



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

October 5, 2006

Hon. Gary O'Brien
Commissioner
Commission on Quality of Care and
Advocacy for Persons with Disabilities
401 State Street
Schenectady, New York 12305

Dear Mr. O'Brien:

This is in response to the draft Adult Home Closure Study Report you recently forwarded for review and comment. The Department of Health has appreciated the opportunity to discuss with you and your staff Commission findings and the Department takes great interest in your recommendations.

As a result of the close cooperative relationship that we have developed, we continue to see improvements in the closure process, all to the benefit of residents. The revision in policies and procedures that are currently utilized, prior to and during a closure, which were developed with input from your staff, Office of Mental Health (OMH) representatives and the Office for the Aging (SOFA), are a result of bimonthly staff meetings. We will continue to focus on further improvements. Since this study includes some residents who were relocated prior to the period in which many of these recent reforms were enacted, we believe the resident satisfaction levels should have increased from even the high levels described.

Your report includes seven recommendations that are important to effect continuation of positive outcomes for residents. Our response to each is outlined below:

Recommendation #1: Assure the Consistent Application of Existing DOH Policy on "Adult Care Facility Closures" and OMH "Supportive Case Management Guidelines."

Prior to the Department's approval of any closure plan from a facility with a significant number of mentally ill residents, Department staff notify the Commission on Quality of Care and Advocacy for Persons with Disabilities

(CQCAPD), OMH and SOFA staff to prepare for the actual implementation of the closure plan and our involvement to monitor the process. Facilities must adhere to the conditions of the approved closure plan during the entire process. Assignment of interagency teams to each facility during this process has greatly improved the monitoring and identification of issues or problems and their resolutions. Actions against operators continue to be an option if these more immediate solutions are not sufficient. We look forward to working together to continue strengthening these approaches.

Recommendation #2: Modify Resident Housing Preference Assessments and Mandate Use for All Individuals Moving

We have implemented this recommendation and the Resident Preference Form was incorporated into the process in the fall of 2003. Department staff, with staff from CQCAPD and OMH, have continued to adapt this form to incorporate and offer each resident the most beneficial opportunities for housing. We are committed to making additional revisions to this document as necessary. This form is critical to the best interest of each resident and it is mandatory that each resident be offered the opportunity to have this form completed. The mental health aftercare providers and programs whose staff is familiar with the residents are also enlisted to assist in completing the assessment.

Recommendation #3: Create a Collaborative Working Document that Lists Need-Related Tasks, Identifies Person Responsible, Identifies Who Might Be Able to Live More Independently and Makes Appropriate Referrals.

As part of the monitoring process in place for facility closures where there is no OMH case manager to complete this process, state staff, in collaboration with the facility case manager, review and identify the most appropriate placement for that person. We look forward to working with our partner agencies to put in place a formal notice of this process to operators as part of the current ACF closure protocols, as well as to define other steps to support the effective implementation and use of this document.

Recommendation #4: Prepare a Referral Packet Containing Seven Elements for Each Individual and Revise Adult Home Closure Policy Regarding this Packet.

We are currently in the process of revising our ACF closure protocols to include a formal referral packet containing consistent documents for each resident. We have also begun the actual practice of preparing this packet for individuals in facilities that are currently closing. We are prepared to review the protocols with you.

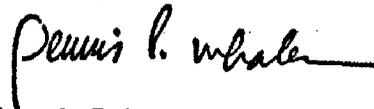
Recommendation #5: Maintain a Roster of Final Placements.

During each closure, Department staff receives a weekly roster that indicates each resident's name, date they were discharged, and the address and telephone number of the facility to which they were discharged. This process has been in place since 2004.

It is our understanding that OMH is developing a response to these recommendations as well, which will specifically address your last two recommendations.

Thank you for your continued assistance and cooperation with these efforts. We remain committed to working with the Commission on Quality of Care and Advocacy for Persons with Disabilities, Office of Mental Health and the State Office for the Aging to continue to improve this process as well as our many other initiatives to promote care and services to the residents of adult care facilities.

Sincerely,



Dennis P. Whalen
Executive Deputy Commissioner

cc: Mr. Wollner
Ms. Wickens
Mr. Dougherty
Ms. Hart
Ms. Mooney