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)

A Review of Preadmission Screening for Serious Mental Illness at Transitional Adult Homes

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I . Introduction

A. Background

The fundamental goal of the litigation in this case was to end discrimination on the basis of disability against persons with serious mental illness (SMI) residing in 22 adult homes in New York City. To this end, the Settlement Agreement offered a class of approximately 4,000 persons with SMI residing in these adult homes the opportunity to move to Supported Housing with necessary support services or to other appropriate community-based alternatives.[1]

Moreover, the Settlement Agreement also sought to bar new admissions of persons with SMI to the impacted adult homes by incorporating references to regulations of the New York State Department of Health (DOH) and the Office of Mental Health (OMH) which were designed to limit discharges of persons with SMI from psychiatric hospitals into adult homes covered by the agreement, and to limit admissions of such persons into these homes. (Settlement Agreement, ECF. No. 23, p. 2) However, the regulations effectuating this intent were the subject of a prolonged Temporary Restraining Order (TRO) entered on February 16, 2017, with the consent of the State, during which new admissions of persons with SMI to these homes continued.[2]

The TRO was lifted almost two years later in January 2019 and the regulations barring new admissions to these adult homes were once again in place.[3] (18 NYCRR Secs. 487.4(d) and 487.13 (c) and (g)) In the interim, the parties entered into a Supplemental Agreement[4] which capped the class as of September 30, 2018. Persons with SMI admitted to transitional adult homes (TAH) after that date will no longer be eligible for the benefits provided by the Settlement Agreement. This makes it all the more important to ensure that such persons are not admitted to these adult homes in the first place. However, and to its credit, the State voluntarily pledged to extend the benefits of the Settlement Agreement to all persons with SMI in the TAHs and to treat them as class members and has been doing so.

Significantly, persons with SMI continued to be admitted to the TAHs even after the TRO had been lifted and the State regulations went back into effect. There were two conditions that led to this result. First, at the time, adult homes reported to the DOH on admissions on a monthly basis, with the State receiving this information several days to weeks after the end of each month. The State then reviewed the information submitted by the adult home regarding the diagnosis of each new person admitted. In addition, the State also reviewed Medicaid claims data to determine whether the newly admitted persons had a history of receiving mental health services for any one

[1] Stipulation and Order of Settlement, Doc. # 5, filed July 23, 2013 in 1:13-cv-04166-NGG-MDG.

[2] *Doe. v. Zucker*, Index. No. 07079/2016, Supreme Court, County of Albany.

[3] *Doe v. Zucker*, Doc. # 81 filed January 4, 2019 in Case 1:17-cv-01005-GTS-CFH (N.D.N.Y.).

[4] Supplement to the Second Amended Stipulation and Order of Settlement ("Supplemental Agreement"), Doc. 196-1, filed March 12, 2018 in 1:13-cv-04166-NG-ST.

of 234 diagnoses taken from the Diagnostic and Statistical Manual of Mental Disorders. The end result was a determination whether to add the person to the class list. This retrospective review resulted in many persons who meet this screen for SMI being admitted to the adult homes despite the regulations but the regulatory violation not being recognized until well after the admission had taken place. While the State DOH could and did invoke its enforcement process to deal with regulatory violations,[5] this process was unsuited to a quick and effective achievement of the desired result of preventing improper admissions in the first place.

The second aspect of this problem was that the screening criteria for the presence of SMI being utilized in this process were believed to be too broad, as an individual would be flagged if they had received a service for anyone of 234 diagnoses regardless of the nature and frequency of service.

Consequently, on October 4, 2019, the State DOH promulgated new regulations creating a preadmission screening process with a tighter definition of SMI. The new process prohibits Transitional Adult Home (TAH) operators from admitting a prospective resident without first requesting preadmission screening from the DOH and, in appropriate cases, conducting or obtaining a mental health evaluation. Under the new process, prior to admitting an individual, TAHs were required to request a preadmission screening by DOH to determine if the individual may be a person with SMI. For prospective admissions enrolled in the Medicaid program, the TAH was expected to provide certain identifying information. For prospective admissions not enrolled in the Medicaid program, the TAH was required to indicate whether a preadmission interview and/or medical evaluation suggested the need for a mental health evaluation. DOH would conduct a preadmission screening by reviewing the prospective resident's Medicaid claims data against relevant Health and Recovery Plan (HARP) eligibility criteria as a flag for possible SMI.

HARP is a managed care product that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health needs. OMH recognizes HARP criteria as a method of identifying individuals with the most serious needs.

Under the new process and modified HARP criteria,[6] the following individuals would be flagged as possibly SMI:

- Anyone with a court order for behavioral health treatment within the past five years;

[5] According to a monthly report on admissions filed by the State for November 2019, 188 admissions were referred for enforcement action. Of these cases, 174 had occurred in the period between January 26 and June 30, 2019, 10 occurred in July and August 2019, three in September and one in October 2019. (Case 1:13-CV-04166-NGG-ST, document 246, filed November 29, 2019) No additional referrals were reported in monthly reports for November and December 2019.

[6] The HARP criteria were modified for screening purposes to eliminate services for substance abuse. The HARP criteria are also not completely consistent with the definition of "serious mental illness' in the Settlement Agreement. For a comparison of the provisions, see the Table in Appendix A.

- Anyone discharged from a correctional facility with a history of behavioral health treatment in the past four years;
- Supplemental Security Income (SSI) individuals with SMI who have received a State licensed or funded mental health service within the past year;
- Anyone with a SMI diagnosis and one of the following:
  - OMH funded housing for persons with mental illness within the past three years;
  - Thirty or more days of inpatient psychiatric services within the past three years;
  - Three or more psychiatric admissions within the past three years;
  - Discharge from an OMH psychiatric facility after an inpatient stay greater than 60 days within the past year; and
  - Three or more of the following services within the past year:
    - Assertive Community Treatment;
    - Personal Recovery Oriented Services; and
    - Prepaid Mental Health Plans.

The new process requires that results of the State's preadmission screening be communicated to the TAH within three business days.

- If the preadmission screening does not indicate the person has SMI, DOH would inform the TAH that the individual may be admitted within 30 days, providing all other admission criteria are met. If the TAH does not admit the individual within 30 days but later wishes to admit him or her, the facility must recommence the process.

- If the preadmission screening indicates the prospective resident may have SMI, the TAH may not admit the individual without conducting or obtaining a mental health evaluation (MHE). The facility may admit the individual only when the MHE concludes he or she is not a person with SMI; or is a person with SMI but is a former resident of a TAH and the facility operator secures a waiver from DOH.

In the case of prospective residents not enrolled in the Medicaid program, and for whom Medicaid claims could not be reviewed, under the revised regulations it was expected that the TAH would inform DOH whether an interview or medical examination indicated the need for a MHE. In these cases, the facility could admit the individual only when the MHE concluded the person is not SMI or does have SMI but is a former TAH resident and a waiver is secured from DOH.

The revised regulations required that the MHE be recorded on a form prescribed by DOH and developed in consultation with OMH. However, the regulations do not require that either DOH or OMH review the completed evaluations and in practice neither does so. DOH learns of new admissions through monthly census reports filed by the adult homes.

Since the implementation of these changes, data provided by the State indicate a significant decline in the numbers of individuals with SMI admitted to TAHs covered by the Settlement

Agreement. In the four quarters preceding the revised regulations (October 2018 through September 2019), of the 694 admissions to the TAHs, 417, or 60%, were deemed as SMI. In the four quarters following the new preadmission screening process, of the 557 admissions to the TAHs, 67, or 12%, were deemed as SMI.

As of September 30, 2020, the State had received 2,051 requests for a preadmission screening since the onset of the program. Most, 1,891 (92%), had sufficient Medicaid data to do a HARP run. In 1,230 (65%) of these cases, the HARP run yielded no flags of SMI, and facilities were free to admit the individual. In the remaining 661, HARP data raised SMI flags and the facilities were requested to conduct an evaluation. Outcomes of evaluations in these cases are largely unknown unless the individual is admitted.

The State's monthly reports to the Court on SMI admissions, however, offer some insight. Between January and September 2020 there were 38 admissions to TAHs which were designated by the State as SMI solely because they were "returning class members," not because of HARP flags or facility MHEs. In 18 cases, there were no HARP flags. In 20 cases, there were HARP flags, triggering the need for MHEs which in six cases found the person had SMI and in the remaining cases determined no evidence of SMI. Regardless of the HARP/evaluation findings, the State classified all 38 individuals as SMI as they were class members who had previously lived in an adult home covered by the Settlement and were returning from a discharge to another setting, such as Supported Housing, a private residence or a nursing home.

B. Independent Reviewer's Review

In the fall of 2020, the Independent Reviewer's office undertook a review to better understand and assess the new screening process. We met with DOH staff and also reviewed records of 21 of the 38 class members, who went through the process and were admitted to adult homes between February and August 2020. The records included the HARP runs generated when the individual was screened for admission; PSYCKES reports which were generated at our request;[7] and the MHEs conducted or obtained by the adult homes in those cases where one was required for admission.

The 21 individuals included 11 people for whom the HARP screen indicated no evidence of SMI, and the facility was permitted to admit them; and 10 people for whom the HARP screen indicated the possibility of SMI, the adult home needed to secure a MHE prior to admission and the evaluation conducted by the adult home concluded the individual was not SMI.

[7] PSYCKES (Psychiatric Services and Clinical Knowledge Enhancement System is a web based platform developed by OMH to support clinical decision-making and quality improvement. Among other things it can generate five-year clinical summaries on Medicaid recipients receiving behavioral health services.

In reviewing the sample of 11 cases of class members returning to adult homes who reportedly had no HARP flag indicating the need for a MHE, the Independent Reviewer's staff sought to determine whether the HARP data provided had any indicators of possible SMI and, if so, what types of indicators and in how many cases. We also looked at PSYCKES data to see if they provided any indicators of possible SMI not captured by the HARP runs. On this latter point, however, we were mindful that PSYCKES data throws a broad net of all behavioral health services over a five-year period whereas the net cast by HARP criteria and data is more focused, *e.g.*, three or more psychiatric hospitalizations or 30 days of psychiatric hospitalizations within the past three years, services by an OMH licensed funded provider within the past year, etc. We were also mindful that the time frame for the five-year PSYCKES reports, run at our request in December 2020, did not fit squarely into the HARP data runs conducted when the individuals were screened anywhere between February and August 2020.

The review of the 10 individuals for whom a MHE was required and concluded that the individual was not SMI focused on the evaluations and whether the conclusions were supported by the evidence in the HARP runs and PSYCKES.

II. Findings

A. Individuals with No HARP Flag

In six of the 11 sample cases, there were no indicators of possible SMI based on HARP data provided to Independent Reviewer staff. In five cases, however, the HARP data provided reflected the possibility of SMI.

- In the three cases of GT, IF and GM, HARP data indicated they had received OMH funded housing for persons with mental illness within the past three years (columns J and K of the HARP data spread sheet). However, these stays in OMH housing were not reflected in PSYCKES data. Other DOH and OMH data reports indicated that before seeking readmission to adult homes which prompted HARP data runs in 2020, these class members had been non-transitionally discharged from their adult homes to nursing homes: GT in 2016, IF in 2014 and GM in 2019. Other than the HARP data, there is no other indication that the individuals were served in OMH residential facilities in the past three years, which suggests that either the HARP data is incorrect or, if correct, the individuals should have been identified as possible SMI clients and thus a mental health evaluation should have been conducted prior to their readmission to an adult home.

- In the case of AS, HARP data indicated that she had received two mental health services with an OMH rate code in the one-year period before the HARP data was run on 3/5/20.

(See column L of the HARP data spreadsheet.) This should have triggered a HARP flag and an evaluation before her readmission.

- In the case of TC, column C of the HARP spreadsheet indicates that he was not flagged by the HARP screen. However, according to the HARP data spreadsheet (columns J and K), he had resided in mental health funded programs within the past three years; he also had numerous non-residential billings with an OMH rate code indicating an SMI diagnosis within the past three-four years. According to PSYCKES and other DOH/OMH data sources, he was transitioned from his adult home to Supported Housing in October 2017 but then discharged to a nursing home in June 2018. Although all these indicators of SMI were reflected in the HARP run, column C of the HARP spreadsheet indicates that he was **not flagged** by the HARP screen. It appears that he should have been flagged and his admission contingent upon a mental health evaluation.

In two of the cases reviewed, PSYCKES data evidenced behavioral health care that was not reflected in the HARP spreadsheet. Although a HARP flag is triggered by receipt of certain mental health services within a one-year period, the HARP spreadsheet also calls for enumerating the number of services received within three and four years of the run.

- In the case of GM, the HARP spread sheet reflected no OMH rate code billings within the first to fourth years preceding its June 2020 run. However, PSYCKES indicates billings for treatment of Major Depression in 2017. PSYCKES also indicates that he was treated for such following his readmission to the adult home in July 2020.

- In AS' case, HARP indicates no OMH billings beyond the one year preceding its run. However, PSYCKES indicates 20+ billings for treatment of schizophrenia and schizoaffective disorder within the three years before the HARP run.

Of note is the case of RS. He was admitted to Brooklyn Adult Care Center in June 2017 and later that year discharged to a nursing home. A HARP run done on 2/3/20 when he was seeking readmission, showed no indications of SMI. He was readmitted to Brooklyn Adult Care Center on 2/21/20. According to PSYCKES, the only behavioral health services he received in the past five years were two mental health emergency room visits on back-to-back days following his February 2020 readmission to the adult home. The diagnoses, though, were listed "Encounter For Other Specified Aftercare" and the only procedure listed was a chest X-ray. PSYCKES notes that the patient is on Medicare and that certain medications may not be shown. It identifies numerous billings for inpatient and outpatient medical treatments and nursing home care, but none for behavioral health services other than the two ER visits. Despite the absence of Medicaid billing information which would suggest SMI, following his readmission to Brooklyn Adult Care Center, RS was in-reached, assessed and approved by HRA in November 2020 to transition to Supported Housing.

This small sample of cases calls into question the accuracy/completeness of data contained in the State's HARP runs and the conclusions drawn thereon. The case of RS in particular illustrates the limitations of Medicaid data runs, not that they are not a good first step in screenings, and underscores the importance of personal mental health assessments.

B. Individuals with HARP Flags Requiring Assessment

1. Mental Health Evaluations, Regulatory Requirements and Forms

Concerning evaluations, adult home regulations require that each mental health evaluation shall be a written and signed report, from a psychiatrist, physician, registered nurse, certified psychologist or certified social worker who is approved by the Department in consultation with the Office of Mental Health, and who has experience in the assessment and treatment of mental illness. Such report shall be documented on a form prescribed by the Department and developed in consultation with the Office of Mental Health and shall include:

> 1) the date of examination;
>
> (2) significant mental health history and current conditions, including whether the resident or prospective resident is a person with serious mental illness as defined in the regulations;
>
> (3) a statement that the resident's or prospective resident's mental health needs can be adequately met in the facility and a statement that the resident does not evidence need for placement in a residential treatment facility licensed or operated pursuant to article 19, 23, 29 or 31 of the Mental Hygiene Law; and
>
> (4) a statement that the person signing the report has conducted a face-to-face examination of the resident or prospective resident within 30 days prior to the date of admission or, for required annual evaluations or evaluations conducted due a change in condition, within 30 days of the date of the report.

Although the key elements of a MHE had been in the regulations for some time, the requirement that they be documented on a form prescribed by DOH and developed in consultation was new and added in when the regulations were revised to create a new preadmission screening process.

DOH reports that, pursuant to the regulations, it developed a form in concert with OMH but, at the request of associations representing adult homes across the State, it has been considering changes to the form to make it more user friendly since August 2020 and has not yet put it into effect. (A copy of the five page evaluation form developed by DOH and OMH is appended for

reference.as Appendix B.) DOH indicated that in the meantime adult homes are expected to document the above key elements.

The 10 sample clients whose mental health evaluations were reviewed were evaluated by seven different adult homes. The forms used to document the evaluations varied. In fact, one adult home, New Haven Manor, used two different forms.

The forms used by three of the seven adult homes did not comply with standards for recording key regulatory elements for assessments. One of the forms used by New Haven Manor did not require that the person completing the evaluation provide his/her credentials and experience in assessing and treating individuals with mental illness. The forms used by Central Assisted Living and New Gloria's Manor did not require the assessor to state whether or not the individual had a serious mental illness and whether this results in a substantial functional disability (an element of SMI as defined elsewhere in the regulations (see Title 18 Part 487 2. (c)).

A secondary but related issue is how contracted clinicians chose to fill out evaluation forms. In some cases, despite prompts for recording key regulatory elements, clinicians answered certain prompts with minimal or tangential information, leading to a more ambiguous evaluation (the most salient example is how clinicians chose to respond to "significant mental health history and current conditions," as described further in section 2 below). This is indicative of the need for review or oversight of how these forms, including those in compliance with standards for recording key regulatory elements, are actually completed.

Evaluation forms used at certain adult homes included issues not directly addressed in the regulations, issues such as specific diagnoses, prescribed medications, frequency of mental health treatment, compliance with medications and treatment, etc. Table 1 below displays elements contained in the various evaluation forms used by the seven facilities which conducted/obtained mental health evaluations for the 10 sample clients.

Regulatory Elements	Central Assisted	Kings ACC	New Gloria	New Haven	New Haven	Sanford Home	Queens ACC	The W
Is to be written and signed by a psychiatrist, physician, registered nurse, certified psychologist or certified social worker approved by DOH/OMH; and	X	X	X		X	X	X	X
who has experience in the assessment and treatment of mental illness	X	X	X		X	X	X	X
Shall include: the date of examination;	X	X	X	X	X	X	X	X
significant mental health history and current conditions,	X	X	X	X	X	X	X	X
including whether the resident or prospective resident is a person with SMI,		X		X	X	X	X	X
that results in substantial functional disability		X		X	X	X	X	X
a statement that the prospective resident's mental health needs can be adequately met in the facility	X	X	X	X	X	X	X	X
a statement that the resident does not evidence need for placement in a facility , licensed under MHL	X	X	X	X	X	X	X	X
a statement that the person signing the report has conducted a face-to-face examination of the prospective resident within 30 days prior to the date of admission	X	X	X	X	X	X	X	X
Medications	X		X	X				
Diagnosis		X	X	X				
Treatment/medication compliance			X					
Treatment frequency	X							

Table 1. Display of Assessment Elements Contained in Various Forms Used by Adult Homes

2. Mental Health Evaluations: The Sample Clients

Just as the forms used by adult homes to record mental health evaluations varied, so did the content of the evaluations recorded for the 10 individuals in the sample whose records were reviewed. In a number of cases, the recorded evaluation did not address key regulatory elements.

- In one case, the form did not indicate the credentials of the assessor and/or his/her experience in assessing/treating individuals with mental illness.
- In four of the 10 cases, the evaluations did not indicate whether or not the individual had an SMI.
- The records for the same four individuals did not indicate whether the person had a substantial functional disability.
- In two of the cases, the evaluations did not state whether the person's needs can be adequately met in the facility.
- In one case, the evaluation form indicated that the individual required treatment in a facility licensed under Mental Hygiene Law; however, it is assumed this was an error as the evaluation also indicates the individual does not suffer from a mental condition that requires services which are unavailable in the adult home.

In some cases, the evaluations conducted or obtained by facilities provided additional information such as treatment and medication compliance, lists of specific diagnoses, etc. Although the regulations do not specifically require this information, the forms employed by these facilities did.

Regulatory Elements	**Compliance**	**Noncompliance**
Is to be written and signed by a psychiatrist, physician, registered nurse, certified psychologist or certified social worker approved by DOH/OMH; and	ES, CS, HP,TB,YH, PH, SK, CL	ET, AP
who has experience in the assessment and treatment of mental illness	TB, SK, YH, PH, CL; CS; ES; HP; AP	ET
Shall include: the date of examination;	All 10	
significant mental health history and current conditions,	TB, SK, YH, PH, CL; CS; ES; HP; AP (minimally and/or tangentially in some cases)	ET
including whether the resident or prospective resident is a person with SMI,	CS, AP, HP, YH, PH, CL	ET, ES, TB, SK
and that results in substantial functional disability	CS, AP, HP, YH, PH, CL	ET, ES, TB, SK
a statement that the prospective resident's mental health needs can be adequately met in the facility	ET, ES, CS, AP, HP, YH, PH, SK,	TB, CL
a statement that the person signing the report has conducted a face-to-face examination of the prospective resident within 30 days prior to the date of admission	All 10	

Table 2. Evaluation Regulatory Requirements Addressed in Sample Client Cases

While in many cases evaluations addressed issues called for by regulations, the information was often minimal. For example, SK's form prompts for "all significant mental health issues and present conditions, including diagnosis". His clinician provides a single diagnosis of "Bipolar Disorder" followed by "Patient is stable. Not a danger to self or others. He denies suicidal or homicidal thoughts. He denies hallucinations and delusions." PSYCKES, however, includes 10 behavioral health diagnoses within the past five years, at least three of which were within the past year but preceding the MHE. These diagnoses include Bipolar I, Schizoaffective disorder, (diagnoses within the past year), two Depressive disorders, Other Bipolar and Personality disorders, and Schizophrenia (the latter two possibly subsequent to the MHE).

Most notably, PSYCKES documents that SK was hospitalized on an inpatient psychiatric ward (Kingsbrook Jewish Medical Center) from 1/6/20 to 6/4/20. His MHE, however, is dated 4/9/20. It appears, then, that SK was evaluated during this lengthy hospital stay, and that the state of his mental health was such that he remained hospitalized for almost two months following this evaluation. Given this context, the evaluating clinician's single diagnosis (bipolar disorder) and generic mental health status text ("Patient is stable…") provide scarce information on an individual 90 days into a 150 day inpatient psychiatric stay, with an extensive mental health history and a most recent diagnosis (Schizoaffective disorder, Bipolar type) different from but preceding that of the evaluating clinician.

In the case of ES, he had lived in O'Toole supported housing since 2015 and was living in a Pibly Brooklyn supported apartment when he asked Central Assisted HFA to admit him in July 2020. In response, DOH was notified of their plans to admit him and a HARP screen was completed on 7/8/20. He received a mental health evaluation on 7/24/20 which notes his "long history of mental illness, PTSD and persecutory thoughts," and that he is "currently stable."

However, the evaluation does not indicate whether or not he is an individual with SMI which results in a functional disability. Nor does the evaluator reflect an awareness of the results of the HARP screen which indicates that he had lived in OMH funded housing for persons with mental illness within the last three years and had SMI. His SMI diagnoses on the PSYCKES included Bipolar 1; Schizoaffective Disorder; Major Depressive Disorder; and Schizophrenia.

The evaluator also did not document that ES was living in Pibly supported housing at the time. On 8/5/20, the Administrator contacted Pibly to inform them that they were admitting ES at his request, of which Pibly was not aware.

Pibly filed an incident report with OMH on 8/18/20 documenting the class member's request to return to an adult home. As of the last Incident Tracker of November 2020, the investigation was still pending. Of note, within a few weeks of his admission to Central Assisted Living, ES asked to return to Pibly's supported housing program. After receiving approval from OMH, he returned on 9/17/20.

In the case of ET, under "any significant mental health history (include diagnosis) and any current conditions (include medications)," his clinician simply wrote "none." By contrast, PSYCKES documents 14 behavioral health diagnoses in the past five years, including two within

the past year but preceding the MHE. These diagnoses include: Unspecified/Other Bipolar, Bipolar I (diagnosed within the past year), Schizoaffective disorder, Major Depressive Disorder, Adjustment disorder, Conduct disorder, Schizophrenia (possibly subsequent to the MHE), and several others.

In addition to this extensive mental health history, ET has a prior adult home residency during which both roster and claims data indicated he had SMI, and he lived in OMH licensed family care housing during a portion of the three years prior to his evaluation. A MHE stating only "none" in response "any significant mental health history (include diagnosis) and any current conditions (include medications)" seems both an unusually minimal and inaccurate depiction of ET's mental health, especially in the context of a HARP run indicating a history of SMI having triggered the need for the evaluation in the first place.

On other evaluation forms, most notably in response to a prompt to list current conditions, many clinicians listed information that was at best tangential to what was requested. More specifically, clinicians reported only what seemed to be the results of a mental status examination. On YH's form, no mental health conditions are listed under current conditions; instead, she was reported to be "…stable on current medication regimen–she is at baseline. No evidence of A/V hallucinations or S/H ideation or self-harming or aggressive behavior." Under current conditions CL's evaluation states: "He was observed to be oriented x 3 with neutral mood, full range affect and adequate cognitive functioning." Similarly, multiple other evaluation forms (TB, PH, AP, HP, ES) respond to current conditions simply by reporting "stable."

In all 10 cases, the evaluations either indicated that the individual did not suffer from a SMI resulting in a substantial functional disability or, if they did not specifically address "serious mental illness" or "functional disability" and instead cited mental diagnoses, concluded that the individuals' needs could be met in the facility. Overall, the evaluations, as documented, did not appear to probe issues such as past hospitalizations, lengths of stay, prior residency in mental health programs, frequency of outpatient services, etc. nor were they supported by HARP, PSYCKES data. Moreover, in some cases, (HP, CS, PH) the HARP data run was conducted ***after*** the MHE had been completed, indicating that the information was not available to the evaluator. In one case (ET), the MHE itself was conducted ***after the date of admission***, rendering any notion of preadmission screening a nullity. Finally, the clinician evaluating SK signed a statement in line with regulations that they had "conducted a face-to-face examination of the prospective resident within 30 days prior to the date of admission." SK, however, was evaluated on 4/9/20 and was not discharged from Kingsbrook Jewish in-patient psychiatric ward until 6/4/20, rendering the MHE much more than 30 days prior to admission to New Gloria's Manor. Consistent with the regulations, a new and more recent MHE should have been done as part of the preadmission screening.

Utilizing the HARP criteria to identify those individuals with the most serious needs, eight individuals met one or more of the following criteria yet were found to be not SMI:

- Supplemental Security Income (SSI) individuals with SMI who have received a State licensed or funded mental health service within the past year (AP, CS, YH);
- OMH funded housing for persons with mental illness within the past three years and an SMI diagnosis (HP, CS, ES, ET, YH, CL).
- Thirty or more days of inpatient psychiatric services within the past three years and an SMI diagnosis (AP, SK); and
- Three or more psychiatric admissions within the past three years and an SMI diagnosis (AP).

PSYCKES data, which tends to throw a wider net than the HARP runs were also revealing.

- PSYCKES reports reflected that two of the class members had been attending NYPCC mental health clinic regularly for the past four years, with over 200 billable visits each (AP, CS);
- One class member had several visits to a MHC and one to a PROS program in the last four years (ES);
- Another class member had been to psychiatric ERs seven times in the last four years and was also an inpatient once for 10 days (ET);
- YH had been to psychiatric ERs 11 times in the last five years and had received 21 services from a provider with an OMH rate code in the last year;
- SK's PSYCKES summary indicated two inpatient psychiatric stays in the past three years; of note is that the second stay was in process (over 30 days in) at the time of the HARP screen and HARP did not pick up on any of these days, just those of his older, 111 day, stay;
- At least three class members (YH, CL, ES) lived in O'Toole Settlement housing before returning to adult homes, though CL and ES were admitted to different adult homes than those in which they resided prior to moving to O'Toole housing.
- One (YH) was readmitted to the same adult home which she had left to live in O'Toole Settlement housing. She lived in both Pibly Apartment and Community Treatment (i.e., Level II) housing for slightly over three years before being readmitted to the adult home.[8]

In sum, extensive information disparities exist between the completed adult home evaluations and HARP and PSYCKES records. As this review was not comprehensive (e.g., we did not interview class members themselves) additional disparities may also exist. One of the benefits of the MHE form developed by DOH in consultation with OMH (see Appendix B), aside from its universality, is that it prods the assessor to probe and document diagnostic, treatment-related and functional deficit issues, as well as recording mental health history and current conditions. Further, it requires clinicians to document the sources of their information, creating a

[8] It is interesting to note that six of the individuals (AP, ES, ET. CS, YH, CL) were originally designated as SMI and added to the Community Transition List earlier in the life of the Settlement Agreement based on the rosters their adult homes submitted to the State.

more transparent and traceable evaluation process. Finally, the DOH form requires both the evaluating practitioner and the adult care facility (administrator) to attest to the circumstances and determination of the evaluation. In this way, it requires an initial level of oversight that adult home evaluations do not; the adult care facility itself must attest to reviewing and understanding the evaluator's work, which could be helpful in addressing issues such as evaluators reporting only "stable" under current conditions. The evaluator is also asked to identify their employer, potentially clarifying the relationship between evaluator and adult care facility.

III. Conclusions

While this review only looked at the records of class members to which the Independent Reviewer team has access, it is evident that the preadmission screening process for TAH is riddled with deficiencies and gaps that would permit persons with SMI to be admitted to these homes despite the screening process and to remain unidentified by the State. To the extent that this occurs, it undermines one of the key goals of the Settlement Agreement between the State and the Plaintiffs in this case.

The reasons for this are several and interrelated.

First, there is no standardized evaluation form to gather the information required by State regulations. Although the State developed one, it has never been put into practice. In its absence, adult homes are using a variety of forms of their own devising which often failed to capture and report the information required by State regulations.

A Case reflecting the need for oversight in review of these forms and the process:

Generally, the HARP run is used to trigger the need for a mental health evaluation. However, in the case of CS, the HARP run was conducted on 6/26/20, two days ***after*** the MHE of 6/24/20, leading up to his admission to Sanford Home on 7/6/20.

Exemplifying the need for review of the MHE by DOH/OMH, the evaluation of CS is filled with contradictions and confusing information. Specifically, the form checks that CS:

A. *Does not suffer from a mental health condition that requires services that are unavailable*; and cannot be safely and effectively provided by local social services agencies or providers;
B. *Does evidence need for placement in residential treatment facility* licensed or operated pursuant to Articles 19,23,29 or 31 NYS Mental Hygiene Law;
C. *Does have a serious and persistent mental illness (SMI)* under the Diagnostic and statistical manual of Mental Disorders; and whose severity and duration of mental illness results in substantial functional disability.

Further confusing the above responses noted on the MHE, the signing physician attached a letter he signed on the same date as the MHE. The letter states that "CS mental health has *not resulted in active serious mental illness or a substantial functional disability."*

Second, the deficiencies in the forms and information gathering in the evaluation process are compounded by the lack of any review by State agencies of the evaluations that are conducted. The results of the evaluation are not reported to the State nor are the evaluation forms submitted by the adult homes. If the adult home evaluation concludes that the person does not have a SMI, and they proceed to admit the individual, the only way the State can learn of this admission is by

scrutinizing a later monthly admission roster and matching the name to a required preadmission screening. But even then, the State would have no way of knowing whether the person has SMI. Thus, the gross deficiencies in many of the evaluations that have been described in this report were not caught or corrected by any review process by the State.

Third, while the State has information data bases like PSYCKES and HARP to screen for a prior history of mental health services, the data contained is not always comprehensive and accurate and, in any event, is not regularly provided to evaluators or used in conducting the required MHEs.

IV. Recommendations.

1. The State should promptly issue a standardized and comprehensive mental health evaluation tool similar to the one it developed but never put into practice and require its use in all adult home preadmission screenings at TAHs.

2. The State should require the submission of the preadmission screening evaluation and review it for completeness and compliance with regulatory requirements.

3. The State should develop a process for sharing information from PSYCKES and HARP with the clinicians who are conducting preadmission screenings at the TAH.

Appendix A. Comparison of HARP Criteria and Settlement Agreement Definition of SMI

HARP Criteria	**Settlement Agreement Definition of SMI**
Enrollment Criteria	
Enrollment in Medicaid	Not required
Enrolled in Mainstream Managed Care	Not required
Not enrolled in Medicare	Not required
Not participating or enrolled in an Office of People with Developmental Disabilities waiver program	not a primary diagnosis of organic syndromes, developmental disabilities or social conditions
Not covered by a Traumatic Brain Injury Waiver	Not addressed
Not covered by a Nursing Home Transition and Diversion Waiver	Not addressed
Clinical Criteria/Risk Factors (This is what the State is using to screen)	
Anyone with a court order for behavioral health treatment (commonly referred to as AOT order) within the past 5 years	Not addressed
Anyone discharged from a correctional facility with a history of behavioral health treatment within the past 4 years	Not addressed
SSI individuals with a Serious Mental Illness who have received a State licensed or funded mental health service within the past year	An individual is presumed to have a substantial functional disability as a result of mental illness if the individual is ***under*** the age of 65 and receives Supplemental Security Income ("SSI") or Social Security Disability Insurance ("SSDI") due to mental illness. (No time limit.)
Anyone with a Serious Mental Illness diagnosis and one of the following:	
• Office of Mental Health funded housing for the mentally ill within the past 3 years	received treatment from a mental health services provider operated, licensed or funded by OMH within the 24 months preceding the date on which this Agreement is "so ordered" by the Court, unless a Health Home or MLTC determines the mental illness has not resulted in substantial functional disability.
• Thirty (30) or more days of inpatient psychiatric services within the past 3 years	Not addressed
• Three (3) or more psychiatric admissions within the past 3 years	Not addressed
• Discharge from an OMH psychiatric center after an inpatient stay greater than 60 days within the past year	Not addressed
• Three (3) or more of the following services within the past year: ✓ Assertive Community Treatment (ACT) ✓ Personal Recovery Oriented Services (PROS) ✓ Prepaid Mental Health Plan (PMHP)	Not addressed

Appendix B. ACF Mental Health Evaluation Form