# Office of Mental Health

## Controls Over the Empire State Supportive Housing Initiative

Report 2022-S-22 | December 2023

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

# Audit Highlights

## Objectives

To determine whether controls over the Empire State Supportive Housing Initiative (ESSHI) are sufficient to ensure the needs of high-risk target populations are being met, and whether providers deliver the services that are required in their contracts with State agencies. The audit covered the period from July 2017 through March 2023.

## About the Program

Established in 2016, ESSHI is part of the Executive's comprehensive plan for affordable and supportive housing to ensure all New Yorkers have access to safe and secure housing. As part of this plan, ESSHI's goal is to develop 20,000 units of supportive housing over a 15-year period ending in 2031. The Office of Mental Health (Office) serves as the lead procurement agency for ESSHI, which provides up to $25,000 annually per individual toward supportive housing for vulnerable populations experiencing homelessness. As such, the Office issues Requests for Proposals (RFPs) annually, with the goal of developing 1,400 units of supportive housing each year.

Proposals should address the needs of the various populations to be served by both the Office and the other State agencies under ESSHI. Each of the Office's ESSHI contracts contains a work plan detailing the provider's objectives as well as the housing-related support services to be provided. The Office's Supportive Housing Guidelines (Guidelines) provide a framework for operating supportive housing programs, such as ESSHI, and require the Office to engage in monitoring of supportive housing programs once per 5-year contract cycle.

Additionally, case managers are required to have monthly face-to-face visits with residents, make quarterly in-home visits, develop an initial support plan within 30 days, and verify their income annually. The face-to-face visits allow case managers to ensure the resident remains stable and to monitor their needs for changes, and aid in ensuring the support plan is relevant. Further, in-home visits allow the opportunity for the provider to see the resident's living environment.

From the program's inception in 2016 through April 26, 2023, there have been 286 ESSHI projects and 8,122 units permanently awarded across all State agencies under ESSHI. The Office has contracts for 87 of these projects, comprising 3,021 units. Of the 87 projects, only 66 (relating to 2,087 units) are currently active and providing supportive housing. The remaining 21 projects are in the process of becoming active and are in various stages of construction.

## Key Findings

We found significant deficiencies in the Office's oversight of the ESSHI program, including insufficient monitoring of Guidelines and contract requirements, provider performance, and conditions at some housing units.

- Of a sample of 61 residents' progress notes, we determined:
  - 11% of the face-to-face meetings were not held
  - 12% of the in-home visits were not conducted
  - 38% of the initial support plans were not developed within 30 days
  - 38% of the annual income verifications were not performed

- During our audit, we found that two residents had been missing for extended periods of time. The provider did locate one of the residents; however, the other resident's location remained unknown. This resident's alleged relative was living in the unit and had changed the locks on the door. In June 2023, the provider located the resident in a nursing/rehabilitation facility following an inpatient hospital stay.
- Four of the six providers' ESSHI projects we inspected had critical issues at the housing units, such as water leaks, water stains, and mold, while two of the six had lesser issues, such as evidence of vermin (i.e., mouse hole), damage to walls, and peeling paint. Water leaks within a building may result in immediate and long-term damage if moisture is not removed appropriately.
- The work plans for each contract did not always include attainable, measurable objectives that would enable each provider to track the progress of their stated objective. In addition, the Office does not monitor the progress of these objectives or evaluate the provider against its work plan despite the inclusion of them in each contract.

## Key Recommendations

- Increase the frequency of the Office's provider monitoring visits to ensure ESSHI units are adequately maintained, provider performance is acceptable, and Guidelines are met.
- Develop and implement a process that ensures provider contracts have objectives and performance measures that are attainable, measurable, and reportable prior to awarding contracts.
- Develop and issue policies and procedures to field offices related to monitoring and reviewing work plans to ensure providers comply with contract requirements.

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

December 21, 2023

Ann Marie T. Sullivan, M.D.
Commissioner
Office of Mental Health
8th Floor, 44 Holland Avenue
Albany, NY 12229

Dear Dr. Sullivan:

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 *Controls Over the Empire State Supportive Housing Initiative*. 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 |
|---|---|---|
| Office | Office of Mental Health | *Auditee* |
| | | |
| BFNC | Buffalo Federation of Neighborhood Centers, ESSHI provider in Buffalo | *Provider* |
| CAIRS | Child and Adult Integrated Reporting System | *System* |
| Community Access | Community Access, ESSHI provider in the Bronx | *Provider* |
| DePaul | DePaul Community Services, ESSHI provider in Albany | *Provider* |
| ESSHI | Empire State Supportive Housing Initiative | *Program* |
| Federation | Federation of Organizations, ESSHI provider in multiple locations across New York City | *Provider* |
| Guidelines | The Office's Supportive Housing Guidelines | *Key Term* |
| Independent Living | Concern for Independent Living, ESSHI provider in Long Island | *Provider* |
| RFP | Request for Proposal | *Key Term* |
| SMI | Serious mental illness | *Key Term* |
| YWCA | Young Women's Christian Association, ESSHI provider of Binghamton and Broome County | *Provider* |

# Background

Established in 2016, the Empire State Supportive Housing Initiative (ESSHI) is part of the Executive's comprehensive plan for affordable and supportive housing to ensure all New Yorkers have access to safe and secure housing. Supportive housing is intended to ensure that residents' options and preferences in choosing long-term or permanent housing are enhanced by increasing the availability of safe and affordable housing options; ensuring the provision of community supports necessary for residents to remain in their preferred housing and meaningfully integrate into their communities; and changing services as necessary to meet their varying needs. As part of this plan, ESSHI's goal is to develop 20,000 units of supportive housing over a 15-year period ending in 2031. The Office of Mental Health (Office) serves as the lead procurement agency for ESSHI, which provides up to $25,000 annually per individual toward supportive housing for vulnerable populations experiencing homelessness. As such, the Office issues Requests for Proposals (RFPs) annually, with the goal of developing 1,400 units of supportive housing each year for persons who:

- Have a serious mental illness (SMI)
- Have a substance use disorder
- Are living with HIV or AIDS
- Are survivors of domestic violence
- Have military service and a disability
- Are chronically homeless (individuals or families)
- Are homeless young adults (including those who left foster care)
- Are seniors who have a disability or infirmity
- Are re-entering the community following incarceration (youth and adults)
- Have high Medicaid costs
- Have an intellectual or developmental disability

Although the Office is the lead contracting agency, proposals accepted through ESSHI RFPs are not solely for persons with SMI, as indicated above. Proposals should address the needs of the various populations to be served by both the Office and the other State agencies under ESSHI. To that end, an ESSHI Interagency Workgroup was established to award ESSHI contracts and includes representatives from other State agencies: Department of Health, including the AIDS Institute; New York State Homes and Community Renewal; Office of Addiction Services and Supports; Office of Children and Family Services; Office for the Prevention of Domestic Violence; Office of Temporary and Disability Assistance; and Office for People With Developmental Disabilities. The ESSHI Interagency Workgroup reviews, evaluates, and scores providers' ESSHI proposals and makes recommendations to the agencies on providers to offer contracts to.

The mission of the Office is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults with SMI and children with a serious emotional disturbance. There are a number of reasons why individuals

(including young adults) are eligible for admission to supportive housing, among them: being discharged from a State-operated psychiatric center or residential program or from a psychiatric inpatient hospital; residing at the Office's licensed housing, adult home, nursing home, or homeless shelter; or living on the streets.

The Office assigns responsibility for review and approval of ESSHI contracts to its field offices. Contract criteria may vary by provider but, generally, they describe the services that will be provided as well as any objectives and performance measures developed by the provider in the work plan section of the ESSHI contract. In some cases, the objectives restate the Office's Supportive Housing Guidelines (Guidelines), and in others, there are detailed metrics and specific milestones related to the provision of services.

ESSHI funds are to be spent on rent and supportive housing services. These services include determining if an individual is eligible for supportive housing; conducting an individual housing needs assessment; developing an individual housing support plan; helping the individual with establishing a household, becoming acquainted with the local community, and applying for entitlements; helping residents understand their rights and responsibilities as tenants; providing instruction and assistance with resolving apartment and building maintenance issues; providing linkages to community resources and health home care coordination; and providing household management and budgeting assistance to ensure that rent and other expenses are paid.

The Guidelines provide a framework of the Office's expectations for operating a supportive housing program, such as ESSHI, and include specific requirements, such as:

- Services that should be provided
- How funds should be used
- Development of a support plan within 30 days of resident move-in and review of the plan with the resident every 3 months
- Annual income verification (to ensure the resident's share of the rent is accurate)
- Minimum requirements for meeting with residents, including one face-to-face resident contact per month, monitoring of the program, and maintenance of housing units
- Development of a policy to identify and follow up on high-risk residents who are at risk of losing their housing
- Home visits as needed, based on the support plan or emergent needs but at least once every 3 months

The Guidelines also identify the basic elements of progress notes, including details such as the date, type, and place of contact; summary of issues addressed; and signature of the housing specialist. Additionally, providers should assist with resolving unit and building maintenance issues.

The Guidelines further state that the Office will engage in periodic monitoring of supportive housing programs, which may include a review of resident records (e.g., leases, rent calculations, referrals), the programs and services (e.g., policies and procedures on services engagement, support plans), the property (e.g., inspection of units, maintenance records and practices), and interviews with residents and residential staff. The Office is required to perform monitoring visits at least once per 5-year contract cycle.

From the program's inception in 2016 through April 26, 2023, there have been 286 ESSHI projects and 8,122 units permanently awarded across all State agencies under ESSHI. The Office has contracted for 87 of these projects, comprising 3,021 units. Of the 87 projects, only 66 (relating to 2,087 units) are currently active and providing supportive housing. The remaining 21 projects are in the process of becoming active and are in various stages of construction. See Table 1 for the breakdown of the 2,087 active ESSHI units by population served.

**Table 1 – Breakdown of Active ESSHI Units by Population Served**

| Population Served | Active Units |
|---|---|
| Individuals with SMI* | 1,567 |
| Individuals with substance use disorder | 53 |
| Individuals living with HIV or AIDS | 3 |
| Survivors of domestic violence | 32 |
| Individuals who have military service and a disability | 81 |
| Chronic homelessness – individuals | 69 |
| Chronic homelessness – families | 28 |
| Youth who left foster care | 15 |
| Homeless young adults | 37 |
| Adults and youth re-entering the community from incarceration | 26 |
| Seniors with a disability or infirmity | 154 |
| Individuals with an intellectual or developmental disability | 22 |
| **Total** | **2,087** |

*Office officials stated that the other categories are examples of where the provider predominantly contracts with the Office for ESSHI or other supportive housing outside of SMI.

The Office uses the Child and Adult Integrated Reporting System (CAIRS) to track all housing for individuals with a mental health issue, including admissions and discharges of residents with SMI. Providers must enter each resident's demographic information, admission and discharge data, reason for discharge, and where the resident was housed prior to admission.

# Audit Findings and Recommendations

While the Office's ESSHI programs are offering services and providing housing for the high-risk target populations it serves, we found significant deficiencies in the Office's oversight of the ESSHI program, including Guidelines and contract requirements that were not being met. Specifically, providers were not meeting monthly and not conducting quarterly visits with residents and support plans were not being developed and reviewed on a timely and ongoing basis.

The safety and well-being of residents can be impacted when the Guidelines are not complied with, as indicated by our discovery that two residents had been missing for extended periods of time during our audit. The provider did locate one of the residents; however, the other resident's location remained unknown. This resident's alleged relative was living in the unit and had changed the locks on the door. In June 2023, the provider located the resident in a nursing/rehabilitation facility following an inpatient hospital stay.

We also found that infrequent monitoring by the Office has resulted in inadequate conditions at some housing units, including instances of mold, vermin, and water leaks. Water leaks within a building may result in immediate and long-term damage if moisture is not removed appropriately.

Additionally, we found that work plans did not always contain attainable, measurable objectives that would enable each provider to track the progress of its stated objective. Further, the Office does not monitor the progress of these objectives or evaluate providers against their work plans despite the contract's requirement to do so, nor does it capture data on Guidelines and contract requirements to sufficiently monitor provider performance.

Further, the Office requires providers to enter admission and discharge information into CAIRS for residents with SMI but not for other ESSHI populations (e.g., domestic violence survivors, veterans with a disability, seniors with a disability), preventing the Office from evaluating program success for approximately 25% of the 2,087 ESSHI housing units it oversees.

## Supportive Housing Guidelines

According to the Guidelines, the case manager is required to have monthly face-to-face visits with residents, make quarterly in-home visits, develop an initial support plan within 30 days, and verify their income annually. The face-to-face visits allow case managers to ensure the resident remains stable and to monitor their needs for changes, and aid in ensuring the support plan is relevant. Further, in-home visits provide the opportunity for the case manager to see the resident's living environment.

Of the Office's 2,087 active ESSHI units, we selected a sample of six providers' ESSHI projects related to 278 active units: DePaul Community Services (DePaul) in Albany, Community Access in the Bronx, Buffalo Federation of Neighborhood Centers (BFNC) in Buffalo, Young Women's Christian Association (YWCA) of Binghamton and Broome County in Binghamton, Concern for Independent Living

(Independent Living) in Long Island, and Federation of Organizations (Federation) in multiple locations across New York City. We reviewed the progress notes for a sample of 61 residents to determine if the Guidelines and ESSHI contract requirements were met. Overall, we found that providers were not meeting the Guidelines' requirements.

## Face-to-Face and In-Home Visits

Forty residents (across all six providers) did not have face-to-face visits with their case manager monthly, and 20 (at four providers) did not receive a visit to their home quarterly. Further, for those 61 resident files, 134 monthly face-to-face visits of 1,244 required (11%) were missed, and 47 in-home visits of 400 required (12%) were missed (see Table 2). For the monthly face-to-face and in-home visits that were missed, we found case notes where attempts to contact the resident were documented; however, we also found instances where there was no evidence that an attempt was made.

**Table 2 – Monthly Face-to-Face and Quarterly In-Home Visit Requirements**

| Provider | Face-to-Face Visits | | In-Home Visits | |
|---|---|---|---|---|
| | Required | Missed | Required | Missed |
| DePaul | 255 | 25 | 81 | 11 |
| Community Access | 221 | 22 | 73 | 30 |
| BFNC | 132 | 24 | 43 | 0 |
| YWCA | 124 | 3 | 37 | 1 |
| Independent Living | 241 | 1 | 78 | 0 |
| Federation | 271 | 59 | 88 | 5 |
| **Totals** | **1,244** | **134** | **400** | **47** |

Office officials stated that, between March 2020 and May 2023, they issued guidance waiving in-person visits and allowed services to be provided via telehealth. Despite this, the six providers we sampled essentially operated as they normally would. We asked providers about not conducting in-person visits due to the COVID-19 pandemic. Responses varied by provider, with some not providing a specific time frame where in-person visits were suspended and others stating they conducted these visits on a case-by-case basis. Therefore, if the provider did not indicate a specific period where they used telehealth, we did not exclude in-person meetings in our review.

## Additional Guidelines Requirements

We also reviewed support plans for initial development and quarterly reviews. We found that, for the 61 residents, 23 (38%) did not have an initial support plan developed within the required 30 days. Further, each of the 61 residents' initial support plans is required to be reviewed and updated quarterly, resulting in 385 reviews that should have taken place. Of those 385 reviews, 119 (31%) were completed late and 51 (13%) were not completed at all. According to Office officials,

guidance in response to the public health emergency was issued in April 2020 that waived support plan requirements between March 2020 and May 2023. However, our testing found the majority of providers were still developing initial support plans and reviewing them quarterly. As such, we evaluated each provider based on their actions and responses regarding how they operated.

We also found income verifications were not completed annually for 23 residents (38%) at the six ESSHI providers, and two of the six providers did not develop a policy to address residents who were at high risk of losing their housing. Most progress notes were signed, as required, by housing support staff; however, we noted instances where notes were not signed at two providers.

The Office does not capture any of this data (face-to-face meetings, in-home visits, initial development plans, quarterly reviews, and income verification), which would allow it to effectively monitor provider performance.

Overall, not meeting conditions and expectations outlined in the Guidelines can have a detrimental impact on residents living in supportive housing, who may have varying degrees of abilities and needs. It is the provider's responsibility to provide safe and secure housing as well as services to help residents integrate into the community. For example, during our visits, we identified incidents that negatively impacted the safety and quality of life of residents. We found two instances where inaction by the providers may have led to health and safety issues for the resident. Due to privacy concerns, this information was provided separately to the Office so it can follow up with the providers.

## Missing Residents

In the course of our audit, we found that two residents at Federation were missing for an extended period of time, with little follow-up by the provider.

When we arrived at one of the resident's units for an inspection, Federation officials stated they hadn't seen the resident in a long time and that the resident was currently missing. When we knocked on the door, an individual – who had previously identified themselves to Federation officials as the resident's niece – refused to let us in. According to officials, this person had been living in the unit since the resident went missing and had also changed the locks. We reviewed the last 6 months of the missing resident's progress notes and found that there had been no contact with Federation staff from November 2022 through March 2023 – the date of our review. Federation officials visited this specific unit and only became aware of the situation on the day we provided them with our sample of units to visit (which included this unit). The progress notes indicate a lack of contact and little follow-up effort to ascertain the resident's whereabouts.

In June 2023 – after the conclusion of our fieldwork and 7 months after the resident was identified as missing – the provider located the resident in a nursing/rehabilitation facility following a hospital stay.

We found another resident who Federation staff were unable to contact for 4 months. In this case, we determined the housing specialist put limited effort into following up with the resident (i.e., having only left voicemails) and didn't report the lack of contact to their supervisor until 4 months had passed. The resident subsequently contacted Federation officials. However, the resident's whereabouts for the 4-month period were not disclosed.

We shared these situations with Office officials, who stated they do not have a policy to address missing persons, as residents are living mostly independently in the community, with supports available as needed. Officials further stated that supportive housing is a program that doesn't require daily or even weekly oversight, which makes it difficult to develop formal guidance. Nevertheless, the safety and well-being of residents can be impacted if the Guidelines are not complied with.

# ESSHI Unit Inspections

We conducted 10 unit inspections at each of the six providers' ESSHI projects for a total of 60 unit inspections. Three of the six providers had newer units (Community Access, BFNC, and Independent Living). The other three providers had older units but two had been renovated (DePaul and YWCA). We observed some inadequate conditions as well as more critical issues at four of the six providers, with Community Access and Federation units having the most issues at the time of our site visits (see Table 3). Unaddressed, these issues may lead to larger problems that could potentially impact additional units and residents – or the building as a whole.

**Table 3 – Breakdown of Conditions Found at Providers' Units**

| Issues Identified | DePaul | Community Access | BFNC | YWCA | Independent Living | Federation |
|---|---|---|---|---|---|---|
| Appliances not functioning or missing shelves or knobs | 1 | 1 | – | – | – | 2 |
| Bubbling, peeling, or chipping paint | 2 | 3 | 1 | – | 1 | – |
| Evidence of vermin in the unit | 3 | 1 | – | – | – | 5 |
| Grounds contained debris or trash | – | 1 | – | – | – | 2 |
| Holes or damage to unit walls | – | 1 | 2 | 2 | – | 4 |
| Furniture provided was damaged, in disrepair, or insufficient | – | 1 | 2 | 1 | – | 1 |
| Staircases and grounds unclean | – | – | – | – | – | 1 |
| Tiled surfaces missing tiles or grout | – | – | – | – | – | 1 |
| Water leaks, stains, or damage | 3 | 2 | 1 | – | – | – |
| Window didn't open, close, or lock properly | – | – | – | – | – | 1 |
| **Totals** | **9** | **10** | **6** | **3** | **1** | **17** |

## Community Access

We found six of the 10 Community Access units to be in acceptable condition; four were in poor condition, with issues including vermin, mold, and water damage. One resident at Community Access had extensive mold in their shower and on their showerhead. A progress note, dated July 12, 2021, stated the service coordinator accompanied the building superintendent to unclog the resident's drain and noticed

extensive amounts of mold. Additional notes document the drain being fixed and a meeting scheduled to help the resident purchase cleaning products to address the mold; however, there was no evidence that the meeting took place or information regarding whether the issue was remediated. Further, when we completed our visual inspection on August 31, 2022, the mold noted in the progress notes was present in the same location in the unit (see Figure 1). This may pose a serious threat to the resident's health and should have been addressed immediately after staff identified the issue. We also found one instance of an active leak in the kitchen that, according to the resident, was reported "months ago" and still wasn't fixed. In this case, a piece of plastic was taped over the leak as a temporary fix (see Figure 2). Water leaks within a building may result in immediate and long-term damage if moisture is not removed appropriately. Prior to remediation, the source of water should be identified.

**Figure 1** – At Community Access: extensive mold in a shower (*left*) and showerhead (*right*).

**Figure 2** – At Community Access: active leak in a kitchen, taped over with plastic as a temporary fix.

## Federation

While we found several of Federation's units to be in adequate condition, we also identified other units that had evidence of vermin (see Figure 3), a broken window, broken tiles, a broken heating baseboard (see Figure 4), and stove burners that didn't work. In fact, the resident associated with Figure 3 showed us that "there were mice holes in the walls." We also found garbage or debris at the entrance to some of the buildings we visited.

## DePaul and BFNC

We also found water leaks and water stains present at DePaul and BFNC. While two of these issues had been addressed (but not fully painted) in one unit, we found the shower had also been leaking. In this case, the resident used duct tape to remedy the leak, but the issue should be properly addressed by the provider and the property owner. A work order was submitted by DePaul on behalf of the resident

**Figure 3** – At Federation: evidence of vermin in unit.

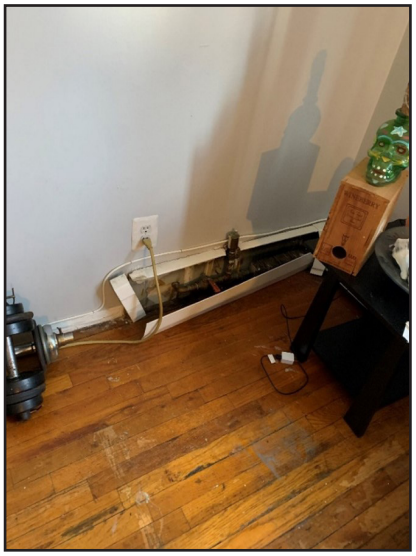

**Figure 4** – At Federation: broken heating baseboard in unit.

approximately 2 months before our site visit; however, we observed the same issue during our unit inspection (see Figure 5). Additionally, at BFNC, we found one unit with water damage from a ceiling leak, which the resident indicated had been repaired five or six times (see Figure 6).

**Figure 5** – At DePaul: leak in shower that went unaddressed and had to be duct-taped by the resident as a fix.

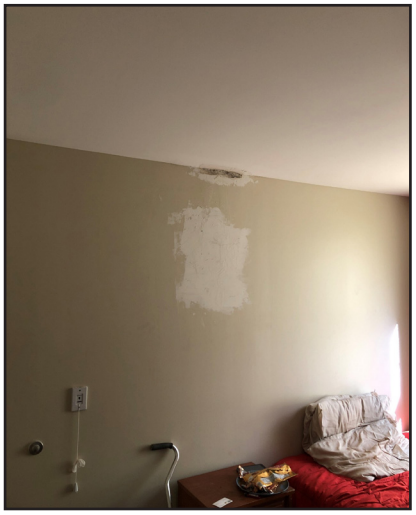

**Figure 6** – At BFNC: water damage from a ceiling leak.

Infrequent monitoring has resulted in inadequate living conditions that continue to exist and negatively impact residents. In response to our preliminary findings, Office officials noted that four of the six providers are not the property owner and, therefore, not responsible for the conditions of the units. Community Access and Independent

Living are both providers and property owners. Office officials noted that, in some cases, the tenant may not let the property owner in to fix issues with the unit. In addition, officials felt that these issues, if left unchecked or not fixed, will not ultimately affect others (or the whole facility). However, as stated previously, water leaks within a building may result in immediate and long-term damage if moisture is not removed appropriately. Of note, Office officials were unaware of the issues we found as they had not conducted monitoring visits to the six providers at the time of our inspections. Further, as of March 2023, only nine of the required monitoring visits (once during the 5-year contract period) were completed for the 66 active ESSHI projects (14%). More frequent visits can hold providers accountable and ultimately help to improve unit conditions as well as quality of life for residents. Units that are not adequately maintained may lead to conditions impacting the health and safety of residents, with hazards such as water damage and mold potentially leading to physical injury and illness.

# Contract Work Plans

## Work Plan Objectives

Contract work plans vary by provider but usually consist of the objectives used to gauge provider performance. Our review found that some included specific, quantifiable objectives, such as “95% of admissions will have the Housing Support Plan completed within 30 days of admission.” However, others included vague, unattainable, or unmeasurable objectives, such as “100% of residents receiving medication management services will increase their skill set.” There were also objectives that were outside of the provider’s control, such as “50% of residents will be working, volunteering, or going to school within 12 months of admission into the program if they choose.” Additionally, providers didn’t always establish a baseline against which progress could be measured.

Only one of the six providers – Community Access – met all its objectives; however, its objectives appeared to be easily attainable. For example, Community Access’ objectives stated “100% of residents will be afforded the opportunity to collaborate with a service coordinator to design a person-centered support plan; 100% of eligible residents will receive the opportunity to complete an annual resident satisfaction survey; 70% of residents completing the survey will report overall satisfaction with services; and 100% of residents will receive support services and assistance to help them remain housed.”

While the other five providers made progress toward their objectives, not all objectives were met, and some providers had not developed a mechanism to track and measure them.

- DePaul met five of its eight objectives (63%); however, its work plan is very stringent despite being specific and measurable. The three objectives not met were:

- *Each resident's goal will be addressed once per month 90% of the time.* Residents' goals were addressed only 42% of the time.
- *Contact notes will reflect that each necessary or desired linkage to outside services is being addressed at least once per month 95% of the time until the linkage is complete.* While the case notes did indicate attempts to address this linkage, none of the residents' contact notes reflected the required 95%.
- *Contact notes will reflect at least quarterly contact with outside providers 95% of the time.* The notes only reflected 83% contact with outside providers.

- BFNC met two of its seven objectives (29%) but did not establish a baseline and mechanism to track its objective of linking residents to a primary care provider to reduce emergency room visits and, subsequently, whether such a decrease occurred. The five objectives not met were:
  - *Ensure that every resident has a household budget, tax assistance, entitlements, and money management coaching.* BFNC provided this support to only 30% of residents.
  - *Develop Plans of Care within the first 30 days of admission for all residents.* This wasn't done for any of the 10 residents.
  - *Conduct a needs assessment for each resident to determine the necessary services and treatments.* BFNC provided this support to only 80% of residents.
  - *Individuals will complete screening and intake with program and management staff within 72 hours to 14 days of acceptance.* Only 70% of individuals completed the tasks within that time frame.
  - *As a result of being linked to a primary care provider, at least 50% of program participants will have a reduction in medical and psychiatric ER visits.* BFNC did not establish a baseline and mechanism to track its performance.
- YWCA met four of its eight objectives (50%) but was unable to track the other four as they were written in the work plan; therefore, we have no assurance the following objectives were achieved:
  - *85% of residents increase participation in job training and rates of employment.*
  - *75% of residents will increase participation in substance use treatment services and develop recovery plans.*
  - *80% of residents will increase participation with mental health providers.*
  - *85% of residents obtain a physical exam annually.*
- Independent Living met two of its five objectives (40%); however, we determined that achieving 100% was not within its control due to voluntary participation by residents. There was also an objective that 100% of residents

would have the opportunity to complete a resident satisfaction survey; however, we were unable to verify this because the completed surveys were unavailable for review. The following two objectives were outside the provider's control:

  - *100% of residents receiving medication management services will increase their skill set.*
  - *100% of residents receiving support with symptom management will increase their skill set.*

- Federation met one of its five objectives (20%) but fell short of its other four objectives related to occupancy rates, time frames for screenings and data entry, and voluntary participation in employment, volunteering, or education activities by residents. Specifically, those four objectives are:
  - *The program will maintain 95% occupancy within 6 months of the program's start date.* We found the occupancy was only 73%.
  - *Federation will screen applicants within 5 business days of receiving a referral.* This was only done timely for 60% of residents.
  - *Federation will report all admissions to CAIRS within 7 days of admission into the program.* This was only done timely for 70% of residents.
  - *50% of residents will be working, volunteering, or going to school within 12 months of admission into the program if they choose.* Regarding residents meeting this objective, there were none in 2019, 11% in 2020, 20% in 2021, and 40% in 2022.

## Work Plan Oversight

Despite requiring work plan objectives in each contract, the Office does not review program outcomes to determine if the objectives are met and whether the program is successful. The Office defers to its field offices to review, approve, and follow up on ESSHI contracts, including work plans. However, only one of five field offices follows up to determine if the provider is meeting its objectives, making progress, and providing services in line with its stated objectives. The Office does not consider the work plans included in ESSHI contracts as functional documents against which providers are evaluated; however, each field office treats work plans differently and may use work plans as a tool to evaluate provider performance if it chooses. According to Office officials, there is no requirement to use the work plan as an evaluation tool; therefore, provider performance is not measured against the objectives and performance measures identified in the work plan. Providers are measured against the Guidelines and additional information provided in their ESSHI application. The work plan is not considered when assessing provider performance, and providers are not penalized for failing to meet their work plan objectives. The Office has not provided guidance to the field offices regarding the work plans and has not set expectations or requirements for developing and monitoring them. This has resulted in field offices using varying methods of contract review and monitoring, including review of work plan objectives that sometimes can include unattainable and difficult-to-measure objectives. We discussed this with Office officials, who stated

they see the value in using the work plans as a functional tool to assess provider performance and view this area as an opportunity to improve provider oversight.

As discussed previously, not all providers were meeting their work plan objectives and, at times, the objectives were not measurable or attainable despite being reviewed by the field offices before contract approval. For example, Federation's occupancy rate objective states it will maintain 95% occupancy within 6 months of the program's start date. This is a scattered-site program (units scattered across multiple housing complexes) that, according to Office officials, has a lower occupancy rate – on average 85% – compared to traditional supportive housing programs, making the objective unrealistic for this particular contract. When asked why this work plan objective would include such a high occupancy rate, Office officials were not sure but agreed that it was unrealistic and should have been more in line with scattered-site program expectations. Failure to monitor contract work plans and objectives has resulted in objectives that are unattainable, unmeasurable, and inconsistent. Increased oversight would serve as a means to improve provider performance and ultimately improve the quality of services delivered.

## Child and Adult Integrated Reporting System

The Office uses CAIRS to track all housing for individuals with a mental health issue, including admissions and discharges of residents with SMI. For each resident, providers must enter their demographic information, admission and discharge data, reason for discharge, and where the resident was housed prior to admission. CAIRS provides program performance indicators, program vacancy, and other relevant information that is used to monitor ESSHI providers as well as other supportive housing programs. However, there is no requirement to enter the same information for non-SMI residents, such as those with a substance use disorder, survivors of domestic violence, and veterans with a disability.

Of the total 2,087 active ESSHI units overseen by the Office, 1,567 units are SMI and 520 are non-SMI. As a result, the Office does not have data for approximately 25% of its active ESSHI units and, therefore, can't determine whether the program for those units has been successful in terms of lengths of stay and occupancy rates. The Office uses these data points as an indicator of program success. The Office's only mechanism to monitor non-SMI units is to conduct an on-site monitoring visit, which is performed by the field office once per 5-year contract cycle; however, this is not frequent enough to provide real-time data. Capturing the lengths of stay and occupancy rates for all ESSHI units would result in a more accurate depiction of the program's success; without access to non-SMI data, the Office can't determine whether the non-SMI providers have been successful at providing stable housing. In response to our preliminary findings, the Office indicated it will consider the feasibility of collecting this data. In addition, the Office did not indicate any privacy concerns regarding the collection of the data for the other populations it serves.

While the Office does not track the performance of its ESSHI units in terms of lengths of stay and occupancy rates, it does track performance for all its supportive housing

units, including ESSHI, through CAIRS. According to the Office's reports on its supportive housing, 74% of its residents' median length of stay was 2 years or more and 63% of its residents' median length of stay exceeded 5 years.

## Program Services

Providers offer supportive housing services to help integrate residents into the existing community services system, increase housing stability, and promote resident well-being. These services include:

- Determining if they are eligible for supportive housing
- Helping them establish a household, become acquainted with the local community, apply for entitlements, and understand their rights and responsibilities as a tenant
- Offering instruction and assistance with resolving apartment and building maintenance issues
- Providing linkages to community resources and health home care coordination
- Assisting with household management and budgeting to ensure that rent and other expenses are paid

All six of the providers we visited offered the services described above, and the support plans and progress notes for the sample of 61 residents indicated that services were regularly offered to residents. However, residents need to be present to accept program services. Additionally, if residents asked to have specific areas addressed (e.g., entitlements, budgeting, community integration), the provider assisted with their progress toward these optional goals and included them in the residents' support plans.

# Recommendations

1. Increase the frequency of the Office's provider monitoring visits to ensure ESSHI units are adequately maintained, provider performance is acceptable, and Guidelines are met.
2. Develop and implement a process that ensures provider contracts have objectives and performance measures that are attainable, measurable, and reportable prior to awarding contracts.
3. Develop and issue policies and procedures to field offices related to monitoring and reviewing work plans to ensure providers comply with contract requirements.
4. Review work plans during the Office's monitoring visits to better evaluate program success.
5. Develop a mechanism to track and monitor non-SMI resident data to incorporate lengths of stay and occupancy rates into measures of success.

# Audit Scope, Objectives, and Methodology

The objectives of our audit were to determine whether controls over ESSHI are sufficient to ensure the needs of high-risk target populations are being met, and whether providers deliver the services that are required in their contracts with State agencies. The audit covered the period from July 2017 through March 2023.

To accomplish our objectives and assess related internal controls, we interviewed Office and ESSHI provider officials and reviewed relevant policies and procedures, RFPs, contracts, support plans, progress notes, summary sheets, income verifications, discharge information, and documentation that supported providers meeting their work plan objectives. We became familiar with and assessed the Office's internal controls as they relate to controls over ESSHI to ensure that the needs of target populations are being met and that providers are delivering services as required in their contracts. In addition, we conducted visits to six ESSHI providers and inspected 60 units to determine provider compliance with the Office's Guidelines.

The Office had 66 active ESSHI projects associated with 2,087 units during our audit scope. We selected a judgmental sample of six ESSHI providers and projects related to 278 active ESSHI units. The judgmental selection of the six providers was based on geographic location through the selection of at least one provider in each of the Office's field office regions; number of housing units; and ESSHI population served (veterans, family units, SMI, and re-entry to the community from incarceration). We selected a judgmental sample of 10 housing units per provider for a total of 61 residents (one unit had two resident files, so both files were reviewed, resulting in an additional resident) to determine if their needs are being met and if providers are delivering services as required in their contract. The units for each provider were selected by taking every other, every fourth, or every 11th unit (depending on the number for each provider) until we had 10 selected. We selected the first 10 at one provider that had 15 units and selected the units for the scattered-site provider based on proximity of locations to minimize travel. We also inspected those 60 housing units to determine if conditions were adequate. During these inspections, we walked through the units and visually inspected the conditions and took photos where appropriate. The findings and conclusions drawn as a result of our judgmental samples cannot and were not intended to be projected to the population as a whole.

Additionally, we verified the reliability of the data used to conduct our audit work that would be used to support our findings and found the data to be sufficiently reliable for the purposes of our audit. We compared the contract data maintained by the Office with that on Open Book New York to determine the accuracy and completeness of the data.

# 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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 the Office's oversight and administration of ESSHI.

## Reporting Requirements

We provided a draft copy of this report to Office officials for their review and formal comment. We considered their comments in preparing this final report and have attached them in their entirety at the end of it. Office officials generally agreed with our audit recommendations and indicated actions they will take to address them, but took exception to certain statements in the report. Our responses to certain remarks are embedded within the Office'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 of Mental Health 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.

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

**KATHY HOCHUL**
Governor

**ANN MARIE T. SULLIVAN, M.D.**
Commissioner

**MOIRA TASHJIAN, MPA**
Executive Deputy Commissioner

September 29, 2023

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

Dear Nadine Morrell:

In accordance with Executive Law § 170, the following are the responses from the Office of Mental Health (OMH) to the Office of the State Comptroller's (OSC's) draft audit report entitled, *"Controls Over the Empire State Supportive Housing Initiative"* (2022-S-22).

While OMH generally agrees with OSC's recommendations, we disagree with, and would like to provide additional clarity on, several of the statements and characterizations made within the draft audit report.

*Face-to-Face and In-Home Visits and Additional Guidelines Requirements*

On page 10, OSC notes that not all residents received face-to-face visits with their case manager monthly and others did not receive a visit to their home quarterly. OSC states, "we found case notes where attempts to contact the resident were documented." It is important to note that housing providers cannot require supportive housing tenants to participate in services. In instances where a provider has documented attempts to contact tenants for monthly visits, OMH considers that provider in compliance with their contractual obligations.

Further, when discussing provider compliance with the *Supportive Housing Guidelines,* OSC states that:

> "Office officials stated that, between March 2020 and May 2023, they issued guidance waiving in-person visits and allowed services to be provided via telehealth. Despite this, the six providers sampled essentially operated as they normally would. We asked providers about not conducting in-person visits due to the COVID-19 pandemic. Responses varied by provider, with some not providing a specific time frame where in-person visits were suspended, whereas others stated they conducted these visits on a case-by-case basis. Therefore, if the provider did not indicate a specific period where they used telehealth, we did not exclude in-person meetings in our review."

The scope of OSC's audit was July 2017 through March 2023, a period including the three years of the federally declared COVID-19 public health emergency. As has been explained, OMH issued guidance to supportive housing providers allowing for certain flexibilities during this time given the unprecedented circumstances of a worldwide pandemic. These flexibilities allowed providers to complete monthly contact and quarterly face-to-face contact using telehealth technology,

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including audio-visual or audio-only methods of communication. Providers should have indicated in their documentation how services were provided but were not specifically required to use the term "telehealth" to describe their efforts. It appears OSC applied different standards based on whether the provider specified they had adopted the flexibilities OMH allowed. By doing so, OSC has disregarded the guidance OMH issued. OMH did not require providers to declare a period in which they would not conduct in-person visits in order to qualify to provide telehealth visits. OSC's implication that this was required is contrary to the intent of the OMH guidance and inconsistent with how providers operate their programs. Any services provided using allowable telehealth modalities from March 30, 2020, through May 12, 2023, should not have been included in OSC's findings regarding the failure to provide face-to-face or in-home visits.

OMH has the same concern with OSC's statement regarding flexibilities afforded during the public health emergency for the completion of support plans. Specifically, OSC states:

> "According to Office officials, guidance in response to the public health emergency was issued in April 2020 that waived support plan requirements between March 2020 and May 2023. However, our testing found that majority of providers were still developing initial support plans and reviewing them quarterly. As such, we evaluated each provider based on their actions and responses to how they operated."

Although, as OSC found, most of the providers were developing initial support plans in the required times frames and reviewing them quarterly, the April 2020 guidance was issued to allow flexibility during the public health emergency. The guidance stated, "service plan reviews are not required and may be postponed *as needed"* (emphasis added). OSC does not have the authority to impose conditions on guidance issued by OMH and any findings related to support plan requirements during the disaster emergency period related to how individual programs operated should not have been included. On the contrary, providers that diligently attempted to comply with requirements during the public health emergency should be praised for their efforts, not penalized for failing to attain 100% compliance during this period.

**State Comptroller's Comment** – As noted in the Office's response to our audit, we acknowledged the Office's COVID-19 guidance allowing flexibility in the services provided. This flexibility allowed providers the options of providing communications using telehealth technology and providing support plans only as needed. During our site visits to the six providers, each provider described the options they selected to meet with residents for monthly and quarterly communication, as well as support plan development. Therefore, we measured the providers' compliance based on their stated methods used at that time.

OMH also disagrees with the OSC's finding that additional data collection would be an efficient strategy for the state to monitor provider performance. On page 11, OSC states the following:

> "The Office does not capture any of this data (face-to-face meetings, in-home visits, initial development plans, quarterly reviews, and income verification), which would allow it to effectively monitor provider performance."

OMH does not believe it would be practical or useful for OMH to request these data for residents of more than 30,000 supported housing beds, of which ESSHI is a small sub-set, which may or may not be indicative of a performance issue (e.g., as noted above, in instances where providers

have documented attempts to contact tenants for monthly visits, OMH considers that provider to be in compliance with their contractual obligations). This would require housing providers to report a minimum of 630,000 data points annually in addition to their internal service or data recording processes. Moreover, the information referenced above is already reviewed as part of the process used to monitor program performance.

**State Comptroller's Comment** – The report points out that Guidelines' requirements were not being met and that the Office may have identified these issues by performing more frequent monitoring visits, as we noted on page 15 of our report, and collecting some of this data. The Office disagrees but does not explain in the absence of this data or increased monitoring how it will address the finding identified.

Lastly, on page 11, OSC discusses the potential impact of not meeting the conditions and expectations outlined in the *Supportive Housing Guidelines* and states, "we found two instances where inaction by the providers may have led to health and safety issues for the resident."

OMH does not agree with OSC's assertion that providers failed to act in instances regarding resident safety. Specifically, OMH disagrees that there was inaction. In one instance, the provider offered assistance multiple times and the tenant repeatedly declined, which is the tenant's right. Without evidence, it is inappropriate for OSC to imply provider actions impaired the individual's health. In the second instance, the provider acted upon request, and although it was not instantaneous, the action was timely.

**State Comptroller's Comment** – Due to the confidential nature of the situations described to the Office in the report, we cannot address these concerns directly. However, based on the documentation available to the audit team during our site visits, we determined that these serious health and safety issues that could affect the resident's quality of life needed to be addressed more appropriately.

*Missing Residents*

Regarding the situations surrounding the two missing residents that OSC cited in the report, OSC stated:

> "We shared these situations with Office officials, who stated they do not have a policy to address missing persons as residents are living mostly independently in the community, with supports available as needed."

This does not accurately characterize OMH's statements. OMH explained the challenges in determining whether an individual, living independently, is truly missing or is simply not responsive to the provider's attempted contact. While OMH does not specify a uniform policy, we also clearly state in the Supportive Housing Guidelines our expectation that programs have an internal policy to identify and follow-up on consumers who are at high risk of losing their housing (e.g., missing person) and what steps program staff should take upon that determination.

**State Comptroller's Comment** – While the Office's response noted that programs should have a policy to identify and follow up on tenants who are at high risk of losing their housing

(e.g., missing persons) and what steps program staff should take upon that determination, it is unclear if this is occurring as we found two residents at the same program were missing – one for 7 months, who was found in a nursing/rehabilitation facility, and one for 4 months, where we found limited effort by the housing specialist to locate this resident.

*ESSHI Unit Inspections*

OMH disagrees with OSC's assertion that ESSHI providers are responsible for the conditions at the units visited by the auditors. The goal of supported housing is for the resident to live successfully in the community and achieve the highest level of independence. With respect to apartment repairs, supportive housing providers are responsible for advocacy between the tenant and property owner when necessary. For example, if there is a repair needed in the apartment, which may be identified by the tenant or the service provider, the provider should support the tenant in submitting a work order or submit it on their behalf if needed, ensuring the maximum amount of tenant independence. These scenarios may also be useful rehabilitative skills training exercises for tenants to increase their functionality and independent living skills, even if that means it may take some time for a repair issue to be addressed.

When it comes to completing repairs and maintenance, it is incumbent upon the individual to allow the contractor or program staff completing the repair into their home to do so. As OSC stated, it is not uncommon for tenants to refuse to allow anyone in the apartment to complete work orders. Supportive housing providers cannot force an individual to allow someone into their home but should work with individuals to schedule and accommodate needed repairs, as this is an important skill for successful community integration.

It should also be noted that ESSHI agencies are contracted with OMH to provide services. ESSHI does not fund property development or management. As OSC notes, four of the six ESSHI providers visited by OSC in this audit were not the property owner or manager. In instances where physical plant issues are present and the ESSHI provider does not own or manage the property, it is the ESSHI service provider's role to provide support and advocacy. It is not their role to make repairs or clean apartments. Any references to concerns about apartment or building conditions without supporting documentation to show that the ESSHI provider failed to provide *support or advocacy requested by the tenant* are not relevant to an assessment of the providers' performance.

**State Comptroller's Comment** – The conditions we identified in the report – instances of extensive mold, vermin, and water leaks – need to be corrected so that residences do not become uninhabitable. Further, ESSHI funding includes a portion for rental assistance with the inherent expectation that unit maintenance issues will be resolved so that safe, healthy, and stable residential conditions exist.

Lastly, OSC states that:

> "Of note, Office officials were unaware of the issues we found as they had not conducted monitoring visits to the six providers at the time of our inspections. Further, as of March 2023, only nine of the required monitoring visits (once during the 5-year contract period) were completed for the 66 active ESSHI projects (14%)."

To the extent this statement suggests that required monitoring visits were not made, any such suggestion is inaccurate. OMH has conducted all monitoring visits required by the OMH policy cited by OSC. As of March 27, 2023, only nine sites had contracts that expired or were approaching expiration, and all were reviewed prior to the expiration of the contract. The six specific providers cited in OSC's report were not due for inspection during the scope of OSC's audit and therefore did not receive monitoring visits.

**State Comptroller's Comment** – As noted on page 15 of our report, Office officials were unaware of the issues we found, as they had not conducted monitoring visits to the six providers at the time of our inspections. Further, as of March 2023, only nine of the required monitoring visits (once during the 5-year contract period) were completed for the 66 active ESSHI projects (14%). We do not state that the required monitoring visits were not made, but rather that monitoring visits conducted earlier and more frequently during the contract period would have provided better assurance that providers were functioning as intended and needed support services and unit maintenance to address quality-of-life issues were occurring.

OMH's responses to the recommendations are as follows:

**OSC Recommendation 1:** Increase the frequency of the Office's provider monitoring visits to ensure ESSHI units are adequately maintained, provider performance is acceptable, and Guidelines are met.

**OMH 30-Day Response:** OMH will consider increasing the frequency of provider monitoring visits by measuring potential benefits against available resources.

**OSC Recommendation 2:** Develop and implement a process that ensures provider contracts have objectives and performance measures that are attainable, measurable, and reportable prior to awarding the contract. Develop and issue policies and procedures to field offices related to monitoring and reviewing work plans to ensure providers comply with contract requirements.

**OMH 30-Day Response:** OMH will organize a work group in calendar year 2024 to study this issue and develop guidelines surrounding workplan objectives and performance measures. Subsequently, policies and procedures relating to monitoring and reviewing workplans will also be developed.

**OSC Recommendation 3:** Review work plans during the Office's monitoring visits to better evaluate program success.

**OMH 30-Day Response:** See response to recommendation #2.

**OSC Recommendation 4:** Develop a mechanism to track and monitor non-SMI resident data to incorporate lengths of stay and occupancy rates into measures of success.

**OMH 30-Day Response:** OMH will explore options to collect and incorporate this data

into current analysis and measures of success.

Please let us know if you have any questions or require additional information concerning the above.

Sincerely,

Moira Tashjian
Executive Deputy Commissioner

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