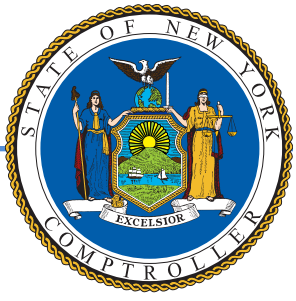
Office of Addiction Services and Supports

Addiction Support Services During Emergencies

Report 2021-S-35 | November 2023

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller
Division of State Government Accountability



Audit Highlights

Objective

To determine whether the Office of Addiction Services and Supports (OASAS) offers adequate guidance to providers to help ensure they're able to deliver addiction support services during emergency situations. Our audit covered the period from January 2019 through November 2022.

About the Program

OASAS' mission is to improve the lives of New Yorkers by leading a comprehensive system of addiction services for prevention, treatment, and recovery. OASAS operates 12 Addiction Treatment Centers and oversees nearly 400 providers that it has certified to operate more than 1,000 substance use disorder and problem gambling treatment and prevention programs (Programs) across the State. These Programs serve an average of 100,000 individuals on any given day. To open and operate a new Program, providers must apply for and obtain OASAS certification. Programs may be certified to operate for a 6-month or 1-, 2-, or 3-year period before recertification.

OASAS issues Local Service Bulletins (LSBs) that provide guidance to addiction service providers and may include administrative directives that providers must follow. OASAS' certified treatment providers are required by certain LSBs to have Emergency Preparedness Plans (Plans) and to re-evaluate and revise them following an incident such as a major fire or flood, disease outbreak, or terrorist attack. These LSBs state that OASAS personnel will review provider Plans at both recertification site visits and visits from the Regional Office. Providers are also required to be set up to use the New York State Evacuation of Facilities in Disasters System (eFINDS), an application that allows them to monitor where a patient is evacuated from and moved to. To use eFINDS, each Program must have at least one assigned Coordinator and one assigned User. In addition, in some circumstances providers must maintain a list of applicants awaiting treatment and report this information in the OASAS Client Data system. OASAS established a Waiting List Report to measure the need for additional treatment capacity and to manage access to treatment. Waiting list information can also be used by OASAS to inform discussions regarding gaps in care and capacity.

Key Findings

Although OASAS provides guidance to help providers ensure they're able to deliver addiction support services during emergency situations, such as fires or evacuations, OASAS should improve upon the extent and clarity of this guidance.

Given the disruptions that accompanied the COVID-19 pandemic, OASAS should also improve its monitoring to better ensure that provider Plans are revised when warranted and that they include strategies to manage and mitigate prolonged disruptions in service to prevent the related loss of progress and momentum.

Further, OASAS should do more to gain assurance that certain tools that providers use – such as eFINDS and waiting lists – are in place and suitable to use for managing services to their clients. The weaknesses we identified indicate that Programs may not be adequately prepared for emergency situations, which could compromise safety and continuity of care.

Specifically, we found that:

- OASAS personnel review Plans only at initial certification, despite guidance that states they will review them at later site visits.
- Some OASAS-certified Programs are not set up to be able to use eFINDS and would likely be unable to access it in the event of an emergency. This increases the risk of losing track of patient movement and transfer locations and may compromise continuity of care.
- Although OASAS uses a central repository for waiting list information, some providers may not be entering required information, and the information that OASAS does receive may not be accurate or entered timely. Further, OASAS doesn't make efforts to improve the accuracy of this information and its usefulness for decision making.

Key Recommendations

- Review and revise the LSBs, site review instruments, and any other guidance, as considered necessary, to:
  - Incorporate provisions that address providers' plans to manage and mitigate prolonged disruptions in service.
  - Clearly describe the responsibilities of both providers and OASAS personnel related to Plans, eFINDS readiness, and waiting list requirements.
- Implement a risk-based method to:
  - Review Plans subsequent to the initial certification.
  - Verify provider access to eFINDS, including verification that assignments to key roles are current.
- Improve the use of waiting list information submitted by providers to better support OASAS' decision making and oversight.

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

November 2, 2023

Chinazo Cunningham, M.D.
Commissioner
Office of Addiction Services and Supports
1450 Western Avenue
Albany, NY 12203

Dear Dr. Cunningham:

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 *Addiction Support Services During Emergencies*. 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

Contents

Glossary of Terms

Term	Description	Identifier
OASAS	Office of Addiction Services and Supports	*Auditee*
CCN	Case-Client Number/Client ID	*Key Term*
CDC	Centers for Disease Control and Prevention	*Federal Agency*
CDS	Client Data System	*System*
DOH	Department of Health	*NYS Agency*
eFINDS	Evacuation of Facilities in Disasters System	*System*
HCS	Health Commerce System	*System*
HERO Act	New York Health and Essential Rights Act	*Key Term*
LSB	Local Service Bulletin	*Key Term*
Pandemic	COVID-19 pandemic	*Key Term*
Plan	Emergency Preparedness Plan	*Key Term*
Programs	Substance use disorder and problem gambling treatment and prevention programs overseen by OASAS	*Key Term*
Report	Waiting List Report	*Key Term*

Background

The tragic, cumulative, and often fatal consequences of alcohol and substance use disorders are a continuing concern in New York and nationally. These disorders are treatable conditions that require a coordinated network of services. To help prevent interruptions in treatment and related loss of progress and momentum, addiction treatment providers must make efforts to ensure the accessibility and continuity of their services during an emergency, such as a fire or an evacuation. The Office of Addiction Services and Supports' (OASAS) mission is to improve the lives of New Yorkers by leading a comprehensive system of addiction services for prevention, treatment, and recovery. OASAS operates 12 Addiction Treatment Centers and oversees nearly 400 providers that it has certified to operate more than 1,000 substance use disorder and problem gambling treatment and prevention programs (Programs) across the State. These Programs serve an average of 100,000 individuals in New York on any given day.

Alcoholism, substance abuse and chemical dependence pose major health and social problems for individuals and their families when left untreated, including family devastation, homelessness, and unemployment. It has been proven that successful prevention and treatment can dramatically reduce costs to the health care, criminal justice and social welfare systems.

– Laws of New York State Mental Hygiene (MHY) Chapter 27, Title D, Article 19 § 19.01 Declaration of policy

To open and operate a new Program, providers must apply for and obtain OASAS certification. Programs may be certified to operate for a 6-month or 1-, 2-, or 3-year period before being recertified. Recertification reviews are done by OASAS personnel, are unannounced, and include an assessment of provider compliance with regulatory requirements. OASAS may also do interim or focused reviews (referred to as Regional Office reviews) to determine whether Program residences are operating in a manner that is safe and suitable for residents and whether key policies are in place and being followed. OASAS personnel use review instruments, which are lists of questions and areas to address during their reviews. Each Program type (e.g., inpatient, residential, opioid treatment) and site visit type (recertification or Regional Office site visit) has an associated review instrument. OASAS personnel use review instruments to help them determine whether Programs are operating in accordance with requirements and to guide their activities.

To help address current events and developing issues, OASAS issues Local Service Bulletins (LSBs) that provide guidance to addiction service providers. An LSB may include administrative directives that providers must follow. In August 2019, OASAS issued "Requirements Under the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant" (hereafter referred to as LSB 1). LSB 1 applies to all OASAS-funded prevention and treatment service providers, regardless of whether they receive these grant funds, and includes information about providers' requirements to maintain waiting lists – in some circumstances – for clients awaiting treatment.

In September 2019, OASAS issued "Emergency Preparedness for Chemical Dependence Treatment Providers" (LSB 2) and "Emergency Preparedness for Opioid Treatment Providers (OTPs)" (LSB 3). LSB 2 was addressed to all residential

treatment providers, inpatient rehabilitation providers, and medically managed/inpatient withdrawal and stabilization providers; LSB 3 was addressed to all Outpatient Opioid Treatment Programs. According to LSBs 2 and 3, each of these providers is responsible for developing, maintaining, and updating an Emergency Preparedness Plan (Plan) to help them prepare for, respond to, and/or recover from an internal or external emergency that may present an immediate danger to personnel, patients, Programs, and/or property. According to the LSBs, the objectives of each Plan are to:

- Identify, assess, and prioritize vulnerabilities to emergencies or disasters and the resources available to prevent or mitigate, respond to, and recover from them;
- Outline short-, medium-, and long-range measures to improve the capability to respond to and recover from an emergency or disaster;
- Provide for the efficient utilization of all available resources during an emergency or disaster; and
- Ensure the continuity of operations in times of emergency or disaster situations.

Although Plans are not required to include specific content or address specific emergency situations, according to the LSBs, providers must review their Plan annually and re-evaluate it following an incident. OASAS officials said that the Plan needs to be updated only if changes to it are necessary. As such, as new information is learned or an unanticipated emergency arises (such as the COVID-19 pandemic [pandemic]), a provider should update its Plan accordingly. Further, during recertification or a site visit from an OASAS Regional Office, LSBs 2 and 3 state that OASAS personnel will review the "command and control document," which OASAS officials said is the Plan.

At its peak in late October 2012 – and for days and even weeks thereafter – Superstorm Sandy forced the sudden evacuation of thousands of vulnerable residents from treatment facilities and nursing homes in the New York City area to safer locations and underscored the need to ensure patient safety and continuity of care in emergency situations. The storm also highlighted the need for a system to track patient locations, which was not in place at the time, and resulted in the creation of the New York State Evacuation of Facilities in Disasters System (eFINDS), which was introduced in 2013.

> ***"They went to crowded shelters and nursing homes as far away as Albany, where for days, they often lacked medical charts and medications. Families struggled to locate relatives."***
>
> **–** New York Times

The eFINDS application, which is housed within the Department of Health's (DOH) Health Commerce System (HCS), is a barcode scanning system designed for real-time tracking of the location of people being cared for in facilities, as well as on-duty staff, if they're relocated to other facilities or their home during an emergency. Using barcode wristbands, eFINDS not only tracks patients' movement and location, but also their health records. According to LSB 2, in the event of an emergency, "all OASAS certified residential Programs will use the barcode wristbands to monitor where a patient gets evacuated to and evacuated from;

locations will be updated and tracked using hand-held scanners, mobile apps, or paper tracking (if power and/or phones are out of service)."

As stated in the Office of the State Comptroller's November 2022 report, "Continuing Crisis: Drug Overdose Deaths in New York," after trending upward for more than 10 years, the number of New York's drug overdose deaths and the death rates started to decrease following the federal government's 2017 declaration of a public health emergency in response to the consequences of the national opioid crisis. That decrease continued for the following 2 years, through 2019. However, the pandemic and the resulting upheaval of people's everyday lives disrupted that trend. Notably, in 2020, New York's opioid-related overdose deaths rose 44% from the prior year.

The unprecedented circumstances surrounding the pandemic had a significant impact on New Yorkers, including people with or susceptible to addictions and their families, as well as the addictions services workforce. Addiction is often referred to as a disease of isolation, and impediments to overcoming that challenge can be amplified during an emergency situation such as the pandemic. The National Institute on Drug Abuse's research on comorbidities involving COVID-19 and substance use indicates that factors related to the pandemic, such as social isolation, stress, and drug use while alone, likely contributed to trends in drug overdose deaths, particularly in fatalities involving fentanyl. Fentanyl is a synthetic opioid that is reportedly up to 50 times stronger than heroin and 100 times stronger than morphine and, according to the Centers for Disease Control and Prevention (CDC), is a major contributor to both fatal and nonfatal overdoses in the United States. According to a health advisory issued by the CDC in December 2020, drug overdose deaths during the pandemic represented a worsening of the U.S. drug overdose crisis. For example, the CDC website reported 5,343 drug overdose deaths for the 12-month period ended April 2021, 31% higher than for the prior 12-month period that ended April 2020.

In a letter from OASAS to the U.S. Department of Health and Human Services, OASAS noted that after 2 years of decline, there were 4,415 drug overdose deaths in New York State from September 2019 to August 2020, 24% higher than the previous year and the highest for any 12-month September–August period. Although OASAS emphasized that housing and residential options are essential to support long-term recovery, the trends during roughly the same period showed a decline in enrollment for people in bedded treatment Programs, as shown in Table 1. In March 2020, OASAS issued pandemic-related guidance that was intended to enhance the ability of its licensed residential Programs to optimize individual and staff safety during the ongoing pandemic while maintaining access to critical addiction services and supports. The guidance provided criteria that prioritized admissions for people with specific needs to reduce the capacity in community-based residential settings. Compared with 9,856 patients enrolled in bedded Programs on May 15, 2019, enrollment on May 15, 2020 was 33% lower, with 6,618 patients enrolled. Enrollment has since increased, though not to pre-pandemic levels.

Table 1 – OASAS-Certified Program Bedded Enrollment

5/15/2019	11/15/2019	5/15/2020	11/15/2020	5/15/2021	11/15/2021	5/15/2022	7/15/2022
9,856	9,514	6,618	6,830	6,553	7,157	7,113	7,583

Some providers we met with during the audit attributed the decline in patients enrolled in bedded Programs to factors such as prospective patients' fear of contracting COVID-19 in a congregate setting; OASAS directives that limited admission to some services; fewer people being required to enter court-ordered treatment as a result of court closures; and providers' adjustments to enrollment to accommodate social distancing, especially for Programs that typically have more than one occupant share a bedded room.

Audit Findings and Recommendations

Given the vulnerability of the client population that relies on OASAS-certified Programs for needed services, monitoring of provider emergency readiness and clear guidance to providers are essential elements that help ensure that these services can continue during emergency situations. We found that OASAS personnel review Plans only at initial certification, despite language in both LSB 2 and LSB 3 that states that they will review them during recertification and/or Regional Office site visits. In addition, OASAS should improve its monitoring to better ensure that providers' Plans include strategies to manage and mitigate prolonged disruptions in service to prevent the related loss of progress and momentum. We also found that the waiting list data that OASAS receives is likely to be inaccurate (due in part to unclear guidance to providers) and that OASAS does little to improve or use this data, even for its stated purpose. In addition, despite the requirement that providers be set up to use eFINDS, we found that some would be unable to access this important client location system in the event of an emergency. These weaknesses indicate that Programs may not be adequately prepared for emergency situations and could compromise safety and continuity of care.

Emergency Preparedness Plans

Existing Programs

We requested the current Plan for 30 existing Programs that provided residential or inpatient services or that administered opioid treatment services and received 27 Plans. We shared information with OASAS officials about not receiving Plans from the three providers.

Of the 27 Plans we reviewed, we found that some included procedures to address situations such as fires, weather events, hazardous materials, and/or active shooters. About half (14) included procedures to address infection control, with some specifically related to the pandemic. For example, one Plan included information about precautions, such as screening upon building entry or testing for COVID-19. Another had guidelines for employees related to sanitizing, travel, large gatherings, quarantining, and staying home if they are feeling unwell. Given the disruptions that accompanied the pandemic, OASAS' guidance should also include provisions that address providers' plans to manage and mitigate prolonged disruptions in service.

In response to the pandemic, several states, including New York, have enacted laws to strengthen emergency response practices. For example, the New York Health and Essential Rights Act (HERO Act) was enacted in 2021 to protect employees against exposure and disease during a future infectious disease outbreak. The HERO Act requires New York employers to adopt airborne infectious disease prevention standards and plans using either a model provided by the State Department of Labor or an alternative plan that meets or exceeds the related standards. According to OASAS officials, infection control procedures are part of a provider's daily activities and are not a required part of Plan content. Nonetheless, given the significance of infection control awareness and practices, OASAS may want to consider incorporating a review of these standards at the time of recertification.

We also found that in some circumstances, OASAS doesn't follow its own LSB procedures for reviewing provider Plans after initial certification. In addition, inconsistencies among the various review instruments used for visits subsequent to certification make it unclear when staff should review a provider's Plan or emergency procedures.

Despite the provisions of LSBs 2 and 3, OASAS personnel said that they review Plans only at initial certification and not during subsequent recertification or Regional Office site visits. They said there is no reason for them to look at a Plan again after initial certification and that it's up to the provider to follow LSBs and update their Plans as necessary. In addition, we found that none of the Regional Office site review instruments used from January 1, 2019 through the version in use in November 2022 included questions about providers' Plans or their emergency procedures. However, some of the review instruments used for recertification included questions asking personnel to verify whether emergency procedures were in place. The inconsistencies in OASAS' review instruments about whether and when provider Plans should be reviewed subsequent to initial certification could be confusing and should be clarified.

We reviewed a sample of Regional Office site visit and recertification records from January 1, 2019 through November 3, 2022 and found 10 of 14 Programs (71%) had no records to support that OASAS verified the existence or content of a Plan or emergency procedures. Two of the 10 Programs without a confirmed Plan did not have a recertification or Regional Office site visit during the almost four-year period. For the other four Programs (29%), records indicated that OASAS personnel confirmed there were emergency procedures.

Newly Certified Programs

We also reviewed OASAS records for a sample of 5 of the 70 programs that were certified during the period from September 25, 2020 to October 27, 2022. The records supported that there were satisfactory Plans or procedures for internal and external emergencies for four Programs. Although LSBs 2 and 3 state that the Plan should help providers prepare for, respond to, and/or recover from an internal or external emergency, the fifth Program, which OASAS certified, had procedures for just internal medical emergencies.

Provider Access to eFINDS

OASAS is one of six State agencies (along with many of their respective facilities, such as addiction service providers) that are required to use eFINDS. However, we found that some OASAS-certified Programs are not set up to be able to use eFINDS and would likely be unable to access it in the event of an emergency. Programs that are not appropriately set up for eFINDS, or that don't have current employees who can access it, risk losing track of patient movement and transfer locations during an emergency, which could jeopardize patients' success in and confidence in the Program. Further, because eFINDS links a patient to their health records via a

wristband, there is an associated risk that the continuity of care – which could include appropriate medication – could be compromised.

According to DOH officials, to use the eFINDS application and track patients when needed, providers must have HCS access, and each Program must have at least one assigned Coordinator and at least one assigned User in HCS. The Coordinator is responsible for assigning the Users. OASAS officials said that when a new residential program is certified to operate, OASAS sends emails that outline all reporting requirements for both client and Program data, including eFINDS requirements, and that it's the provider's responsibility to comply with these. However, we found that OASAS does little to determine whether Programs are adequately set up to use eFINDS and that they have current employees assigned to the Coordinator and User roles. In some cases, these roles are not assigned at all, or are assigned to people who may no longer be working for the Program.

OASAS personnel conduct recertification reviews and Regional Office Program reviews, but they determine whether a Program has appropriate eFINDS components only during Program reviews. During the Program reviews, personnel assess whether the Program has policies and procedures that incorporate eFINDS, whether the scanners are operational and there is a sufficient supply of wristbands, and whether the eFINDS Coordinator and User information is up to date. However, unlike recertification reviews, there is no schedule for Program reviews and they may not take place at all. As such, OASAS lacks assurance that providers are appropriately set up to use eFINDS when needed.

Of OASAS' list of 325 certified inpatient and residential Programs:

- 38 were not required to be set up for eFINDS at the time of our audit, including:
  - 10 that had closed or were in process of closing.
  - 28 that are not required to have eFINDS because they are either hospital-based and have their own DOH-administered evacuation protocols or are designated as scatter sites, where the use of eFINDS is impractical because individuals may reside in apartments in multiple locations.
- 287 are subject to the eFINDS requirement.

For the 10 closed or closing sites, the Programs didn't have assigned eFINDS Users and wouldn't have been able to use the system when the Programs were operational. Of the 287 Programs that are required to be set up to use eFINDS, 252 Programs had both a Coordinator and User listed in HCS, and 35 Programs (12%) were not set up for appropriate access, as follows:

- 3 were not included in DOH's eFINDS data (i.e., were not established in the application).
- 1 lacked both an assigned Coordinator and an assigned User.
- 28 lacked an assigned User.
- 3 lacked an assigned Coordinator.

Of the 252 Programs with both a Coordinator and User assigned in HCS, we selected a random sample of 50 to determine whether the people in these roles would be able to appropriately access and use eFINDS if needed. Based on our communications with Program staff, we concluded that just six of the 50 (12%) had Users who said they could access eFINDS and Coordinators who were still employed with the Program. For the remaining 44 Programs, there was either an impediment to eFINDS use, such as a User or a Coordinator who no longer worked for the Program or reported not having access, or we couldn't obtain assurance that the people assigned to these roles worked for the Program, or a combination of those issues, as shown in Tables 2 and 3.

Table 2 – Results of Review of eFINDS User Access for a Sample of 50 Programs

Result	Number of Programs
None of the assigned Users were able to access eFINDS (User was reported no longer working for the Program, or User stated they do not have access)	11
Users no longer worked for the Program, or we could not obtain confirmation about User	9
At least one (but not all) assigned Users reported having access to eFINDS	19
All the Program's assigned Users reported having access to eFINDS	11
Total	**50**

Notably, of the 11 Programs whose assigned Users either did not work for the Program or said that they didn't have eFINDS access, three also lacked an assigned Coordinator still working at the Program.

Table 3 – Results of Review of eFINDS Coordinators for a Sample of 50 Programs

Result	Number of Programs
No assigned Coordinator still working for the Program	4
At least one (but not all) assigned Coordinators still working for the Program	12
At least one (but could not confirm all) assigned Coordinators still working for the Program	10
All assigned Coordinators still working for the Program	21
Undetermined	3
Total	**50**

In response to our findings about assigned Users and Coordinators no longer working for the related Programs, OASAS cited the significant loss of health care workers during the pandemic and the ongoing struggle to find replacement staff as a contributing factor.

Limited Use of Waiting List Data

We found that although OASAS uses a central repository for waiting list information, some providers may not be entering information that's required, and the information that OASAS does receive may not be accurate or entered timely. Further, OASAS doesn't make efforts to improve the accuracy of this information and its usefulness for decision making.

According to LSB 1, providers must establish policies to offer admission preference to people who are pregnant and/or who inject drugs intravenously and must establish waiting lists under some circumstances. If a person in need of treatment cannot be admitted into a Program within 14 days due to insufficient capacity in both a particular treatment Program and the surrounding community, the provider must establish a waiting list of applicants seeking treatment, including those receiving interim services while awaiting admission to such treatment.

Waiting list applicants must be eligible for admission and must not be currently in treatment in any substance use disorder program, although they may currently be in treatment in another Program but awaiting transfer to a different level of care that's available in the applied-for Program. According to OASAS officials, these applicants may also opt to stay on a waiting list for reasons such as seeking a preferred location or counselor. LSB 1 states that under no circumstances should a person be on a waiting list for longer than 120 days. There are provisions for a person's replacement on the waiting list if they cannot be found or refuse treatment.

OASAS requires Programs to report waiting list information – including Client ID or Case-Client Number (CCN); county of residence; date placed on the list; placement reason; date of birth; last four digits of the applicant's Social Security number; and whether the applicant is pregnant, injects intravenous drugs, or has a history of, or current, mental illness – in OASAS' Client Data System (CDS) using a standard form. According to OASAS officials, providers should put applicants on a waiting list on the day the applicant is assessed and deemed fit for a Program, if the Program is unable to begin providing services that day. They also said that they require providers to update the waiting list information in the CDS at least on a monthly basis and that they send monthly email notices to providers with applicants who have been on a waiting list for more than 90 days, advising them to verify the applicants' status and either admit them or refer them to another Program.

However, we found that providers we interviewed may not be complying with the provisions of LSB 1 regarding waiting list requirements, and the information that OASAS is able to view related to waiting lists may therefore be incomplete or inaccurate. We met with personnel from 30 OASAS-certified treatment providers to discuss a selected treatment Program they offered. Of the 30 providers:

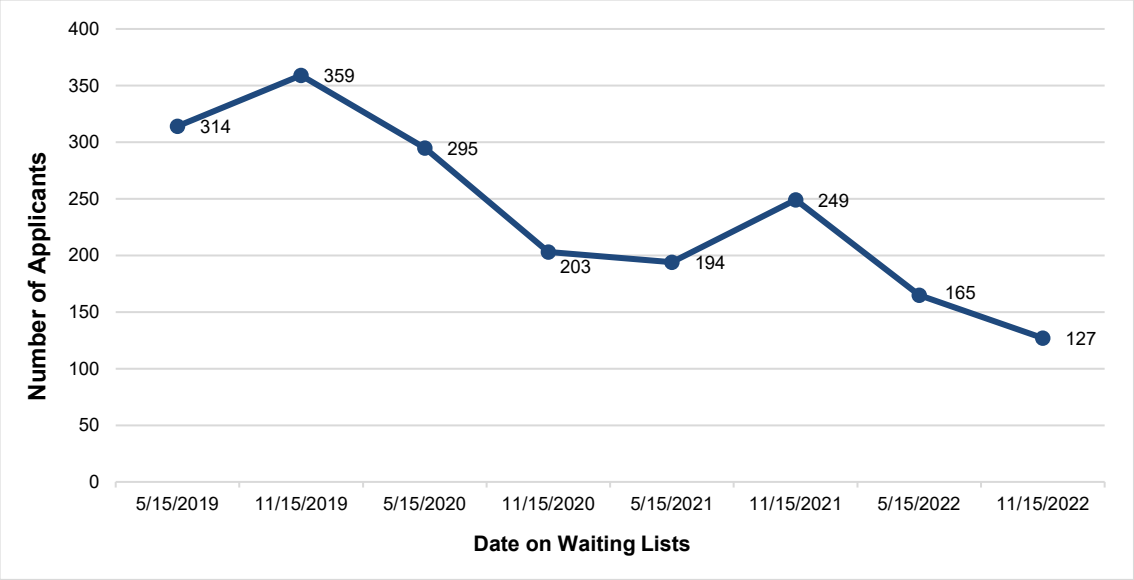
- 22 said that they keep a waiting list for the relevant Program, including:
  - 14 (64%) that said that they keep it internally and that OASAS does not have access to it unless they specifically request to see it. This could indicate that applicants on these internal lists don't meet the criteria for

being entered into the CDS, but it may also indicate that a provider is not complying with the LSB's information-sharing requirement. Notably, for two of these 14 providers, we found that OASAS did in fact have waiting list data in the CDS for the Program, indicating that there may be gaps in communication both at the provider level and between providers and OASAS about the responsibilities to maintain and share this information with OASAS.
    - 7 that said that OASAS always has access to the data, suggesting that these providers enter this information into the CDS.
    - 1 that didn't provide a response.
- 8 said that they don't keep a waiting list because they are generally not operating at a capacity where they would have someone waiting for services, or they refer people to another Program that can provide services immediately.

According to LSB 1, OASAS established a Waiting List Report (Report) in the CDS to measure the need for additional treatment capacity and to manage access to treatment. The LSB also states that the Report enables OASAS to monitor whether an applicant is on more than one waiting list, whether they meet one of the priority admission criteria (e.g., are pregnant), and how long they have been on the list. Officials also said they may use Report data on an ad hoc basis to inform discussions regarding, for example, gaps in care and capacity. However, OASAS doesn't make effective use of its waiting list data, which diminishes its value for these purposes.

For example, the CCN for a given client differs from provider to provider. Applicants could be receiving the level of treatment that they need while simultaneously being on a waiting list for another provider, but it would appear to OASAS that they're awaiting services. Because the waiting list data that providers submit includes both the applicants' birthdate and the last four digits of their Social Security number, OASAS could use this information to potentially identify whether applicants are on more than one waiting list, a stated purpose of the Report, but they said that they don't. Figure 1 presents OASAS' waiting list information in graph format.

Figure 1 – Bedded Program Waiting List Applicants, May 2019 – November 2022



Factors that likely contributed to the decrease in bedded enrollment, such as fear of contracting COVID-19 and providers' need to maintain distance between patients, may explain the general decrease in the number of applicants on waiting lists. Based on the data we obtained from OASAS, we could not determine if any applicants were directed toward outpatient services (rather than continuing to seek out inpatient options) or if they stopped seeking treatment altogether. Also, because of the limitations of the data, the points on the graph may not reflect the actual number of people who met the waiting list criteria and were awaiting services at the selected points in time.

OASAS can and should take action to provide stronger assurance that the waiting list data it receives from providers is timely and accurate. Data that is not received timely or is incomplete or of poor quality could mask the existence of gaps or surpluses in Program capacity and could unfavorably affect OASAS' decisions – including how it allocates resources – and the information it makes public. For example, incomplete waiting lists might inappropriately signal that people awaiting services are receiving care. In response to our observations, OASAS officials acknowledged that the LSB and related guidance to providers does not address all necessary areas and needs improvement.

Recommendations

1. Review and revise the LSBs, site review instruments, and any other guidance, as considered necessary, to:
   - Incorporate provisions that address providers' plans to manage and mitigate prolonged disruptions in service.

- Clearly describe the responsibilities of both providers and OASAS personnel related to Plans, eFINDS readiness, and waiting list requirements.

2. Implement a risk-based method to:
   - Review Plans subsequent to the initial certification.
   - Verify provider access to eFINDS, including verification that assignments to key roles are current.
3. Improve the use of waiting list information submitted by providers to better support OASAS' decision making and oversight.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether OASAS offers adequate guidance to providers to help ensure they're able to deliver addiction support services during emergency situations. The audit covered the period from January 2019 through November 2022.

To accomplish our objective and assess related internal controls, we reviewed relevant laws, regulations, policies, procedures, LSBs, and certain OASAS and DOH-maintained data. To gain an understanding of OASAS' role in offering guidance to providers regarding emergency preparedness plans, we met in person or virtually with OASAS representatives and with employees of OASAS-certified treatment providers. We also reviewed OASAS reports, review instruments, corrective action plans, and OASAS' email correspondence with providers.

To better understand aspects of the eFINDS application, including the Coordinator and User roles, we met with DOH personnel. To assess whether OASAS-certified Programs were set up to access eFINDS, we selected a random sample of 50 of the 252 certified inpatient and residential Programs that OASAS required to be set up for eFINDS and that also had assigned Users and Coordinators in the eFINDS data. We attempted to contact the people assigned to those roles to determine if they still worked for the Program and had access to the eFINDS application. In some cases, the provider contact said that the person in the assigned role no longer worked for the Program. When we could not determine whether the assigned User or Coordinator was still employed at the Program and/or had access to eFINDS, we did not draw a conclusion about their eFINDS access.

We judgmentally selected 30 of the 427 Programs that are required per the LSBs (bedded Programs and opioid treatment Programs) to have emergency Plans and spoke with a Program contact about whether they had a Plan and about eFINDS access and waiting lists. We also requested the Plans for each of the 30 Programs. In selecting our sample, we considered factors such as geographic location and Program type (e.g., inpatient, youth residential) and capacity.

In reviewing OASAS' certification records, we judgmentally selected five of the 70 Programs that were certified during the period from September 25, 2020 to October 27, 2022 to determine if the records included information related to the Plan, OASAS' review of the Plan, or the relevant provider's access to eFINDS. In selecting our sample, we considered Program type and whether any of the 30 providers we spoke with opened during this period.

To determine whether OASAS' recertification and Regional Office Program review records included anything related to OASAS' review of Plans or actions taken to confirm provider access and setup to use eFINDS, we judgmentally selected a sample of 14 Programs. We selected nine Programs based on the results of our eFINDS testing (two of four Programs we identified that did not have a User or Coordinator and seven of 17 Programs we identified with no Users) and five of 30 Programs based on information we obtained through our discussions with the providers, such as whether the Program had a Plan. We also took into consideration the date of the last recertification.

To assess OASAS' waiting list information, we reviewed LSB requirements and the Waiting List Report and related instructions, discussed the handling of waiting list information with OASAS providers, and reviewed OASAS CDS waiting list data files for eight points in time between January 2019 and November 2022. In selecting the points in time, we included those both prior to the pandemic's emergence (i.e., pre-March 2020) and those during the pandemic.

We performed data reliability testing on OASAS' list of 325 inpatient and residential Programs and DOH's eFINDS data. While we could not verify the completeness of these data sets, we considered them sufficiently reliable for the purposes of our audit. Because OASAS relies on providers entering their waiting list information in the CDS, and because we did not test this data at the provider level, its reliability is unknown. We reported our conclusions about the limitations of this data within the relevant section of this report. We did not design any of our samples to project their results to the populations from which they arose, nor did we project those results to the related populations.

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 OASAS' guidance to providers regarding providing addiction support services during emergencies.

Reporting Requirements

We provided a draft copy of this report to OASAS officials for their review and formal written comment. We considered their response in preparing this final report and have included it in its entirety at the end of the report. Though OASAS officials offered explanations in response to some findings in the report, they generally agreed with our recommendations and indicated steps they will take to consider and address them. We address certain aspects of their response in the report's 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 OASAS 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.

Agency Comments

NEW YORK STATE | Office of Addiction Services and Supports

KATHY HOCHUL
Governor

CHINAZO CUNNINGHAM, MD
Commissioner

September 10, 2023

Ms. Heather Pratt, Audit Director
NYS Office of the State Comptroller
Division of State Government Accountability
110 State Street 1 11th Floor
Albany, NY 12236

Response to Draft Audit Report 2021-S-35

Dear Ms. Pratt:

Thank you for the opportunity to comment on the NYS Office of the State Comptroller's draft audit report entitled "Addiction Support During Emergencies" (report #2021-S-35 dated August 7, 2023. Attached is the response being submitted by the NYS Office of Addiction Services and Supports.

Very truly yours,

Steven J. Shrager

Steven J. Shrager
Director, Office of Audit Services

cc: Dr. Chinazo Cunningham, Commissioner
Tracey Collins, Executive Deputy Commissioner
Trishia Allen, General Counsel
Keith McCarthy, Associate Commissioner

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INTRODUCTION

The New York State Office of Addiction Services and Supports (OASAS) appreciates the opportunity to respond to the Office of the State Comptroller's (OSC) draft audit report entitled "Addiction Support Services During Emergencies" (Report 2021-S-35) which covers the period January 2019 through November 2022 (hereinafter "draft").

OASAS shares OSC's goal of ensuring that our provider community is prepared to best serve its target population in case of an emergency.

OASAS' RESPONSE TO FINDINGS AND RECOMMENDATIONS IN THE OSC's DRAFT REPORT

Key Findings:

Although OASAS provides guidance to help providers ensure they're able to deliver addiction support services during emergency situations, such as fires or evacuations, OASAS should improve upon the extent and clarity of this guidance.

A prospective provider must submit an emergency plan at the time it applies to provide substance use disorder services in New York State. OASAS reviews this plan to ensure that it complies with the existing regulations and facilitates any needed revisions through direct contact with the applicant. As needed, OASAS issues guidance to the provider community covering a wide variety of topics including updates that pertain to patient health and safety as well as emergency preparedness.

From the start of the pandemic in early 2020 to the present, OASAS has issued numerous guidance documents to the provider community to help maintain patient health and safety. OASAS is diligent when crafting new or updated guidance, asserts that the issued guidance was appropriate, and that the guidance was clear. Additionally, various OASAS divisions provide ongoing support directly to the provider community. This includes a dedicated Regional Office (RO) program manager assigned to each certified program.

Given the disruptions that accompanies the COVID-19 pandemic, OASAS should also improve its monitoring to better ensure that provider Plans are revised when warranted, and that they include strategies to manage and mitigate prolonged disruptions to prevent the related loss of progress and momentum.

The Covid-19 pandemic changed the face of emergency preparedness. In addition to the issuance of multiple advisements to the provider community, OASAS increased its monitoring and technical

assistance to our providers to help anticipate and mitigate concerns. On an annual basis, OASAS requires provider senior management and/or its board of directors to attest that they reviewed the existing emergency plan and that the plan continues to be relevant and appropriate. In addition to the required annual review, providers are expected to reevaluate their plan at the end of an incident. This reevaluation is required regardless of the incident's magnitude and is for the purpose of review, training, and future enhancement of the plan. The OASAS RO conducts a debriefing session with the provider and directs them to revise policies and procedures accordingly.

OASAS will direct providers to incorporate any newly issued guidance and recommendations into their operations and emergency plans.

In 2013, in response to the disruptions caused by Super Storm Sandy in October of 2012, the New York State Department of Health created the New York State Evacuation of Facilities in Disasters System (eFINDS). It was introduced to provide secure, confidential, fast, and easy-to-use real time access to healthcare and human services patient and residential locations in an emergency. Under the eFINDS program, all OASAS-certified residential programs are directed to use barcode wristbands to monitor a patient's location when they are evacuated, with locations to be updated and tracked using hand-held scanners, mobile apps, or paper tracking (if power and/or phones are out of service). This system has not needed to be deployed since its inception, because there have been no instances of prolonged disruptions of services nor issues with continuity of care under the terms of how an emergency was previously defined.

Further, OASAS should do more to gain assurance that certain tools and that provider's use – such as eFINDS and waiting lists – are in place and suitable to use for managing services to their clients. The weaknesses we indicate that Programs may not be adequately prepared for emergency situations, which could compromise safety and continuity of care.

At the time an organization is certified to provide residential services in New York State, OASAS provides information pertaining to the eFINDS program. Organizations are also provided instructions how to sign up for eFINDS and its operational requirements. Overseen by the New York State Department of Health, eFINDS was originally created with nursing homes and other long-term care facilities in mind to be prepared for a possible evacuation. OASAS has adopted the eFINDS program for all certified residential programs.

The OSC audit identified some gaps where a small number of providers were either not fully set up in the eFINDS system or were not in compliance with the requirements of identifying specific staff to oversee and operate the program. OASAS addresses the eFINDS issue in the recommendation section below.

OASAS created a waiting list process to limit the amount of time an individual would need to wait before getting into treatment. OASAS requires providers to enter patient specific information into an OASAS database when they had insufficient capacity to serve them. While most individuals look for treatment close to their homes, OASAS also maintains an on-line "Treatment Availability Dashboard"

that maintains current openings across the state to help identify alternative providers for the individual's consideration.

The OSC audit identified a small number of providers who were not in compliance with the waiting list requirements (e.g., adding names to the list and/or not properly managing the waiting list information so that the information was accurate in the OASAS system). OASAS addresses the waiting list issue in the recommendation section below.

Regardless of any issues that might have been found during the audit, the waiting list does not impact emergency preparedness or in any way compromise safety and continuity of care.

Comment 1

Recommendation #1

OSC recommended that OASAS review and revise LSBs, site review instruments, and any other guidance, as considered necessary, to:

- ***Incorporate provisions that address providers' plans to manage and mitigate prolonged disruptions of service.***

On an ongoing basis, OASAS reviews its issued guidance, site instruments, and Local Service Bulletins (LSB) to ensure relevancy, accuracy and appropriateness. In May of 2022, in response to discussions with OSC auditors, OASAS added questions to the RO site instruments to ensure that field staff were appropriately reviewing provider documents that attest to the required annual internal review of a provider's existing emergency plans. In addition, OASAS is currently updating LSBs that specifically pertain to emergency management to address ambiguity in language. OASAS will be completing and issuing the revised LSBs imminently.

Due to the uniqueness of each program, OASAS has not set forth a template of how to create an emergency plan. Instead, OASAS allows providers to have discretion in their emergency plan based on each provider's specific circumstance and the existing State and Federal regulations. Again, providers submit an emergency plan with the certification application. OASAS will not approve an application unless the plan complies with the required regulations.

Comment 2

Although OASAS is updating its LSBs, it believes that the agency has taken appropriate steps and issued appropriate guidance to mitigate any potential disruptions of service for our provider community. OASAS further notes that the Report's findings seem at times to conflate emergency plans relevant to evacuating a facility with guidance for living through and operating during a pandemic. During the pandemic, OASAS issued multiple advisements to the provider community as circumstances developed during COVID.

- ***Clearly describe the responsibilities of both providers and OASAS personnel related to Plans, eFINDS readiness, and waiting list requirements.***

OASAS believes that the responsibilities of both providers and OASAS personnel are clearly defined in guidance as it pertains to emergency plans, eFINDS readiness, and waiting list requirements. Nonetheless, OASAS will undertake a review of all such guidance to ensure that instructions are as clear as possible to promote compliance.

Recommendation #2

Implement a risk-based method to:

- ***Review plans subsequent to the initial certification***

OASAS will review its current guidance to determine whether any updated reviews of providers' emergency plans are necessary. OASAS will direct providers to revise and update their plans to account for prolonged disasters, using the lessons learned from COVID.

Verify provider access to eFINDS, including that assignments to key roles are current.

OASAS will review the providers who are required to employ eFINDS and provide technical assistance for those found to be deficient.

Recommendation #3

- ***Improve the use of waiting list information submitted by providers to better support OASAS' decision making and oversight.***

In compliance with federal block grants, providers are issued guidance that establishes a priority list for admittance into programs. Such priority individuals, such as someone who is pregnant, could be admitted over someone who is already on a facility's waiting list. There are also instances where an individual who has been admitted to a program is still on the waiting list of another program. This may happen when the preferred program does not have an available room, and the individual chooses to start treatment elsewhere.

The OSC audit identified instances where OASAS data base information was not accurate and instances where providers were not entering information into the waiting list system. OASAS will review the existing program to determine which providers are not in compliance and will take steps to ensure that the program is utilized as designed. The current state of the waiting list, even considering improvements that can be made, does not in any way impact or hinder OASAS' decision making nor its appropriate oversight of its residential programs.

Comment 3

State Comptroller's Comments

1. OASAS officials' statement that the waiting list doesn't impact emergency preparedness or in any way compromise safety and continuity of care understates the potential effects of a poorly managed or undermanaged waiting list. A fundamental purpose of the waiting list, as stated in OASAS' LSB 1, is to manage access to treatment. An emergency situation that brings about a temporary or permanent closure of a treatment facility could result in waiting lists for alternative facilities, which would need to be effectively managed to best ensure access to treatment.
2. We acknowledge that OASAS issued advisements to the provider community as circumstances developed during COVID-19. However, it is unclear what OASAS means by its statement about the audit findings seeming to "conflate emergency plans relevant to evacuating a facility with guidance for living through and operating during a pandemic." We assert that an emergency plan, or plans, should do the following, all of which are stated in the OASAS LSBs that we used as criteria in our audit:
   - Identify and address vulnerabilities to emergencies or disasters and the resources available to prevent or mitigate, respond to, and recover from them;
   - Outline short-, medium-, and long-range measures to improve the capability to respond to and recover from an emergency or disaster;
   - Provide for the efficient utilization of all available resources during an emergency or disaster; and
   - Ensure the continuity of operations in times of emergency or disaster situations.
3. See State Comptroller's Comment 1.

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