City of New York

OFFICE OF THE COMPTROLLER

Scott M. Stringer
COMPTROLLER

MANAGEMENT AUDIT

Marjorie Landa
Deputy Comptroller for Audit

Audit Report on the Department of Health and Mental Hygiene's Monitoring of the Local Assisted Outpatient Treatment Program

MH12-138A
November 12, 2014
http://comptroller.nyc.gov

THE CITY OF NEW YORK
OFFICE OF THE COMPTROLLER
1 CENTRE STREET
NEW YORK, NY 10007

SCOTT M. STRINGER
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November 12, 2014

To the Residents of the City of New York:

My office has audited the adequacy of the Department of Health and Mental Hygiene's (DOHMH's) monitoring of its assisted outpatient treatment (AOT) program to ensure the proper administration of court-ordered mental health treatment plans. The 1999 enactment of a New York State Law known as "Kendra's Law" provided for court-ordered AOT for certain individuals who were considered unlikely to live safely in the community without supervision. We audit programs such as this to ensure that they are being effectively implemented.

Because of scope limitations that restricted the type of information that auditors could independently retrieve and review, auditors were unable to obtain sufficient, appropriate evidence to determine whether DOHMH is adequately monitoring the local AOT program in order to ensure that court-ordered mental health treatment plans are being properly administered. The audit found that DOHMH has taken a proactive approach in identifying weaknesses in its program and has reportedly implemented control procedures to improve its administration of the program. Through limited testing of a selected sample, results indicate that these control procedures may have effectively addressed some of those weaknesses. However, the audit concluded that DOHMH does not track or follow up on incoming community referrals to make certain that consumers who might benefit from the AOT program are considered for eligibility.

The audit recommended that DOHMH require logging, tracking, and follow-up on application forms sent to community members attempting to make a referral to AOT.

The results of our audit have been discussed with DOHMH officials, and their comments have been considered in preparing this report. Their complete written response is attached to this report.

If you have any questions concerning this report, please e-mail my audit bureau at audit@comptroller.nyc.gov.

Sincerely,

Scott M. Stringer

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OFFICE OF THE COMPTROLLER
MANAGEMENT AUDIT

Audit Report on the Department of Health and Mental Hygiene's Monitoring of the Local Assisted Outpatient Treatment Program MH12-138A

EXECUTIVE SUMMARY

The objective of this audit was to determine whether the Department of Health and Mental Hygiene (DOHMH) is adequately monitoring the assisted outpatient treatment (AOT) program to ensure the proper administration of court-ordered mental health treatment plans.

In 1999, New York State enacted Kendra's Law (New York Mental Hygiene Law § 9.60), named after Kendra Webdale, a young woman who died in January 1999 after being pushed in front of a New York City subway train by a person who had a long history of mental illness but who was not receiving treatment at the time of the incident. The law provides for AOT for certain individuals who, in view of their treatment history and circumstances, are determined by the court to be unlikely to live safely in the community without supervision.

The AOT process is initiated when a correctional facility, a treatment facility, or a member of the community (which may include a family member, friend, or neighbor) refers an individual to the program. DOHMH, through its Division of Mental Hygiene, is responsible for implementing the law in the five boroughs.

Upon the issuance of a court order, individuals accepted to the program (referred to as "consumers") are required to follow the treatment plan promulgated by the court. Responsibility for directly monitoring the consumers' progress and for coordinating the mandated services rests with care coordinators employed by privately operated care providers pursuant to contracts with the City and State. DOHMH AOT case monitors and private care coordinators are required to maintain communication with each other on a regular basis to ensure consumers are receiving all the mandated services.

DOHMH served 1,917 AOT consumers in Fiscal Year 2012 and 1,922 AOT consumers in Fiscal Year 2013.

Audit Findings and Conclusion

Because of the scope limitations resulting from restrictions to our access to certain confidential data as described later in this report, we were unable to obtain sufficient, appropriate evidence to determine whether DOHMH is adequately monitoring the local AOT program in order to ensure that court-ordered mental health treatment plans are being properly administered. We observed that DOHMH has taken a proactive approach in identifying weaknesses in its program and has reportedly implemented control procedures to improve its administration of the program. Our limited testing indicates that these control procedures may have effectively addressed some program weaknesses. However, the audit concluded that DOHMH did not track or follow up on the application forms sent to community referrers who inquired about the possible eligibility of individuals for the AOT program. As a result, consumers who might benefit from the program may not have been considered for eligibility.

Audit Recommendation

To address the one issue identified, the audit recommends that DOHMH require logging, tracking, and follow-up on application forms sent to community members attempting to make a referral to AOT.

Agency Response

In its response, DOHMH agreed with our one recommendation, stating that it "will further explore the feasibility of tracking and following up on application forms sent to individuals in the community who have called to inquire about the program." However, DOHMH took issue with the scope limitation described in the report, specifically questioning "what the identification of the consumers would add to the auditing process, and exactly why all the data provided still left the auditors unable to reach a conclusion." It added that it provided the auditors with all the records maintained by AOT, except the data fields that identify the AOT consumers.

We disagree with DOHMH's position regarding our scope limitation. As we stated in the draft report, due to mental health record privacy concerns, we were limited as to the type of information we could independently retrieve and review. Accordingly, we were unable to conduct certain independent observations and walkthroughs of the AOT process or obtain information directly from the contracted care providers and could only perform limited testing of sampled cases based on documents retrieved and redacted by agency personnel. As a result, we did not have reasonable assurance that the information we received was reliable or complete, nor did we have sufficient, appropriate evidence to provide a reasonable basis for an overall conclusion regarding our audit objective.

AUDIT REPORT

Background

In 1999, New York State enacted Kendra's Law (New York Mental Hygiene Law § 9.60), named after Kendra Webdale, a young woman who died in January 1999 after being pushed in front of a New York City subway train by a person who had a long history of mental illness but who was not receiving treatment at the time of the incident. The law provides for AOT for certain individuals who, in view of their treatment history and circumstances, are considered unlikely to live safely in the community without supervision. Acceptance into the AOT program can help mentally ill individuals live more safely in the community, avoid repeated inpatient hospitalizations, and obtain access to comprehensive outpatient treatment services.

Under Kendra's Law, the New York State Office of Mental Health is responsible for monitoring the AOT program statewide. DOHMH, through its Division of Mental Hygiene, is responsible for implementing the law in the five boroughs.[1] Eligibility for the AOT program requires the individual to be a City resident who is at least 18 years of age, suffers from a documented mental illness for which the person is unwilling to participate in treatment, and who because of lack of treatment, poses a risk to the community or himself/herself.

In May 2011, DOHMH assumed complete responsibility for the administration of the AOT program in the City from the Health and Hospitals Corporation (HHC). Previously, DOHMH had contracted with HHC to provide AOT services while DOHMH oversaw HHC's provision of those services. According to DOHMH, it decided to assume full responsibility for AOT services so that it would have a more efficient and unified program for investigating referrals, petitioning the courts, and monitoring the implementation of court orders for AOT. The transfer of responsibilities was also prompted, in part, by a recommendation from a joint State and City mental health and criminal justice panel.[2] The panel focused on opportunities to improve services for individuals with serious mental illness who were at risk of both poor treatment outcomes and involvement with the criminal justice system.

The AOT process is initiated when a correctional facility, a treatment facility, or a member of the community (which may include a family member, friend, or neighbor) refers an individual to the program. The Manhattan Borough AOT team is responsible for facilitating referrals from Rikers Island and other City and State correctional facilities. A correctional facility's discharge planning staff submits the necessary application and forms to the Manhattan AOT team. The team investigates these referrals, develops treatment plans, and coordinates referrals for services with the discharge staff. For a treatment facility referral, the facility must submit to the AOT program eligibility documentation and a proposed treatment plan. For a community referral, AOT personnel gather the information needed to document that an individual meets the AOT criteria. A psychiatric evaluation is required as well. Based on the person's history and the results of the examination, AOT personnel will develop a treatment plan if they determine that the person meets the AOT criteria. Once a court order is obtained, if the consumer refuses to comply with the treatment plan,

[1]There are four borough AOT teams that operate out of DOHMH's headquarters in Long Island City, Queens, covering the following areas: 1) the Bronx; 2) Brooklyn and Staten Island; 3) Manhattan and Rikers Island and other correctional facilities; and 4) Queens.

[2] New York State/New York City Mental Health Criminal Justice Panel Report and Recommendations, June 2008.

an *Order to Compel* is obtained. The AOT program receives the majority of its referrals from hospitals.

Upon completion of the necessary investigations and psychiatric evaluations, a petition is made to the court for an order mandating AOT.[3] Once a court order has been obtained, consumers are bound to follow the treatment plan promulgated by the court. Responsibility for directly monitoring the consumers' progress and for coordinating the mandated services rests with private vendors who contract with the City and the State to provide these services. Health Home Care Manager (HHCM) and Assertive Community Treatment (ACT) teams are care coordinators who work under the privately operated care providers. Assignment to either an HHCM or an ACT team depends on the severity of the consumer's mental illness. Consumers deemed to have more severe mental illnesses are assigned to ACT teams, which are designed to provide services that are more comprehensive to consumers who require close monitoring.

HHCM and ACT care coordinators are required to maintain periodic contact with consumers to ensure that they adhere to their treatment plans. AOT case monitors and care coordinators are required to maintain communication with each other on a regular basis. HHCM and ACT care coordinators document consumers' progress in weekly progress notes, which are faxed to the AOT case monitors. The case monitors must then review and enter the information into the AOT Data System and note whether the consumers are receiving all the mandated services and whether the information has any inconsistencies.[4] If the AOT case monitors determine that consumers are not receiving all the mandated services or that the weekly progress notes have inappropriate or inconsistent information, the monitors must follow up with the care coordinators and document the explanations provided. When significant events occur, the care coordinators are supposed to notify the AOT case monitors within 24 hours.[5]

DOHMH served 1,917 AOT consumers in Fiscal Year 2012 and 1,922 AOT consumers in Fiscal Year 2013.

Objective

To determine whether DOHMH is adequately monitoring the AOT program to ensure the proper administration of court-ordered mental health treatment.

Scope and Methodology Statement

We conducted this 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 was insufficient to provide a reasonable

[3] The Division of Mental Hygiene makes the petition for correctional facility and community referrals and the treatment facilities make the petitions for cases that they refer.

[4] The AOT Data System is a centralized consumer management database. It is used to document consumers' treatment progress as well as to provide up-to-date statistical data on program operations, the AOT consumers' characteristics, and the outcome of each consumer's case.

[5] There are six types of significant events that must be reported to the State Office of Mental Health. These include: 1) acts of violence against others or self; 2) consumer death by any cause; 3) consumer at risk of being discharged or released from court-ordered treatment services without a viable alternative; 4) consumer not receiving services in a timely manner; 5) consumer cannot be located; and 6) consumer attempted or committed suicide.

basis for an overall conclusion based on our audit objective for the reasons set forth in the subsequent paragraph. This audit was conducted in accordance with the audit responsibilities of the City Comptroller as set forth in Chapter 5, §93, of the New York City Charter.

In consideration of confidentiality restrictions imposed by the New York State Mental Hygiene Law § 33.13 and City Health Code § 3.25, which provide protection for patients' individually identifiable health information, we entered into a confidentiality agreement with DOHMH on October 15, 2012 in connection with this audit. The agreement limited the type of information that we could independently retrieve and review. For example, we could not obtain access to original files or to the AOT data system. Instead, AOT officials provided us with redacted copies of the files. In addition, we were unable to conduct certain observations and walkthroughs of the AOT process or obtain information directly from the contracted care providers, whose names were also redacted from the information provided to us. Due to these constraints, we were only able to perform limited testing of sampled cases and could not independently review or test the records of contracted providers. As a result, we do not have reasonable assurance that all of the information received during this audit was reliable, nor do we have sufficient, appropriate evidence to provide a reasonable basis for an overall conclusion regarding our audit objective.

The original audit scope period was Fiscal Year 2012. However, we expanded our scope to July 1, 2013, through October 31, 2013 to review the results of more recently implemented monitoring procedures.

Please refer to the Detailed Scope and Methodology at the end of this report for the specific procedures and tests that were conducted.

Discussion of Audit Results with DOHMH

The matters covered in this report were discussed with DOHMH officials during and at the conclusion of this audit. A preliminary draft report was sent to DOHMH officials on May 13, 2014, and was discussed at an exit conference held on June 3, 2014. On September 17, 2014, we submitted a draft report to DOHMH officials with a request for comments. We received a written response on October 1, 2014.

In its response, DOHMH agreed with our one recommendation, stating that it "will further explore the feasibility of tracking and following up on application forms sent to individuals in the community who have called to inquire about the program." However, DOHMH took issue with the scope limitation described in the report, specifically questioning "what the identification of the consumers would add to the auditing process, and exactly why all the data provided still left the auditors unable to reach a conclusion." It added that it provided the auditors with all the records maintained by AOT, except the data fields that identify the AOT consumers.

We disagree with DOHMH's position regarding our scope limitation. As we stated in the draft report, the access restrictions in the confidentiality agreement limited the type of information that we could independently retrieve and review. Due to these restrictions, we were unable to conduct certain independent observations and walkthroughs of the AOT process or verify information in DOHMN records by obtaining information directly from the contracted care providers. For example, we could only perform limited testing of sampled cases based on documents retrieved and redacted by agency personnel because we did not have access to original files or the AOT system. We were also unable to conduct certain observations and walkthroughs of the AOT process or to obtain information and records directly from the contracted care providers in order to substantiate the reliability and completeness of the records that DOHMH provided to us. Due to

these constraints, we could only perform limited testing of sampled cases. As a result, we did not have reasonable assurance that some of the information received during this audit was reliable or complete, nor did we have sufficient, appropriate evidence to provide a reasonable basis for an overall conclusion regarding our audit objective.

The full text of DOHMH's response is included as an addendum to this report.

FINDINGS AND RECOMMENDATIONS

Due to the scope limitations discussed in this report, we were unable to obtain sufficient, appropriate evidence to determine whether DOHMH is adequately monitoring the local AOT program in order to ensure that court-ordered mental health treatment plans are being properly administered. We observed that DOHMH has taken a proactive approach in identifying weaknesses in its program and has reportedly implemented control procedures to improve its administration of the program. Our limited testing indicates that these control procedures may have effectively addressed some program weaknesses. However, the audit concluded that DOHMH does not track or follow up on incoming community referrals to make certain that consumers who might benefit from the AOT program are considered for eligibility. These issues are discussed in more detail below.

Monitoring of the AOT Program

Subsequent to our initial review of DOHMH's monitoring of AOT consumers, DOHMH informed us that it was in the process of systematically enhancing its monitoring efforts. According to DOHMH, six months after the agency assumed administration of the program from HHC, Division of Mental Hygiene officials sought the assistance of DOHMH's Office of Program Review and Evaluation (OPRE) to review the program and identify areas of concern following the transfer of the program. The DOHMH internal review covered the period from January 2012 to August 2012 and covered 12 areas, including determination of eligibility for AOT services; timeliness of initial contact by AOT officials with consumers' care teams; documentation and verification of services provided to AOT consumers; and verification of the reporting and follow-up on significant events.

In October 2012, OPRE issued a summary of its findings. Although the summary did not make any recommendations, it identified a number of conditions that needed improvement. Specifically, the summary noted that the AOT data system lacked sufficient evidence that AOT case monitors actually contacted care coordinators to obtain missing weekly progress notes. It also noted that there was insufficient evidence that AOT case monitors forwarded significant event reports they received from the care coordinators to the New York State Office of Mental Health or that they obtained monthly service verification updates from the care coordinators.

During our initial review of 12 Fiscal Year 2012 cases, we had identified similar conditions. There were deficiencies with how care coordinators reported their monitoring of consumer progress to AOT case monitors. For example, we identified deficiencies in 273 (67 percent) of the 405 weekly progress notes submitted by the care coordinators that we reviewed. These deficiencies included progress notes that care coordinators submitted late or that contained missing, incorrect, or incomplete information (e.g., results of drug tests or visits to medical providers). Some had even reused previously submitted weekly progress notes and so what was reported did not accurately reflect the consumer's current status. For example, one care coordinator did not change the written comments section for four consecutive weeks.[6]

We also identified deficiencies with how AOT personnel (i.e., AOT case monitors, psychiatrists, or supervisors) recorded the consumers' progress in the AOT data system. Of the 574 AOT

[6] The comments section is intended to update the consumer's status to show whether the consumer is adhering to the treatment plan.

monitoring notes we reviewed, there were issues with 91 (16 percent) of them. These issues included late entries of monitoring notes and verification updates in the AOT data system and incorrect or missing information.

We also reviewed all 18 significant events associated with the 12 case files. As described in footnote 5 above, significant events are major incidents that could have a major impact on the health or well-being of the consumer or a member of the community (which may include acts of violence or suicide attempts) that must be reported to the State Office of Mental Health. Of the 18 significant events reviewed from the hard copy files, one was not reflected in the data system. However, this missing report did not affect the consumer's care because other notes in the system indicated that appropriate follow-up was performed.

After conducting this review, we were informed that during the period under review in our 12 case samples, DOHMH had been in the process of implementing corrective action plans to mitigate the conditions its internal review identified in the OPRE report. Notwithstanding a request to DOHMH in August 2012 to provide us with "copies of any internal and external reports, including audits and performance reports or reviews that were previously conducted," we did not receive the OPRE report related to these corrective measures until December 2013, after we shared our 12 case review results with the agency. Once we received the report from DOHMH, we expanded our review to include more current records (July 1, 2013 to October 31, 2013) for these same 12 cases.

Of the 12 cases we intended to review for the period July 1, 2013 to October 31, 2013, six had been closed because the clients were no longer AOT consumers. We verified that the closures were adequately supported in the records and that they complied with the court order. For the remaining six files, we did not find any significant issues that could affect the consumers' adherence to the treatment plans or that indicated any weaknesses in DOHMH's monitoring efforts. This indicated that the control procedures that DOHMH has reportedly implemented may have had a positive effect, specifically with regard to our sampled cases. Apparent improvements noted included that care coordinators seemed to have promptly notified AOT case monitors of events that might have affected adherence to the court-ordered treatment plans and that follow-up action was taken. In addition, there appeared to be no significant contradictions or material errors that would indicate that the sampled consumers were not being adequately monitored or that services were not being provided as mandated by the court-ordered treatment plans.

Tracking and Following Up on Initial Community Referrals

DOHMH does not have a policy concerning its tracking and following up with callers who make community referrals and are sent referral forms to complete on behalf of potential consumers. According to the AOT policy and procedures manual, AOT telephone intake personnel have to obtain initial eligibility information from callers about potential referrals. The individual inquiring about a possible referral must first answer affirmatively whether the person being referred resides in the City, is at least 18 years of age, and has been previously treated for mental illness.

If it is determined that the referred individual may not qualify for the program based on the responses, the caller is referred to LifeNet.[7] If, based on the responses, the individual qualifies for

[7] LifeNet is a free, confidential mental health and substance abuse information referral and crisis prevention hotline that callers may use to find appropriate assistance.

the AOT program, the caller is emailed an *Assisted Outpatient Treatment Program Referral Form*. If email is not an option, the form may be mailed or faxed. The form consists of five pages requesting in-depth personal, criminal, substance abuse, and psychiatric information regarding the potential consumer.

DOHMH AOT personnel only start to track a referral upon receipt of a completed application, not when the application form is sent to the referrer. Information on the potential consumer and the decision as to whether the individual is ultimately accepted or denied is entered in the AOT data system. If accepted, a designation letter giving an examining psychiatrist permission to petition the court is sent to the referrer. The State Office of Mental Health is notified that the referred individual has been approved and that the court will be petitioned. A judge will hear testimony from the psychiatrist regarding the reasons that the proposed treatment plan is necessary and then will decide whether or not to issue a court order. Once a court order is obtained, if the consumer refuses to comply with the treatment plan, an *Order to Compel* is obtained.

Because DOHMH does not follow up with callers who have not yet completed or returned referral forms, it is unable to determine why the callers have not done so or help them complete the application process if assistance is needed. DOHMH may wish to track this information to provide better service to those seeking help.

Recommendation

1. DOHMH should require logging, tracking, and follow-up on application forms sent to community members attempting to make a referral to AOT.

DOHMH Response: "DOHMH has a policy and procedures to track and follow-up on incoming referrals, which are distinguishable from telephone calls seeking information from the program. We will further explore the feasibility of tracking and following up on application forms sent to individuals in the community who have called us to inquire about the program."

DETAILED SCOPE AND METHODOLOGY

We conducted this 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, for the reasons discussed in the beginning of this report and below, that the evidence obtained was insufficient to provide a reasonable basis for an overall conclusion based on our audit objective. This audit was conducted in accordance with the audit responsibilities of the City Comptroller as set forth in Chapter 5, §93, of the New York City Charter.

Because of confidentiality restrictions imposed by New York State Mental Hygiene Law § 33.13 and City Health Code § 3.25, we entered into a confidentiality agreement with DOHMH on October 15, 2012 that limited the information we could independently retrieve and review for this audit. For example, we could not obtain access to original files or the AOT data system. Instead, AOT officials provided us with redacted copies of the files. In addition, we were unable to conduct certain observations and walkthroughs of the AOT process or obtain information directly from the contracted care providers, whose names were also redacted from the information provided to us. Due to these restraints, we could only perform limited testing of the sampled cases and could not independently review or test the records of contracted providers. As a result, we do not have reasonable assurance that some of the information received during this audit was reliable, nor do we have sufficient, appropriate evidence to provide a reasonable basis for an overall conclusion regarding our audit objective.

The original audit scope period was Fiscal Year 2012. However, we expanded our scope to July 1, 2013 through October 31, 2013 to review the results of more recently implemented monitoring procedures.

To obtain an understanding of the objectives, responsibilities, and laws governing the DOHMH AOT program, we reviewed and used as criteria:

- Kendra's Law (New York Mental Hygiene Law § 9.60);
- New York State Mental Hygiene Law § 33.13;
- New York State Public Health Law, Articles 23 and 27-F;
- New York City Health Code, Section 3.25;
- New York State/New York City Mental Health Criminal Justice Panel Report and Recommendations (June 2008);
- AOT Program Policy and Procedures (September 14, 2012); and
- AOT Data System Manual (February 5, 2013).

We also met with and interviewed DOHMH officials responsible for overseeing the AOT program, including the deputy director of the Bureau of Mental Health, the director of the AOT program, the AOT senior medical director, and the director of Quality Assurance.

To understand DOHMH's procedures for monitoring the AOT program and for ensuring the accuracy of the information it receives from care coordinators, we met with the deputy director for the AOT Program, who is also the information technology administrator, and the four deputy directors who oversee the AOT borough teams. We also met with one supervisor from each team and seven AOT case monitors whose cases we reviewed.

To gain an understanding of the AOT data system and how case monitors use it to document the progress of AOT consumers, the deputy director for the AOT Program/IT administrator and personnel from the IT unit demonstrated to us the types of data entries that can be made and the edit controls in place.

We obtained a list of the 1,917 consumers for Fiscal Year 2012 and a dataset for June 30, 2011, through April 30, 2013. The dataset contained consumer information from the AOT data system relating to, among other things, significant events, case closures, and consumer housing. We reviewed the dataset to determine whether there were any duplicate records.

We randomly selected 12 cases from the listing of 1,917 consumers — two from each of the five boroughs and two from Rikers Island. We obtained redacted copies of the paper case files of the same 12 consumers. To determine whether the copies we received from DOHMH were reliable, we attempted to verify the accuracy of the information contained in those files with the records held by the contracted care providers. However, because of the State-based privacy limitations imposed on our audit, the names of the care providers associated with the 12 consumers were not made available. As a result, we were unable to ascertain that the files we received were reliable without independently obtaining and reviewing records and other information in the possession of the care providers.

To determine whether the data in the AOT data system matched the information contained in the 12 paper files we obtained, we compared the dataset information to the information in the paper files. To determine whether these 12 consumers received the services mandated by their court-ordered treatment plans in a timely manner and whether AOT adequately monitored the progress of consumers during Fiscal Year 2012, we reviewed relevant documentation, such as court orders and approved treatment plans. We also reviewed 405 weekly progress notes, 574 monitoring notes, 18 significant event reports and, where applicable, 61 monthly service verifications related to our 12 cases. During our review of the case files, we attempted to determine whether all the pertinent documents were in the file. We also attempted to determine whether pertinent documents received from care coordinators were entered into the database by AOT case monitors and whether the consumer case files were continuously updated and kept current. In addition, we attempted to determine whether there was adequate and timely follow-up by AOT monitors to ensure that consumers needing additional treatment actually received this treatment.

To assess whether significant events were noted in the AOT database and whether they were followed up in a timely manner, we compared the information for the significant events in the database to the information contained in the monitoring notes. We also evaluated whether the follow-up steps taken were appropriate.

To evaluate the effectiveness of DOHMH's implementation of new controls in response to the OPRE report, we reviewed the same 12 cases for the period of period July 1, 2013, through October 31, 2013. Six of the 12 cases were closed prior to that period. For those closed cases, we attempted to determine whether the records adequately supported the outcome and were consistent with the court order. For the remaining six consumers, we performed the same review procedures as we had for the earlier period.

NEW YORK CITY DEPARTMENT OF
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October 1, 2014

Marjorie Landa
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1 Centre Street, Room 1100
New York, NY 10007-2341

Re: Audit report on the Department of Health and Mental Hygiene's Monitoring over the Local Assisted Outpatient Treatment Program
Audit Number MH12-138A

Dear Deputy Comptroller Landa:

The NYC Department of Health and Mental Hygiene (DOHMH) reviewed the draft report on the monitoring over the Local Assisted Outpatient Treatment Program issued on 9/17/2014. The objective was to determine whether DOHMH is adequately monitoring the assisted outpatient treatment ("AOT") program to ensure the proper administration of court-ordered mental health treatment plans.

The auditors acknowledge that DOHMH was proactive in identifying opportunities to improve the program following the transfer of the AOT program from Health and Hospitals Corporation ("HHC") to DOHMH and implemented control procedures to improve its administration of the AOT program.

The attached response details DOHMH's position in regards to the scope limitation claimed by the auditors. With regard to the auditors' recommendation, DOHMH will further explore the feasibility of tracking and following up on application forms sent to individuals in the community who have called to inquire about the program.

We appreciate the efforts and professionalism of your staff during the audit. If you have any question, please contact Sara Packman, Assistant Commissioner for Audit Services at (347) 396-6679.

Sincerely,

Oxiris Barbot, M.D.

cc:

Mary T. Bassett, M.D., MPH, Commissioner, DOHMH
Gary S. Belkin, M.D., PhD, MPH, Executive Deputy Commissioner, Mental Hygiene, DOHMH
Thomas Merrill, ESQ., General Counsel, DOHMH
Sara Packman, Assistant Commissioner, Audit Services, DOHMH
Nancy Hulbrock, Director of AOT, DOHMH
George Davis, Director, Mayor's Office of Operations

Attachments:

RESPONSE TO THE NEW YORK CITY COMPTROLLER'S AUDIT OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE'S MONITORING OF THE LOCAL ASSISTED OUTPATIENT TREATMENT PROGRAM AUDIT NUMBER MH12-138A

The Department of Health and Mental Hygiene (DOHMH) reviewed the draft audit report on DOHMH's monitoring of the Local Assisted Outpatient Treatment ("AOT") program and thanks the auditors for the opportunity to respond. The objective of the audit was to determine whether DOHMH is adequately monitoring the AOT program in order to ensure the proper administration of court-ordered mental health treatment plans.

The auditors state that because of the confidentiality restrictions imposed by the New York State Mental Hygiene Law §33.13 and City Health Code §3.25, which protects the DOHMH's confidential records regarding AOT consumers, they signed a confidentiality agreement with DOHMH in connection with the audit. The agreement limited the type of information they could independently retrieve and review. The auditors state that they were unable to observe and conduct certain walk-throughs of the AOT process or obtain information directly from the contracted care providers. The auditors conclude that due to the scope limitation, they "were unable to obtain sufficient appropriate evidence to determine whether DOHMH is adequately monitoring the local AOT program in order to ensure that court-ordered mental health treatment plans are properly administered[1]."

The auditors acknowledge that (i) DOHMH was proactive in identifying opportunities to improve the program and had requested that its Office of Program Review and Evaluation ("OPRE") review the AOT program and identify areas of concern following the transfer of the AOT program from Health and Hospitals Corporation ("HHC") to DOHMH; and (ii) DOHMH implemented control procedures to improve its administration of the AOT program. The auditors note that they expanded their scope to fiscal year 2013 to review the results of more recently implemented monitoring procedures and acknowledge that the "control procedures implemented by DOHMH may have positive effects, especially with regard to [the] sample tested[2]."

The audit report includes one issue namely that DOHMH does not have a policy on tracking and following-up with callers who make community referrals and receive referrals forms to complete on behalf of potential consumers. The auditors recommend that DOHMH "require logging, tracking and follow-up on application forms sent to community members attempting to make a referral to AOT[3]."

The following details DOHMH's response to the auditor's report. DOHMH finds the auditors' claim that they were "unable to obtain sufficient, appropriate evidence to determine whether DOHMH is adequately monitoring the local AOT program…[4]" to be an incomplete representation of what took place.

First, at the very outset of the audit, DOHMH expressed its desire to fully cooperate with the audit while protecting the confidentiality of the consumers, whose information is protected by various laws, rules

[1] Page 6 of the draft audit report on DOHMH's monitoring of the Local Assisted Outpatient Treatment Program
[2] Page 7 of the draft audit report on DOHMH's monitoring of the Local Assisted Outpatient Treatment Program
[3] Page 8 of the draft audit report on DOHMH's monitoring of the Local Assisted Outpatient Treatment Program
[4] Page 6 of the draft audit report on DOHMH's monitoring of the Local Assisted Outpatient Treatment Program

and regulations, including the New York State Mental Hygiene Law and the New York City Health Code. Beginning with our early discussions with the auditors and continuing through the auditing process, the Comptroller's Office expressed its complete agreement that the identity of the consumers should not be disclosed without the consumers' consent and the confidentiality agreement (also referred to as the Memorandum of Understanding (MOU) was meant solely to protect the consumers, and not to in any way hinder the auditing process.

As such, DOHMH and the Comptroller entered a MOU on October 15, 2012 to prevent the disclosure during the auditing process of individually identifiable information, as defined by the MOU as information "which would enable the subject of the record or report to be identified either directly or in combination with other publicly available records," and requiring any such information be redacted from the documents DOHMH produced for the audit. As noted in the MOU, records that identified individuals receiving [treatment services] were deemed confidential and were protected from re-disclosure without an individual's consent in accordance with the New York City Health Code, § 3.25 and other applicable law. Specific data elements were only redacted from records in the interest of consumer privacy and with the auditors' agreement.

Second, DOHMH provided the auditors with all available information that was requested. More specifically, we received requests for data, documents, reports, questions that resulted in the production of 49 documents that were submitted to the auditors. DOHMH exported more than 65 database fields requested for all consumers, redacting the identifiable consumer information such as name, date of birth and address.

For the sample selected by the auditors, DOHMH provided the Comptroller with all AOT reports and other records maintained by AOT, including the treatment summaries and other similar communications sent to DOHMH by the external Intensive Case Managers, except the data fields that are protected from re-disclosure by Mental Hygiene Law § 33.13. Whenever the auditors expressed concern over DOHMH's approach to redacting information about the consumer, DOHMH discussed this issue and arrived at a consensus with the auditors regarding the data elements that could be produced. Each agreement regarding data privacy and security entered with the auditors were subject to their negotiation and agreement, coupled with an assurance that the auditors did not desire data that would identify a consumer. We further discussed our agreement and mutual understanding in a March 22, 2013 meeting and resulting amendment to the MOU to provide additional relevant information to accommodate the auditors in the assessment of DOHMH's monitoring of the AOT program.

During the audit, the auditors met with over 20 AOT program staff, including psychiatrist, directors, supervisors and monitors who discussed their monitoring procedures and oversight. DOHMH also presented to the auditors the AOT database during a February 12, 2013 "walk-through" meeting and provided the auditors with the data dictionary, screen shots and lists of (i) all database reports, (ii) users with administrative rights, (iii) type of notes captures in the system, and (iv) significant events.

Third, it is unclear from the draft report, precisely what the identification of the consumers would add to the auditing process, and exactly why all the data provided still left the auditors unable to reach a conclusion.

Finally, from an auditing standpoint, DOHMH's efforts to protect consumer confidentiality should be seen as good practice, and had DOHMH disclosed confidential information without undergoing the

necessary precautions taken during this audit, we think there would have been some concern on the Comptroller's part.

With regard to the auditors' recommendation, DOHMH has a policy and procedures to track and follow-up on incoming referrals, which are distinguishable from telephone calls seeking information from the program. We will further explore the feasibility of tracking and following up on application forms sent to individuals in the community who have called us to inquire about the program.