NEW YORK STATE OF OPPORTUNITY. Department of Health

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September 9. 2022

Kenneth Shulman
Assistant Comptroller
Division of State Government Accountability
NYS Office of the State Comptroller
110 State Street, 10th Floor
Albany, New York 12236

Dear Mr. Shulman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2020-S-55 entitled, "Use, Collection, and Reporting of Infection Control Data."

Please feel free to contact Mischa Sogut, Assistant Commissioner for Governmental and External Affairs, at (518) 473-1124 with any questions.

Sincerely,

Kristin M. Proud

Kristin M. Proud
Acting Executive Deputy Commissioner

Enclosures

cc: Mr. Sogut

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2020-S-55 entitled, "Department of Health Use, Collection and Reporting of Infection Control Data"

The following are comments by the New York State Department of Health (the "Department" or "NYSDOH") in response to Final Audit Report 2020-S-55, entitled "*Department of Health – Use, Collection, and Reporting of Infection Control Data*" (the "Final Report"), prepared by the Office of the New York State Comptroller's Division of State Government Accountability ("OSC"). The Department welcomes the opportunity to comment on the Final Report and its final conclusions. In particular, the Department appreciates the opportunity to clarify multiple areas in which the Final Report appears to misapprehend the Department's significant Covid-19-related undertakings and relies on an incomplete set of relevant facts – including with regard to the available sources and uses of public health data during the course of the Covid-19 pandemic.

General Comments:

The Department appreciates the stated goal of OSC's audit, which the Final Report indicates was intended to determine whether NYSDOH is collecting sufficient data to make accurate and informed public health decisions and to promote strong infection control policies. The Department also appreciates OSC's efforts to ensure that New York State's public health systems are as robust as they can be given the resources made available to the Department. However, in reaching its final conclusions, including OSC's final conclusions regarding New York State's public reporting of Covid-19 mortality data under the previous Cuomo Administration, the Final Report does not take proper account of the various types of quantitative and qualitative information that Department personnel have used to assist in responding to the Covid-19 pandemic; the various practical trade-offs that exist between different types of infection and mortality data; or the affirmative efforts that Department personnel have made over the past several years to enhance both the scope and the reliability of the information collected from nursing homes and hospitals to meet the challenges faced in the ongoing pandemic.

The Department further disagrees with the Final Report's conflation of transparency concerns that have been raised regarding the prior Administration's public disclosures of Covid-19 information and the Department's own development and use of public health data for epidemiological and infection control purposes. As the Final Report acknowledges and the New York State Assembly concluded during its investigation concerning the State's public disclosures, the scope of health data that was released to the public by the prior Administration was determined by the Executive Chamber, not Department personnel, and any Department-issued data was accurately described. Whatever criticisms may now be directed at the prior Administration relating to issues of transparency, or the particular categories of information that were publicly disclosed, those ultimately were matters for the Executive Chamber of the prior

Administration and not Department personnel.[1] The Department's use and analysis of available data for public health purposes was not affected or constrained in any way by the prior Administration's public reporting determinations, and included both nursing home and hospital-supplied information encompassing the full range of data collected from healthcare providers impacted by the pandemic.

State Comptroller's Comment – The findings in each section of the report are distinct with separate causation. Moreover, while problems existed with reliability and completeness, information being inaccurately described was not one of the issues identified related to the Department's development and use of public health data.

The Final Report does not address the practical challenges that the Department, together with federal and other state health departments, encountered from the earliest days of the Covid-19 pandemic to gather time-sensitive and comprehensive infection, mortality, and personal protective equipment ("PPE") information that was not available using the traditional data collection methods historically used to monitor and combat infectious diseases or track mortality data. Nor does the Final Report fairly address the significant and successful efforts that Department personnel have made to enhance and transform New York State's existing data collection regimes to meet those challenges. The Department was required to make pragmatic decisions to meet the need for daily, real-time information, and the Department moved quickly to repurpose and augment New York's existing systems to gather the information it needed from nursing homes and hospitals. In congruence with the stated purpose of OSC's final audit report, the Department continually improved these systems over the course of the pandemic to gather new categories of information, to enhance its reliability and audit its results, and to conform New York's information-gathering practices to applicable regulatory standards.

While Department personnel updated and expanded the State's health data collection systems in March and April of 2020, it was only after the initial 2020 surge was already largely *over* in New York that the Centers for Medicare & Medicaid Services ("CMS") – the federal regulator responsible for overseeing nursing homes – first began to collect detailed Covid-19 infection and mortality data using the National Healthcare Safety Network ("NHSN"). Even then nursing homes still were not required to supply CMS with comprehensive retrospective information of the type that the Department has required.

As the Final Report acknowledges, for the past two years, the Department's dedicated professionals have tirelessly responded to an unprecedented global pandemic. They did so under difficult conditions and with limited federal assistance. The Department also made the best use of the resources it had and steadily improved its systems throughout the pandemic.

State Comptroller's Comment – As the report acknowledges, Department staff worked tirelessly throughout the pandemic. However, that does not negate our belief that better data and information systems prior to the pandemic would have provided them with more accurate and complete information early on to assist them in their work. Moreover, a more adaptable and scalable centralized information system would have more readily allowed the Department to

[1] The Department notes that the current Administration moved swiftly to address these concerns by further expanding the scope and sources of public reporting data. The Department is unaware of any continuing disputes or criticism regarding the scope of New York State's current public reporting regime.

quickly expand the State's data collection needs, collect accurate and complete information, and share data with relevant stakeholders.

The Final Report does not explain how any alternate systems would have worked in practice; whether other alternate tools (including CDC's Infection Control Assessment and Response ("ICAR") tool, which the Final Report references) could have been quickly deployed in New York or would have yielded more reliable information; how the Department could have done a better job addressing the significant information-gathering challenges that led the Department to embrace and enhance its existing systems; or how data from distinct systems relayed by different types of providers could be combined or compared given the different methods, means, and purposes for each collection mechanism.

State Comptroller's Comment – Our findings are based in part on research presented by the Department's own staff and local health departments prior to and during the pandemic as well as conversations with public health experts from across the country. By listening to the Department's own experts as well as those from other states who identified tools they found to be effective in assisting with their response to the pandemic, we believe that Department officials can answer these questions and identify best practices they can employ in the future.

More fundamentally, the Final Report's implication that collecting data in a different manner prior to the pandemic's outbreak or publicly reporting that information differently during the pandemic could have altered the course of the pandemic in New York is simply not correct. The Department used all the information at its disposal to identify outbreaks; to arrange follow-up on site facility visits to ensure compliance with regulatory requirements and to assess infection prevention and control processes and practices; and to determine whether particular nursing homes or hospitals were in need of additional PPE. New York was one of the first states to identify and plan for the Covid-19 threat, to make ambitious sourcing and funding decisions to independently acquire ventilators, PPE and other materials needed to respond to the pandemic, and to ramp up its own independent testing capacity when the federal government was telling states that they were on their own. Where the Department was not able to provide requested assistance, this was due to nationwide shortages in PPE and testing availability, not failings of the Department's infection control surveillance.

State Comptroller's Comment – The report does not state or imply "that collecting data in a different manner prior to the pandemic's outbreak or publicly reporting that information differently during the pandemic could have altered the course of the pandemic in New York." Rather, we state, on page 11 and throughout the report, that better analysis and data reliability efforts might have allowed the Department to more effectively use resources at its disposal for day-to-day operations and in response to public health emergencies. Further, we credit the Department in areas where it did successfully use its data, specifically on page 22 in regard to its efforts to track and provide PPE to facilities.

Finally, the Department respectfully disagrees with the Final Report's suggestion that the Department did not fully cooperate with the OSC's Staff's audit. Responding to the ongoing pandemic has imposed around-the-clock demands on the Department and its personnel for nearly two years. These demands continue to the present day as the result of the recent Delta and Omicron variants. At the outset of OSC's review, the Department requested that OSC defer its audit efforts until the Covid-19 crisis abated. OSC declined that request. The Department

nonetheless met or spoke with OSC Staff on not less than seven separate occasions to answer OSC's questions. Given the broad range of questions asked by OSC, the Department also requested that the audit team forward detailed questions in writing so that the Department could compile consolidated responses to OSC's numerous information requests. This request was made to facilitate accurate and comprehensive responses, not to impede OSC's review. OSC resisted this request as well, requiring Department personnel to respond directly on an ad hoc basis. The result was a slower and less orderly audit process than either OSC or the Department would have preferred. However, any associated delays in that process were simply the result of an overstretched public health workforce that is still actively addressing the ongoing pandemic.

State Comptroller's Comment – Throughout the course of the audit, the audit team respected the work that the Department was performing – specifically by agreeing to limited meetings just once every 2 weeks to accommodate the Department's schedule. However, as noted on pages 12 and 35, the team encountered numerous delays that had less to do with an unavailability of staff and more to do with the Department's lack of willingness to share requested information. For instance, prior to each meeting, we provided officials with a summary of the topics to be discussed. However, Department management would invariably bring staff to the meeting who could not or would not answer questions or provide needed documentation in the identified subject areas of the meeting. This was not a good use of either Department staff's or auditors' time and resulted in further delays and extending the audit.

Recommendation #1:

Develop and implement policies, procedures, or processes to:

- Expand use of infection control data, including but not limited to NORA, HERDS, and nursing home survey data, to identify patterns, trends, areas of concerns, or non-compliance, and use this information as the basis for policy recommendations for infection control practices and for executing nursing home surveys as necessary;

- Improve quality of publicly reported data;

- Strengthen communication and coordination with localities on collection, reporting, and use of infection control-related data; and

- Collect supplemental data through additional sources, such as the ICAR tool, and incorporate its use with current data sets.

Response #1:

The Department agrees with OSC Staff that expanding and improving the data available to the Department for epidemiological and other public health purposes is a worthy goal. The Department shares that goal, and the Department's public health professionals have worked throughout the Covid-19 pandemic to improve the Department's existing systems and meet the challenges created by the pandemic. These efforts have included substantial efforts with respect to the State's existing data collection tools, especially data collected using the State's Health Electronic Response Data System ("HERDS"). The Department likewise is open to exploring new and improved mechanisms for collecting data from nursing homes, hospitals, and other

health care providers where authorized and appropriately funded under applicable law. The Department shares OSC's view that New York should always be looking for newer and better ways to inform its public health initiatives. The Department will also be taking the data-related lessons it has learned from the Covid-19 pandemic into account going forward. However, the Department respectfully disagrees with the Final Report's conclusions in its entirety.

First, the Final Report does not address the practical complexities associated with the various data sources available to the Department during the pandemic. The Department has collected several distinct categories of public health data during the course of the pandemic. For example, as the Final Report indicates, throughout the course of the pandemic, infection, mortality, PPE, and other information has been gathered directly from hospitals, nursing homes, and adult care facilities using New York's HERDS system, which gives the State the ability to transmit daily information-gathering surveys directly to health care providers and institutions. Certain Covid-19-related information likewise has been collected via the Nosocomial Outbreak Reporting Application ("NORA") maintained on the State's Health Commerce System, as well as via facility surveys. At the same time, mortality-related information historically has been collected pursuant to New York's Electronic Death Registration System ("EDRS"), which is a longstanding death-reporting system that predates the pandemic and is commonly referred to in New York as "Vital Records."

State Comptroller's Comment – We recognize there are complexities in using various data sets and systems cooperatively. However, as noted on page 11 of the report, the Department does not routinely analyze the data broadly, nor does it take advantage of certain other data sources, to detect interfacility outbreaks, geographic trends, and emerging infectious diseases or to shape its infection control practices and policies and its oversight of facilities. This is contrary to its own guidance, which states that the reporting and collection of the data is important for these reasons. We again note on page 21 that the Department did not prioritize the use of its various data sets collectively to make decisions, despite the vast amounts of data available and despite prior audits by our office recommending that the Department do so. Had the Department addressed integrating these data sets prior to the pandemic, it would have had greater intelligence at its disposal during the pandemic.

Each of these systems has its distinct advantages and limitations, including key differences in data timing, collection, and formatting that makes aggregating or syncing data across different datasets problematic as a statistical matter. Each of these systems serves a different purpose, so each system has different sources, settings, and contents. Further, because overlapping HERDS information is gathered separately from both nursing homes and hospitals concerning the same patients, certain nursing home resident information can be duplicative of information supplied by hospitals for patients transferred from nursing homes.

Correspondingly, these available data sources have distinct uses and limitations. For example, the Department's Vital Records reporting historically has been based on EDRS, a well-established data collection and reporting system that is based on certified death records and the actual location (*e.g.*, hospital, nursing home, private residence) of the individual's death.[2] A

[2] Given New York's longstanding (pre-pandemic) Vital Records practice of reporting deaths based on the actual location of the decedent's passing, the Department does not agree with the Final Report's suggestion that disclosing HERDS data based on in-facility deaths at facilities is misleading in any respect. This is how Vital Records in New

certified death record is the legal record of death as submitted by a medical certifier (*i.e.*, medical examiner, coroner, physician) to the local registrar. However, for much of the initial phase of the pandemic, New York (along with other states) experienced significant system-wide delays in the local certification and reporting of deaths, as medical examiners and other local certifiers struggled to keep up with the volume of deaths and correctly identify deaths caused by Covid-19 as opposed to other comorbidities (a process that was made even more difficult during the initial phase of the pandemic by the general unavailability of testing). As such, for much of the initial 2020 "surge" in New York, EDRS (and parallel CDC) data based on death certificates simply could not provide the type of timely data that the Department needed to surveil and evaluate the pandemic's impact on hospitals or nursing homes.

To address this timing challenge, the Department quickly repurposed its HERDS data collection system at the outset of the pandemic to gather real-time infection, mortality, and other information from both nursing homes and hospitals. By contrast to EDRS and Vital Records data, the HERDS system was not established (or intended) in the first instance for comprehensive Vital Records collection or public reporting purposes. It was instead used for more limited information-gathering purposes, such as in connection with weather-related or other emergencies. However, given the pressing need to obtain information on cases and deaths as quickly as possible to surveil the real-time experiences of healthcare providers, starting in March 2020 the Department began using HERDS to gather Covid-19 information from hospitals, nursing homes, and adult care facilities using a flexible survey format. Because HERDS allowed DOH to issue daily surveys to those facilities, this gave NYSDOH access to a broader range of information than was being collected using EDRS or NORA. Because certified death records were also experiencing substantial delays, using HERDS to contact providers directly also offered much more timely death information for monitoring purposes than was otherwise available at the time.

As the Final Report acknowledges, the Department's HERDS surveys evolved and became more elaborate over time, collecting information about disease burden, capacity, supplies, and resident fatalities. Department personnel routinely followed up directly with healthcare providers regarding the specific contents of their responses, to gather additional information, and to address and resolve any potential inaccuracies or inconsistencies identified during the course of DOH's review given that health care providers were self-reporting information on accelerated timelines without the benefit of the types of independent confirmation and patient-level detail associated with Vital Records.

These efforts, together with various initiatives by the Department over the past few years to audit and further diligence the information being supplied by nursing homes, did result in periodic updates and refinements to the Department's statistics as facilities' information was checked and updated. This reflects the kind of improvement that OSC is recommending the Department should be undertaking. HERDS data has various practical limitations, including the limitation that it is based on self-reporting, second-hand information for out-of-facility outcomes, and does not contain sufficient personally identifying information to conclusively identify

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York have historically been reported. However, in line with current Administration policy, the Department currently posts both in-facility and out-of-facility mortality information for nursing home residents even though certain out-of-facility nursing home resident deaths are also reflected in hospital death statistics.

individual patients whose outcomes may be simultaneously reflected in both nursing home and hospital-supplied data. But in conjunction with other survey results, NORA data, and the other information available to the Department, this data gave the Department a useful window into nursing homes' real-time infection experience and a mechanism for Department staff to monitor facility resources and capacity.

Second, the Final Report's conclusions relating to the Department's NORA reporting system do not fairly address either the purpose of that system or its effectiveness. The NORA system was never intended to function as a comprehensive, retrospective vital statistics system. It was instead intended to function as an epidemiological notification system designed to flag potential outbreaks at facilities for Department follow-up. Taken together with the HERDS and other survey data available to the Department, NORA has served that purpose throughout the course of the pandemic.

State Comptroller's Comment – We do not suggest that NORA was intended to function as a comprehensive vital statistics system. Rather, we agree with the Department that not only is NORA an epidemiological notification system designed to flag potential outbreaks at facilities for Department follow-up but that "timely and **complete** [emphasis added] reporting of communicable diseases is critical for NYSDOH response activities" (see footnote 24). Unfortunately, the audit found NORA data is neither complete nor reliable, and Department officials, despite identifying this problem prior to the pandemic, did not follow through on the corrective actions they themselves suggested. This limited the usefulness of the data.

Further, the Final Report states that OSC cannot conclude whether NORA data is complete or omits certain information. It also criticizes NORA data for not matching certain other patient-level information separately retrieved from CMS. However, NORA data is merely surveillance information that reflects a snapshot of an outbreak at the time a report is filed by a facility, and is not intended to sync up with CMS's separate datasets or function as vital records statistics. Initial NORA report information is instead used by the State's regional epidemiologists to prioritize their own direct outreach to facilities. When a facility submits a NORA report, an automated email is sent to the Department's Central Office staff, all epidemiology staff in the facility's region, and facility infection prevention staff. Regional regulatory staff and local health departments also have access to NORA reports for their respective jurisdictions. Many facilities will therefore receive outreach from a regional epidemiologist even before Central Office staff have triaged the report. This process ensures that facilities receive Department epidemiology outreach and support in a timely manner. Once an outbreak is over, regional epidemiologists do collect various historical data (including case counts) and enter that information into NORA to "close" the investigation. However, because the principal purpose is to respond to the outbreak in the first instance, responding to outbreak reports, not retrospective data reporting, is the purpose of this system.

The Final Report criticizes various NORA-related statistics and emphasizes that certain facilities previously had not reported information to the Department through NORA for a period of time. However, the Final Report elsewhere concedes that these outliers previously were identified and remediated by the Department itself, which addressed that oversight directly as part of a grant-funded project. Notably, during the administration of that project, the Department's epidemiology team proactively searched for facilities that might benefit from

targeted supplemental training and education about New York State's reporting requirements. Department epidemiologists continue to reach out to facilities in their regions to provide NORA-related training.

Additionally, the Final Report places significant emphasis on typographical and clerical errors concerning a small number of NORA reports. However, the errors cited comprised only 125 (0.15%) of the 7,757 overall reports, all of which had already been addressed by an epidemiologist at the time of the report. Nor does the NORA system's reporting of near-duplicate reports reflect "unreliable" or "inaccurate" results. Out of epidemiologic and scientific necessity, each facility initially determines what constitutes an outbreak in its facility. Facilities also sometimes enter multiple reports that could be misinterpreted as duplicates. However, these decisions are often made in collaboration with Department epidemiologists and reflect the facility's conclusion that the cases being reported have no epidemiological link to each other and constitute separate outbreaks within the same facility. If and when an epidemiologist decides that duplicate reports have been filed those duplicates are purged from NORA.

State Comptroller's Comment – The Department states that the report "places significant emphasis on typographical and clerical errors"; and points to one example cited in the report and calculates the error rate to be 0.15%. However, this is an example (i.e., illustrative) and thus, by definition, is not meant to be a complete listing of the numerous data reliability issues present within the data. A point demonstrated in the subsequent paragraph (page 29) offers a second example of why we concluded NORA to be unreliable: "there were 18,807 confirmed patient cases of COVID-19 in CMS' data, but only 4,939 such cases in NORA – a difference of 13,868 cases." The Department's self-described "epidemiological notification system designed to flag potential outbreaks at facilities for Department follow-up" potentially not including 13,868 reported COVID-19 cases is of far more concern than any typographical or clerical error.

Third, the Final Report is incorrect in its conclusion that the Department "does not routinely analyze the data broadly to detect inter-facility outbreaks, geographic trends, and emerging infectious diseases or to shape its infection control practices and policies and its oversight of facilities." From the very outset of the pandemic, the Department has used HERDS data and other available information to monitor resident and staff infection rates; identify outbreaks; track levels of available PPE; ensure compliance with regulatory requirements; confirm that appropriate infection control measures are in place; and track vaccination status, among other things.[3] In addition to using NORA for its primary function as a notification

[3] The Department also disagrees with the Final Report's use of the correlation coefficient statistic calculation to identify high-risk facilities for future outbreaks. The correlation coefficient is a statistic for assessing the linear relationship between two variables. It is a global summary measure of the linear relationship between two continuous variables in a data set. Infectious disease outbreaks, however, are complex and involve numerous factors, and the relationships may be quite nonlinear, rendering the use of the correlation coefficient questionable, simplistic, and unreliable. The Department, instead, relies on more sophisticated statistical approaches to detect potential outbreaks, including multivariate regression models that can address the complex relationships across multiple variables.

State Comptroller's Comment – The Department misunderstands the system we used to calculate the correlation coefficient statistic. The Department incorrectly assumed that the calculation was done using both HERDS and NORA. As we state on page 23, our calculation was based on one system: NORA. Further, the Department states that it performs analysis on the data; however, despite our repeated requests, the Department did not provide us with any documentation of such analysis, as stated on page 23.

system, the Department uses NORA data to provide situational awareness to stakeholders. All NORA reports are addressed directly with each facility by an epidemiologist, including all 7,757 reports that were identified during the audit period.

State Comptroller's Comment – The efforts the Department describes demonstrate that it uses its data largely as a notification and inventory system, not for analysis. The Department does not use its data for trend analysis, predictive analysis, or other more advanced functions that could be used for broader decision-making purposes. Further, as noted in our previous comments, we credit the Department in areas where it did successfully use its data, specifically its efforts to track and provide PPE to facilities.

Similarly, the Department has used the results of facility surveys to respond to the pandemic. The Department used data received from HERDS surveys to help determine where to perform focus infection control surveys ("FICS"). To date, the Department has completed 2,934 FICSs since March 2020. These surveys have proven to be a useful tool to ensure that nursing homes comply with state and federal infection prevention and control requirements. In addition, the Department updated its survey tool in May 2020 to ensure compliance with additional reporting and public health emergency requirements. The Department's adult care facility ("ACF") program also uses an infection control survey tool tailored to ACFs' unique non-clinical setting, which was developed in partnership with the Division of Epidemiology. In addition, based in part on its own surveillance efforts, each year the Department issues thousands of citations for issues relating to the provision of health care and life safety noncompliance. Over the course of the pandemic, in addition to conducting more than 2,900 FICSs, the Department responded to extensive provider inquiries, assisted with facility education and guidance, and generated over 1,700 enforcement referrals relating to nursing home non-compliance in the areas of infection control and prevention, PPE non-compliance, and state licensure requirements.

State Comptroller's Comment – As noted on page 9, the efforts regarding focused infection control surveys (FICSs) were generally directed by CMS, including any updates. Further, as we state on page 26, the Department was slow to begin conducting FICSs until CMS required they be completed by July 31, 2020. In fact, as noted in our report again on page 26, according to the U.S. Department of Health and Human Services Office of Inspector General's report, the Department had surveyed only 3% of nursing homes in the first month following CMS' directive, and by May 30 had only performed Infection Control and Complaint – immediate jeopardy surveys for 20% of nursing homes between March 23 and May 30, 2020, compared with over 90% for other states. Finally, adult care facilities were generally outside the scope of this audit as our focus was largely on nursing homes.

The Department's efforts in this regard were also accompanied by various other targeted actions focused on facility training, regulation, and surveillance, all of which were informed by the information being gathered in real time by the Department. For example, among other things, during the course of the ongoing pandemic, the Department:

- Issued multiple guidance documents, including the Covid-19 Preparedness Self-Assessment Checklist, which also functioned as an investigative tool during facility investigations by the Department. The Checklist provided nursing homes with guidance regarding the infection prevention and control elements that needed to be in place before and after recognition of confirmed or suspected cases of Covid-19;

- Provided targeted assessments and guidance by the Department's epidemiology team to strengthen infection prevention and control practices and provide mitigation recommendations. This included direct phone outreach by Department epidemiologists to all nursing homes in the early weeks of the pandemic to ensure that facilities were aware of the infection prevention and control measures that could be implemented;

  State Comptroller's Comment – While the efforts listed in the bullets are commendable, they largely fall outside the scope of this audit, which focuses on the utilization and reporting of the Department's data.

- Worked in collaboration with CDC from March 7, 2020 through April 20, 2020 to conduct multiple nursing home investigations, provide guidance, and conduct on-site visits, which resulted in CDC feedback that the Department had implemented all recommended infection control strategies;

- Moved swiftly after New York's first reported Covid-19 case to require face masks and health screenings, as of March 13, 2020, for nursing home staff and focus the Department's surveillance activities on Covid-19;

- Launched innovative video conferences using smart phones ("COVID-eos") to augment on-site epidemiology infection control visits;

- Developed and maintained a dedicated bureau mail log ("BML") system to respond 7 days a week to Covid-19-related questions by providers;

- Made daily calls to facilities reporting high transmission rates of Covid-19, as well as facilities with data inconsistencies, as part of our ongoing response and quality control efforts to strengthen facilities' infection prevention and control strategies and to improve the quality and integrity of self-reported nursing home data;

- Managed facility capacity using the Department's Nursing Home Assistance Call Center; and

- Used HERDS data to develop PPE recommendations and allocate in-demand PPE to facilities across the state.

In sum, the Department used available data sources to inform its overall Covid-19 response. Infection, mortality, and PPE data have been used daily for the past several years to inform virtually every aspect of the Department's activities. The Department will continue to use these data sources for this purpose and will look for other opportunities to enhance its sources of available data.[4]

[4] The Final Report recommends that the Department collect supplemental data through additional sources, such as CDC's ICAR tool. CDC updated its ICAR tool on January 7, 2022, but only 14% of all states have acknowledged their use of that tool. Regardless, the Department's epidemiologists will review the new version of that tool and

Fourth, it is not proper to conflate the prior Administration's separate public reporting determinations with the Department's own use and analysis of available Covid-19 data. As the Final Report concedes, decisions regarding the scope of public reporting were made by the prior Administration, not the Department. Nor did those prior Administration decisions impact the Department's own epidemiological use of data collected by the Department – including both nursing home self-reported data and information collected directly from hospitals at which nursing home residents were hospitalized.

State Comptroller's Comment – Our report makes no such assertions. In fact, our report made a concerted effort to separate how the Department used data throughout the pandemic and how the death data was reported.

Further, while the Final Report criticizes the prior Administration for a lack of transparency in not disclosing more information, none of the reports that were made to the public under the Department's purview were false or inaccurate, as the Final Report now implies. Instead, all reports issued by the Department plainly identified the data sources they included and were accurate, a fact that the New York State Assembly's investigative report has acknowledged.

State Comptroller's Comment – As noted on page 13, we found that the reports of deaths were inaccurate for the period April 15 to May 2, 2020. This was not a matter of disclosure or transparency, but an inaccuracy in the data as reported and as supported by the Department's own data compared to what was reported to the public at that time. Further, when asked, Department officials admitted they could not explain the reason for the inaccuracy.

In any event, with the direction and strong support of the current Hochul Administration, the Department has undertaken new initiatives to make more data available so that the legislature, agency stakeholders, and the public may better understand the State's pandemic response. A new Department website incorporates a single landing page for Covid-19 dashboards that is easy to access[5], rather than having to navigate different dashboards on different platforms. In addition, the Department has retooled several dashboards to provide information in a manner that is easier to understand and more relevant to current needs. Health Data NY also now includes additional self-reported data from the Covid-19 School Report Card, nursing home and adult care facility fatality data, and hospital admissions by gender and zip code, as well as hospital capacity and staff vaccination numbers. Under Governor Hochul's leadership and the oversight of the Department's Commissioner, Dr. Mary Bassett, these efforts have been widely praised and the Department expects them to continue going forward.

Recommendation #2:

Provide guidance to facilities on how to submit information into NORA and maintain support for data submitted on HERDS surveys to improve data quality, consistency, and accountability.

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consider it in conjunction with the tools that epidemiologists have adapted to their individual needs and the needs of the nursing homes they serve, including but not limited to the Department's own COVID-19 checklist.

[5] https://coronavirus.health.ny.gov/covid-19-data-new-york

Response #2:

The Department has conducted extensive trainings with nursing homes and their associations regarding completion of the daily HERDS surveys. Extensive instructions were incorporated into the survey itself, and the Department has routinely provided direct input and guidance during daily quality control calls and in response to inquiries made via the Department's dedicated BML.

Similarly, regarding the NORA system, regional epidemiologists have provided and continue to provide ongoing education, as needed, regarding the technical aspects of submitting a NORA report and when reporting is warranted. The need for such assistance depends on the experience and expertise of facility personnel. Additionally, the Department has taken steps to ensure that NORA reports are appropriately triaged. This includes no longer "holding" reports while epidemiologists research to determine if the reports are warranted (typically in cases where multiple reports are submitted by the same facility within a short timeframe). Epidemiologists triaging NORA reports now operate under the assumption that every report is justified and all reports are triaged and submitted. If a report is later deemed to be in error or duplicative, it is purged from NORA. This requires an additional staffing commitment but improves triage data reliability. Triage staff also have been instructed to use the NORA software's calendar function, rather than manually entering dates, to improve accuracy and reduce human errors in recording dates. Regional epidemiology staff will also continue to provide NORA training on an individual basis to any nursing home requiring assistance.

In addition to these efforts, the Department enhanced its FICS survey process in May 2020 to include onsite review of critical data elements, including nursing home fatalities and compliance with state requirements and Executive Orders, as an additional means to assess compliance and validate the information submitted through HERDS. During onsite reviews, observations, record reviews, and interviews were conducted with nursing home personnel and others to verify not only death reporting, but also the various metrics associated with the Department's HERDS data collection (case counts, lab results, etc.). Data validation has continued to be a top focus for the Department. Although patient-level data is not encompassed within each of the available HERDS fields, the Department's data collection efforts and personal follow-up by Department call center personnel has enhanced the reliability of HERDS data over the course of the pandemic.

Recommendation #3:

Develop and implement processes to improve controls over additions and deletions from CMS' database and determine if publicly reported nursing home survey data is reliable.

Response #3:

On November 5, 2021, the Department supplied OSC's audit team with an explanation and response regarding their stated concerns regarding their October 28, 2021 inquiry concerning differences between publicly reported survey data reported in CMS data and NYS Nursing Home Profile Data. As the Department noted in that response, there are different types of citations:

those cited for violations of only a state regulation and those cited for violations of only a federal regulation. In some cases, the Department may issue citations for violations of both state and federal regulations. However, there are certain federal citations that may only be levied by CMS. A review and reconciliation of data maintained in the federal CMS survey database was conducted in April and May 2018, and again in January and February 2020. The Department reviewed the discrepancies identified by OSC staff between CMS and NYS Nursing Home Profile Data. As noted above, CMS only posts federal citations, not state-only citations. This is the reason for three of the discrepancies identified by OSC. The remaining discrepancies concern citations involving federal regulations that were wholly subject to CMS' purview.

State Comptroller's Comment – The correspondence from the Department did not explain the reasons for the discrepancies; rather, the Department responded that it was unable to explain why certain citations were not in CMS' data.

Recommendation #4:

Evaluate and request resources as necessary to establish a foundation to adequately address public health emergencies in furtherance of the Department's mission.

Response #4:

The Department shares OSC's stated goal of requesting and evaluating further resources and will continue to do so going forward. The Department looks forward to working with all stakeholders to secure the appropriate resources to attract, train, and fund the necessary epidemiologists, infection preventionists, and public health specialists to carry out the Department's public health responsibilities. The Department has a renewed sense of purpose and optimism from the new Administration and Health Commissioner and is committed to rebuilding its resources to support a strong and diverse public health workforce.

Recommendation #5

Assess and document the adequacy of the internal control environment at the Department and the Executive Chamber, and take necessary steps to ensure the control environment is adequate, including cooperation with authorized State oversight inquiries, communication with localities, and external reporting.

Response #5

See letter from Kathryn Garcia, Director of State Operations.

State of New York
Executive Chamber
Albany 12224

Kathy Hochul
GOVERNOR

Kathryn Garcia
Director of State Operations and Infrastructure

February 8, 2022

Thomas P. DiNapoli
Office of the State Comptroller
110 State Street
Albany, NY 12236

Re: OSC Draft Audit Report 2020-S-55

Dear Comptroller DiNapoli,

The Executive Chamber welcomes the opportunity to comment on the above-referenced Office of the State ("OSC") Comptroller Draft Audit Report of the New York State Department of Health ("DOH"). We understand that OSC raised concerns about the adequacy of the internal control environment under the prior administration, including cooperation and communication with authorized State oversight inquiries and localities, and other external reporting. We want to assure the OSC that upon taking office, Governor Kathy Hochul directed her administration to dramatically change course and prioritize transparency, including cooperation and communication with oversight agencies on all levels. To this end, Governor Hochul directed each executive agency and public authority to create transparency plans, announced steps to expedite the Freedom of Information Law process, implemented recusal policies at the Executive Chamber, and proposed the formulation of an independent commission on ethics and lobbying. In addition, under her new leadership, DOH and the Executive Chamber will continue to work together to ensure the highest standards of internal controls.

Sincerely,

Kathryn Garcia
Director of State Operations