UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA, Plaintiff, v. STATE OF NEW YORK, Defendant.	)	Civ. Action No. 13-CIV-4165 (NGG)
RAYMOND O'TOOLE, ILONA SPIEGEL, and STEVEN FARRELL, individually and on behalf of all others similarly situated, Plaintiffs, v. ANDREW M. CUOMO, in his official capacity as Governor of the State of New York, NIRAV R. SHAH, in his official capacity as Commissioner of the New York State Department of Health, KRISTIN M. WOODLOCK, in her official capacity as Acting Commissioner of the New York State Office of Mental Health, THE NEW YORK STATE DEPARTMENT OF HEALTH, and THE NEW YORK STATE OFFICE OF MENTAL HEALTH, Defendants.	)	Civ. Action No. 13-CIV-4166 (NGG)

REVIEW OF DEFENDANTS' IMPLEMENTATION OF THE INCIDENT REPORTING AND REVIEW SYSTEM AS REQUIRED BY THE SUPPLEMENT TO THE SECOND AMENDED STIPULATION AND ORDER OF SETTLEMENT

SUBMITTED BY

CLARENCE J. SUNDRAM
INDEPENDENT REVIEWER*

* The members of the Independent Review team, Mindy Becker, Thomas Harmon, and Stephen Hirschhorn contributed substantially in the research and preparation of this report.

Introduction

At the request of the Court at the December 2018 status conference, the Independent Reviewer initiated a review of the State's implementation of a post-transition incident reporting and review system which was required by Section D.6 of the March, 2018 Supplement to the Second Amended Stipulation and Order of Settlement (Doc. 196-1, Case 1:13-cv-04166 -NGG, filed March 12, 2018, "Supplemental Agreement").

Specifically, the Supplemental Agreement required that, within 60 days of its effective date, the State was to evaluate the incident reporting policies and procedures of Health Homes, MLTCPs and Housing Contractors; and ensure that within 90 days of the effective date these entities promptly report to the State any incident or condition which jeopardizes the ability of a transitioned individual enrolled in Adult Home Plus care management to remain stable in supported housing, endangers his or her health and safety or results in the individual's death. It specified instances which should trigger reporting to the State, which follow:

- Unsafe or unsanitary living conditions that jeopardize the ability of an individual to remain stably housed in Supported Housing, endanger his or her health and safety, or result in death;
- Death while living in Supported Housing;
- Circumstances that jeopardize a transitioned individual's ability to remain in Supported Housing by placing him or her at risk of eviction;
- Insufficient basic life necessities, including food or medications, which jeopardize the ability to remain stably housed in Supported Housing, endanger health and safety or result in death;
- Repeated crisis episodes, including two or more Emergency Room visits or psychiatric hospitalizations within a 12-month period; or
- An individual's request to move back to an adult home or from Supported Housing to community housing other than Supported Housing.

The Supplemental Agreement required that the State investigate, analyze and make reasonable attempts to correct and prevent a recurrence of situations reported. It also required the State to notify the Plaintiffs and Independent Reviewer of the reports it receives, including the name of the reporting entity, the type of incident, the outcome for the individual, any technical assistance or guidance offered to the Health Home, MLTCP or housing contractor and any remedial measures taken by the State and its contractors. The State instituted an Incident Tracker as a tool to track and share this information about reported incidents with the Plaintiffs and the Independent Reviewer.

In conducting this review, the Independent Reviewer and staff:

- Met with State representatives from the Department of Health (DOH) and Office of Mental Health (OMH) in late December 2018 to discuss their efforts to institute an incident reporting and review system;
- Reviewed State policy directives and memoranda to service providers on incident reporting and review requirements; and
- Reviewed the State's investigation/review files on all 27 incidents which were reported during Quarters 17 and 18 (7/1/18-12/31/18).[1] Among other items, these files contained incident reports filed by service/support agencies; various documents secured by the State during its review (e.g., providers' assessment reports, care plans, progress notes, etc.); and the State's Incident Review Summary (IRS) which described its actions, root cause analysis and remedial/corrective measures.

In reviewing the 27 closed case files, the Independent Reviewer's team focused on reporting compliance issues (e.g. did all required agencies report incidents, timeliness of reporting, etc.) and the thoroughness of the State's review efforts, in terms of securing needed records, conducting interviews, etc., to enable it to identify root causes and needed and appropriate remedial/corrective action to reduce the likelihood of similar incidents recurring.

The Independent Reviewer's summary and commentary on each case is presented in Appendix A. This report references them by their case number in Appendix A.

Findings

1. Infrastructure of the Incident Reporting System

Prior to the Supplemental Agreement, there were no incident reporting requirements for Housing Contractors; and while there were some incident reporting requirements for Health Homes and MLTCPs, they did not require the reporting of the events defined by the Supplemental Agreement, and they also varied: Health Homes were to report incidents to the State within two business days whereas MLTCPs would do so on a quarterly basis.

By early June 2018, DOH and OMH had issued directives to Housing Contractors, Health Homes and MLTCPs requiring the reporting of incidents defined in the Supplemental Agreement involving transitioned individuals receiving Adult Home Plus care management. The directives prescribed the forms to be used in reporting. In addition to providing information on the type of incident and dates of its occurrence and/or discovery, the forms required the reporter to describe the event and actions taken to address it. Pursuant to the directives, incident reports are to be

[1] The Independent Reviewer requested "closed" investigation/review files on the 27 incidents reported during the two quarters. The files were provided in two batches. The first, received on 1/9/19, contained six cases which had been closed as of that date. Although the Independent Reviewer requested files as case reviews were closed by the State, the second batch, received on 4/23/19, contained files on the remaining 21 closed cases. The Independent Reviewer issued a preliminary report to the Parties on the first six closed cases on 4/24/19. This report is based on a review of all 27 cases.

submitted to the State at the time of its occurrence/discovery (MLTCPs) or within 48 hours (Housing Contractors) or two business days (Health Homes).

The State also established an Incident Review Committee consisting of representatives from DOH and OMH which meets twice weekly to review newly reported incidents and previously reported or pending cases.

According to information provided to the Independent Reviewer, upon receipt each incident is assigned a lead reviewer who follows up on the incidents (requesting additional information, records, etc.) and reports to the committee. The lead reviewer also generates and maintains an Incident Report Summary which, upon completion of a case, provides:

- a summary of the incident;
- a list of the documentation gathered and reviewed;
- the findings developed from the documentation and discussions with relevant entities;
- an analysis which identifies the factors contributing to the incident and determines whether the matter is a one-time issue or indicative of broader systemic issues;
- the outcome for the class member; any technical assistance or guidance offered; and
- any remedial measures taken.

The committee reviews the lead reviewer's work and considers whether relevant findings and outcomes are sufficiently comprehensive, whether the analysis sufficiently identifies the underlying causes of the incident and whether appropriate technical assistance and remedial measures, if any, have been identified and implemented. As part of this review the committee considers the need for corrective action on a systemic basis and guidance needed for all providers or a subset of providers.

2. The Reported Incidents

As of December 31, 2018, 27 incidents had been reported to the State. The Supplemental Agreement specifies six conditions or events that should trigger an incident report (described above). However, an incident report may cite more than one of these conditions or events. In the 27 incidents reports, 34 conditions or events were cited.

Table 1 presents the conditions or events which triggered each of the 27 incidents. Table 2 presents the frequency with which the 34 conditions or events triggering the 27 reports were cited. Repeated crisis episodes and requests to return to an adult home, or from Supported Housing to other housing, were the most frequently cited.

Table 1. Incidents by Condition or Event Triggering the Report
N=27

Condition/Event	Number of Incidents
Unsafe/Unsanitary Conditions	2
Death	3
Risk of Eviction	1
Insufficient Life Necessities	2
Repeated Crisis Episodes	8
Request to Move	5
Request to Move AND Repeated Crisis Episodes	4
Repeated Crisis Episodes AND Insufficient Life Necessities AND Unsafe/Unsanitary Conditions	1
Insufficient Life Necessities AND Unsafe/Unsanitary Conditions	1

Table 2. Frequency of Conditions or Events Triggering Incident Reports
N=34

Condition/Event Cited as Triggering Incident Report	# of Times Cited	% of All Cited Reasons
Repeated Crisis Episodes	13	38.2%
Request to Move	9	26.5%
Insufficient Life Necessities	4	11.8%
Unsafe/Unsanitary Conditions	4	11.8%
Death	3	8.8%
Risk of Eviction	1	2.9%

3. Compliance with Reporting Requirements

The Supplemental Agreement and policy directives issued by the State require that Health Homes, Housing Contractors and MLTCPs report incidents. The reporting patterns behind the 27 reported incidents raise concern about compliance with this requirement.

All the class members involved in the 27 incidents were enrolled in Health Homes. Incident reports submitted by Health Homes are generated by their Care Management Agency (CMA) which serves the individual. In 26 of the 27 cases, the class member's Health Home reported the incident. In the 27th case, the class member was receiving care management services from an

Assertive Community Treatment (ACT) team and not the Health Home's CMA. The incident reporting requirements of the Supplemental Agreement specifically address Health Homes, Managed Long Term Care Plans and Housing Contractors but do not cover other providers who may be engaged in supporting class members in the community, such as ACT teams and it is unclear whether the State has required these other providers to also report incidents. (Supplemental Agreement, para. D. 6)

Of more concern is the inconsistency of Housing Contractors in reporting incidents. The class members involved in the incidents were supported by seven Housing Contractors. While all seven Housing Contractors filed at least one incident report, six of the seven did not report other incidents. In total 16 of the 27 incidents (59.25%) were not reported by Housing Contractors; the State was made aware of these incidents by Health Homes or MLTCPs.

Four MLTCPs were serving class members involved in 13 incidents. However, only two reported five incidents: Elder Serve/River Spring reported four and Centers Plan reported one. In the remaining cases, involving class members served by Archcare and Senior Whole Health MLTCPs, the State became aware of the incident via reports filed by Health Homes. An individual involved in two incidents was being served by a Managed Care Plan, Health First, according to the Health Home report. It does not appear that Managed Care Plans are required to report incidents under the Supplemental Agreement.

4. Timeliness of reporting

For the most part, agencies reported the incidents within the 48 hour/two-business-day time frame. However, in eight cases (29.6%) there were reporting delays of between two weeks to three months. (Appendix: Cases 1, 2, 5, 6, 12 19, 20, 23.)

The 27 incidents involved 23 class members; four individuals were involved in two incidents. The timeframe from date of transition to the date of the first reported incident ranged from 12 days to 1,161days or slightly more than three years. The median length of time was 206 days or nearly seven months. This is noteworthy in that the protections of the incident reporting system are extended only to individuals receiving Adult Home Plus care management (AH+CM). Enrollment in this program is time-limited for the first six months after transition, with periodic reviews thereafter to determine whether they continue to require this level of care coordination. As of December 2018, only 179 of the 774 class members who had transitioned, or less than a quarter, were enrolled in the time-limited AH+CM program. As indicated by the 27 reported cases, serious events and conditions are encountered by individuals long after the first six months since they had transitioned. And as noted above, even for those class members covered by the incident reporting requirements, not all of the providers who support them are required to report serious incidents which occur.

By April 19, 2018, the State had completed its reviews of the 27 incidents. The timeframe for case closure ranged from 3 to 284 days; the median time was 161 days or almost five and-a-

half months. In response to a discussion of incident reporting at the Status Conference on February 6, 2019 and the issuance of the Independent Reviewer's Preliminary Review of Six Incidents Involving Class Members Reported to and Reviewed by the State, issued on April 24, 2019, the State indicated its agreement with the necessity for a deadline of approximately 60 days for the completion of its review in most cases .

5. Adequacy of the State Reviews

Based on the State's investigation files provided to the Independent Reviewer it appears that the State's incident investigation and analysis process is largely a record review.

There was no documentation in the case files of interviews being conducted by the State with support providers or class members, even when such could have clarified issues in the reported incident. Examples include:

- In Case 7, which involved a report of insufficient basic life necessities, the records or reports of the Housing Contractor and AH+CM differ about conditions in the class member's apartment. Staff from neither agency were interviewed, nor was the class member who experienced the conditions firsthand.

- In Case 10, involving a class member who wanted to return to an adult home, the records reflect that there were conversations among support staff and the class member about his desire to return. However, the records do not address the content of the conversations and whether additional services to better support the individual, as an alternative to returning to the adult home, were discussed. Perhaps they were, but there is no evidence of the content of these discussions. Interviews with the support staff could have clarified this.

Although largely a record review process, in many cases it did not appear that the State had secured and reviewed all the relevant records. In the vast majority of cases, the State did not review Housing Contractor service plans and progress notes. Housing Contractor records were secured in only Cases 7, 11, 12, 19 and 27. In other cases, MLTCP records were not reviewed. And in some cases where Health Home/AH+CM records were secured and reviewed, they did not cover periods of time relevant to the incident.

Absent such records (and interviews) it was difficult for the Independent Reviewer to determine if the State had identified the root causes of an event and whether the remedial or corrective actions were sufficient to prevent recurrence. Examples include:

- In Case 1, where the absence of heat may have been a factor in the class member's hospitalization, Housing Contractor records were not reviewed, and the cause and duration of the heating problem were not probed. Also, according to the State's Incident Review Summary, remedial actions were taken as documented by the AH+CM;

however, there were no notes by the AH+CM to this effect in the file provided to the Independent Reviewer.

- In Case 2, wherein the class member's skills were steadily declining and she wanted to return to an adult home, neither the Health Home's care plan nor the Housing Contractor's service plan and progress notes were secured and reviewed. It did not appear that the State probed why she wanted to move and what the support agencies did to address the many challenges she faced and whether care/service plans were revised appropriately to address the challenges.

- In Case 6, which pertained to unsafe and unsanitary living conditions in the class member's apartment, the State did not secure/review the Housing Contractor's service plans and progress notes or plans and notes from the MLTCP which provided aide services, which had been discontinued.

- In Case 9, roommate issues were cited as a factor in the class member's 6/18/18 hospitalization, his second in less than a month. Although he moved into the apartment in March of that year, the AH+CM notes date back to only 6/5/18, two weeks before his hospitalization, and no Housing Contractor service plans or progress notes were secured/reviewed.

- Case 19 involved a class member with repeated crisis episodes who also requested to return to an adult home after more than two years of ~~l~~iving in the community. In its review, the State included Housing Contractor records, but not the records from his MLTCP which provided daily aide services, or his ACT team which provided care management and behavioral health clinical services. Reportedly, it was the ACT team which facilitated his readmission to an adult home. Absent these records, it is difficult to determine the adequacy of his supports in the community, changes (if any) in care plans to better support him in the community and what alternatives to placement in an adult home were considered and offered.

- In Case 21 a class member was threatened with eviction by the landlord over conditions in the apartment and his conduct. However, many months before, shortly after he first transitioned, the class member himself had complained about apartment conditions and the neighborhood and wanted to move to a different apartment. Although these matters were squarely within the purview of the Housing Contractor, the Housing Contractor's records were not secured as part of the State's review.

Given the lack of interviews and the inadequacy of reviews included in the State's review, in many cases it was difficult for the Independent Reviewer to assess whether the State had identified the underlying causes for events and whether actions to address these were sufficient to

prevent recurrence. However, based on the documents provided, in most cases it appeared that front-line staff took prompt and appropriate protective and supportive actions when events arose: rearranging aide coverage/schedules to better suit client's schedules; providing class members with funds, access to food and other necessities while they awaited benefits; accompanying class members to clinical appointments to ensure compliance; providing respite living arrangements when needed; etc.

In some cases, the State's Incident Review Summary reported that it offered guidance to staff of reporting agencies. For example, in Case 9 the State reinforced the importance of meeting roommates with the AH+CM; and in Case 16 it instructed the Health Home and Care Management Agency to report to DOH when benefits are not received immediately after transition.

The State's investigation/review files, however, contained no record indicating how, with whom and when such guidance was shared. Memorializing such discussions in the case record is sound investigative practice.

Furthermore, when it appears that there is a need for such guidance, consideration should be given as to whether it should be issued to an audience broader than the agency/staff involved in the particular incident who may face similar incidents down the road.

Recommendations

1. We recommend strongly, as we have previously, that the requirements for Incident Reporting be extended to include all class members living in supported housing, and not be limited to those receiving AH+ CM services. As this review reinforces, class members experience serious incidents in the community. Most of them are not covered by the incident reporting requirements as they do not receive AH+CM, or their enrollment may have been terminated while their exposure to risk continues. Moreover, some class members are served by providers who are not specifically covered by the Supplemental Agreement's incident reporting requirements. It seems incongruous that two class members could be sharing the same apartment and have different levels of protection based on factors that are not related to the potential risks they face. The requirements for reporting and investigating incidents should be comprehensive and cover all class members and all providers who support them. A single, consistent reporting and investigation obligation is also much easier to communicate to the diverse groups of providers and staff who support class members than the current scheme which requires parsing who reports what to whom and when.

2. We recommend that the State establish an expectation that incident investigations be completed within 60 days from when the incident is first reported, with the ability to extend

the deadline 30 days when exceptional circumstances reflect the need to do so. Only in the most unusual of cases should an investigation extend beyond 90 days.

3. In view of the many cases that lacked/failed to include a review of the Housing Contractor's Support Plans and Progress Notes, even when the need to do so was clear and apparent, there needs to be greater coordination in the review of these cases between DOH and OMH. While it is unclear who sits on the current IRC, the composition should include representatives of both DOH and OMH, with links to oversight of the Health Homes, Case Management Agencies, MLTCPs, ACT teams and Pace Programs.

4. We further recommend that when the Incident Review Committee (IRC) meets twice weekly to discuss the status of the open investigations, that the discussion addresses the need to review specific documents and case records from ALL the providers of service in the case under review, including the support plans/care plans and progress notes of HH/CMA, Housing Contractors, MLTCPs and PACE or ACT Teams, where applicable. This review should also consider the need for interviews if needed to clarify essential facts.

5. When guidance is provided at the conclusion of an investigation, the Incident Review Summary should reflect the content of the guidance and how, with whom and when such guidance was shared. In addition, consideration should be given as to whether the guidance should be issued to an audience broader than the agency/staff involved in the particular incident who may face similar incidents down the road.