

Office for People With Developmental Disabilities

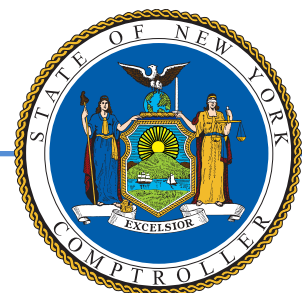
Pandemic Planning and Care for Vulnerable Populations

Report 2021-S-9 | April 2023

OFFICE OF THE NEW YORK STATE COMPTROLLER

Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability



Audit Highlights

Objectives

To determine whether the Office for People With Developmental Disabilities (OPWDD) adequately addressed the needs of the vulnerable population it serves in its emergency plans and took appropriate actions to care for this vulnerable population during the COVID-19 pandemic. The audit covered the period from January 2019 to April 2022.

About the Program

OPWDD is responsible for coordinating services for individuals with intellectual and developmental disabilities (IDD) – a lifelong disability that involves functional limitations in the areas of learning, language, and behavior. OPWDD provides these services, which include employment, day services, and housing, directly through State-operated programs and through a network of private non-profit agencies (voluntary agencies). Several residential service options, such as Individualized Residential Alternatives (IRAs) and Intermediate Care Facilities (ICFs), allow clients to live in a community home setting with others and be as independent as possible. As of November 24, 2021, 34,117 clients were living in either an IRA (30,652, or 90%) or an ICF (3,465, or 10%). Voluntary agencies operate the majority of these facilities and are responsible for 83% (28,553) of OPWDD's total population of community home residents.

OPWDD is responsible for certifying and regulating all residential facilities and providing guidance and best practices to both its own staff at State-operated facilities and voluntary agency staff. One component of OPWDD's mission is to provide a safe environment for all staff, clients, and families served in homes and programs that it operates and/or certifies, including disaster preparedness. OPWDD's regulations require certified community residences such as IRAs and ICFs to have written policies or procedures addressing emergencies or disasters and health and safety issues. Further, OPWDD has developed its own Emergency Management Operations Protocol (EMOP), which applies to all OPWDD-operated and/or certified facilities or programs, including OPWDD staff who manage and deliver specialized care. The EMOP includes OPWDD's overarching policies, authorities, and response organizational structure to ensure an integrated and coordinated local approach to managing emergencies. However, the EMOP does not specifically apply to the emergency management planning and response efforts of voluntary agency-operated facilities; rather, it provides a mechanism for communications between OPWDD and its network of voluntary agencies. As per State and federal regulations, voluntary agencies are responsible for creating their own emergency management programs and plans.

People with IDD have a higher prevalence of comorbidities and immune dysfunction that render them more vulnerable in a public health emergency, such as the COVID-19 crisis, and result in more severe, potentially deadly, outcomes. Further, congregate living poses special challenges to infection control. From March 2020 to April 5, 2022, OPWDD reported a total of 13,079 COVID-19 cases and 657 deaths among clients within its residential programs.

Key Findings

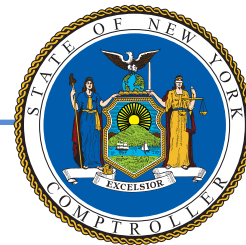
- OPWDD did not provide consistent oversight and guidance to all types of homes to ensure they were adequately prepared to manage public health emergencies. For instance, OPWDD developed and issued specific COVID-19 plans to only State-operated ICFs – eight facilities that accounted for less than 1% of OPWDD's residential clients. The remaining 6,921 facilities, which

collectively account for 34,048 clients (99%), were required to create their own plans – but could have benefited from OPWDD’s expertise. Although we did not establish a causal relationship between OPWDD’s actions and COVID cases, we did find that these homes accounted for the majority of COVID-19 cases and deaths among OPWDD residential clients (12,895 and 649 vs. 33 and four, respectively, for the eight ICFs).

- While OPWDD’s emergency management and overarching emergency planning documents considered pandemics as a risk even before the COVID-19 pandemic, OPWDD did not take proactive steps to ensure that all homes – either State- or voluntary agency-operated – had followed suit in their own emergency plans.
 - Among the 16 homes (seven State- and nine voluntary agency-operated) that we visited, only one had expressly considered pandemics in its emergency plans.
 - Some of the homes updated their plans to address pandemics after the COVID-19 state of emergency was declared; however, many of the plans did not include important aspects of an emergency response, such as staffing strategies, personal protective equipment inventory, and public health protective measures.
- OPWDD took some steps in response to the COVID-19 pandemic to enhance the protection of IDD clients, such as issuing guidance and conducting surveys to ensure compliance; however, its efforts have been largely reactive rather than proactive. Further, there are still improvements that can be made now, before another pandemic or infection control incident, to ensure a stronger response.
 - COVID-19 reviews did not adequately provide assurance that homes were in compliance with OPWDD guidance. Investigators didn’t always use the most current checklist during COVID-19 reviews, creating the risk that a given home is not being held accountable for compliance with critical requirements for proper infection control.
- OPWDD officials were uncooperative with the audit team at the beginning of the audit – questioning OSC’s authority to conduct the audit and rejecting initial data requests. Ultimately, it took several months for OPWDD officials to provide data and access to key personnel to complete our audit tests, including 10 requests over an 8-month period to receive data related to COVID-19 cases and deaths in homes. Although OPWDD’s cooperation subsequently improved, officials were not forthcoming with concerns they had with our preliminary findings – not providing substantive comments during verbal discussions of the audit findings, as well as not responding openly to auditor requests to discuss concerns they had with the findings.

Key Recommendations

- Periodically review and update as necessary the EMOP and supplemental documents to ensure all homes implement current policies and procedures in the event of another public health emergency.
- Develop procedures to ensure facility-level emergency plans encompass planning for and responding to public health emergencies.
- Establish effective communication with individuals responsible for infection control policies and procedures when pertinent deficiencies are identified.
- Ensure monitoring and review protocols address infection control practices, are well developed, and are consistently applied when conducting reviews at homes.



Office of the New York State Comptroller Division of State Government Accountability

April 6, 2023

Kerri E. Neifeld
Commissioner
Office for People With Developmental Disabilities
44 Holland Avenue
Albany, NY 12229

Dear Commissioner Neifeld:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit entitled *Pandemic Planning and Care for Vulnerable Populations*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

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Glossary of Terms

Term	Description	Identifier
OPWDD	Office for People With Developmental Disabilities	<i>Auditee</i>
CDC	Centers for Disease Control and Prevention	<i>Federal Agency</i>
CEMP	Comprehensive Emergency Management Plan	<i>Key Term</i>
COOP	OPWDD's Agency Continuity of Operations Plan	<i>Key Term</i>
DDSOO	Developmental Disabilities State Operation Office	<i>Auditee Office</i>
DOH	Department of Health	<i>State Agency</i>
DQI	Division of Quality Improvement	<i>Auditee Unit</i>
Emergency Plan	Emergency plan developed at the facility level	<i>Key Term</i>
EMOP	OPWDD's Emergency Management Operations Protocol	<i>Key Term</i>
ICF	Intermediate Care Facility	<i>Auditee Facility</i>
ICN	Infection Control Nurse	<i>Key Term</i>
IDD	Intellectual and developmental disabilities	<i>Auditee Term</i>
IRA	Individualized Residential Alternative	<i>Auditee Facility</i>
PPE	Personal protective equipment	<i>Key Term</i>
Supplemental annex	OPWDD's supplemental guidance	<i>Key Term</i>

Background

The Office for People With Developmental Disabilities (OPWDD) is responsible for coordinating services for individuals with intellectual and developmental disabilities (IDD) – a lifelong disability that involves functional limitations in the areas of learning, language, and behavior. People with IDD face significant health issues that render them more vulnerable in an emergency. For example, individuals with IDD have a higher prevalence of comorbidities and immune dysfunction; are more susceptible to infectious diseases, such as the highly contagious COVID-19; and are at greater risk for more severe outcomes, including intensive care unit admission, invasive mechanical ventilation, and mortality. Further, OPWDD’s clients largely receive services in congregate settings, which poses special infection control challenges, especially evident during the COVID-19 public health emergency. For example, OPWDD reported a 15% death rate (2,593 cases/400 deaths) among its residential clients within the first 3 months of the COVID-19 pandemic compared with 8% (396,098 cases/31,634 deaths) for the State overall, according to the Centers for Disease Control and Prevention (CDC). OPWDD has a responsibility to protect this vulnerable population through proper emergency planning.

OPWDD assists its clients to live the life they want through access to supports and services, including employment, day services, and housing. OPWDD provides these services directly, through State-operated programs administered by 13 Developmental Disabilities State Operations Offices (DDSOS) across the State, and through a network of about 600 private non-profit agencies (voluntary agencies), under the guidance of one of OPWDD’s five Developmental Disabilities Regional Offices.

OPWDD oversees several residential service options, which allow clients to live in a community home setting with others and be as independent as possible. Two such community residences – Individualized Residential Alternatives (IRAs) and Intermediate Care Facilities (ICFs) – serve the majority of clients and are thus the focus of this report.

- IRAs are family-style group homes that provide support as well as individualized protective oversight.
- ICFs are designed for individuals whose disabilities severely limit their independence. Because ICFs are a Medicaid benefit, which includes federal funds, the Department of Health (DOH) has some oversight responsibilities over these facilities.

OPWDD is responsible for certifying and regulating all residential facilities and providing guidance and best practices to both its own staff at State-operated facilities and to voluntary agencies that deliver direct care to people with IDD. According to OPWDD’s website, its regulations and guidance are intended not only to make certain that minimum acceptable standards are met but also to ensure that providers are both encouraged and equipped to exceed those standards.

As shown in the following table, as of November 24, 2021, 34,117 clients were living in either an IRA (30,652, or 90%) or an ICF (3,465, or 10%). Voluntary agencies

operate the majority of these facilities and are responsible for 83% (28,553) of OPWDD’s total population of certified community home residents.

**Enrollment at Certified Residential Programs by Home Type
as of November 24, 2021**

Home Type	State Operated		Voluntary Agency		Totals	
	No. Sites	No. Residents	No. Sites	No. Residents	No. Sites	No. Residents
IRA	1,004	5,495	5,574	25,157	6,578	30,652
ICF	8	69	343	3,396	351	3,465
Totals	1,012	5,564	5,917	28,553	6,929	34,117

New York State regulations require certified community residences, such as IRAs and ICFs, to have written policies or procedures addressing emergencies or disasters and health and safety issues.

OPWDD’s Division of Quality Improvement (DQI) is responsible for certifying homes, which for the initial certification involves on-site visits to ensure that the physical plant environment meets program-specific standards, codes, and regulations, and that staffing is adequate. Thereafter, DQI recertifies homes every 3 years and conducts full-site reviews annually. According to OPWDD officials, each year OPWDD certifies more than 7,500 sites and programs and conducts over 10,000 on-site visits to ensure the provision of quality services and compliance with applicable regulatory requirements. Additionally, ICFs must meet federal regulations (42 CFR Part 483) that require establishing and maintaining an emergency preparedness program and having an active program for the prevention, control, and investigation of communicable diseases. Pursuant to the State’s Medicaid Plan agreement with the Centers for Medicare & Medicaid Services, all ICFs are routinely surveyed by DOH for compliance with State and federal regulations.

One component of OPWDD’s mission is providing a safe environment for all staff, clients, and families served in homes and programs operated and/or certified by OPWDD, including disaster preparedness. Executive Law, Article 2-B establishes disaster preparedness plan requirements at both the State and local levels. Such plans are required to include, but are not limited to: disaster prevention and mitigation, including the identification of hazards and assessment of risk; disaster response, including mechanisms to coordinate the use of resources and manpower for service during and after disaster emergencies and the delivery of services to aid citizens and reduce human suffering from a disaster; and disaster recovery, including mechanisms for recovery and redevelopment. OPWDD modeled its Emergency Management Operations Protocol (EMOP; see Exhibit A) on the State’s Comprehensive Emergency Management Plan (CEMP; see Exhibit B), which was developed by the Division of Homeland Security and Emergency Services and the New York State Disaster Preparedness Commission, which included OPWDD. The EMOP is composed of three tiers of planning – Continuity of Operations Plan (COOP), Facility-Level Emergency Plans, and Emergency Response and

Reporting Guides – and provides OPWDD’s overarching policies, authorities, and response organizational structure to all OPWDD-operated and/or certified facilities or programs, as well as OPWDD staff who manage and deliver specialized care (see Exhibit C) to ensure an integrated and coordinated local approach to managing emergencies. The EMOP does not specifically apply to the emergency management planning and response efforts of voluntary agency-operated facilities, but rather provides a mechanism for communications between them and OPWDD. As per State and federal regulations, voluntary agencies are responsible for creating their own emergency management programs and plans.

Audit Findings and Recommendations

People with IDD have a higher prevalence of comorbidities and immune dysfunction that render them more vulnerable in a public health emergency and result in more severe, potentially deadly, outcomes. These risks are further compounded by the challenges to physical distancing (e.g., congregate living and the necessity of considerable personal assistance) as a means to minimize the spread of any disease, much less one as virulent as COVID-19. OPWDD has a responsibility to protect this vulnerable population through proper emergency planning and ensure its overarching planning policies have been adopted by all facilities, both those operated by the State and those operated by voluntary agencies.

OPWDD did not provide consistent oversight and guidance to all homes to ensure they were adequately prepared to manage public health emergencies. For example:

- Even before the pandemic, OPWDD's EMOP and subsequent overarching emergency planning documents included pandemics as a hazard and potential risk to the life and safety of its clients. However, OPWDD did not take proactive steps to ensure that all homes – either State- or voluntary agency-operated – followed suit in their emergency plans. Among the 16 homes (seven State- and nine voluntary agency-operated) that we visited, only one (a voluntary agency-operated ICF) had considered pandemics in its emergency plans.
- In September 2020 and November 2021, OPWDD developed supplemental annexes covering COVID-19 emergency planning and response but restricted their distribution to the eight State-operated ICFs – excluding the remaining 6,921 State-operated IRAs and voluntary agency-operated ICFs and IRAs, which collectively account for an exponentially larger population. Although we did not establish a causal relationship between OPWDD's actions and COVID cases, we did find that:
 - State-operated ICFs represented only about 0.2% of OPWDD's residential clients and, as of April 5, 2022, accounted for 0.6% of COVID-19-related deaths.
 - Most deaths (545, or 83%) involved clients residing at certified IRAs – including 141 deaths at State-operated IRAs and 404 deaths at voluntary agency-operated IRAs.

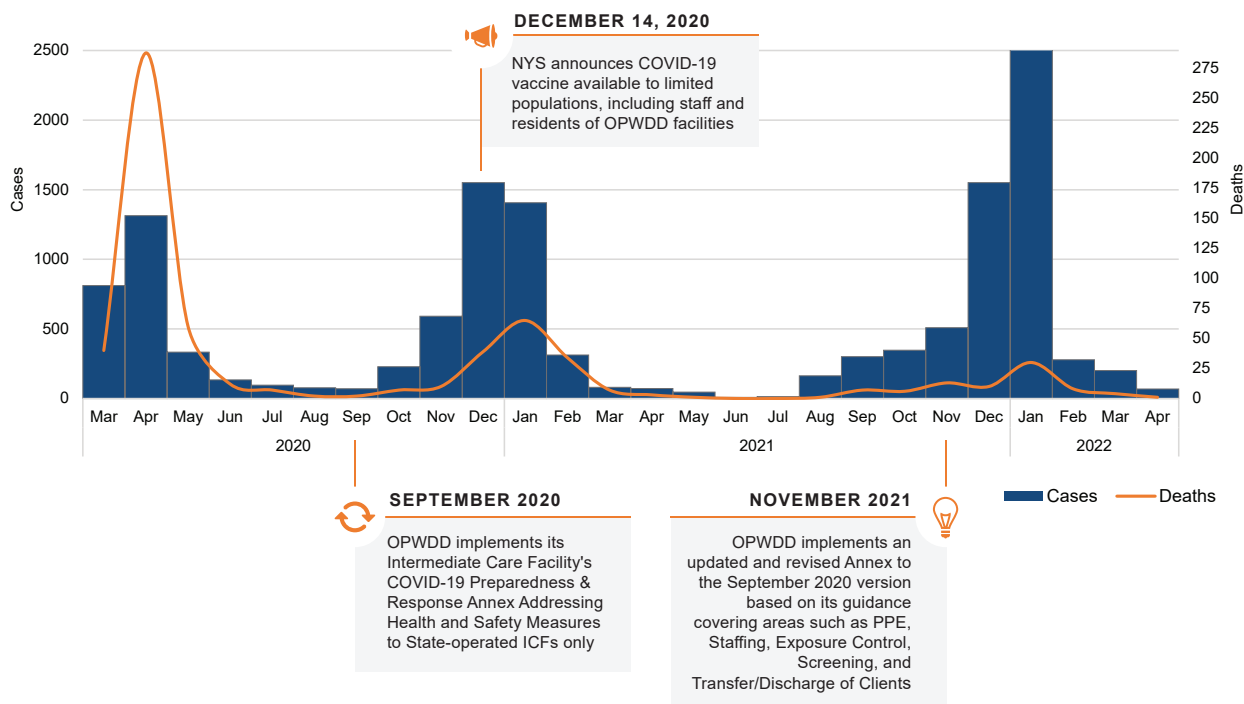
While OPWDD complied with the law in exercising its oversight responsibilities, improvements in policies and processes are needed to better protect all clients. We question why OPWDD developed and issued COVID-19-related annexes to only State-operated ICFs and overlooked the value of such plans to all other facilities that were equally if not more in need. The gravity of the crisis at the time demanded more action by OPWDD beyond simply what was required.

OPWDD officials disagreed with our audit findings and recommendations, stating it had controls in place to combat the pandemic, such as infection control procedures. We acknowledge that OPWDD did take some steps to protect its clients – such as offering trainings, issuing guidance, implementing a centralized personal protective equipment (PPE) system within State-operated homes, and conducting targeted COVID-19 surveys at homes; however, OPWDD's efforts to support facilities during

the pandemic were more reactive than proactive, implementing corrective steps only after the need had been identified. There are still improvements that can be made now, before another pandemic or infection control incident, to ensure a stronger response. For example, as relayed to us by staff at many of the homes we visited, when the pandemic began, they had concerns regarding obtaining PPE supplies and having adequate staffing. Also, the COVID-19 surveys that OPWDD performed during the crisis were done inconsistently, and only 20% of IRAs, which house most of the clients, had been surveyed.

Our analysis shows that from March 12, 2020 to April 5, 2022, OPWDD reported a total of 12,928¹ COVID-19 cases and 653 COVID-19-related deaths at ICFs and IRAs. As shown in Figure 1, the first wave of the pandemic, in March–May 2020, accounted for about 59% of all COVID-19-related deaths, with the rate decreasing with each subsequent wave. The number of COVID-19 cases, however, did not have a similar downward trend after the first wave. That COVID-19 cases continued unabated indicates the need for improved oversight of homes' infection control practices and planning. Further, the majority of COVID-19 deaths and cases occurred in IRAs, as shown in Figures 2 and 3.

Figure 1 – COVID-19 Cases and Deaths at Facilities Through April 5, 2022



We also note that OPWDD officials were uncooperative with the audit team at the beginning of the audit – questioning OSC’s authority to conduct the audit and rejecting our initial data requests. Ultimately, it took numerous months for OPWDD

¹ Includes 543 clients who had multiple COVID-19 infections.

officials to provide data and access to key personnel to complete our audit tests, including 10 requests over an 8-month period to receive data related to COVID-19 cases and deaths in homes.

Pandemic Preparedness

Inclusion of Pandemics in Emergency Plans

According to the CDC's 2017 Community Mitigation Guidelines for community administrators who serve vulnerable populations, community-wide planning is essential to respond to and recover from a pandemic. Organizations should update their existing emergency operations plans and prepare to address key prevention strategies, including planning for extra supplies, worker absences, and a designated quarantine area and developing a risk assessment and risk management process.

According to the EMOP, facility-level emergency plans support different emergency response types, describe staff responsibilities, and contain reporting requirements specific to each OPWDD-certified home. Although the EMOP references facility-level emergency plans as part of its emergency management program, it does not distinctly mandate them for State-operated facilities. Furthermore, voluntary agencies, encompassing 5,917 sites and accounting for more than 28,000 residents, are responsible for their own emergency management programs, including developing emergency plans.

Whereas OPWDD, on a statewide and overarching level, considered pandemics in its emergency planning and supporting documents, we determined that, generally, OPWDD-certified homes did not have pandemics in their emergency plans prior to the COVID-19 outbreak. We interviewed facility staff and reviewed facility-level emergency plans and Emergency Response and Reporting Guidelines (hereafter collectively referred to as Emergency Plans) at 16 homes (11 IRAs and five ICFs), and found that the vast majority did not address pandemics or emerging infectious diseases prior to the COVID-19 outbreak. Rather, their on-site emergency plans addressed more immediate emergencies and response actions, such as fires, severe weather, and missing persons events.

None of the 11 IRAs (six State- and five voluntary agency-operated) we visited had pandemics addressed in their Emergency Plans prior to the COVID-19 pandemic. Five of the 11 IRAs updated their Emergency Plans to include pandemics in response to COVID-19; however, the updated plans were often reactionary, focusing more on response than preparedness. For example, rather than delineating such actions as staffing strategies, inventories of PPE, and public health protective measures, these plans simply instructed the facility to follow OPWDD guidance in the event of a pandemic. At the time of our reviews, completed between January and April 2022, the remaining six IRAs had yet to include pandemics into their Emergency Plans.

Pursuant to federal regulations, ICFs are required to have an Emergency Plan with a documented risk assessment. Four of the five ICFs we visited had documented risk

assessments, including hazard vulnerability assessments; however, only one of the four had considered pandemics a high risk in their existing assessment at the onset of the COVID-19 pandemic. One other did not include pandemics in its initial facility-based risk assessment, and another did not have a documented risk assessment. All ICFs had pandemics included in their Emergency Plans in response to COVID-19.

By not including pandemics in their Emergency Plans, homes lacked the framework to efficiently form their response and mitigate the potential for loss of life as the COVID-19 pandemic hit. When presented with confirmed COVID-19 cases, home staff had to await guidance from OPWDD – and, in the case of ICFs, from DOH and the CDC – before taking action. This included developing isolation/quarantine plans, which often necessitated consulting with a medical expert (e.g., an Infection Control Nurse) and consuming precious time. Also, staff had to take on additional responsibilities – most notably, the coordination of PPE distribution. The added stress of managing the spread of COVID-19 without proper preparation could have been alleviated if such responsibilities had been defined in Emergency Plans.

Staff also had to contend with uncertainty regarding the availability of PPE. Although OPWDD had some stockpiled PPE, the supply was exhausted early in the pandemic due to the unprecedented demand. On April 6, 2020, OPWDD adopted DOH guidance, based on CDC recommendations, that aimed to prepare staff for the lack of PPE. Staff at 11 of the 16 homes we visited expressed difficulties accessing and acquiring PPE during the early stages of the pandemic, and staff at three homes (two IRAs and one ICF) operated by voluntary agencies told us they resorted to reusing facemasks and gowns. We note that none of the homes ran out of PPE and OPWDD established a centralized PPE system for State-operated homes to track and order PPE supplies. However, staff felt OPWDD should have a stockpile of PPE in preparation for any future events to ensure availability.

The pandemic also exacerbated staffing issues across OPWDD, including staffing shortages and vacancies in key positions, such as Treatment Team Leader and Residential Manager. However, only nine of the 16 homes we visited had emergency staffing plans. While none of the homes ever operated below the minimum staffing level, some frontline workers worked days at a time, slept at the home, and worked across different homes to fill staffing gaps – conditions that increase the risk of physical and emotional fatigue and mental distress, tax the ability of staff to work effectively, and increase the risk of COVID-19 transmission. From the onset of the pandemic through November 24, 2021, 81 homes were closed or temporarily suspended. OPWDD officials explained these were related to staffing shortages and not to COVID-19.

To improve its emergency planning efforts as well as homes' preparedness in managing any future public health emergency, we recommend OPWDD frequently update its EMOP public health emergency annex and develop policies and procedures to ensure that all homes adequately prepare for any future public health emergencies.

Distribution of EMOP Emergency Planning Annexes

While OPWDD had developed supplemental annexes for emergency planning and response, they were specific to State-operated ICFs only: in September 2020, OPWDD implemented its Intermediate Care Facilities' COVID-19 Preparedness & Response Annex addressing COVID-19 health and safety measures, such as disinfection, visitations, cleaning, and testing, and in November 2021 issued an updated annex covering areas such as PPE; staffing considerations; exposure control protocols; screening protocols for clients, staff, and visitors; and transfer and discharges of clients. Although these annexes provided useful guidance, OPWDD only issued them to State-operated ICFs, which, as of November 2021, represented only 0.2% of OPWDD's residential clients. While we did not establish a causal relationship between OPWDD's actions and COVID cases, we did find that, as of April 5, 2022, State-operated ICFs accounted for 0.6% (4) of COVID-19-related deaths. In contrast, certified IRAs had the greatest number of deaths (545, or 83%), including 141 deaths at State-operated IRAs and 404 deaths at voluntary agency-operated IRAs (see Figure 2).

Similarly, State-operated ICFs had the fewest COVID-19 cases while certified IRAs had the most, including 2,764 cases at State-operated IRAs and 8,756 cases at voluntary agency-operated IRAs (see Figure 3).

The significant disparity in COVID-19 case and death rates between State-owned ICFs and all others notwithstanding, the crisis at the time demanded action by OPWDD on behalf of all facilities.

OPWDD Actions During the COVID-19 Pandemic

Administering COVID-19 Surveys and Communicating Results

While OPWDD recertifies homes every 3 years, DQI informed us that it attempts to visit homes annually for a full-site review. Prior to the COVID-19 pandemic, full-site reviews involved verifying that homes had written plans specifying how the home will deal with life-threatening emergencies. However, these reviews did not address homes' infection control practices or whether homes had documented plans addressing public health emergencies.

Figure 2 – Number of COVID-19-Related Deaths at ICFs and IRAs

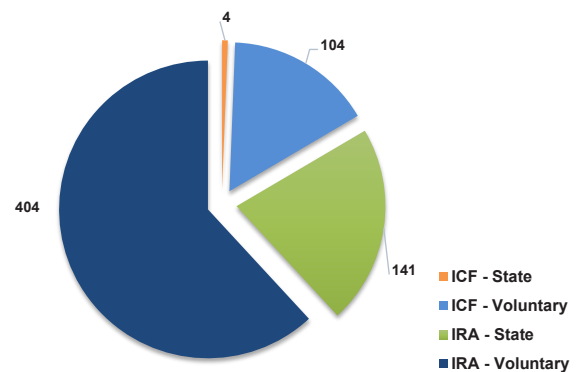
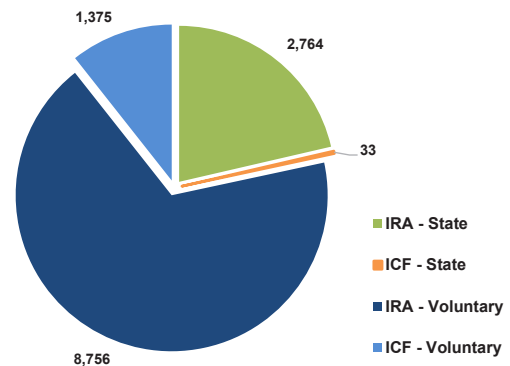
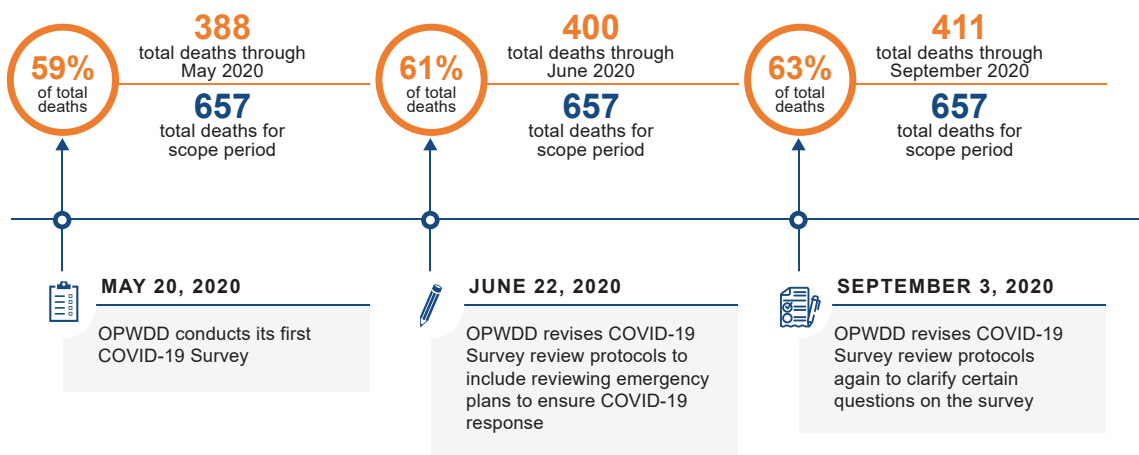


Figure 3 – COVID-19 Cases by Facility Type



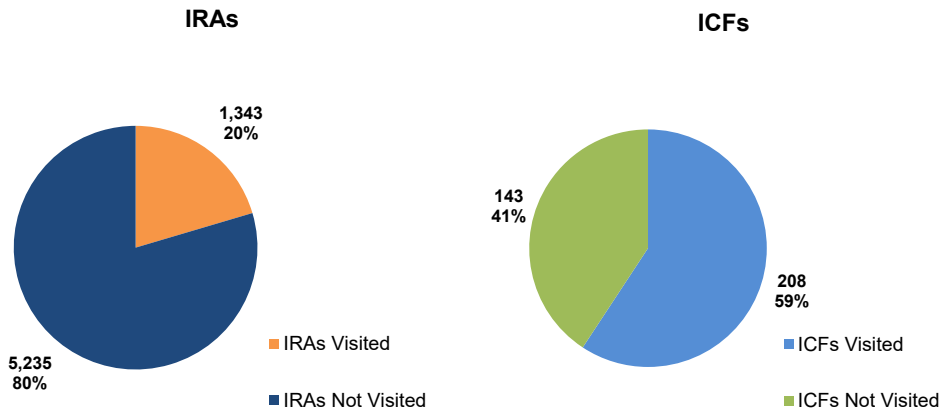
In May 2020, DQI started to conduct COVID-19-specific surveys (COVID-19 Surveys) at State-operated and voluntary agency sites – the first being completed on May 20, 2020 (2 months into the pandemic and subsequent to 2,239 cases and 373 deaths) – on an ad hoc basis to evaluate the implementation and effectiveness of infection control measures and COVID-19 response strategies within homes and ensure the health and safety of all staff and clients. DQI developed guidelines and checklists for its investigators to follow during COVID-19 Surveys. DQI investigators completed the checklists based on off-site phone interviews and reviews of written procedures and trainings as well as on-site observations and interviews. Checklist items included: observing residential activities; interviewing staff about general infection control and cleaning practices; and reviewing procedures to determine if they address 24-hour nursing coverage, COVID-19 infection control and signs and symptoms training, and PPE training. The COVID-19 Survey guidelines and resulting checklists were updated twice during the pandemic, once on June 22, 2020 (after 148 completed visits, including 21 at ICFs) to require investigators to review facility emergency preparedness plans to verify a COVID-19 pandemic response has been included, and again on September 3, 2020 (after 592 completed visits) to clarify certain questions on the survey (see Figure 4).

Figure 4 – Timeline of OPWDD Surveys in Relation to COVID-19 Deaths



Through February 2, 2022, OPWDD conducted 2,152 COVID-19 Surveys at 1,551 homes. We found OPWDD completed surveys at only 22% of all homes, including 208 ICFs (of 351, or 59%) and 1,343 IRAs (of 6,578, or 20%) (see Figure 5). While OPWDD did visit more IRAs than ICFs, the percentage of all IRAs visited was much lower than for ICFs. As previously mentioned, ICFs must meet several federal regulations, including establishing and maintaining an emergency preparedness program, and are routinely surveyed by DOH. IRAs and the clients of these homes may have benefited more from the findings of the COVID-19 Surveys.

Figure 5 – COVID-19 Surveys Among IRAs and ICFs



We also found investigators inconsistently applied guidance in conducting COVID-19 Surveys, and their checklists often lacked meaningful notes or comments, which are important to ensure compliance and staff and client safety during an emergency. OPWDD completed a total of eight COVID-19 Surveys at seven of the 16 homes we visited (one ICF had multiple surveys). We reviewed the eight checklists and found that six lacked meaningful comments regarding observation of home practices even though OPWDD’s guidance states surveyors should “document significant information regarding the observation such as staff involved, individual(s) involved, and what you saw.” These observations include paying close attention to PPE use by staff and clients, practices to minimize the risk of the spread of infection, ability to isolate infected individuals, and other infection control strategies (e.g., use of hand sanitizer, screening of staff and/or visitors). These observations are important to then compare to guidance documents, with any deficiencies brought to management’s attention for corrective action, such as the need to retrain staff and/or monitor infection control practices and/or revise procedures. In one example, the observation comments simply stated that two clients were eating a meal, while others were in their rooms resting, watching TV, or listening to the radio. There was no mention of the use of PPE or screening of individuals or visitors.

Furthermore, we found that investigators didn’t always use the most current checklist during their COVID-19 Surveys, creating the risk that a given home is not being held accountable for compliance with critical requirements for proper infection control. We reviewed five COVID-19 Survey checklists completed between June 10, 2020 and October 21, 2021 for four ICFs we visited, and found three were outdated checklists, with no verification that the ICFs’ emergency preparedness plans addressed COVID-19. While we were ultimately able to confirm that the emergency preparedness plans at these ICFs did address COVID-19, if investigators used outdated surveys elsewhere, OPWDD potentially would not have been able to identify those homes with emergency preparedness plans that fail to address COVID-19.

Lastly, Infection Control Nurses (ICNs) play an important role in infection control at State-operated homes. ICNs ensure the development of infection control programs, including policies and procedures that eliminate risk of infection to clients, facility personnel, and visitors through surveillance and appropriate control measures. Additionally, ICNs provide education on infection control and isolation techniques, practices, and policies to employees at all levels; identify areas demonstrating infection risk and initiate programs to eliminate infection hazards; and participate in education and research epidemiology programs. However, ICNs were not always notified of infection control deficiencies found at homes during COVID-19 Surveys. Only one of five ICNs we interviewed had COVID-19 Survey findings communicated to them; and none of the nurses had direct contact with DQI or provided input for the checklists used. Considering the ICN's role in implementing infection control practices and training staff, any deficiencies found related to infection control during COVID-19 Surveys should be communicated to them.

Guidance and Training

Prior to the pandemic, OPWDD required infection control training for all new OPWDD employees. The training included topics such as communicable disease, tuberculosis, bloodborne pathogens, and exposure control. Additionally, OPWDD required its employees to complete annual refresher trainings on infection control, bloodborne pathogens, and tuberculosis. OPWDD did not require the training or the refreshers for employees at voluntary agencies. Additionally, each DDSOO developed infection control policies and procedures for the State-run facilities in their respective region. Voluntary agencies develop their own trainings, policies, and procedures related to infection control. We found that some agencies used OPWDD's guidance to provide training to their staff, while others implemented a hybrid training based on both OPWDD and other sources, such as guidance from the Occupational Safety and Health Administration, DOH, and/or the CDC, to get staff information immediately during the pandemic.

Additionally, in March and April 2020, OPWDD offered training courses to assist facilities in dealing with the COVID-19 pandemic. Such offerings included topics such as containment measures, infection control refreshers, DOH guidance, and revised staff guidance for the management of COVID-19 in facilities and programs. These trainings were made available to, but not required for, voluntary agencies throughout March and April 2020.

Since March 5, 2020, OPWDD issued other guidance covering topics such as cleaning and disinfection, management of coronavirus, return to work following COVID-19 exposure or infection, options when PPE is in short supply or not available, COVID-19 testing protocol, visitation guidance, and vaccine prioritization. OPWDD based its guidance on DOH and CDC guidance. Due to variations in home design and the diversity of OPWDD's clients – not to mention the numerous iterations of rapidly changing guidance coming from all sources – voluntary agencies and DDSOOs provided an interpretation of the guidance documents to make them understandable for clients and staff at their homes. At times, residential staff had

difficulty implementing guidance or defining terms (e.g., extended vs. regular home visits). Staff did inform us, however, that OPWDD officials were generally available to provide clarification.

According to the CDC, people with IDD can experience communication barriers that make it harder for them to understand and act on crucial health guidance. As previously mentioned, in September 2020, OPWDD implemented an Intermediate Care Facility's COVID-19 Preparedness & Response Annex at State-operated ICFs based only on its COVID-19 guidance. However, because it was only implemented for ICFs, this guidance only applied to a fraction of OPWDD's homes (0.1% of all homes) and clients (0.2% of residential clients).

In response, OPWDD stated that all home staff are trained yearly on infection control procedures. While such infection control procedures are beneficial to reduce the spread of disease, having a well-thought-out Emergency Plan that addresses other important components of a home's response, such as isolation/quarantine rooms, staff responsibilities, and staffing plans, would help prepare homes at the onset of any future public health emergencies. Furthermore, OPWDD officials stated that staff and ICNs are informed of issues but are not informed about how the issues were identified or why changes were brought about (e.g., Surveys). Officials also commented that the auditors did not meet with appropriate staff to gain a full understanding of the communication of COVID-19 deficiencies, to which we note that we worked tirelessly with OPWDD officials to ensure all appropriate staff were identified and interviewed.

We recommend OPWDD officials continue to develop and update guidance for all homes to assist in their response to events affecting the health and safety of the clients' receiving services, to improve communication with ICNs concerning deficiencies related to infection control identified during reviews of homes, and to ensure monitoring protocols and guidance are well developed, followed, and consistently applied during reviews.

Poor Agency Cooperation

For almost a year, OPWDD officials were uncooperative with the audit team – questioning OSC's authority to conduct the audit, rejecting initial data requests as unduly broad, and ultimately taking 8 months (from April 1, 2021 to December 1, 2021) to provide data and access to key personnel. Further, only after making 10 requests over the course of the 8-month period did the auditors receive data related to COVID-19 cases and deaths in homes.

While OPWDD's cooperation subsequently improved, officials were not forthcoming with any concerns they had with our preliminary findings. We presented these preliminary findings verbally to OPWDD officials, with no substantive response from them. We further issued the findings in writing prior to our closing conference. Agencies are given 10 business days to respond with any concerns, which are taken into consideration in preparing the draft report. In the interim, OPWDD expressed to auditors that they had concerns but did not respond openly to auditors' efforts

toward resolution, and provided its written response to the preliminary findings 1 month after the issuance of the preliminary report. When the auditors reached out to begin discussions on what these concerns were, OPWDD failed to openly respond. Withholding information from auditors exhibits a lack of transparency and accountability, which are cornerstones of good government. When public officials believe that they are not required to be transparent and accountable, the internal control environment suffers. Consequently, there is increased risk that internal controls do not function properly and less assurance that program goals and objectives are accomplished efficiently and effectively.

Recommendations

1. Periodically review and update as necessary the EMOP and supplemental documents to ensure all homes implement current policies and procedures in the event of another public health emergency.
2. Develop procedures to ensure facility-level emergency plans encompass planning for and responding to public health emergencies.
3. Ensure monitoring and review protocols address infection control practices, are well developed, and are consistently applied when conducting reviews at homes.
4. Establish effective communication with individuals responsible for infection control policies and procedures when pertinent deficiencies are identified.

Audit Scope, Objectives, and Methodology

The objectives of our audit were to determine whether OPWDD adequately addressed the needs of the vulnerable population it serves in its emergency plans and took appropriate actions to care for this vulnerable population during the COVID-19 pandemic. The audit covered the period from January 2019 to April 2022.

To accomplish our objectives, we interviewed OPWDD officials; reviewed federal and State codes, laws, rules, and regulations related to our audit objectives; and reviewed guidance documents issued by OPWDD and the CDC. We became familiar with and assessed the adequacy of OPWDD's internal controls related to emergency planning and care for individuals with IDD living in OPWDD-certified homes. We interviewed OPWDD officials to gain an understanding of their emergency management processes, and reviewed OPWDD's emergency planning documents, including its EMOP, COOP, and Emergency Response and Reporting Guides.

We judgmentally selected and interviewed DDSOO Directors from four of six regions and reviewed each DDSOO's infection control policies and procedures to assess OPWDD's preparedness prior to the COVID-19 pandemic. We selected DDSOO Directors based on regional data and county infections and deaths.

IRAs and ICFs account for the vast majority of home types and residential enrollments, and thus are the focus of this audit. We obtained and analyzed COVID-19 infection and death data from OPWDD's Incident Reporting Management Application through April 5, 2022. We used these data to judgmentally select 11 IRAs (six State-operated and five voluntary agencies), including one from each Developmental Disability Regional Office and DDSOO region based on the percentage to capacity, capacity, and numbers of COVID-19 cases and related deaths. We also considered whether the residential agencies operating the homes were identified as showing signs of decreased quality through OPWDD's Early Alert Process – a system used by OPWDD that identifies agencies with issues (e.g., repeated certification deficiencies), thus increasing the risk of non-compliance with certification requirements. We judgmentally selected five ICFs, including four voluntary agencies and one State-operated, based on geographic region and the percentage to capacity, capacity, and numbers of COVID-19 cases and related deaths. Overall, we visited 16 homes (nine voluntary agencies and seven State-operated). During these site visits, we interviewed home staff; reviewed and assessed facility-level Emergency Plans, infection control/COVID-19-related policies and procedures, visitor logs, cleaning logs, and staff training logs; and verified COVID-19 infection and death data reported in the Incident Reporting Management Application. Based on this verification, we believe the data were sufficiently reliable for the purposes of our audit. The results from our review of selected homes were not, and cannot be, projected to the entire population of OPWDD-certified homes.

We interviewed DQI staff regarding the certification of homes and the COVID-19 Survey process. We reviewed eight COVID-19 Survey checklists and related letters sent to all seven of the homes we visited where COVID-19 Surveys were conducted.

We interviewed OPWDD's Director of Nursing and Statewide Services and ICNs at five DDSOOs to understand their roles in preparing for and responding to the pandemic.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of OPWDD's oversight and administration of pandemic planning and care for the vulnerable populations it serves.

Reporting Requirements

A draft copy of the report was provided to OPWDD officials for their review and formal comment. Their comments were considered in preparing this final report and are attached in their entirety at the end of it. In general, officials agreed with our recommendations and indicated actions they would take to implement them, but took exception to certain statements in the report. Our responses to certain remarks are embedded within OPWDD's response as State Comptroller's Comments.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office for People With Developmental Disabilities shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Exhibit A

OPWDD's EMOP Basic Plan

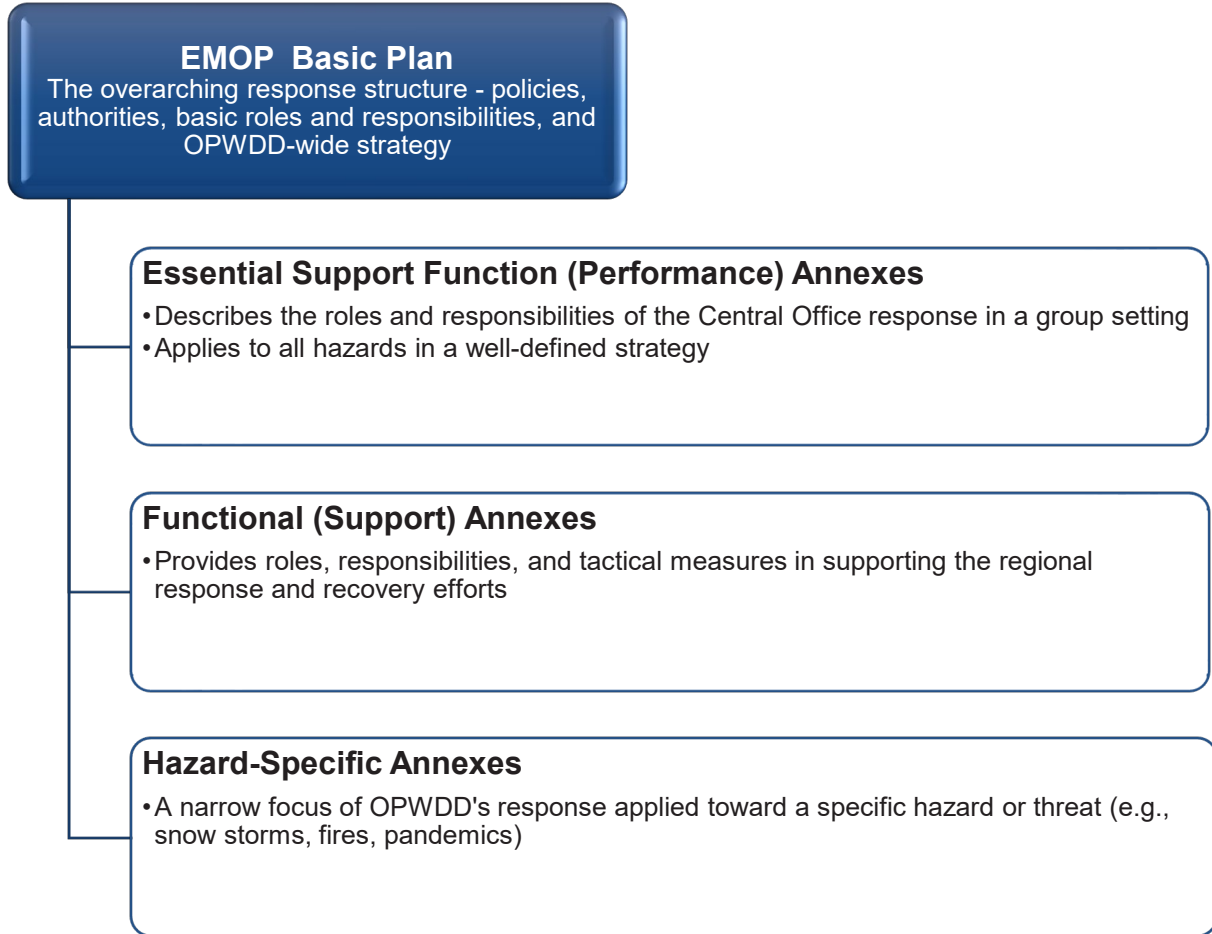
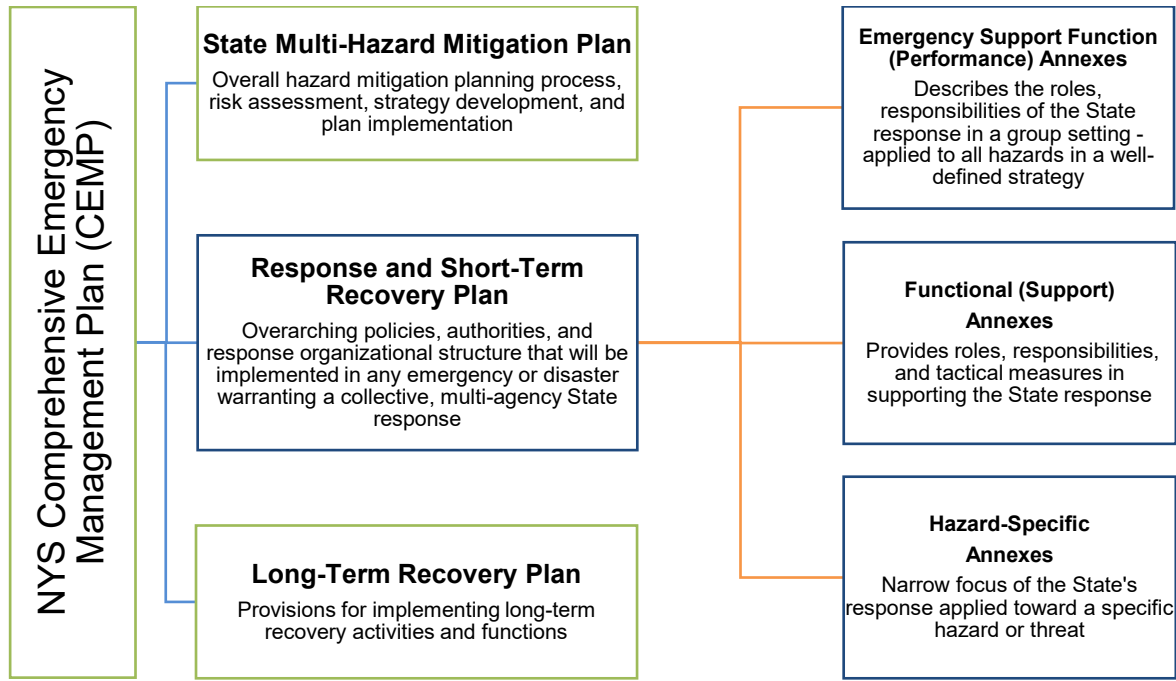


Exhibit B

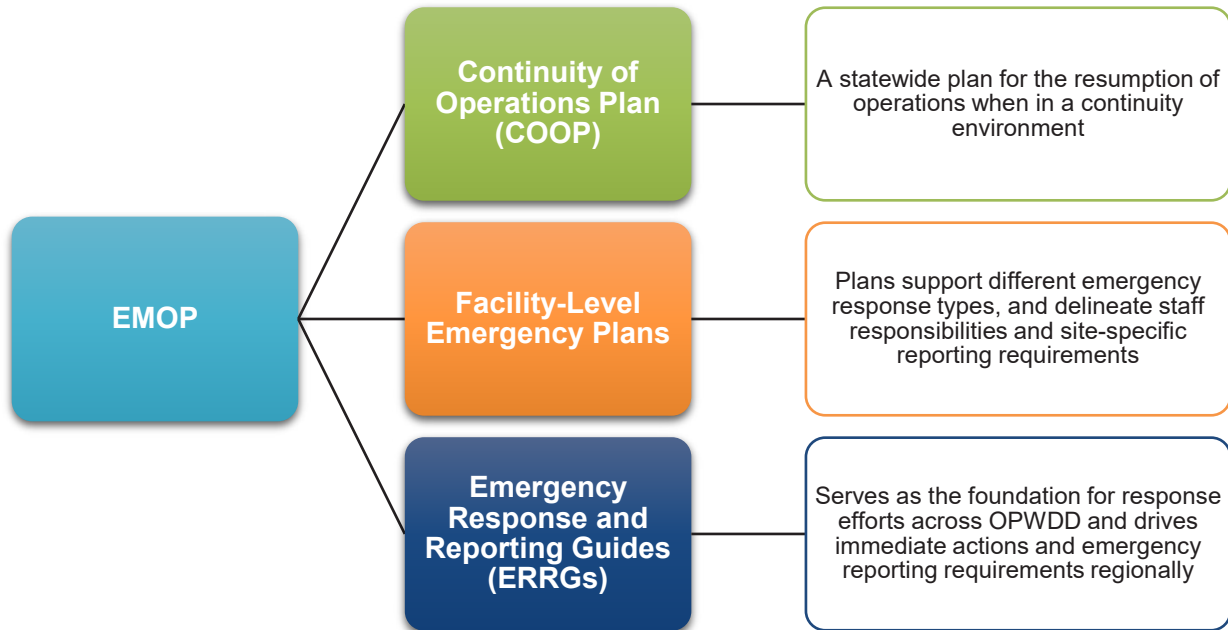
New York State's Comprehensive Emergency Management Plan



Note: The CEMP serves as the foundational framework for the State's emergency response and as the operational basis for other functional and hazard-specific annexes. The annexes address a broad range of consequences to respond to the State's highest-rated hazards, including in April 2019 an annex to address non-natural hazards that incorporated pandemics. Accordingly, as part of the Response and Short-Term Recovery Plan, the State has maintained a hazard-specific annex to address the State's preparation for, responding to, and recovering from a pandemic.

Exhibit C

OPWDD's Emergency Management Program Structure



Note: Continuity environment is an event that requires staff relocation to alternate work sites not normally equipped with routine supplies and equipment required to complete job tasks.

Agency Comments and State Comptroller's Comments



**Office for People With
Developmental Disabilities**

KATHY HOCHUL
Governor

KERRI E. NEIFELD
Commissioner

ROGER BEARDEN, J.D.
Executive Deputy Commissioner

January 20, 2023

Nadine Morrell, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street - 11th Floor
Albany, NY 12236-0001

Dear Director Morrell:

Thank you for the opportunity to comment on the NY State Office of the State Comptroller's draft audit report entitled "Pandemic and Care for Vulnerable Populations" (Report number 2021-S-9 dated December 2022). Attached is the response being submitted by the NY State Office for People with Developmental Disabilities.

Sincerely,

Richard Cicero, CPA CMA CFE
Director, Office of Audit Services

Enclosure

cc: Kerri E. Neifeld, OPWDD Commissioner
Anthony Dolan, CPA, OPWDD External Audit Liaison

Executive Office

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Office for People With Developmental Disabilities' Response to the Office of the State Comptroller's Draft Audit Report (No: 2021-S-9, December 2022): "Pandemic Planning and Care for Vulnerable Populations"

I. INTRODUCTION

The New York State Office for People With Developmental Disabilities (OPWDD) appreciates the opportunity to respond to the Office of the State Comptroller's (OSC) draft audit report entitled "Pandemic Planning and Care for Vulnerable Populations" which covers the period of January 2019 to April 2022 (hereinafter "draft").

OPWDD shares OSC's goal of ensuring the protection of the vulnerable population it serves and welcomes thoughtful input and suggestions for improvement. However, OPWDD is concerned that certain methodology and assumptions underlying this audit have led to conclusions that will not assist—and, to the extent they are not corrected, may undermine—this crucial objective.

State Comptroller's Comment – We will address OPWDD's concern with our audit methodology and conclusions at certain points throughout OPWDD's response – we note that OPWDD ultimately agrees with several of OSC's recommendations to further strengthen and improve emergency planning and response for any future public health emergencies.

As a fundamental matter, OPWDD reiterates its concern with the focus and scope of this audit. In April 2021, when OSC launched this audit covering "pandemic planning and care," OSC's audit impacted virtually every aspect of OPWDD's operations since the start of the pandemic, despite OPWDD's request to narrow the scope. This expansive review presented challenges for OPWDD staff in the midst of the pandemic, and in some cases unfortunately appears to have contributed to OSC's perceived lack of agency cooperation. Despite the sweeping scope of its audit, however, OSC's review of "pandemic planning" was narrowly focused on emergency planning documents which are designed to plan for a variety of potential future disasters, not just pandemics. As such, the OSC audit did not incorporate a meaningful review of the extensive guidance documents OPWDD issued in response to the actual COVID-19 pandemic, dismissing them as "reactive" instead of assessing their real-world and real-time effectiveness at addressing the challenges of the pandemic. OSC drew conclusions when emergency planning documents did not contain certain topics, without considering how the relevant topics were specifically addressed in an extensive array of other governance documents issued by OPWDD throughout the course of the COVID-19 pandemic.

State Comptroller's Comment – OPWDD for much of the audit did not cooperate. However, rather than acknowledge and take responsibility for its actions, which are well documented in our report, OPWDD attempts to explain it away by claiming OSC's scope was too broad. Even if OPWDD believed this to be true, it fails to explain why this prevented it from cooperating with OSC or why, after this issue was resolved, it continued not to cooperate for over half a year. OSC engaged OPWDD in March 2021 and, after considering OPWDD's concern related to the audit scope, informed OPWDD in April 2021 that the audit would focus on residential programs. As noted on page 17 of the audit report, OPWDD then raised another objection – to OSC's authority to conduct the audit – and

delayed providing the audit team with requested information and access to people between April 2021 and December 2021. OPWDD then claims OSC's audit was narrowly focused and did not incorporate a review of guidance documents. Our objectives, as stated on page 2, were to determine whether OPWDD adequately addressed the needs of the vulnerable population it serves in its emergency plans AND took appropriate actions to care for this vulnerable population during the COVID-19 pandemic. On page 16, OSC acknowledged OPWDD's efforts before, at the onset of, and during the pandemic. Specifically, the report outlines its efforts in providing trainings and issuing guidance documents to facilities to assist them in combatting the pandemic. Moreover, as the definition of reactive is "acting in response to a situation rather than creating or controlling it" OSC, to a great extent, agrees with OPWDD's conclusion that, based on our assessment, many of the actions it took were reactive rather than proactive. Rather than being defensive, OPWDD should learn from this experience and examine how it can be more proactive in the future.

As discussed below, OSC makes many generalizations that seem to assume a lack of all-inclusive emergency planning documents placed providers at a disadvantage, but the draft report provides no specifics. To put these planning documents in context, they are only required to be updated bi-annually,¹ or in some cases annually,² yet OSC focuses on these documents rather than the numerous policies which were updated regularly throughout the pandemic, sometimes on a daily basis. Furthermore, the draft report relies on statistics to support many of its inferences, yet OPWDD has concerns with the underlying assumptions, as will be discussed later in this response.

State Comptroller's Comment – Our report pointed to the differences in pandemic planning among the various residences, and on page 12, we cited specific issues that direct care workers on the front lines at selected facilities expressed to us related to the lack of emergency planning surrounding pandemics.

It should be noted that OPWDD had planning documents in place prior to COVID-19, which considered the risks of a hypothetical pandemic, and commensurate evaluations were made at the onset of COVID-19. The planning process included consideration of the adequacy of existing policies, such as those covering infection control. However, the COVID-19 pandemic presented many unparalleled circumstances that could not have been reasonably foreseen.

OPWDD acknowledges and appreciates OSC's conclusions that at no time during the COVID-19 crisis did OPWDD fail to comply with the law; that none of the homes it oversees ever operated below the required staffing levels; that none of its homes ran out of Personal Protective Equipment (PPE); that OPWDD staff were generally available to provide clarification on guidance; and that OSC established no causal relationship between OPWDD's actions and cases of COVID-19.

State Comptroller's Comment – OPWDD's generalization and lack of context related to the audit findings is misleading. As noted on pages 10 and 11, we visited 16 homes, and the audit findings and observations are only applicable to those homes visited – as expressed on page 17. Moreover, by ignoring the context of these findings, OPWDD fails to take away necessary lessons learned that can improve its future performance. For instance, on page 12, we relay the difficulty experienced by providers during the pandemic in obtaining PPE stating: "Staff also had to contend with uncertainty regarding the

¹ Federal regulations require ICFs to have an emergency plan that is reviewed and updated every two years [42 CFR § 483.475(a)]. OSC found "OPWDD complied with the law in exercising its oversight responsibilities." [draft p.9]

² A guideline in OPWDD's Continuity of Operations Plan states the plan should be reviewed and updated each year.

availability of PPE. ...Staff at 11 of the 16 homes we visited expressed difficulties accessing and acquiring PPE during the early stages of the pandemic, and staff at three homes (two IRAs and one ICF) operated by voluntary agencies told us they resorted to reusing facemasks and gowns. We note that none of the homes ran out of PPE and OPWDD established a centralized PPE system for State-operated homes to track and order PPE supplies. However, staff felt OPWDD should have a stockpile of PPE in preparation for any future events to ensure availability." Problematically, OPWDD's only take away is that no one ran out of PPE, not only generalizing the finding past this limited group of providers but, of greater concern, failing to address the very real problems experienced by these providers and failing to acknowledge a potential lesson learned from their experience.

It is undisputed that the COVID-19 global pandemic created enormous challenges for health and human services agencies throughout the United States and New York State, including OPWDD, our not-for-profit service providers (i.e., "voluntary" providers), and people with intellectual and developmental disabilities and their families. From the beginning of the pandemic, OPWDD was committed to working with its federal and state public health partners to preserve the health and safety of the people we serve. OPWDD took immediate action to contain and stop the spread of COVID-19 in the state and to assist local governments and people with intellectual and developmental disabilities in responding to and recovering from this disease. Throughout this extraordinary global health emergency, OPWDD, consistent with evolving guidance from the federal Centers for Disease Control and Prevention and in collaboration with other state agencies and local health districts, issued directives for state and voluntary providers to close congregate day habilitation settings, eliminated visitation in community residences, ceased most community outings, and issued dozens of guidance documents, including on how to isolate and quarantine, infection control practices specific to OPWDD settings, and best practices on use of PPE. Additionally, OPWDD conducted countless trainings, updates, and question and answer sessions to assist provider agencies and the people they serve to respond to this unprecedented global pandemic.

In addition, OPWDD worked with the Centers for Medicare & Medicaid Services to provide immediate regulatory flexibility and financial relief to voluntary agencies who were struggling to respond to this crisis. OPWDD established contact tracing protocols and reporting mechanisms, in consultation with Department of Health (DOH) and in collaboration with the Justice Center for the Protection of People with Special Needs and set up a 24/7 hotline for providers to report new COVID-19 cases. This allowed OPWDD's Division of Quality Improvement to respond to those areas of the state where the virus was most prevalent and to make risk-stratified site visits to ensure compliance with COVID-19 protocols and precautions. OPWDD continuously issued new guidance to deal with unique situations arising from the unprecedented spread of the novel coronavirus. OPWDD's response was swift and constant. Difficult decisions were made to best protect the people we serve, guided by the best available data, direction from public health experts, and communication with our stakeholders.

OPWDD is proud of the numerous actions we took to mitigate the risks of the pandemic and of the extraordinary efforts of staff to keep people safe, often at risk to their own health and safety. While the draft report acknowledges the "taxing" conditions for frontline staff, we hope OSC's final report will more fully recognize the superhuman efforts of the staff caring for people with developmental disabilities during the pandemic, in particular the direct care and clinical staff who risked their health on a daily basis to ensure that those being served were safe and properly cared for. Failure to acknowledge these essential workers who gave their all throughout this unprecedented and extremely challenging time would be a grave disservice. OPWDD once again thanks its staff for their selfless service. We are truly grateful.

State Comptroller's Comment – As noted on page 12, we acknowledge how frontline staff worked consecutive days, slept at their facilities, and worked across different homes to maintain adequate staffing levels.

Finally, OPWDD notes that notwithstanding its concerns with the methodology of this draft report and certain of its findings, OPWDD agrees with the recommendations of OSC except, as discussed below, to the extent they include certain inferences about the procedures already in place.

II. OPWDD’S RESPONSE TO FINDINGS IN OSC’S DRAFT REPORT

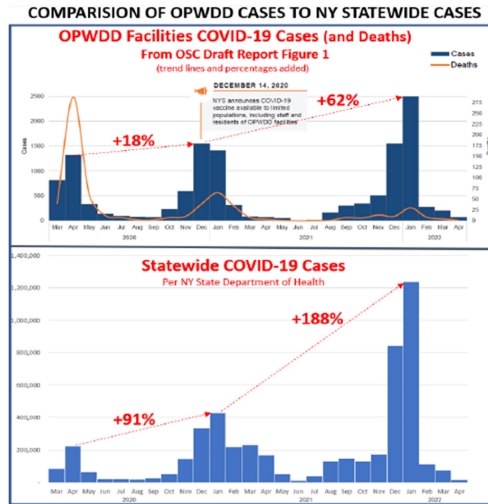
1. OPWDD REQUESTS OSC RECONSIDER CERTAIN CONCLUSIONS BASED ON DATA ANALYSIS

A. OSC Is Requested to Correct the Conclusion it Draws Based on its Figure 1

The first chart shown below is Figure 1 from the OSC draft report which shows COVID-related deaths at OPWDD residential facilities decreasing while COVID-19 cases increased with each subsequent wave of infection. Based on this chart, OSC’s draft concludes “[t]hat COVID-19 cases continued unabated indicates the need for improved oversight of homes’ infections control practices and planning.” [draft p.10]

To reach this conclusion, OSC is assuming that, if OPWDD implemented improved oversight following the first wave, case counts for each successive wave should be lower. This assumption does not consider a significant expansion of access to reliable testing and significantly increased reporting over time. Importantly, it also does not acknowledge that successive waves of COVID-19 involved new variants of the virus, which were progressively more infectious over time, including the widely publicized Omicron variant.

A more meaningful analysis would be to compare OPWDD cases to all cases in New York State (see bottom chart below).



State Comptroller’s Comment – The graph shown above, which OPWDD misrepresents as our Figure 1, is not the graph presented on page 10 of our report. Whether intentional or not, OPWDD’s alterations – not only adding trend lines, percentages, and headings but deleting significant timeline details – deflect from the point of our graph: that COVID-19 cases at OPWDD facilities continued unabated, with increasingly higher rates with each wave.

As can be seen by comparing the number of cases reported within OPWDD facilities (top chart) to the number of NY State cases (bottom chart), the increased infections within OPWDD facilities were significantly less than the trend for NY State's population overall. Specifically, comparing the last wave in the winter of 2021/22 with the wave a year earlier, the peak for the NY statewide cases increased 188% but only 62% at OPWDD facilities. Similarly, the prior statewide wave increased 91% while OPWDD facilities only experienced an 18% increase. This more informed analysis would suggest that OPWDD's practices drastically helped control infection, contrary to OSC's assertion.

OSC is requested to remove the conclusion from its report and acknowledge that the statistics instead indicate OPWDD infection control practices were effective.

State Comptroller's Comment – As noted on pages 6 and 9 of the report, individuals with IDD are more susceptible to severe and potentially deadly outcomes during public health emergencies due to underlying conditions. As such, New York State included this population among the first groups eligible for the COVID-19 vaccine. OPWDD's comparison of its client population with the general population of New York State as indicative of effective infection control practices is meritless and disregards other factors such as vaccinations and prior infections.

Even so, using OPWDD's logic in comparing its rate of cases to the State's overall population, with each wave of the pandemic, although the percentage increase in cases was lower within OPWDD's client population, the percentage of its population infected was higher than the State's:

- 7.2% (OPWDD) compared to 1.9% (overall State) in wave 1;
- 12.2% compared to 7.1% in wave 2; and
- 14.2% compared to 11.8% in wave 3.

This is based on OPWDD's residential enrollment of 34,117 as of November 24, 2021 and an average State population of 19.9 million using U.S. Census Bureau data between April 2020 and July 2022.

B. OPWDD is Concerned with Certain Inferences in the Draft Report Based on Statistics

OPWDD is concerned with OSC's use of certain data it relies on for its findings, and the resulting conclusions. For example, Figure 5 and the accompanying narrative in the draft report states that, through February 2, 2022, OPWDD conducted surveys at 59% of ICFs (208 out of 351) and 20% of IRAs (1343 out of 6578). From this statistic, the report infers:

*"While OPWDD did visit more IRAs than ICFs, the percentage of all IRAs visited was much lower than for ICFs. As previously mentioned, ICFs must meet several federal regulations, including establishing and maintaining an emergency preparedness program, and are routinely surveyed by DOH.³ IRAs and the clients of **these homes may have benefited more from the findings of the COVID-19 Surveys.**" [draft p.14, emphasis added]*

OSC's apparent inference that OPWDD did not focus sufficiently on IRAs appears to be based on an assumption about "the percentage" visited, but OPWDD's process for selecting survey sites was soundly based on demonstrated risk factors. As was detailed to OSC auditors during a May 12,

³ The referenced surveys performed by OPWDD were not duplicative of the surveys that were performed by DOH.

2022 meeting with staff from OPWDD's Division of Quality Improvement, OPWDD selected sites for review based on a number of relevant factors, including medical need of the residents living in a home. ICFs were examined at a higher rate (59% vs. 20% of IRAs) because ICFs generally serve people with more complex behavioral and medical needs and are more institutional in nature, representing greater risk for more severe outcomes from the virus.

As many of OSC's statistical inferences and conclusions were not presented to OPWDD prior to the issuance of the draft report, OPWDD was not given an opportunity to address OSC's understanding of the service system or characterizations of available data.

State Comptroller's Comment – We recognize there are various factors when selecting the sites to visit. However, as we noted on page 14, DQI began conducting COVID-19 Surveys in May 2020. Up to that point, according to OPWDD data, 82% of OPWDD cases and 79% of related deaths had occurred at IRAs. Further, as noted on page 13, this trend continued throughout the pandemic (as of April 5, 2022). While ICFs receive guidance and oversight by various entities, IRAs receive less – and warrant greater attention by OPWDD to further ensure the health and safety of its IRA clients.

2. OSC's Narrow Focus on Certain Emergency Plans Omits Crucial Information About OPWDD's COVID-19 Response

Despite OSC's broadly framed objectives to review "pandemic planning and care," its audit narrowly focused on records specifically labeled as emergency planning documents. OSC's draft report does not sufficiently address the numerous measures covered elsewhere in an extensive array of other governance documents issued by OPWDD. Many of the conclusions in the draft report are based on this narrow review.

State Comptroller's Comment – We did not rely solely on documents specifically labeled as "emergency planning documents." During meetings with facility officials, we asked for policies and procedures related to emergency planning, policies and procedures for infection control, and any guidance documents issued in relation to the COVID-19 pandemic. We relied on facilities to determine which documents met that request and reviewed any such documents collectively to determine if facilities had plans to address pandemics as well as actions taken to address their clients during the pandemic.

Prior to the unprecedented COVID-19 pandemic, OPWDD had existing policies covering all its facilities, addressing foreseeable pandemic-related concerns such as infection control procedures and training. Once COVID-19 struck, OPWDD acted swiftly to address the unique circumstances that had arisen, enacting numerous policies and procedures covering such aspects as worldwide PPE shortages, vaccinations, closure of its day programs, visitation restrictions, contact tracing, infection control refresher trainings, COVID-specific and OPWDD-specific infection control procedures, and much more. OPWDD frequently updated these policies and added new policies based upon evolving guidance from federal and state public health experts, at times updates occurring daily as the entire world learned how to respond to the novel coronavirus.

OSC's generalized assertion that emergency planning documents should have better anticipated issues associated with this extraordinary world-wide health emergency does not address the specific guidance. OSC's more specific assertions, such as that OPWDD could have better anticipated shortages of personal protective equipment (PPE) and staffing, are also not accompanied by specific factual findings or reference to specific guidance issued by OPWDD. OSC acknowledges that

OPWDD never ran out of PPE nor did its staffing levels ever fall below established standards [draft p.12) despite facing a never-before-seen virus which caught the world by surprise. OPWDD suggests that its “planning and care” could more productively be evaluated with respect to the actual guidance and procedures it issued.

State Comptroller’s Comment – The report does not state or imply that emergency plans should have better anticipated issues associated with the pandemic. Rather, as reported on page 11, based on guidance issued in 2017 by the Centers for Disease Control, emergency plans should consider key prevention strategies, including extra supplies, worker absences, and isolation strategies (e.g., quarantine areas). To some extent, OPWDD agrees as these areas were included in its November 2021 supplemental annex, as reported on page 13. Furthermore, our report does not specifically assert that OPWDD should have better anticipated shortages of PPE. As noted on page 12, staff at 11 of 16 homes we visited expressed difficulties accessing and acquiring PPE during the early stages of the pandemic.

One section of the draft report highlights OPWDD’s concern. In the section titled “*Distribution of EMOP Emergency Planning Annexes,*” starting on page 13, the draft report states:

“in November 2021 [OPWDD] issued an updated annex covering areas such as PPE; staffing considerations; exposure control protocols; screening protocols for clients, staff, and visitors; and transfer and discharges of clients. Although these annexes provided useful guidance, OPWDD only issued them to State-operated ICFs, which, as of November 2021, represented only 0.2% of OPWDD’s residential clients. While we did not establish a causal relationship between OPWDD’s actions and COVID cases, we did find that, as of April 5, 2022, State-operated ICFs accounted for 0.6% (4) of COVID-19-related deaths. In contrast, certified IRAs had the greatest number of deaths (545, or 83%), including 141 deaths at State-operated IRAs and 404 deaths at voluntary agency-operated IRAs (see Figure 2).

Similarly, State-operated ICFs had the fewest COVID-19 cases while certified IRAs had the most, including 2,764 cases at State-operated IRAs and 8,756 cases at voluntary agency-operated IRAs (see Figure 3).

The significant disparity in COVID-19 case and death rates between State-owned ICFs and all others notwithstanding, the crisis at the time demanded action by OPWDD on behalf of all facilities.” [draft p.13]

This conclusion does not acknowledge that the annexes were developed from guidance previously issued to all facilities, not just state-operated ICFs. Therefore, the receipt of annexes should not be used as a basis to assert that only state-operated ICFs benefited from the guidance that ultimately was incorporated in their emergency planning documents, an inference made throughout the draft report.

State Comptroller’s Comment – As noted on page 13, OPWDD created supplemental annexes to its emergency plans for State-operated ICFs only to comply with a federal requirement for ICFs to develop emergency plans and update them every 2 years. Even so, as noted on page 9, we question why the annexes were not provided to all residential facilities, which would have benefited from the ease of a single-source compilation of key guidance throughout the pandemic – particularly IRAs, which accounted for the vast majority of cases and deaths (page 13) compared to ICFs, which accounted for less than 1% of residential clients.

Notably, the draft report emphasizes the statistics breaking down the percentage of residents served in different settings by ignoring the other factors relevant to pandemic planning and care. The following statistic is relied on heavily by the draft report:

Percentage of Residents Served	
Voluntary-operated IRAs	73.7%
Voluntary-operated ICFs	10.0%
State-operated IRAs	16.1%
State-operated ICFs	0.2%
Total	100.0%

In two other sections of the draft report, OSC uses the very low percentage of residents in State-operated ICFs to assert that the other 99 percent of residents living in other types of facilities could have benefited from the annexes. But the draft report does not identify specific guidance or information it concludes was not provided to these other residents. Notably, the draft report also states it “*did not establish a causal relationship between OPWDD’s actions and COVID cases.*” [draft pp. 2, 9 and 13]. Although it acknowledges no established cause and effect, the report repeats numbers for all other facility types (i.e., IRAs and voluntary operated programs), showing their higher number of cases and deaths, without also discussing the probability that the reason these other facility types have higher incidents of COVID is because they serve more people.

Lastly, OPWDD would like to provide clarification in relation to the question below which OSC raised in the draft report.

“While OPWDD complied with the law in exercising its oversight responsibilities, improvements in policies and processes are needed to better protect all clients. We question why OPWDD developed and issued COVID-19-related annexes to only State-operated ICFs and overlooked the value of such plans to all other facilities that were equally if not more in need.” [draft p.9]

First, given that the OSC draft report cites federal regulation 42 CFR Part 483 (draft p.7), it appears OSC is aware the annexes were developed to comply with federal regulations which require ICFs to have an emergency plan that is reviewed and updated every two years [42 CFR § 483.475(a)].⁴ Second, as discussed above, the information contained in the ICF plans updated in September 2020 and November 2021 came from guidance that OPWDD supplied to all providers on a contemporaneous basis. OSC’s focus only on records that were labeled “emergency planning documents” does not include the guidance and planning provided to OPWDD’s providers.

State Comptroller’s Comment – As previously mentioned, we take exception to OPWDD’s assertion that we relied solely on documents specifically labeled as “emergency planning documents.” OPWDD’s argument that it was not aware of this is inconsistent given that as many as three OPWDD officials were present at every meeting throughout the audit and should have been aware that we accepted all documents that facilities considered part of their emergency planning and/or pandemic response. Additionally, as previously discussed, our audit distinguished between emergency planning efforts and efforts made in response to the pandemic.

⁴ Although the OSC preliminary findings reports included the fact that federal regulations only require emergency plans be updated every other year, the draft report omits that piece of information.

Notwithstanding its concerns with conclusions in the draft report, OPWDD intends to continue periodically reviewing and updating its emergency planning documents, including based on its experience with COVID-19.

3. OSC Is Requested to Remove Its Statement that Survey Checklists “Often Lack Meaningful Comments”

The draft report concludes six of eight OPWDD survey checklists “lacked meaningful comments regarding observation of home practices.” [draft p. 15] OPWDD has reviewed the six checklists and, for the following reasons, requests that OSC reconsider and remove this statement. OSC cites one specific example in its draft report to support its conclusion, as follows:

“the observation comments simply stated the two clients were eating a meal, while others were in their rooms resting, watching TV, or listening to the radio. There was no mention about the use of PPE or screening of individuals or visitors.” [draft p.15]

An excerpt from this survey checklist is shown in blue below, and it is not consistent with OSC’s statements that “there was no mention about the use of PPE or screening” or that it “lacked meaningful comments.”

Excerpt From Completed Survey Questionnaire Referenced by OSC:

[SECTIONS 8 AND 9 COVER SCREENING]

Section 8: Visitor (Surveyor) Health Checks:

8a. Was the Surveyor asked all of the COVID symptom screen questions? YES

Comment: [staff name]-LPN asked surveyor upon arrival. Surveyor was asked to sign in and fill out a form asking the questions regarding symptoms.

8b. Was the surveyor’s temperature taken? YES

Comment: [staff name]-LPN took surveyors temperature and had surveyor document.

8c. Did staff person who performed the health check wear a facemask? YES

Comment: [staff name] wore a surgical mask and N95 mask.

8d. Did the staff person who performed the health check wear gloves? YES

Comment: [staff name] wore gloves during the temperature, applied sanitizer, then doffed the gloves appropriately.

8e. Is there a written and observably used and up-to-date log of completed COVID symptom screen questions and temperature checks? YES

Comment: [staff name] showed surveyor the documentation after applying sanitizer to the outside of the binder.

Section 9 Visitor/Program Restrictions:

9a. Has the program posted signs at the entrances advising that no visitors may enter the Program? YES

Comment: Sign was posted on the door.

9b. If visitors (other than surveyor) arrived during site visit, did program staff require those essential visitors to wear facemasks while in the program? YES

Comment: There was an investigator – [staff name] who had arrived prior to surveyor arrival. Surveyor saw the investigators name on the sign in sheets, along with their information (signs/symptoms/temperature).

Section 10 Residential Observations-

Report what is observed during the first 10-minutes of the site visit:

10. Which care activity(ies) are you observing?

1. Dining
2. Observed two individuals eating a meal. Other individuals were in their rooms resting, watching Blues Clues, listening to the radio.

[SECTION 11 COVERS USE OF PPE]

Section 11: General/Routine Infection Control Practices:

11a. At anytime during the visit, were any staffed observed not wearing masks while on duty? **NO**

Comment: All staff were observed wearing their masks.

11b. If yes, how many staff were not wearing facemasks? **N/A**

11c. Are gloves being worn? **YES**

Comment: It should be noted that during meal time, two individuals were eating, but staff were not wearing gloves at the time. This was discussed with [staff name]- House Manager- and explained that it would be recorded on the letter.

11c1. If yes, were gloves changed after contact with each individual? **YES**

Comment: [staff name] was observed changing gloves regularly

11c2. If gloves were not changed, are they being re-used as part of a conservation measure due to lack of access to gloves? **NO**

Comment: N/A

11c3. If gloves were worn, did the staff person wash hands before donning and after removing gloves? **YES**

Comment: [staff name] was observed using hand sanitizer donning and doffing

11c4. If gloves were worn, did staff person remove gloves properly to prevent contaminating their hands? **YES**

11d. Did staff refrain from touching their faces during their observation? **YES**

Comment: At no time did surveyor observe staff touching their faces

11e. Did staff use hand sanitizer appropriately per guidance? **YES**

(Note: There are several other sections in the survey questionnaire which cover other PPE and Infection Control topics.)

In short, the survey document includes meaningful comments and discusses the use of PPE and screening. It may be that OSC focused on the response to question 10 rather than information contained elsewhere in the survey document. Practically speaking, not every yes/no response requires comments, except in instances where a deficiency is found. In the example above, in response to item 11c, the survey supplied meaningful comments on the noted deficiency.

Most importantly, OSC did not identify any instances when a deficiency was found but was not properly documented or communicated. Accordingly, OPWDD requests that OSC remove this statement from the draft report.

State Comptroller's Comment – As noted on page 15, in reviewing completed checklists for selected COVID-19 Surveys, we found that observation notes did not provide enough detailed information to ascertain the conditions found at the time related to infection control practices, such as the use of PPE and social distancing. The lack of detail is contrary to the guidance issued by OPWDD to conduct COVID-19 Surveys.

4. OSC Is Requested to Revise the Draft Report's Characterization of Slightly Revised COVID Checklists

Early in the pandemic, OPWDD developed and implemented an extensive survey questionnaire containing over 100 inquiries specific to COVID-19 precautions and protocols, some of which are

shown in the section above. The questionnaire subsequently underwent two minor revisions. OSC identified that, at three ICFs, the OPWDD surveyors used the original form rather than the slightly revised form. While OPWDD agrees the revised form should have been used, it requests that OSC reconsider its characterization of the minor changes as “critical requirements for proper infection control.” [draft pp.2 and 15].

The minor changes to the survey are summarized below:

June 22, 2020 Revision

- Added a question to ask if the Emergency Preparedness Plan addresses their response to the COVID pandemic (applies to ICFs only).
- Added two questions for sites with newly reported positive cases, although a separate phone questionnaire was also developed which gathered this information.

September 3, 2020 Revision

- Changed the inquiry on number of days permitted to return to work after testing positive from 14 to 10 days, consistent with newly released *less-restrictive* protocols.
- Modified the inquiry on wearing gloves during health checks to add an acceptable alternate of appropriate handwashing and hand sanitizer.
- Modified the inquiry on the physical locations where hand sanitizer is available to specifically explain how to document when staff are carrying sanitizer on their person.

OPWDD notes the significance of these changes should be considered in the context of the 100+ detailed questions contained in the original survey document that provided a thorough assessment of COVID-related protocols.

State Comptroller’s Comment – Although OPWDD revised its checklist to require the additional questions be completed, it is now considering those questions to be “minor” changes. Beyond the revision requiring surveyors to determine whether or not ICFs’ Emergency Preparedness Plans address their response to the pandemic, the additional questions determined if a site was on a quarantine level and provided explanations of precautions implemented to prevent the spread of COVID-19. These revisions should not be considered minor in light of the pandemic’s impact to the health and safety of OPWDD staff and clients.

5. OPWDD is Effectively Communicating Survey Findings to Appropriate Staff

The draft report contains the following recommendation:

“Establish effective communication with individuals responsible for infection control policies and procedures when pertinent deficiencies are identified.” [draft pp. 2 and 18]

OPWDD agrees that effective communication is integral and already has an effective means of communicating any found deficiencies to the appropriate responsible parties. OPWDD utilizes the same method OSC uses to notify agencies of their audit findings: a written audit report is submitted to top management who then, based on the type of findings, disseminates the report to the appropriate staff responsible to carry out corrective actions. When significant findings are identified, OPWDD immediately informs the responsible staff verbally as well. An example of this latter action was shown in the survey excerpt above, and is restated here:

Comment: It should be noted that during meal time, two individuals were eating, but staff were not wearing gloves at the time. This was discussed with [staff name]- House Manager- and explained that it would be recorded on the letter.

In this situation, the House Manager was given instantaneous feedback so that corrective actions could be taken immediately. Also, OPWDD's DQI staff presented its survey findings in a letter dated three days later to top management at the district office.

To the extent OSC's recommendation suggests that Infection Control Nurses (ICNs) must directly be notified, this recommendation appears to be based on interviews with ICNs, who are mid-level management, providing policy and education development.⁵ The OSC interviews with ICNs focused on the extent of direct contact DQI had with the ICNs. OSC's suggestion that DQI directly notify the ICNs is unnecessary given the notification process already in place. The ICNs do not need to be notified of every isolated incident of someone not wearing gloves, but need be brought into the discussion only if district office management noted systemic issues on the survey reports. However, OSC did not find any examples of systemic deficiencies which were not communicated by district office management to the ICNs.

State Comptroller's Comment – As noted on page 16, ICNs play a vital role in infection control across State-operated facilities, ensuring the development of infection control programs, including policies and procedures that eliminate risk of infection to clients, facility personnel, and visitors through surveillance and appropriate control measures. OPWDD would benefit from consulting with ICNs and using their unique perspective and expertise in developing a survey protocol focused on mitigating a highly infectious virus with serious health effects, as well as communicating to them the results of the COVID-19 Surveys for their respective regions.

6. OPWDD Requests OSC Reconsider the Draft Report's Finding of Poor Cooperation

OPWDD values the work of OSC and shares its goals of ensuring effective agency operation. It accordingly requests that OSC reconsider many of the descriptions contained in the draft report section titled "Poor Agency Cooperation," which begins on page 17. While acknowledging some delays occurred, albeit to a lesser extent than described in the draft, delays were not caused by poor OPWDD cooperation but instead were generally the result of the following:

- The audit was initiated in April 2021 during the midst of the pandemic when OPWDD prioritized addressing the unprecedented challenges of protecting the health and safety of the people we serve and the staff who serve them.
- The audit topic of pandemic planning and care appeared so broad as to create difficulties in response, and OPWDD sought clarification to ensure a workable scope.
- OSC requested customized data reports that were not in OPWDD's possession and had to be specially created by OPWDD staff to OSC specifications.
- OSC did not divulge its specific conclusions promptly, with most details only provided in the preliminary findings reports issued in July 2022 and the draft report issued in December 2022. It is OPWDD's hope that its response to the draft report will permit the resolution of any outstanding misunderstandings

⁵ The full description of an ICN's role as described in the OSC draft report is as follows: "ICNs ensure the development of infection control programs, including policies and procedures that eliminate risk of infection to clients, facility personnel, and visitors through surveillance and appropriate control measures. Additionally, ICNs provide education on infection control and isolation techniques, practices, and policies to employees at all levels; identify areas demonstrating infection risk and initiate programs to eliminate infection hazards; and participate in education and research epidemiology programs." [draft p.16]

State Comptroller’s Comment – We have addressed the “broad” scope in previous comments. However, we disagree with OPWDD’s assessment of its cooperation. For example:

- As with many information requests, we rely on the agency and/or facilities to provide documentation relating to the audit objectives. For instance, we initially requested information related to the audit in April 2021. Our request included general descriptions of items but noted that *“if the documents available do not match exactly the information being sought but approximates the requested data, we ask that you provide us with whatever currently exists in whatever format it may be assembled.”* Furthermore, as noted on page 17, OPWDD delayed providing data on OPWDD cases and deaths, and ultimately provided such data in November 2021. As the data initially received only included aggregate data by facility – similar to data published on OPWDD’s website – and not detailed data by site and client, we met with staff from OPWDD’s Division of Data Strategy and Management (DDSM). During this meeting, DDSM staff explained that the information we requested was available and that it wouldn’t be difficult to run such a report. We received the detailed data in December 2021 – less than 2 weeks after meeting with DDSM staff.
- OPWDD officials attended all meetings with facilities and ICNs – at times having up to four OPWDD officials at one of these meetings. As such, OPWDD officials should have had a general understanding of the issues brought up by direct care workers and ICNs and the items we requested.
- After meeting with OPWDD officials to discuss preliminary findings and issuing written preliminary reports (July 2022), OPWDD requested and received more detailed information on the findings. Our auditors even reached out to have further meetings on the preliminary reports, but OPWDD officials never responded to our efforts toward resolution.
- Lastly, it was only in OPWDD’s response to the preliminary report received in August 2022 that we learned OPWDD issued the specific annexes mentioned on pages 9, 10 (Figure 1), and 13. We were provided copies of such annexes in September 2022 and assessed the impact of this guidance being issued to State-run ICFs only.

7. OPWDD Requests that OSC Include Information to Correct any Misimpression that OPWDD was Withholding Data from the Public

OPWDD requests that the draft report include vital information it currently does not disclose, to correct any mistaken impression that OPWDD was somehow withholding data from the public. There are numerous references throughout the draft report to delays in providing OSC data, but the report does not include the information that reports needed to be specially created for OSC. OPWDD was not required to produce such customized reports but did so, diverting already strained staff resources to assist OSC’s audit efforts.

The draft report also omits that throughout the time OSC was requesting the creation of additional, specific reports, OPWDD was posting weekly data to its public website showing COVID deaths and cases for both residents and staff, detailed by provider. OPWDD prioritized preparation of this important time-sensitive public information to assist its leadership and the voluntary providers in identifying COVID “hot spots” where extra precautionary actions may be needed.

OPWDD went to great lengths to keep the public and its stakeholders informed with further website material, including prompt updates for COVID-19 guidance, protocols, policies, procedures, and other COVID-related information. Additionally, OPWDD regularly held stakeholder conference calls to discuss the data trends and relevant guidance. For the sake of completeness and accuracy, OSC is requested to modify its draft report to include this important information and avoid leaving the wrong impression.

State Comptroller’s Comment – Our report does not state or imply that OPWDD withheld information from the public as it was not within the scope of our review. However, this is a finding in a March 2021 report by others, including DRNY – the Protection & Advocacy System and Client Assistance Program (P&A/CAP) for persons with disabilities in New York. As noted on page 18, OPWDD initially withheld information from the auditors and failed to respond to auditors’ request to address OPWDD’s concerns regarding the preliminary findings. We requested information and met with OPWDD and facility officials to ascertain what information they had to meet our requests. Again, pertaining to COVID-19 data, OPWDD staff expressed that the information was available and not difficult to obtain and provide to us. As our report is an accountability mechanism that provides stakeholders including the public an independent assessment of OPWDD’s performance, based on the actions taken by the agency we believe making such modifications would not only be inaccurate but create the wrong impression.

III. RESPONSES TO OSC RECOMMENDATIONS

1. **OSC RECOMMENDATION:** *Periodically review and update as necessary the EMOP and supplemental documents to ensure all homes implement current policies and procedures in the event of another public health emergency.*

OPWDD RESPONSE: The OPWDD Emergency Management Operations Protocol (EMOP) is constructed with an approach to incident management universally applicable to various types of hazards OPWDD might encounter requiring emergency response. This overarching framework provides the agency with the operational principles to adequately evaluate and manage emergency situations that the agency faces using nationally accepted incident management concepts.

OPWDD specifically identified pandemics as a potential hazard within the emergency planning process as clearly outlined in the *Hazards and Vulnerability Analysis* completed by the agency.

The EMOP is reviewed and updated annually and subsequently submitted to New York State's Division of Homeland Security and Emergency Services for review and approval.

OPWDD will continue to review and update the EMOP and supplemental documents annually to ensure they comply with all requirements and provide sufficient considerations pertaining to the possibility of a future pandemic.

2. **OSC RECOMMENDATION:** *Develop procedures to ensure facility-level emergency plans encompass planning for and responding to public health emergencies.*

OPWDD RESPONSE: In conjunction with the annual review of the EMOP described above, OPWDD will ensure its Facility-Based Emergency Plans include planning for and responding to public health emergencies.

3. **OSC RECOMMENDATION:** *Ensure monitoring and review protocols address infection control practices, are well developed, and are consistently applied when conducting reviews at homes.*

OPWDD RESPONSE: Early in the pandemic, OPWDD developed and implemented an extensive set of infection control review protocols containing over 100 inquiries specific to COVID precautions. As described in the response above, these protocols underwent two minor revisions as COVID response evolved. While OPWDD would not characterize that the minor edits constituted "critical requirements," OPWDD agrees staff should use the most up-to-date forms when conducting surveys and has implemented a system to ensure the latest form is used.

4. **OSC RECOMMENDATION:** *Establish effective communication with individuals responsible for infection control policies and procedures when pertinent deficiencies are identified.*

OPWDD RESPONSE: OPWDD believes it effectively communicated its infection control policies and procedures to key staff. The OSC audit did not cite any instance in which an infection control deficiency was not properly communicated. OPWDD will continue to employ effective methods of communicating its findings to agency management who will then disseminate the findings to the appropriate responsible staff. In significant instances of noncompliance, OPWDD staff will also continue to communicate immediately with facility staff when appropriate.

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