THOMAS P. DINAPOLI
STATE COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

February 25, 2021

Theodore Kastner, M.D, M.S.
Commissioner
Office for People With Developmental Disabilities
44 Holland Avenue
Albany, NY 12229

Re: Compliance With Jonathan's Law
Report 2020-F-26

Dear Commissioner Kastner:

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 have followed up on the actions taken by officials of the Office for People With Developmental Disabilities (OPWDD) to implement the recommendations contained in our audit report, *Compliance With Jonathan's Law* (Report 2017-S-67).

Background, Scope, and Objective

In February 2007, Jonathan Carey, a 13-year-old non-verbal autistic and developmentally disabled boy, died while in the care of a State facility operated by the Office of Mental Retardation and Developmental Disabilities (subsequently renamed the Office for People With Developmental Disabilities, or OPWDD). Jonathan's parents attempted multiple times to obtain information concerning several unexplained injuries, unauthorized changes in treatment, and suspected abuse and neglect while at a privately run facility and then at a State-run facility. In May 2007, "Jonathan's Law" was enacted to expand parents', guardians', and other qualified persons' access to records relating to incidents involving family members residing in facilities operated, licensed, or certified by OPWDD, the Office of Mental Health, or the Office of Alcoholism and Substance Abuse Services (now called the Office of Addiction Services and Supports). Under Jonathan's Law, facility directors are required to do the following in response to any incident involving a patient receiving care and treatment:

- Provide telephone notification to a qualified person within 24 hours of the initial reporting of an incident;
- Upon request by a qualified person, promptly provide a copy of the written incident report;
- Offer to hold a meeting with a qualified person to further discuss the incident;
- Within ten days, provide the qualified person with a written report on the actions taken to address the incident (Actions Taken Report).

In addition, upon written request to the provider, qualified persons may obtain records and documents related to reportable incidents within 21 days of either the conclusion of the investigation or the written request, whichever is later.

OPWDD operates 13 Developmental Disabilities State Operations Offices in six regions across the State to oversee over 1,100 certified programs. OPWDD also regulates, certifies, sponsors, and oversees approximately 650 community-based service providers subject to Jonathan's Law requirements. (The State- and community-operated programs are hereafter referred to collectively as "Facilities.")

We issued our initial audit report on November 18, 2019. The audit objective was to determine whether OPWDD was complying with the requirements established under Jonathan's Law. We determined that OPWDD did not implement processes to effectively monitor whether Facilities were complying with Jonathan's Law. While Facilities established practices for notifying qualified persons within the required time frame, 11 percent of the incidents we reviewed lacked support that the requisite notification was made within the required time frames, and 7 percent lacked support that an Actions Taken Report had been issued within the required time frames. We also found that Facilities did not always provide records to qualified persons when requested or did not provide them within 21 days of the request or the conclusion of the investigation (whichever is later), as required. In a sample of 63 record requests, 32 percent (20) were either not provided on time or not provided at all. In addition, Facilities provided inconsistent information – with some offering more detail than others – to qualified persons in response to record requests.

The objective of our follow-up was to assess the extent of implementation, as of October 19, 2020, of the three recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

OPWDD officials have made limited progress in addressing the problems we identified in the initial audit. Of the initial report's three audit recommendations, one was implemented and two were not implemented.

Follow-Up Observations

Recommendation 1

Provide updated guidance to Facilities on their responsibilities related to Jonathan's Law requirements – including clear and consistent implementation procedures – and require Facilities to follow procedures.

Status – Implemented

Agency Action – OPWDD has provided updated guidance to Facilities on their responsibilities related to Jonathan's Law requirements. In May 2018, OPWDD posted to its website an updated summary of the Jonathan's Law requirements, including the amended definition of qualified persons to include adult siblings. Additionally, in July 2019, OPWDD issued a memorandum to Facilities outlining the Jonathan's Law requirements related to releasing investigative records to a qualified person for reportable incidents. Furthermore, in October 2019, OPWDD provided training to Facilities that included a review of Jonathan's Law requirements.

In addition to providing updated guidance to Facilities, OPWDD worked with three community-based providers we identified that lacked documentation of fulfilling record requests to qualified persons. OPWDD ensured these providers understood their obligations and verified that the records were provided to qualified persons.

Recommendation 2

Take steps to improve the use and quality of data in the Incident Reporting Management Application (IRMA), including:

- *Implementing procedures for quality assurance and timely input of incident data; and*
- *Incorporating additional fields to capture information on the request for and release of records.*

Status – Not Implemented

Agency Action – OPWDD officials informed us that they have not taken steps to improve the use and quality of IRMA data. In their 90-day response dated May 15, 2020, OPWDD officials stated that additional data fields in IRMA are unnecessary to improve their monitoring of compliance with Jonathan's Law. In addition, OPWDD officials stated that modifying IRMA to include information that is already contained within Facilities' supporting documentation would pose an unnecessary and expensive undertaking. Alternatively, OPWDD implemented a quality improvement program in April 2019 as part of its routine on-site Facility surveys. The surveys include reviewing compliance with Jonathan's Law notifications and disclosures, as well as all written requests for records. OPWDD provided the results of a completed survey that cited non-compliance with Jonathan's Law requirements – including notifications to qualified persons and providing records upon request.

However, as we noted in our initial audit report, IRMA captures certain information related to compliance that OPWDD could use to actively monitor compliance at all Facilities' as opposed to waiting for the results of onsite surveys. For example, OPWDD could readily detect instances where Facilities failed to notify qualified persons within required time frames and prevent further delays in providing incident information to these persons.

In addition, OPWDD should continue to work to improve the quality and timely input of incident data into IRMA, as well as capture additional information such as documents released in record requests to ensure Facilities provide the correct information and comply with Jonathan's Law. This would allow OPWDD to identify issues on non-compliance in a timelier manner.

Recommendation 3

Implement procedures to perform periodic data analysis of IRMA data to identify patterns and/or areas of concern that may be indicative of non-compliance with Jonathan's Law.

Status – Not Implemented

Agency Action – OPWDD officials informed us that procedures were not implemented to perform periodic analysis of IRMA data to identify patterns and/or areas of concern that may be indicative of non-compliance with Jonathan's Law. Instead, OPWDD relies on its

quality improvement program to routinely test for, and provide assurance of, compliance with Jonathan's Law. OPWDD officials indicated these procedural alternatives would allow OPWDD to more accurately monitor Jonathan's Law compliance in lieu of evaluating IRMA data. As mentioned in Recommendation 2 above, OPWDD provided us documentation supporting OPWDD's implementation of its quality improvement program, which includes a review of Jonathan's Law compliance.

While OPWDD relies on its quality improvement program to test for compliance with Jonathan's Law, IRMA already includes much of the necessary information to monitor compliance with certain Jonathan's Law requirements. We continue to urge OPWDD officials to use IRMA and the information it provides to systematically monitor compliance with Jonathan's Law requirements; and use the data to identify trends and/or other areas of concern that are indicative of non-compliance.

Major contributors to this report were Scott Heid, Charles Lansburg, Ryan Gregory, and Melissa Patnaude.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of OPWDD for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Daniel Towle
Audit Manager

cc: Mr. Anthony Dolan, OPWDD