53 percent had complete CAIRS data. Provider teams generally cited staffing turnover as well as prioritization of recipient issues over data entry as reasons for poor data reporting.

CAIRS reports can also be helpful in alerting both the ACT provider teams and the Office about gaps in reporting, such as those illustrated above. However, their value is diminished when the analysis is based on inaccurate or incomplete data. According to Office staff, they routinely review CAIRS data with field staff, who then review data with the provider teams. At times,

Office staff have met directly with provider teams to give guidance on the importance of accurate data reporting and to help provider teams improve performance on behalf of recipients. Despite these efforts, provider teams have still not been successful in maintaining accurate and current CAIRS data.

We also noted that some provider teams do not know how to independently access and analyze CAIRS reports to identify their own program needs. When surveyed, 29 (45 percent) of 65 provider teams indicated they have not received any recent formal technical training on CAIRS. Office staff indicated training could be provided on skills needed to use CAIRS proficiently or to use CAIRS data for performance measurement and quality improvement.

In response to our findings, the Office's ACT program staff stated they were not aware of the extent to which data in CAIRS was not being updated, and they plan to monitor the accuracy and completeness of the CAIRS data as a result of this audit. The Office also immediately informed ACT provider teams of the need to update CAIRS data to ensure more accurate representation. Some ACT provider teams have already updated their data based on the Office's communication of our findings.

Required Training Not Completed by Staff

To ensure effective delivery of services to recipients, the ACT program has established specific training courses for provider teams to complete within six months of licensure as well as core training for new hires to complete within 30 days of employment. In addition, all staff must participate in ongoing, recurrent training. We found not all staff had completed the required training. Further, the Office does not adequately oversee its vendor's training program to ensure all staff receive required core training within the mandated time frame. Without adequate training, there is the risk that provider teams are not performing their work in accordance with the program's requirements. Provider team staff who lack appropriate training, yet still provide services, can weaken and affect the team's collective ability to meet recipients' specified goals.

The Office's independent vendor manages and monitors staff training using a computer program to track provider team staff and their training fulfillment. However, staff must be in the system in order to be identified for required training. Provider teams are responsible for notifying the vendor when staff are hired, resign, or change teams. The vendor then provides ACT provider teams with monthly e-mails, and the Office with annual reports, on the status of training for all provider teams.

To determine whether the vendor has maintained accurate training data for all staff, we visited 11 provider teams, accounting for 111 current staff, and compared the vendor's data with staff lists that the teams provided. We found not only did the vendor not have records for all staff, but not all staff who were entered in the system had received all their required training. Specifically, we found:

- 56 percent of staff hadn't completed all their required training.
- 17 staff across seven ACT provider teams were not entered in the training system and had

- not received any training. One of the employees had been with the program since 1999.
- 10 staff who were no longer employed by the ACT provider teams were still active in the vendor's system.

We identified several key factors that undermine compliance with training requirements:

- The Office does not actively monitor training to ensure that ACT program team staff are trained as required, does not have a process in place to verify that all staff have been reported to the vendor and are working toward completing their training requirements, and does not verify the vendor is tracking all staff. Furthermore, since the Office does not have a collective list of ACT provider team staff, it cannot perform independent checks to ensure all staff are trained as required.
- The Office does not act on the vendor's reports of overdue training.
- Although program teams and field staff each receive e-mails highlighting any lack of compliance with training requirements, there has not been sufficient follow-through at the ACT provider team level to ensure that untrained staff are compliant.
- There is no established time frame for provider teams to notify the vendor of staffing changes.

Service Treatment Plans Not Completed Timely With Required Signatures

The Office relies on provider teams to prepare a comprehensive service plan within 30 days of a recipient's admission, and then to review the plan at least every six months to assess recipient progress on the established goals and make adjustments to goals as appropriate. The ACT provider team's leadership, generally the team physician or psychiatric nurse practitioner and a designated ACT provider team leader, is responsible for overseeing each recipient's treatment. Both individuals are required to sign off on all treatment plans to signify they've reviewed and agree with the outlined treatment. The Office does not have a formal mechanism to ensure that provider teams are completing all their plans as required, and instead relies on its certification process.

Based on our analysis of available records during visits to 11 provider teams, we concluded that teams completed most of their six-month service plan reviews on time. However, on a site visit to one ACT provider team, we found one recipient had not had a service plan review assessing progress since 2012. More than 20 recipients from that same ACT provider team were overdue for their six-month service plan review. We brought this issue to the Office's attention and this provider team has since updated its service plans.

Further, although plans were timely, they often were not signed off by the doctor and/or the ACT provider team leader and therefore are considered incomplete based on program guidelines. When services are provided that are not approved by the team leadership, there is greater risk that ACT provider teams may not be meeting recipients' needs, that services may not be adequate or appropriate, or that there is no agreement on the outlined treatment.

For our analysis, we selected 129 recipients and sampled 538 of their treatment plans to determine

whether the plans were completed timely with the required signatures. To be conservative, our methodology to determine timeliness included an additional 15-day allowance. Of the 129 recipients, slightly more than half (67) had plans that were completed timely with the required signatures. The remaining 62 recipients' plans were not completed timely with the appropriate approvals. While some plans were overdue a few days, weeks, or months, one recipient's plan was overdue by over three and a half years. Only 3 of the 11 teams sampled had all recipients' plans completed as required. In total, 136 plans (25 percent of 538) were not completed timely with the appropriate signatures. ACT provider team staff attribute some of the delay in finalizing plans to difficulties they have in locating recipients being reviewed, since recipients are asked to sign the plan signifying their agreement.

We also found ACT provider teams use a variety of methods to track plan review due dates, including manual systems, Excel spreadsheets, and other electronic systems such as CAIRS. A tracking system that records when plan reviews are due, and the monitoring of that system to ensure compliance, is critical. Without close monitoring at the provider team and Office levels, plan reviews become overdue or lack appropriate approval. Further, we determined some provider teams were not aware of the specific signature requirements established in the guidelines. Additionally, although some teams have a quality assurance process that reviews certain aspects of their program, plan dates and signatures are not always included in the review.

Lack of adherence regarding required periodic service treatment plan reviews could lead to ineffective ACT recipient goals and treatment as well as potentially improper Medicaid payments. We reviewed Medicaid transmittal data to determine whether the eight provider teams that had late or unsigned plans had received subsequent payment for services rendered to Medicaid recipients. We found seven of the provider teams received Medicaid payments for 326 of 333 billing transactions prepared after April 1, 2012. In 233 cases (71 percent), the payments related to recipients whose plans were missing one or both required signatures.

We provided Office officials with a list of teams where treatment plans were missing one or both required signatures, for their review and follow-up. Officials took immediate action and had field staff investigate the discrepancies. According to officials, they and officials from the Office of the Medicaid Inspector General (OMIG) agree that a review of the overall quality of services reflected in recipient records is essential to determine whether recipients are receiving required treatment, and there is other evidence – not just signatures on plans – that may show practitioners have reviewed and approved plans. Officials also stated that although the signatures are important, the overall totality of services is more important than strict signature compliance. However, plans that are unsigned – and potentially unauthorized – increase the risk that payments will be made for inappropriate services.

Achievement of Assertive Community Treatment Program Goals

The goals of the ACT program are to reduce inpatient and emergency department use for individuals with severe mental illness and to improve symptom levels and social functioning. Individual goals also exist for each recipient in their treatment plan. We found the Office has not yet established measurements to assess the extent to which it is achieving these overall program

goals. Furthermore, the Office does not fully utilize CAIRS to ensure recipients' progress toward their goals, and instead relies exclusively on the ACT provider teams in the field to monitor individual recipient progress.

Officials believe that when treatment plans are in place, the recipients are always working toward their goals and the program is thus working as intended. However, as demonstrated earlier, the Office doesn't actively monitor whether treatment plans are completed or not. As a result, officials cannot be assured that recipients are receiving services that are appropriate for their specific goals and, ultimately, that recipients are meeting goals. Further, although the certification process verifies goals are set and recipients are working toward their goals, findings are based on an after-the-fact assessment of only a sample of recipients.

Without specific measurable goals, the Office is not able to assess the program as a whole. At inception, the ACT program was considered to be a "forever" program, providing support for recipients over their life span. However, program officials are now helping some recipients to transition out of the program. Program officials have conducted a study to identify best practices that can allow recipients to succeed at a lower level of care. According to Office staff, this study has shown that the program is most successful when recipients are able to live in the community. With this change in the program's objective, the Office has not set targeted ACT program goals. Officials agreed that specific targeted goals could be looked at going forward.

Even though there is an absence of established measurements to assess achievement of overall program goals, Office staff use CAIRS data to produce reports on program outcomes and progress. Based on CAIRS and Medicaid data, officials discuss six-month team-level reports with field representatives, who then communicate with the ACT provider teams about their data. These reports, also known as ACT packets, assess recipient outcomes, such as length of stay, turnover, and hospitalization after program discharge. We also found staff are working on preparing a "team profile" tool to identify additional opportunities for quality improvement and performance measurement. Since the intent of the ACT program is now also to transition eligible recipients out of the program, transition readiness should be an important recipient factor that the team profile tool is able to assess, assuming data is complete and accurate. As a result of our audit, the Office is adding CAIRS data and staff training in the profile. This will allow the Office to compare individual team performance against that of other teams throughout the State.

The Office also publishes certain ACT program data on its website, including Medicaid and CAIRS data. However, it does not consider CAIRS data if more than 25 percent of the data for a given indicator (e.g., ACT program admissions and discharges) is either missing or reported as unknown. Because this is public information, any individual or group using it could have a skewed perception based on inaccurate and incomplete CAIRS data.

Because of concerns about the completeness and accuracy of CAIRS data, we compared intake and assessment data for sampled recipients with the actual data retained in their case files. We found reported recipient progress was overstated in some instances. For example, for one provider team, the original data showed that one of 12 recipients had an increase in their level of substance abuse. However, data in the case files identified another recipient who also had an

increase in substance abuse.

According to the available CAIRS data during our audit scope, 1,136 recipients participated in the ACT program for the 11 provider teams we visited. Of the 457 (40 percent) who were discharged from the program, 110 (24 percent) met all their program objectives. However, without measurable standards to assess achievement of overall program goals, these statistics lack perspective. Lacking such standards, it is impossible to determine whether a 24 percent success rate for meeting all program objectives is an acceptable outcome. Similarly, of the other 76 percent of discharged recipients, 44 (10 percent) were jailed and 55 (12 percent) were hospitalized. According to Office staff, there is no clear and consistent answer as to whether these events represent success or failure. For instance, a recipient's hospitalization could indicate the program was not successful for that person or, based on other related factors (e.g., the hospitalization was shorter than others that occurred prior to enrollment in the ACT program), the hospitalization could be seen as progress.

After our audit, the Office began measuring ACT program outcomes by comparing recipient inpatient hospital use before, during, and after participating in the ACT program. For a sample of 1,745 discharged recipients, the Office analysis showed:

- 76 percent were hospitalized at least once in the year prior to ACT admission;
- 40 percent were hospitalized at least once during their last year of ACT enrollment;
- 60 percent were hospitalized at least once during their entire ACT enrollment; and
- 32 percent were hospitalized at least once in the year following ACT discharge.

With these statistics, the Office can consider, for example, whether these numbers are positive, if the length of hospital stays has changed, and may use these results as a baseline for measuring program progress going forward. Officials agreed to consider what other outcomes should be measured to assess program achievement of its goals.

Recommendations

1. Establish controls to effectively oversee the ACT program to ensure provider teams are complying with program requirements and recipients are receiving needed services. Improve monitoring to ensure:
 - Provider teams are recertified timely.
 - Program data is complete and accurate, including providing ACT team staff with CAIRS technical instruction and performance measure/quality improvement training.
 - Program staff complete required training. Procedures should include establishing formal processes to ensure complete, accurate staff rosters are provided to the training vendor and verifying all staff are receiving and have completed the required training timely. Develop specific written procedures for ACT provider teams, outlining their responsibilities to ensure all staff receive timely, required training.

- Program recipients' treatment plans are completed on time, with required clinical approvals. Provide guidance to the ACT provider teams clarifying which signatures are required on the plans.

2. Establish measurements to assess the extent to which overall program goals are achieved.

Audit Scope and Methodology

The objective of our audit was to determine whether the Office is effectively overseeing the ACT program to ensure that provider teams are complying with requirements and that program goals are achieved. The audit covers the period April 1, 2012 through October 31, 2014.

We visited 11 of 78 ACT provider teams, judgmentally selected based on our assessment of their relative risk for not complying with requirements. For example, some provider teams were selected because they were overdue for their licensing recertification or because they did not update their CAIRS data. On our visits, we reviewed: provider teams' billing information to ensure recipients were billed in keeping with the requirements; whether service treatment plans were completed timely with the required signatures; and controls over certain program expenses. We also reviewed training vendor data as of May 31, 2014 to determine whether staff completed all required training and reviewed CAIRS data to assess the reliability of recipient data. This analysis was also considered in selecting which ACT provider teams to visit.

To accomplish our audit objective and assess related internal controls, we reviewed relevant State laws as well as applicable policies and procedures, and analyzed data obtained from both the Office and the vendor. We interviewed Office staff to gain an understanding of their processes for monitoring the ACT program as well as program team staff to determine how they comply with program requirements.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

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. 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 functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed 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.

Reporting Requirements

A draft copy of this report was provided to Office officials for their review and comment. Their comments were considered in preparing this report and are attached in their entirety at the end. Officials indicated their agreement with, and the steps they are taking to implement, the report's recommendations.

Within 90 days after 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 if the recommendations were not implemented, the reasons why.

Contributors to This Report

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments



State of New York
Andrew M. Cuomo
Governor



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44 Holland Avenue
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April 10, 2015

John Buyce, CPA, CIA, CGFM
Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Mr. Buyce:

The Office of Mental Health has reviewed the Office of the State Comptroller's (OSC's) draft audit report entitled, "Assertive Community Treatment Program" (2014-S-25). Our comments to the findings and recommendations are enclosed.

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

Many thanks for your continued help and cooperation.

Sincerely yours,


Martha Schaefer
Executive Deputy Commissioner

Enclosure



**OFFICE OF MENTAL HEALTH
RESPONSE TO THE OFFICE OF THE STATE COMPTROLLER
DRAFT AUDIT REPORT 2014-S-25
ASSERTIVE COMMUNITY TREATMENT PROGRAM**

Overall OMH Comments

OMH has reviewed the findings and recommendations in the Office of the State Comptroller's (OSC) report, entitled "Assertive Community Treatment Program" (2014-S-25). OMH agrees with the report's recommendations. In fact prior to the audit, OMH had identified some of the same issues and had begun to take corrective measures. Additionally, as stated in the report, OMH immediately addressed many of the other issues identified by OSC during the review and continues to take additional steps to make improvements. These steps will be described later in OMH's responses to OSC's recommendations, but first OMH would like to provide some general comments and clarification to OSC's report.

100% of OMH's Assertive Community Treatment (ACT) Teams have been previously certified. OSC's certification finding centered around the timeliness of re-certifications of which OSC determined that 82% were re-certified on time in accordance with OMH established timeframes. As stated in the report, the late re-certifications were caused by staffing shortages in one area of the state. The shortages were addressed so that currently, as of 3/31/15, all but two of the licensed ACT teams have current re-certifications. Both of those teams have had visitations by inspectors and the issuance of re-certifications is in process. Additionally, to ensure that needed improvements identified during re-certification visits and included in the team's Performance Improvement Plan (PIP) are implemented in a timely manner, OMH will establish a formal follow-up process to hold providers accountable.

In their second recommendation, OSC asks OMH "to establish measurements to assess the extent to which overall program goals are achieved." While we understand OSC is requesting that overall ACT program goals be set, OMH already has quality measurements in initiatives in place that deserve mention.

During 2013, OMH began efforts to specifically improve the performance and the oversight of the ACT program. The result is a multi-layered approach to assist providers and reviewers to identify core and exemplary practices and processes associated with the delivery of successful ACT services, and to assist and encourage the capacity for program self-evaluation and continuous quality improvement. In particular, a new licensing tool was developed that contains "anchor elements" identifying processes and practices within 17 focus areas. The anchor elements, which include standards for service plan reviews, Child and Adult Integrated Reporting System (CAIRS) data compliance and staff training, support the development of program evaluation measurements and performance improvement initiatives.

The ACT Team Profile is another new tool designed to provide ACT teams and OMH with a "point-in-time" snapshot of each team. The profile is comprised of descriptive, process and performance measures organized into substantive domains (i.e., CAIRS compliance, length of stay, engagement in services, hospitalization, medication adherence, substance use and treatment, housing, medical problems, risk behaviors medical problems and transition from ACT). It expands on information that has been available on the ACT Reports portal found on OMH's website, and

performance packets previously issued by OMH. The profile includes statewide, regional and team measures for easy comparison, with its primary purpose to allow OMH and ACT teams to describe success as well as identify potential areas of needed quality improvement

OMH's Responses to OSC's Recommendations

OSC Recommendation No. 1

1. Establish controls to effectively oversee the ACT program to ensure provider teams are complying with program requirements and recipients are receiving needed services. Improve monitoring to ensure:
 - Provider teams are recertified timely.
 - Program data is complete and accurate, including providing ACT team staff with CAIRS technical instruction and performance measure/quality improvement training.
 - Program staff complete required training. Procedures should include establishing formal processes to ensure complete, accurate staff rosters are provided to the training vendor and verifying all staff are receiving and have completed the required training timely. Develop specific written procedures for ACT provider teams, outlining their responsibilities to ensure all staff receive timely, required training with contract requirements and other regulations and documenting the actions taken.
 - Program recipient's treatment plans are completed on time, with required clinical approvals. Provide guidance to the ACT provider teams clarifying which signatures are required on the plans.

OMH Response

OSC's First Bullet – During the latter months of OSC's 30-month audit scope OMH implemented a recertification process which established a hierarchy of OMH monitoring activities based upon a program's performance in key areas. This risk-based system seeks to more effectively utilize limited OMH and provider staff time for inspections resulting in more timely recertifications.

OSC's Second Bullet – OMH, in contract with the ACT Institute, has implemented a CAIRS ACT Webinar Series that will focus on both the technical instruction provided by CAIRS IT, as well as performance measure and quality improvement with emphasis on data and outcome measures.

OSC's Third Bullet – Currently OMH's Central Office (CO) and Field Office review the data collected of ACT Team training and follow-up with those programs that may have missing or incomplete training rosters. CO is now taking steps to establish a formal process that will address OSC's concerns including timeframes, written procedures, training requirements and follow-up to ensure that team members are receiving the required training. This process will be distributed to ACT teams statewide.

OSC's Fourth Bullet - A guidance memo will be provided to ACT teams and will include clarification on which signatures are required on treatment plans and the requirement that the plans are completed and approved on time.

OSC Recommendation No. 2

Establish measurements to assess the extent to which overall program goals are achieved.

OMH Response

OMH's Clinical Performance Measurement and Evaluation Group (PME) will work to identify appropriate measurement tools that can be utilized to assess overall ACT program goals. OMH already has the components of these measurements available in its ACT Team Profiles, CAIRS and Standards of Care licensing tool and will use the information from these sources to establish overall program measurements.