



COMMISSION ON QUALITY OF CARE
AND
ADVOCACY FOR PERSONS WITH
DISABILITIES



Annual Report
2006 - 2007

DAVID A. PATERSON
GOVERNOR

STATE OF NEW YORK
COMMISSION ON QUALITY OF CARE AND ADVOCACY
FOR PERSONS WITH DISABILITIES
401 STATE STREET
SCHENECTADY, NEW YORK 12305-2397
1-800-624-4143 (Voice/TTY/Spanish)
www.cqcapd.state.ny.us

JANE G. LYNCH
CHIEF OPERATING OFFICER

BRUCE BLOWER
PATRICIA OKONIEWSKI
MEMBERS

Executive Message

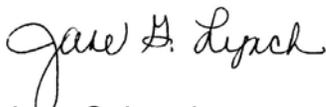
I am privileged to begin my service to the Commission. The Commission exists to protect and improve the quality of life for New Yorkers with disabilities. This legislative mandate established the Commission as a unique and independent oversight agency charged to improve the quality of life for persons with disabilities, to protect their rights, and to advocate for needed systemic changes. The Commission respectfully accepts this legislative charge and fulfills this responsibility in relation to both the systems of services and supports and the individuals served and supported by these systems. We strive to achieve these goals with independence, integrity, compassion, and respect.

The Commission's accountability to the people it serves and the public at large is paramount to its mission. We struggle to find the appropriate balance between our role as monitors and change agents; the balance between individual representation and systemic change; and the balance between governmental oversight and systems advocacy. I am inspired by the talent and dedication of Commission staff, the dedication and commitment of persistent and tireless advocates, and the strength and resilience in each individual we serve. I want to express my appreciation to Governor Paterson for his confidence and support; and to our volunteers, Commission members Bruce Blower and Patricia Okoniewski, our Advisory Council, our Medical Review Board, and the volunteers who serve on the Surrogate Decision Making Committee panels across the state; all give generously of their time and talents.

This report sets the tone for the increased use of data and technology to inform our work and communicate the outcomes achieved. This biennial report presents more than statistics on the Commission's activities in 2006 and 2007; it contains explanations of the reasons we perform each activity. This information is important in order to understand the mission and depth of the agency. We are beginning to provide comparative data and give a glimpse of what we hope to expand upon in the future. We will work to translate that historical data to give outcome measures and multi-year trend information that will assist in our efforts to educate, advocate and inform policy decision-making.

We hope the information included in the report will raise questions, as these questions will be of great value as we continue to seek improvements in our systems of care. This questioning is an inherent and necessary part of being open, honest, and accountable. I look forward to engaging in difficult conversations with our partners that will continue our progress in fulfilling our mission. We must never forget that individuals young and old and their families are at the core of this data. It is their human stories that drive us to create better programs, policies, and a brighter future.

Sincerely,



Jane G. Lynch
Chief Operating Officer

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Case Activities

In 2006 and 2007, the Commission responded to over 92,000 requests for assistance, reviewed over 25,500 deaths and allegations of abuse reported by mental hygiene facilities, and conducted over 2,200 program reviews and investigations into reported deaths and allegations of abuse. The Commission is assisted in its clinical investigations by the Mental Hygiene Medical Review Board, a panel of volunteer medical professionals appointed by the Governor.

The Commission staffs a toll-free telephone line for people who have concerns about their care, or that of a family member or friend, or who are in need of assistance in navigating the system; reviews all allegations of abuse and deaths occurring within the system, conducting direct investigations into those where facility investigations seem lacking or the nature of the event warrants independent scrutiny; maintains investigative staff on-call 24 hours-a-day, seven days-a-week; and conducts hundreds of announced and unannounced site visits and program reviews each year.

Types of Investigation and Review Background Information

Child Abuse:

The NYS Mental Hygiene and Social Services Laws require the Commission to conduct independent investigations into reports alleging abuse/neglect of children residing in OMH, OMRDD, and (effective January 2009) OASAS operated or licensed facilities pursuant to definitions and procedures spelled out in the NYS Social Services and Mental Hygiene Laws.

Adult Abuse:

The NYS Mental Hygiene Law requires that facilities operated or licensed by OMH, OMRDD, and OASAS report all allegations of abuse or mistreatment to the Commission for appropriate action.

Death Reports:

The NYS Mental Hygiene Law requires OMH, OMRDD, and OASAS facilities to report all deaths to the Commission. Additionally, Social Services Law requires adult homes to report deaths of individuals with histories of mental hygiene treatment to the Commission. Cases of unusual death (e.g., suicide) are assigned for further action and, when warranted, referred to the Mental Hygiene Medical Review Board.

Care and Treatment:

Anyone can contact the Commission with concerns about their care or treatment, that of a loved one, or of someone cared for by a facility or program where they work. If these concerns can not be addressed by giving the concerned parties information, or by contacting the facility directly on their behalf, the Commission may initiate an independent review.

Individual Case Activities 2006 - 2007

Child Abuse Investigations*	627
Adult Abuse Reports Reviewed ☆	19,516
Adult Abuse Reports Assigned for Further Action	639
Death Reports Reviewed ☆	6,004
Death Reports Assigned for Further Action	574
Care and Treatment / Program Reviews*	451
Toll-Free Calls for Assistance	92,309

* Data is compiled by date closed.

☆ Data is compiled by date screened.

Note: The current methodology employed in this report has changed from previous CQCAPD reports. We expect this new methodology to be used in all future reporting to make long-term trending and analysis more consistent and helpful to readers.

Children's Oversight and Investigations

State Central Registry (SCR) Investigations

Under the New York State Mental Hygiene and Social Services Laws, allegations reported to the State Central Register's hotline for child abuse and maltreatment involving children in Office of Mental Health (OMH) or Office of Mental Retardation and Developmental Disabilities (OMRDD) and, effective January 2009, Office of Alcoholism and Substance Abuse Services (OASAS) residential facilities, are routed to the Commission for investigation. Commission investigators respond to these reports within 24 hours to assure the safety of the children involved, and then begin an investigation that results in a recommendation to the New York State Office of Children and Family Services (OCFS). Recommendations will be either that a report be "indicated," meaning there is some credible evidence that abuse or maltreatment, as defined in Social Services Law, occurred or "unfounded," meaning there is no credible evidence that abuse or maltreatment occurred and that the record should be sealed.

Residential Child Abuse Investigations OMH and OMRDD Residential Care Facilities 2006 & 2007

	Total Cases 2004/2005	Total Cases 2006/2007	Indicated Cases 2004/2005	Indicated Cases 2006/2007	Cases Resulting in Recommendations 2004/2005	Cases Resulting in Recommendations 2006/2007
OMH - Licensed	143	165	8	16	25	20
OMH - State Operated	83	142	5	3	10	0
OMRDD - Licensed	264	257	7	10	7	21
OMRDD - State Operated	70	63	5	3	3	3
Totals	560	627	25	32	45	44

In 2006 - 2007, the Commission conducted 627 child abuse and maltreatment investigations. This is a 12% increase in total cases as compared to 2004-2005. The chart above shows the number of cases reported from the State Central Register, the number of those cases that were indicated, and the number of those cases that resulted in recommendations in OMH and OMRDD facilities for 2006- 2007. The term "recommendations" refers to recommendations to improve care or treatment.

Highlights from the data:

- There was a significant increase in reports from OMH state-operated facilities in 2006 - 2007 when compared to 2004 - 2005.¹
- Recommended indications for OMH-licensed facilities doubled in 2006 - 2007 when compared to 2004 - 2005.
- Recommended indications rose in both OMRDD- and OMH-licensed facilities during 2006 - 2007, but dropped in their state-operated facilities when compared to 2004 - 2005.
- The overall rate of indication for both OMRDD and OMH investigations was 5% for 2006-2007, as compared with 4% in 2004 - 2005.
- In 7% of the cases investigated during 2006-2007, the care provided or the conduct of staff was found to be substandard, warranting recommendations and remedial action. This is a decrease of 3% from 2004 - 2005.

¹ CQCAPD Annual Report 2004 - 2005, Section "Watching Over the Children"

A majority of the 2006-2007 investigations (64%) pertained to allegations of physical abuse by staff, including the inappropriate use of or excessive force during, restraint (8% of the 64%). Allegations of lax supervision and staff negligence were the focus of 19% of the cases. Inappropriate sexual contact between staff and children or between children was alleged in 10% of the cases, with psychological abuse or other forms of mistreatment constituting the remaining 7% of allegations investigated.

Care and Treatment Investigations

A core function of the Commission is to conduct investigations of complaints regarding the care and treatment of children with disabilities in certain residential care facilities operated or licensed by OMH, OMRDD, or effective 2009 OASAS.

Care and Treatment Reviews for Children OMH and OMRDD Residential Facilities

	Cases 2004 - 2005	Cases 2006 - 2007	Recommendations 2004 - 2005	Recommendations 2006 - 2007
OMH - Licensed	46	40	30	22
OMH - State Operated	7	11	2	5
OMRDD - Licensed	30	27	21	19
OMRDD - State Operated	10	18	8	9
Total	93	96	61	55

The chart above provides information on investigations undertaken as a result of calls received by the Commission regarding the care and treatment of children residing in an OMH or OMRDD residential care facility. Care and Treatment investigations are often commenced in response to cases of alleged abuse which did not meet the definition of child abuse under Social Service Law, but warranted closer examination of supervision, behavior management or staffing issues. The term “recommendations” refers to recommendations to improve care.

Highlights from the data:

- The total number of Care and Treatment Reviews for children in both licensed and state-operated OMH and OMRDD residential facilities remained relatively unchanged in 2006 – 2007 when compared to 2004 – 2005.
- Although the total number of cases remained relatively constant, there was an increase in cases at OMRDD state-operated facilities, however, recommendations to OMRDD state-operated facilities did not correspondingly increase.
- Commission recommendations to improve care in both licensed and state-operated OMH and OMRDD facilities saw a decrease (9%) in 2006 – 2007 when compared to 2004 – 2005.

Child Advocacy and Family Training

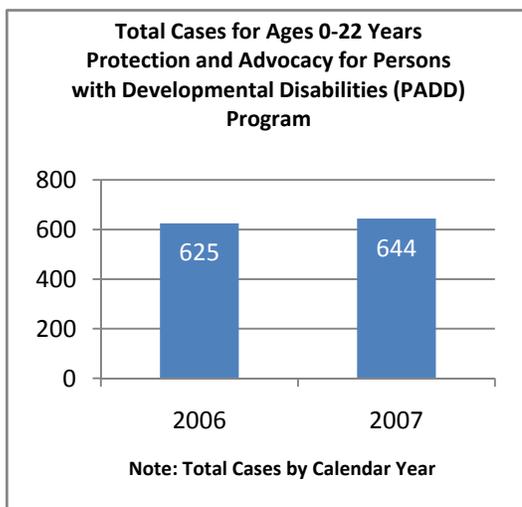


Protecting and promoting the rights of persons with disabilities is an essential aspect of the Commission's mission. Commission staff conduct training activities to ensure that persons with disabilities, their families, service providers and other concerned parties have an understanding of the rights established by both state and federal legislation for persons with disabilities, and to help individuals and their families engage in self-advocacy.

In addition, the Commission contracts with three non-governmental agencies to provide special education training and advocacy activities throughout the state. The graph to the left provides information on the Commission's Special Education Advocacy training efforts in 2006 – 2007.

The Commission also contracts with a statewide network of legal services corporations and non-profit organizations through the federally-funded Protection and Advocacy Program for Persons with Developmental Disabilities (PADD) program.

Almost 70% of PADD cases involve children under the age of 21 and most of these cases concern access to appropriate special education and related services. PADD attorneys and paralegals assist families at Committee on Special Education (CSE) meetings, "resolution" negotiations, impartial hearings and, in limited situations, appeals to the State Review Officer (SRO) and the courts.



In 2006 – 2007 the three most prevalent case categories in the 0-22 years age group were related to access to appropriate special education; combined, they represented 50% of PADD cases in that age group. The top three case categories were as follows: Individualized Education Plan (IEP) not appropriate (26%); not receiving special education services (12%); and IEP not being implemented (12%).

Residential Treatment Facility Study (June 2007)

In response to concerns expressed by parents who believed their children with serious emotional disturbances waited too long for residential treatment, parents whose children had not had successful discharges from residential treatment, and advocates who cited the dearth of residential options for young adults leaving Residential Treatment Facilities (RTFs), the Commission undertook a study of 60 youths who had been discharged from OMH-licensed RTFs between January 1, 2004 and June 30, 2005.

The major findings of the study were that youths in the sample were, indeed, seriously emotionally disturbed. Few children came to the RTF directly from their homes. The single largest group of youngsters (27) came to the RTF from OMH certified or operated inpatient beds. There also was a high level of disruption of family life experienced by the children, their siblings and parents prior to the child's admission to the RTF, with 87% of the sample children having already experienced a mental health inpatient stay or other out-of-home placement.

Other findings included:

- Despite the general approval ratings given to the children's education, upon discharge from an RTF, many youths left lacking basic age-appropriate skills.
- The effectiveness of the working relationship between the single point of accountability entities (SPOAs) and the Preadmission Certification Committees (PACCs) varied among the counties visited. The variance among geographic regions left unanswered the question of whether the child could have been served with community services.
- There were differences of opinions among RTF administrators, PACC and SPOA interviewees on the role of the RTF in the mental health system of care for children and adolescents. Some said the problem was simply an insufficient number of RTF beds. Others said it was the limited number of specialty beds; still others said the RTF was an anachronistic model and should be replaced with smaller, community-based services (both treatment and residential).

The full report, including recommendations and OMH's response, can be found on line at <http://www.cqcapd.state.ny.us/OnlineReports/RTFReport.htm>.

“Jonathan’s Law”

In 2007, legislation was approved affording individuals receiving mental hygiene services, their parents or others authorized to make health care decisions on their behalf, increased access to records regarding the individual's care and treatment. This legislation (Chapters 24 and 271 of the Laws of 2007), which is known as Jonathan's Law, also sets certain requirements for prompt notification of such parents or others when an incident occurs which affects the health or safety of the individual receiving services.

The Commission, as required by the new law, prepared and disseminated an educational pamphlet which describes how individuals receiving services, their parents and others can access records relating to care and treatment. This pamphlet is available on the Commission's website, in two formats and English and Spanish, at <http://www.cqcapd.state.ny.us/Brochures/Access-to-MH-Records.htm>. By encouraging more timely and effective communication, among people receiving mental hygiene services and members of their family and service providers, implementation of Jonathan's Law should lead to improvements in the services provided, increase accountability on the part of service providers, and result in an enhanced quality of life for individuals served through New York's mental hygiene service system.

Protection and Advocacy

Background

With the amendments to the Developmental Disabilities Assistance and Bill of Rights Act of 1975, Congress created for the first time a Protection and Advocacy program that was designed to provide legal and non-legal assistance to persons with developmental disabilities in order to protect and promote their legal rights. Under this law, each state was required to establish such a system, with the Governor to designate an entity that was independent of the service delivery system to administer this newly-authorized program.

The Governor has designated the Commission to administer all of the federally mandated Protection and Advocacy (P&A) programs. In 2006 – 2007 the Commission contracted with over 30 not-for-profit agencies in various regions of the State to carry out administrative and legal advocacy for individuals with disabilities. The P&A's regional model promotes timely, efficient and locally-responsive services.

Each year, the Commission's contracted advocacy agencies serve nearly 100,000 individuals by providing information and referral services, training, direct representation in legal and administrative matters, and systemic advocacy through class action law suits and other means.

Case Example:

In early 2007, a landmark settlement was reached to improve the treatment and housing of prisoners with mental illness in New York State prisons. The lawsuit, which was brought by Disability Advocates Inc., a Commission P&A contractor, alleged that prisoners throughout the New York State prison system did not get the mental health treatment they needed. The plaintiffs alleged that many prisoners in need of treatment were instead punished with lengthy stays in isolated confinement in Single Housing Units (SHU) or keeplock, where their serious mental illnesses were exacerbated.

The settlement requires that prisoners with serious mental illness confined in the SHU's will receive a minimum of 2 hours per day of out-of-cell treatment and that prisoners in Residential Mental Health Units (RMHU) receive as many as 4 hours, in addition to an hour of recreation. In addition, this settlement also provides for multiple reviews of disciplinary sentences for prisoners with mental illness for the purpose of removing prisoners with serious mental illness from isolated confinement.

Under federal and state statutes, the Commission administers the following advocacy programs:

- **Protection and Advocacy for Persons with Developmental Disabilities (PADD)** and the **Protection and Advocacy for Individuals with Mental Illness (PAIMI)** which, as their names imply, respectively serve people with developmental disabilities and mental illness;

- **Client Assistance Program (CAP)**, which assists individuals with a wide variety of disabilities secure training and services leading to employment and independent living;
- **Protection and Advocacy for Individual Rights (PAIR)**, which serves people with disabilities not covered by the federally authorized PADD, PAIMI or CAP programs;
- **Protection and Advocacy for Assistive Technology (PAAT)**, which aids individuals with disabilities who require assistive devices (e.g., wheelchairs, special communication equipment, etc.) in their every day lives;
- **Protection and Advocacy for Beneficiaries of Social Security (PABSS)**, which provides advocacy services to assist recipients of Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) obtain, maintain or regain employment;
- **Protection and Advocacy for Persons with Traumatic Brain Injury (PATBI)** which provides legal and other advocacy services for individuals with traumatic brain injury;
- **Protection and Advocacy for Voting Access (PAVA)**, which seeks to ensure the full participation of individuals with disabilities in the electoral process; and
- **Adult Home Advocacy**, established by New York State law in 1995, which provides advocacy services on behalf of people with mental disabilities residing in adult homes.

For more information on the Commission's Protection and Advocacy programs, please visit us on line at www.cqcapd.state.ny.us or call 1-800-624-4143

Surrogate Decision-Making Committee Program

Background

Persons with mental disabilities who reside in facilities or programs licensed, operated, or funded by OMH and OMRDD sometimes require major medical and dental treatment. In some instances, they lack the capacity to provide an informed consent for the proposed major medical treatment.

Additionally, in many cases, they don't have a family member or guardian who is legally authorized and willing to make this important decision on their behalf.

When a true medical emergency exists, New York State law allows these individuals to receive emergency treatment without consent. If the proposed major medical procedure is not of an emergency nature, and there is no one authorized and willing to provide informed consent or refusal of treatment on behalf of the patient, one option is obtaining a court order for treatment. That process is sometimes expensive, impersonal and time consuming, and often results in a delay in obtaining needed medical services for the patient.

Surrogate Decision-Making Committees (SDMC) use panels of volunteers that provide an alternative approach to the court system for obtaining an informed decision about major medical treatment and are intended to provide a quicker, more easily accessible, cost-free and personalized decision on behalf of mentally disabled individuals:

- Average time from receipt of the case in SDMC to hearing and decision – 14 days
- Expedited hearings also available
- Second opinions are not required
- Patient attends the hearing
- No fees to either the patient or their provider agency

SDMC Case Example:

Twin girls, age 20, who are both severely physically disabled and are diagnosed as having a developmental disability, lived at home with their mother, and the only services they were receiving were in-home health care. One of the girls was in need of spinal surgery, and the procedure had already been scheduled, but the mother explained to the Commission that she feared it would be postponed since she lacked legal guardianship to consent to the procedure. After making some inquiries about her daughter's need for service with the local school system, the Commission contacted the Central NY DDSO and successfully arranged for a local agency to begin providing case coordination services to the family. With this service in place, the Commission's SDMC program now had jurisdiction over the case and was able to arrange an expedited hearing for the family at which consent for the spinal cord surgery was granted without having to delay the scheduled procedure. According to the mother, her daughter is doing well and no longer in discomfort or having difficulty in breathing.

Several changes in the SDMC program took effect in 2006 – 2007. The program's jurisdiction was expanded to include persons who had a previous SDMC determination regardless of residential setting (Chapter 715 of the Laws of 2005 effective 2006), and to persons receiving service coordination or case management through a program approved by OMRDD (Chapter 312 of the Laws of 2007). These changes allowed the SDMC program to broaden the scope of its outreach, and the case example found on the previous page demonstrates how the Chapter 312 change directly relates to individuals and their families.

In 2006 and 2007, the SDMC program utilized 1,600 volunteers to assist over 2,000 individuals in need of medical procedures. To find out more information on the SDMC Program or inquire about becoming an SDMC volunteer please visit <http://www.cqcapd.state.ny.us/sdmcforms/sdmc.htm> or call 1-(800)-624-4143.

Adult Homes

Background

NYS Mental Hygiene Law requires the Commission to oversee the quality of care provided to residents of adult homes which serve people who are receiving or have received services from a provider of mental hygiene services.

During the report period, the Commission conducted 35 comprehensive reviews of adult homes serving over 2,600 people, most of whom have mental disabilities. Each review was conducted by a team, which made an unannounced visit. During the two-day reviews, through observations, record reviews, and staff and resident interviews, teams assessed:

- basic living conditions, including housekeeping, furnishings and maintenance;
- fire/safety and food service/nutritional issues;
- personal care and medication management;
- resident activities; and
- protection of resident rights.

Reports of findings, with recommendations or requests for plans of corrective action, were issued to the adult homes visited. Copies of the reports were also provided to OMH, the State Office for the Aging (SOFA), and DOH, which ensured that facilities responded to the Commission's findings.

An additional 33 visits were made to homes to follow up on deaths, complaints, or problematic conditions found earlier. In 2006 – 2007, 12 “impacted”² and 25 non-impacted adult homes were closed.

Adult Home Closure Study (November 2006)

In 2005, the Commission undertook this descriptive study of adult home closures, looking at 80 residents from 17 impacted homes that closed between 2002 and 2004. The Commission's purpose in conducting this study was to assess each individual's circumstances regarding their housing after the home they live in was closed. The study looked at whether closure policies and related protocols promoted each individual's involvement; choice and satisfaction with housing received; whether current living arrangements and support services addressed each person's need and preferences; and whether there was a plan in place to refer the person to alternate housing if the individual was dissatisfied with the alternate housing secured.

The Commission's findings were generally positive. Most (85%) of the individuals interviewed were satisfied with the new home to which they moved, at least for the present time, and nearly half (46%) of the individual's moves were judged to have been undertaken in a way which “went well” for the resident.

² Adult homes serving significant numbers of individuals with mental disabilities (25 residents or 25%, whichever is less) are defined as “Impacted” under state law.

Nevertheless, based on an analysis of what factors contributed to a positive outcome for each individual in our sample, the Commission found that some individuals were concerned about:

- their lack of choice in selecting a new home;
- their inability to access community recreation, and serious job-related consequences caused by the move;
- some residential records were silent on the person's satisfaction with their new living arrangement and their desire to live elsewhere; and
- mental health clinical records sometimes failed to assess needs and address the individual's perspective on his/her move from the closed adult home as it may impact on mental health.

The full report, including recommendations and the DOH response, can be found on line at <http://www.cqcapd.state.ny.us/AdultHomes/ClosureStudyRpt.doc>

Health Care in Impacted Adult Homes: A Survey (May 2006)

The Commission undertook a study of the health care provided to a selected sample of residents in impacted adult homes. The intention of the study was to understand some of the health issues common among persons living in adult homes.

Findings included:

- In several disease categories, the incidence among adult home residents far exceeded the incidence in the general population. All persons in the sample carried multiple diagnoses. Twenty percent of the sample carried between two and four diagnoses, while the remainder carried more. Over one-third of the sample (36%) carried more than eight diagnoses.
- Of the 58 persons carrying a diagnosis of schizophrenia, two-thirds were receiving one of the newer anti-psychotic medications, either singly or in combination with an anti-depressant, anti-anxiety drug or other newer anti-psychotic medication. Over 80% were treated with multiple medications.
- At least 80% of the relevant persons in the Commission sample were receiving medical attention for chronic medical conditions under review. The care often included the attention of a specialist.

The full report, including recommendations and the DOH response, can be found on line at <http://www.cqcapd.state.ny.us/HealthCare.htm>

Advocacy and Outreach

Background

The Division of Advocacy and Outreach (A&O) was created to foster internal and external collaborative efforts around advocacy, training, and to provide technical assistance and outreach to individuals with disabilities, their families, advocacy organizations, community agencies, local governments and others on issues of concern to people with disabilities. Although this Division serves all individuals with disabilities, it is especially concerned with addressing advocacy needs of people with physical and sensory disabilities to help ensure that they are afforded the opportunity to exercise all of their rights and responsibilities.

In 2006 – 2007 the division provided 231 trainings to over 6,700 individuals on topics including the Americans with Disabilities Act, accessibility, special education advocacy, assistive technology, disability/diversity awareness/conflict resolution are offered in various school, community and workplace settings.

Other highlights included:

- 500 state and local election officials were trained on providing reasonable accommodations and election assistance for individuals with disabilities as part of the Commission's collaborative efforts to support the implementation of the Help America Vote Act (HAVA).
- 220 agency attorneys, human resource managers, ADA/504 coordinators and affirmative action officers of New York State agencies attended the Non-Discrimination in Employment and Government Services conference that was co-sponsored by the Commission with the Governor's Office of Employee Relations (GOER), the Division of Human Rights, and the Department of Civil Service.

Fiscal/Policy Studies and Reviews

Background

Fiscal Bureau: NYS Mental Hygiene Law charges the Commission with reviewing the cost-effectiveness of mental hygiene programs and procedures with particular attention to efficiency, effectiveness, and economy in the management, supervision and delivery of such programs.

Policy Bureau: NYS Mental Hygiene Law charges the Commission with reviewing the organization and operations of the department of mental hygiene and advising and assisting the Governor in developing policies, plans and programs for improving the administration of mental hygiene facilities and the delivery of services therein, and for ensuring that the quality of care provided to persons with mental disabilities in the State is of a uniformly high standard.

This section highlights Fiscal and Policy Bureaus studies and reviews released during 2006 – 2007. Following each heading is a description of the study or review, a summary of findings, and a reference to the complete study with recommendations and agency responses.

I. Assisted Living Programs (June 2007)

The Commission reviewed the programmatic and financial practices of Assisted Living Programs (ALP) operated in 13 adult homes which serve individuals who had received mental hygiene services in impacted homes.

The ALP was established by law in 1991 to provide a cost-effective alternative to nursing home placement. Beginning in 1994, DOH has been issuing new operating certificates for ALP beds in order to reach its need estimate of 4,200 beds. As of January 2006, operating certificates had been issued to 60 ALP facilities with a total capacity of 3,747 beds. In 2005, annual Medicaid charges for ALP statewide totaled \$63 million.

The Commission has jurisdiction over certain adult care facilities defined as impacted because they house a significant number of residents who receive or had received mental hygiene services (see footnote page 10). The Commission examined both the program and fiscal operations of ALP's operated at 13 such facilities, containing a total of 885 beds. The program study involved an in-depth look at 78 residents residing in these homes, while the fiscal review involved an examination of the revenues, expenses and staffing patterns.

A brief summary of the findings discussed in this report are bulleted below:

- At the 13 homes reviewed by the Commission, Medicaid payments for ALPs averaged \$60 per day per resident, while ALP spending was about one-half that amount. The disparity between the funding and program cost was greatest at homes in New York City, where providers received higher rates, despite spending less than the rest of the state. This finding raises concerns about the cost effectiveness of this program, as the additional services provided were not commensurate with the increased charges to Medicaid.

- The Commission believes that in some instances Medicaid payment levels were inflated due to unsupported level-of-need assessments that indicated residents needed substantial assistance with toileting.
- The Commission found substantive disparities between level-of-need ratings and plans of care and between plans of care and actual services provided.
- The Commission found that the annual financial reports filed with DOH by the homes did not contain adequate disclosures on related-party transactions, thus diminishing the usefulness of the report.

The full report, including recommendations and the Department of Health response, can be found on line at <http://www.cqcapd.state.ny.us/OnlineReports/ALPReport.htm>.

II. Residential Treatment Facilities (June 2007)

See the Children's Oversight and investigations section of this report for more details. <http://www.cqcapd.state.ny.us/OnlineReports/RTFReport.htm>.

III. Continuing Day Treatment (December 2006)

The New York State Office of Mental Health (OMH) oversees a network of programs and services which provide critical support for 600,000 New Yorkers who have a diagnosis of mental illness. The programs available through this network provide a safety net to protect vulnerable individuals and their families, and a framework to support those same individuals as they seek greater independence and dignity through rehabilitation and recovery.

One of the core community treatment programs in this system is the Continuing Day Treatment (CDT) program, which provides a comprehensive array of services for persons with a diagnosis of mental illness on a relatively long-term basis. By regulation, CDTs are designed to maintain or enhance a participant's current level of functioning and skills, ability to maintain community living, and develop self-awareness and self-esteem. CDTs provided services to more than 23,000 individuals in 2003 at a total cost of approximately \$175 million.

The Commission undertook a statewide review of CDT programs, following reviews that revealed instances of questionable services being provided and a lack of accountability for some services being billed to the Medicaid program.

A brief summary of some of the major findings discussed in this report are bulleted below:

- The Commission's review found wide variability in the quality of services provided, not only throughout the state but also within individual programs.
- Services ranged from those which were creative, individualized and beneficial to recipients to those which engaged recipients in meaningless activities providing little therapeutic value. Some programs even allowed recipients to wander halls or sleep throughout the day.
- There was poor quality of treatment planning evident in many of the programs visited. The quarterly revisions of these plans often demonstrated no meaningful consideration of treatment needs, but rather were rewordings of previous plans, with the same objectives or the same objective with changed attainment criteria. Commonly, treatment plans failed to address significant life events that consumers were wrestling with, such as the death of a loved one, divorce, or the loss or regaining of custody of a child.

- Programs often lacked appropriate documentation to support reimbursement for services provided.

The full report, including recommendations and the OMH response, can be found on line at <http://www.cqcapd.state.ny.us/OnlineReports/CDTReport.doc>.

IV. Adult Home Closure Study (November 2006)

See the Adult Home section of this report for more details.

<http://www.cqcapd.state.ny.us/AdultHomes/ClosureStudyRpt.doc>

V. Health Care in Impacted Adult Homes (May 2006)

See the Adult Home section of this report for more details.

<http://www.cqcapd.state.ny.us/HealthCare.htm>

VI. Facility-Specific Fiscal Reviews

The Fiscal Bureau, in addition to the reviews listed above, also conducted over 40 investigations of specific agencies over the past two years. For more information on any of these investigations, please contact the Commission.

Other Quality Assurance Reviews

A Review of the NYS Office of Alcoholism and Substance Abuse Services' Addiction Treatment Centers (March 2006)

At the request of the Commissioner of the Office of Alcoholism and Substance Abuse Services (OASAS), the Commission undertook a review of conditions and selected policies at the 13 state-operated Addiction Treatment Centers (ATCs). Specifically, the OASAS Commissioner was interested in an objective assessment of the consistency of services and conditions across the different centers.

This report presents the Commission's findings as gleaned through unannounced site visits, interviews with ATC patients and staff, record reviews, and comparisons of OASAS regulations and policies with those of the individual ATCs.

A brief summary of some of the major findings discussed in this report are bulleted below:

- Overall, the ATCs offered clean, well-maintained, and comfortable treatment environments. During unannounced site visits, Commission staff found programming occurring as scheduled.
- The patients interviewed spoke highly of their care at the ATCs. When asked what they found most helpful in their treatment, the top three categories of responses were: the staff, programming, and peer support. All the patients, save one, indicated that they felt safe in their ATCs.
- Most events that could adversely impact on patient health and safety were duly reported and managed as "incidents" consistent with OASAS policies.
- The policies of individual facilities on topics including admission and discharge practices, incident management, psychiatric and medical emergencies, and patient rights were generally consistent. The Commission was very impressed with the patient handbooks given to patients at each ATC at the time of their admission, orienting them to the facility, the treatment process, their rights and responsibilities, and the grievance processes, should they have any concerns.
- There were some areas which the Commission recommended OASAS could devote attention to ensure best practices and consistency in service across the ATC system;
 - Some ATCs were not accessible to individuals with physical disabilities.
 - Although the vast majority of ATC staff felt safe, a small number of staff indicated that they did not feel safe within the ATCs, some citing the increasing number of patients with mental illness and/or behavioral difficulties.
 - There also appeared to be variations among the facilities on how they managed discharges against clinical advice (ACA), with some treating the event as an incident and examining the reasons why patients left, and others not.
 - In each of the policy areas examined, better or best practices emerged at different ATCs which may be worthy of replication statewide.

The full report, including recommendations and the OASAS response, can be found on line at <http://www.cqcapd.state.ny.us/OnlineReports/ATCReport.htm>.

Assistive Technology

Background

The Assistive Technology (AT) Act of 1998 supports efforts in all 56 states and territories to improve the provision of assistive technology to individuals with disabilities of all ages through comprehensive statewide programs designed to increase the availability, access, acquisition, funding, and training for assistive technology devices and assistive technology services.

The Commission provides statewide coordination of the AT Act through the Technology Related Assistance for Individuals with Disabilities (TRAID) program. The program contracts with 12 Regional TRAIID Centers (RTEs) where staff provides information, training, device demonstration, device loan, technical assistance and advocacy on how to obtain and use assistive technology services and devices.

Example:

A mom and her young daughter, who has Spina Bifida, came to one of TRAIID's Regional Centers to borrow a Ready Racer. The Ready Racer is a mobility device that allows a child to sit long-legged and use her arms to roll big wheels to move around, and is often described as a "pre-wheelchair trainer for toddlers." The mom was not thinking at the time that her daughter could operate it independently, but as soon as she placed her on the Ready Racer, the child spontaneously grabbed the big wheels and propelled herself backwards. A giant grin appeared on her face and, within 20 minutes, she was propelling herself forward and backward at will. The mom reports that her daughter wants to do everything in the racer, and it has made it possible for the family to do outdoor activities they could not have done without it.

In May 2006, the TRAIID program held a Governor's Expo on Assistive Technology "Technology Opens Doors," at the Empire State Plaza. Sponsored by the Commission and other members of the NYS Interagency Partnership on Assistive Technology, the Expo was attended by nearly 900 people. Assistive devices and services including adaptive software for individuals who are blind or learning disabled, adaptive telephone equipment for persons who are deaf, accessible vehicles and recreation and mobility products were featured during the one-day event.

Additionally, the Commission sponsors the TRAIID-IN equipment exchange program, an electronic service designed for individuals seeking to sell, donate or obtain used assistive devices for persons with disabilities.

For more information on the TRAIID program, including the program's state plan and annual report, please visit <http://www.cqcapd.state.ny.us/AssistTechTRAID/Asst-Tech-TRAID.htm>.



MISSION

To improve the quality of life for persons with disabilities, to protect their rights, and to advocate for needed changes by:

- ❧ Promoting the development of laws, policies and practices that advance the inclusion of all persons with disabilities into the rich fabric of our society;
- ❧ Enhancing the availability and use of assistive technology for persons with disabilities;
- ❧ Ensuring and furthering programmatic and fiscal accountability within the State's mental hygiene system;
- ❧ Providing person-specific and systemic investigative, educational and advocacy services; and
- ❧ Offering impartial and informed training, technical assistance, advice and recommendations on disability issues to government officials, individuals with disabilities, their families and advocates, service providers, and the public-at-large.

VALUES

Charged with a variety of investigatory, advocacy and educational activities, our work is guided by principles which all Commission staff and volunteers embrace:

- ❧ Independence: We will faithfully carry out the agency's mission undeterred by external forces.
- ❧ Integrity: We will exercise diligence in our quest for accuracy, fairness and truth, inviting review and dialogue.
- ❧ Compassion: We will connect with the people we serve with empathy by listening and responding with caring and truthfulness.
- ❧ Empowerment: We will assist people to assume responsibility for and control over their lives.
- ❧ Respect: We will treat the people we serve and each other with respect.

