NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Oxiris Barbot, MD
Commissioner

DIVISION OF MENTAL HYGIENE

OFFICE OF PROGRAM REVIEW AND EVALUATION

1100 SERIES

STANDARDS FOR PROGRAM AUDIT OF HOUSING PROGRAMS

APPLICABLE BUT NOT LIMITED TO THE FOLLOWING PROGRAMS:

PERMANENT HOUSING

- Supported SRO (Congregate Housing)
  - NYC 15/15 (congregate)
- Supported Housing (Scattered-site Housing)
  - NYC 15/15 (scattered-site)
  - Justice Involved Supported Housing (JISH)

SHELTER-BASED & TRANSITIONAL HOUSING

- On-Site Rehabilitation (Shelter-based)
- Transitional Living Community

Highlights of Changes to Standards for Program Audit

1100 Series
Housing Programs

Those standards which reflect significant changes are listed below. Standards which have undergone minor editing changes are not included in this list.

COMPLIANCE CATEGORY: PROGRAM ADMINISTRATION (PA)

PA.1102 Service Modalities

- The stipulation added in FY18 and applicable only to NYC 15/15 programs regarding program completion of annual rent calculation forms, has been removed from this standard effective July 1, 2018. While the requirement for programs regarding completion of these forms has not changed, OPRE will not be reviewing or rating this program function.

- Requirement C has been modified for NYC 15/15 programs to include weekly supervision of direct service staff by a qualified professional as a training requirement. **This modification will be reviewed but not rated effective December 1, 2018. It will be rated effective July 1, 2019.**

COMPLIANCE CATEGORY: SERVICES AND TREATMENT (ST)

ST.1103 Initial Assessment and Service Planning

- A requirement to assess the recent criminal justice system involvement, and history of involvement for each resident, required in JISH and NYC 15/15 programs, was reviewed but not rated in all other permanent housing programs in FY18. This requirement will be rated in all permanent housing programs effective July 1, 2018.

ST. 1104 Provision of Ongoing Services

- A requirement for housing programs serving youth up to age 26 was clarified in FY18 to stipulate that documentation in case records must include periodically updated information describing obstacles to timely discharge planning as well as efforts to work with youth to eliminate these when they interfere with discharge planning and/or a timely discharge due to aging out at age 26. This was reviewed but not rated in FY18; it will be rated effective July 1, 2018.

- All housing programs are expected to conduct diligent searches for absent/missing residents. Diligent search requirements for JISH programs remain unchanged. For all other housing programs, diligent search requirements have been modified, and will be rated, as specified in the standard.

COMPLIANCE CATEGORY: RESIDENT RIGHTS (CR)

CR.1101 Resident Rights

- The requirement for programs to inform residents of their right to call 311 with grievances and complaints regarding their supported housing program, which was reviewed but not rated in FY18, has been modified to clarify the types of issues that may be directed to 311 for assistance. This requirement will be rated effective January 1, 2019.

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PA.1101 **TARGET POPULATION**

Standard PA.1101 The program serves the target population and the number of residents specified in the provider contract or agreement.

Requirements: The provider shall:

Serve individuals who meet the criteria specified in the contract/ agreement, and serve the number of residents stipulated in the contract/agreement.

Examples of Evidence of Implementation: Case records and other service delivery documentation indicate that individuals served are of the target population. Resident rosters show that sufficient numbers of residents are being served.

Scoring:

1. The provider is in minimal compliance with the requirement.
2. The provider is in partial compliance with the requirement.
3. The provider is in substantial compliance with the requirement.
4. The provider is in compliance with the requirement with minor inconsistencies.
5. The provider is in full compliance with the requirement.

PA.1102 **SERVICE MODALITIES**

Standard PA.1102 The program implements treatment/service modalities, interventions, and other program activities specified in the provider contract or agreement.

Requirements: The provider shall:

A. Implement the full range of services and/or program model specified in the contract/agreement.

B. Ensure that services are structured and scheduled to meet the intended goals and objectives of the program, and maximize resident participation and progress.

C. Provide or arrange for program staff to participate in relevant training to promote staff knowledge and implementation of mental health recovery principles and strategies (including, but not limited to, training in motivational interviewing; trauma-informed case management; conflict resolution; crisis intervention); programs demonstrate successful implementation of person-centered, strength-based service planning and provision. ***In NYC 15/15 programs, provide or arrange for ongoing supervision of direct service staff (weekly, at minimum) by a qualified Master's level professional. This will be reviewed but not rated effective December 1, 2018 and will be rated effective July 1, 2019.***

Training resources relevant to Requirement C may be located through any of the following websites: www.cucs.org www.nyaprs.org www.samhsa.gov http://coalitionny.org http://practiceinnovations.org.

Examples of Evidence of Implementation: Case records and other service delivery documentation, logs, supervision notes, and resident and staff interviews, demonstrate that the program provides the full range of services, including staff training and as appropriate, supervision for direct service staff, and meets its goals and objectives.

Scoring:	1.	The provider is in minimal compliance with the requirements.
	2.	The provider is in partial compliance with the requirements.
	3.	The provider is in substantial compliance with the requirements.
	4.	The provider is in compliance with the requirements with minor inconsistencies.
	5.	The provider is in full compliance with the requirements.

PA.1103 PROGRAM STAFF

Standard PA.1103 The program maintains the staffing pattern specified in the provider contract or agreement.

Requirements: The provider shall:

A. Maintain the staffing pattern specified in the contract/agreement.

B. Have a written description of the qualifications and responsibilities for each staff, volunteer and student/trainee position whose job performance directly affects the quality of resident care.

C. Ensure that qualifications for staff positions are met as specified in the contract/agreement.

Examples of Evidence of Implementation: Copies of the current license or certification for those program service staff whose professional organizations require it; OR, a report by the credentialing service utilized by the agency; OR, a copy of the diploma earned from the appropriate academic program for all other program service staff. If there are vacancies, the program demonstrates ongoing recruitment efforts such as newspaper or internet advertisements, job fair participation or graduate school postings.

Scoring:

1. The provider does not meet requirement C, and/or prolonged staffing vacancies have had significant negative impact on the provision of program services.

2. The provider meets requirement C and partially meets requirements A and/or B.

3. The provider meets requirement C and substantially meets requirements A and B.

4. The provider meets requirement C and meets requirements A and B with minor inconsistencies.

5. The provider meets all requirements.

PA.1104 **PERSONNEL POLICY AND PROCEDURES**

Standard PA.1104 The provider has personnel policies and procedures for the hiring of staff.

Requirements: The provider's policies and procedures facilitate the appropriate hiring of staff and shall include the following:

A. Written policies and procedures that:

- Prohibit discrimination on the basis of race, color, creed, disability, gender, sexual orientation, marital status, age or national origin.

- Stipulate that the employment history and qualifications of all job applicants and volunteers must be verified.

- Require that pre-employment background checks be conducted for prospective employees and volunteers as prescribed by current laws and regulations.

Notes on the NYC Fair Chance Act and NYS Justice Center:

The NYC Fair Chance Act, Local Law No. 63 (2015) stipulates that employers may not inquire into an applicant's criminal history until after a conditional offer of employment is made.

Service providers whose programs are funded, certified, or licensed by the NYS Office of Mental Health (OMH) are required to conduct pre-employment background checks, in accordance with NYS Justice Center and OMH regulations for prospective employees and volunteers who will have the potential for, or may be permitted, regular and substantial unsupervised or unrestricted contact with clients. This includes programs funded by OMH through NYC DOHMH contracts. Requirements include requesting a Staff Exclusion List (SEL) check. For applicants not on the SEL, providers are required to follow established procedures for requesting a criminal background check (CBC), and an inquiry of the Statewide Central Register of Child Abuse and Maltreatment (SCR) through the New York State Office of Children and Family Services (OCFS).

Providers may contact Charles Pace, OMH's liaison for mental health providers, at Charles.Pace@omh.ny.gov for assistance with pre-employment background check requirements.

- For all provider agencies (including non-residential facilities licensed or operated by OMH) subject to Social Services Law 424-a, require that clearance will be obtained from the Statewide Central Register of Child Abuse and Maltreatment for all prospective employees, consultants, volunteers or other providers of goods and services, who will have the potential for regular and substantial contact with children under age 18, being considered for employment or hired after September 17, 1997.

OR

- Only in cases where a provider agency that serves children under age 18 is not entitled under the law to obtain clearance from the Statewide Central Register of Child Abuse and Maltreatment (SCR), require that for all job applicants, including consultants, volunteers or other providers of goods and services, who have the potential for regular and substantial contact with children, inquiry will be made by the agency, and a statement signed by the applicant as to whether they have been the subject of a founded report to the SCR or similar registry in any other jurisdiction and under penalty of perjury, and that the information they provide is accurate. The policy and procedures include provision for the confidentiality of such information.

B. For all program staff who have regular and substantial contact with children under age 18, including consultants, volunteers, or other providers of goods and services to the agency, evidence of clearance obtained through Statewide Central Register of Child Abuse and Maltreatment (SCR), or, in cases where a provider agency that serves children under age 18 is not entitled under the law to obtain clearance from the Statewide Central Register of Child Abuse and Maltreatment (SCR), evidence of the provider's inquiry and a statement signed by the staff member attesting to whether they have been the subject of a founded report to the SCR or similar registry in any other jurisdiction.

C. Written verification of previous employment with at least one former employer.

Examples of Evidence of Implementation: Written personnel policies and job application forms. Copies of clearance documentation received from the Statewide Central Register of Child Abuse and Maltreatment or, when applicable, documentation of self-certification. Documentation of written or telephone contacts with at least one previous employer.

Scoring:

1. The provider does not meet requirement B and/or 0-49% of personnel files reviewed meet requirement C.

2. The provider meets requirement B and 50-79% of personnel files reviewed meet requirement C.

3. The provider meets requirement B and 80-99% of personnel files reviewed meet requirement C, but does not meet all components of requirement A.

4. The provider meets requirements B and C and meets requirement A with minor inconsistencies.

5. The provider's policies and procedures meet all requirements.

RULES APPLICABLE TO CLINICAL DOCUMENTATION STANDARDS

The following rules are applicable to all clinical documentation standards:

1. **All information must be clearly dated.**

2. **All information must be legible in order to be rated. Illegible information will be rated unacceptable.**

3. **The provider must document the reasons why information is missing or an assessment is not completed (e.g., resident refused to answer, or, if a resident is described as a "poor informant" in a particular area of assessment, an explanation must be given as to the reason, such as, "resident was too disoriented to answer questions appropriately".)**

4. **All positive findings must be explained. For example, in an evaluation of mental status, an assessment indicating a perceptual disorder is present must be accompanied by a description of the form and content of the perceptual disorder. It must be clear from clinical documentation (e.g., progress notes, treatment plans) that there is a plan to address positive findings.**

5. **Outreach conducted to re-engage or follow-up with missing or absent residents must be clearly documented.**

ST.1101 DISPOSITION OF REQUESTS FOR SERVICES

Standard ST.1101 Eligible individuals are accepted into the program based on the goals and objectives of the program specified in the contract or agreement.

Requirements: The provider shall:

A. Document all requests for services from potential residents and referral sources, and include name of individual and date of referral.

B. Demonstrate that eligible individuals are accepted into the program, and document the specific and appropriate reasons for not accepting individuals into the program.*****

C. Demonstrate that individuals who are not accepted to the program are referred to appropriate services, by documenting that appropriate referrals are provided when individuals are determined to require an alternative level or type of care.

NOTE**: *When a referred individual is not accepted by the program upon initial interview/assessment, in some circumstances, based upon the reason for non-acceptance, it is expected that an additional opportunity to interview for admission to the program is provided. For example, an individual who is unable to be interviewed due to intoxication or a mental status change, should be rescheduled when they are able to participate in an interview. If that individual is referred or recommended to another type of service upon initial screening/ assessment (e.g. detoxification program; hospital) and remains in need of housing upon their discharge, the program is expected to schedule a new interview/assessment, providing the program has a vacancy at that time.* ***JISH providers should also refer to Guidance under ST.1102 (Timeliness of Access to Services) regarding requirements for diligent outreach for referred individuals who cannot be located following referral to the JISH program.

Examples of Evidence of Implementation: Documentation in the intake logs and/or case records, resident grievances or other information regarding the provider's admission practices demonstrate that individuals who meet program eligibility criteria are admitted to the program, and that decisions not to accept individuals into the program are based on appropriate reasons.

Scoring:

1. The provider does not meet requirements A and B.
2. The provider meets requirements A and B and 0-59% of the cases reviewed for requirement C are rated acceptable.
3. The provider meets requirements A and B and 60-79% of the cases reviewed for requirement C are rated acceptable.
4. The provider meets requirements A and B and 80-99% of the cases reviewed for requirement C are rated acceptable.
5. The provider meets requirements A and B and 100% of the cases reviewed for requirement C are rated acceptable.

ST.1102 TIMELINESS OF ACCESS TO SERVICES

Standard ST.1102 Eligible individuals have access to program services expeditiously.

Requirements: The provider shall:

Ensure timely and efficient access to program services, by:

- Facilitating entry into the program.

- Ensuring that services begin without delay.

Provider Guidance for Justice Involved Supported Housing programs (JISH):

JISH housing providers shall conduct and document outreach and diligent search efforts for referred individuals in accordance with DOHMH Office of Housing Services diligent search and documentation guidelines.

Upon receiving the referral from DOHMH, programs shall initiate outreach to the potential resident or the collateral contact within two (2) business days to facilitate the first face-to-face contact with the potential resident; whenever possible, face-to-face contact should occur within one week of the referral.

When the provider is unable to locate a referred individual within a week of receiving the referral, diligent outreach efforts shall be initiated, as follows:

- Calls to any known telephone number including the potential resident, collateral contacts, or other providers
- A letter sent to the potential resident's last known residence
- Twice weekly for a period of two weeks, and then weekly for an additional two weeks if needed, the program shall try to locate the individual by checking:
  - ✓ Department of Homeless Services
  - ✓ Street Outreach Teams
  - ✓ NYC and NYS correctional systems
- Following two (2) weeks of diligent search, the program shall notify DOHMH Office of Housing Services that the individual has not been located; following an additional two weeks of search (4 weeks total) the program shall again notify the DOHMH Office of Housing Services so that a further plan of action may be developed
- All outreach and search efforts shall be documented and include date and time of outreach/search and the plan for continued follow-up.

Examples of Evidence of Implementation: Case records, intake logs, diligent search logs and/or any other documentation of services.

Scoring:	1.	0 – 39% of the documentation reviewed is rated acceptable.
	2.	40 – 59% of the documentation reviewed is rated acceptable.
	3.	60 – 79% of the documentation reviewed is rated acceptable.
	4.	80 – 99% of the documentation reviewed is rated acceptable.
	5.	100% of the documentation reviewed is rated acceptable.

ST.1103 INITIAL ASSESSMENT AND SERVICE PLANNING

Standard ST.1103 Residents receive a complete initial assessment of strengths, problems, and expressed needs to facilitate the development of an individualized comprehensive service plan.

Requirements: The provider shall:

A. Complete an initial assessment* prior to or upon the completion of the service plan that contains sufficient information to begin the service planning process. The assessment process elicits and gathers relevant information that is based on the resident's strengths, problems, and expressed needs.

> ***Note:** *While current or historical information gathered from any source, including the HRA application, can inform the program's assessment of the resident, it **cannot** substitute for an initial assessment completed by the provider within the required timeframe.*

> ***Guidance:***
> - *Information relevant to the resident's "current" status will be accepted from any source only if dated 3 months before admission, up to or upon completion of the service plan. Information from any source relevant to the resident's past history may be incorporated into the provider's evaluation of the resident.*
> - *The Bureau of Mental Health recommends programs utilize the Self-Assessment Employment History and Preferences tool developed by the Corporation for Supportive Housing, when engaging residents regarding their vocational interests and preferences and their capacity to become employed. Regardless of the assessment tool utilized, it should be evident that the program has conducted an assessment of the resident in each of these vocational areas prior to, or upon completion of, the initial service plan.*

Include the required information listed below in the initial assessment:

Family Supportive Housing programs only: Case record documentation includes assessment information on all family members residing in the program, including children: it must be evident that services are provided to all family members as applicable, based upon the strengths, problems and needs identified for each member. The program may choose to maintain separate case records for children.

INITIAL ASSESSMENT

For All Programs except Transitional Living Community (TLC) and Justice Involved Supported Housing (JISH)

ADMISSION AND REFERRAL INFORMATION
- Presenting problem
- Source of referral
- Date of admission/active status
- Resident's ability to communicate effectively in English or their preferred spoken language

MENTAL HEALTH
- Current or most recent mental health provider
- Name and phone number of provider or treating professional

SUBSTANCE USE
- Current use of alcohol and other substances
- Resident's assessment of the effects of substance use on his/her life

VOCATIONAL ASSESSMENT
(*Not applicable to Shelter-based programs and Optional for Residents in Permanent Housing who are age 62 and Older).*
- Employment history
- Current interests and employment preferences

CRIMINAL JUSTICE INVOLVEMENT
- History of involvement with criminal justice system
- Most recent involvement with criminal justice system

LIVING ARRANGEMENTS
- Household composition (including names and ages of minor children)

PARENTING SKILLS ASSESSMENT
- An assessment of resident's ability to meet the needs of minor children when the resident is responsible for the care of minor children
- Presence or absence of child abuse (sexual and physical abuse) or neglect of children for whom the resident is responsible
- History of ACS involvement
- Current ACS involvement including current case status

Initial Assessment For Transitional Living Community Programs (TLC)

ADMISSION AND REFERRAL INFORMATION
- Presenting problem
- Source of referral
- Date of admission
- Resident's ability to communicate effectively in English or their preferred spoken language

MENTAL HEALTH

-Mental status evaluation (including a risk assessment)
- Diagnosis
- Mental health history and treatment
- Family mental health history and treatment

SUBSTANCE USE

- Current and past use of alcohol and other substances
- Frequency, amount and types of alcohol and substances used
- History of treatment for substance use
- Resident's assessment of the effects of substance use and dependence on his/her life
- Family history of substance use

CRIMINAL JUSTICE INVOLVEMENT

- History of involvement with criminal justice system
- Most recent involvement with criminal justice system

LIVING ARRANGEMENTS

- Type of housing prior to admission
- Household composition (including names and ages of minor children)

PARENTING SKILLS ASSESSMENT

- An assessment of resident's ability to meet the needs of minor children when the resident is responsible for the care of minor children
- Presence or absence of child abuse (sexual and physical abuse) or neglect of children for whom the resident is responsible
- History of ACS involvement
- Current ACS involvement including current case status

Initial Assessment For Justice Informed Supportive Housing (JISH)

ADMISSION AND REFERRAL INFORMATION

- Presenting problem
- Source of referral
- Date of acceptance of program services
- Date of admission into scattered-site apartment
- Resident's ability to communicate effectively in English or their preferred spoken language.

MENTAL HEALTH

- Current or most recent mental health provider
- Name and phone number of provider or treating professional
- Diagnosis or self-report of MH or SUD
- Mental health history and treatment (if known)
- Family mental health history and treatment (if known)

SUBSTANCE USE

- Current and past use of alcohol and other substances
- Resident's assessment of the effects of substance use on his/her life
- Diagnosis or self-report of MH or SUD
- History of treatment for substance use (if known)
- Family history of substance use (if known)

CRIMINAL JUSTICE INVOLVEMENT

- History of involvement with criminal justice system
- Most recent involvement with criminal justice system

LIVING ARRANGEMENTS

- Type of housing prior to admission
- Household composition (including names and ages of minor children)

VOCATIONAL/EDUCATIONAL ASSESSMENT

- Employment history
- Current interests and employment preferences
- Educational history, including last grade completed and current educational needs

PARENTING SKILLS ASSESSMENT

- An assessment of resident's ability to meet the needs of minor children when the resident is responsible for the care of minor children
- Presence or absence of child abuse (sexual and physical abuse) or neglect of children for whom the resident is responsible
- History of ACS involvement
- Current ACS involvement including current case status

B. COMPREHENSIVE SERVICE/TREATMENT PLAN*

For All Programs

Develop an individualized comprehensive service/treatment plan with the resident's participation, completed within 30 days of admission,* that is based on the information gathered during the initial assessment, including recommended services for the resident in the HRA-approved application (as applicable).

For Justice Informed Supportive Housing (JISH)

The individualized comprehensive service/treatment plan is completed with the resident's participation within 30 days of the move-in date,* and is based on the information gathered during the initial assessment.

The plan shall include:

- Relevant and measurable goals and objectives, including the resident's expressed goals, based upon strengths, problems and expressed needs of the resident identified during the initial assessment.

- Recommended treatment modalities and/or service interventions and the frequency of each treatment or service intervention.

- Evidence of resident collaboration in the service plan process.

- Signature of the staff who developed the service/treatment plan; signature of the psychiatrist (when required or applicable) OR signature of the supervisor when a psychiatrist signature is not required or applicable.

Evidence of Implementation: Documentation in case records

Scoring:

1. 0 – 39% of the case records reviewed are rated acceptable.
2. 40 – 59% of the case records reviewed are rated acceptable.
3. 60 – 79% of the case records reviewed are rated acceptable.
4. 80 – 99% of the case records reviewed are rated acceptable.
5. 100% of the case records reviewed are rated acceptable.

ST.1104 **PROVISION OF ONGOING SERVICES**

Standard ST.1104 Residents receive services that are individualized and appropriate to their identified strengths, problems and expressed needs based on ongoing assessments.

Requirements: The provider shall:

Guidance For Programs for Youth Up To Age 26
Housing programs serving youth up to age 26 shall maintain and update case record documentation describing obstacles that interfere with discharge planning that is expected to begin one year prior to the youth turning age 26, and/or a timely discharge. Documentation in individual case records should periodically reflect the program's efforts to work with individuals as required, and when they remain in the program beyond age 26, towards identifying, reducing and eliminating such obstacles.

For All Supported Housing (Scattered-Site)* Programs (includes JISH and NYC 15/15 Programs):

Note: Case record documentation for ***Family Supportive Housing Programs** includes information on all family members, including children, residing in the program and it must be evident that services are provided to all family members based upon the strengths, problems and needs identified for each member, as applicable. The program may choose to maintain separate case records for children.

A. Provide timely services to the resident consistent with those recommended and described in the HRA-approved application (as applicable), service plan and service plan reviews.

B. Develop service plan reviews with the resident that contain relevant and measurable goals and objectives, including the resident's expressed goals, based upon strengths, problems, and expressed needs of the resident.

C. Complete service plan reviews that contain recommended services and/or service interventions and frequency of each service or service intervention.

D. Demonstrate collaboration with the resident in the service plan review process.

E. Complete service plan reviews within the required time frames. (In NYC 15/15 scattered-site housing, service plan reviews are completed every 90 days)

F. Have signatures of the supervisor and other staff who participated in the development of the service plan reviews.

G. Demonstrate in contact notes that services and interventions are related to the goals and objectives of the resident, as documented in the service plan reviews, and indicate the resident's progress toward the stated goals and objectives. Contact notes shall also include: the date of contact; description of the services provided; the name and title of the person providing the services; and the setting of the services.

H. Document changes in recommended care or services in the service plan reviews and other case record documentation.

I. Coordinate services with the resident's treatment and other service providers and make referrals and linkages to additional services for the resident when necessary.

J. Maintain current information on all psychotropic medications prescribed to the resident by qualified health professionals outside of the program, and include: the name and telephone number of the qualified health professional, list of prescribed medications, dosages and dosing intervals of each medication.

K. Maintain continuity of services to the resident who is absent or stops participating in services, by conducting appropriate outreach based on the resident's needs.**

****Guidance On Diligent Search Applicability:**

All housing programs are expected to conduct a diligent search for any absent/missing resident. Documentation of diligent search shall include the persons and/or locations checked and the date conducted. Each housing program, regardless of population served, shall follow steps (i) and (ii) noted below, and utilize the list of contacts in item (iii) to extend their search as needed. **JISH programs will continue to follow all steps and timelines for diligent search, as indicated below.**

Diligent Search Procedures for JISH programs:

The JISH provider shall conduct a diligent search for any missing resident in accordance with the DOHMH Bureau of Mental Health, Office of Housing Services guidelines for missing residents. If a resident is discovered to be missing, the JISH provider shall:

(i) Call all known telephone numbers (resident, collateral/family, other providers

(ii) Check the apartment and any known location where the resident might be (e.g.: with family member; service provider/program locations)

(iii) Twice weekly for two (2) weeks and then weekly for an additional four (4) weeks the provider shall check the following:

- ✓ Department of Homeless Services
- ✓ Street Outreach teams
- ✓ NYC and NYS correctional systems
- ✓ Local morgues
- ✓ Hospitals near the resident's apartment and those the resident has utilized in the past
- ✓ Additional outreach efforts identified by the program based on their knowledge of the resident.

- Following the first two (2) weeks, and every two weeks thereafter up until six (6) weeks, the provider shall notify the DOHMH Office of Housing Services that the individual has been or remains missing.
- Following week six (6), the provider shall notify the DOHMH Office of Housing Services for development of a further plan of action.

L. Provide the resident with a minimum of 1 face-to-face contact per month from the supported housing staff, **or the number and types of contacts as stipulated in the provider's contract/agreement.** For the supported housing resident with whom the provider had no face-to-face contact in the month, there should be documentation of at least one attempted face-to-face contact.

For JISH Programs: Provide JISH residents with at least one contact weekly during the first year of tenancy; at least twice monthly such contacts shall take place in the resident's apartment. After the first year of services has been completed, the frequency and intensity of contacts may be reduced, consistent with the needs of the individual, as documented in the case record.

M. For all residents under the age of 62, update the employment/ vocational assessment at least every six months prior to, or upon completion of the service plan review. If the resident has previously established a vocational goal, a review of the resident's progress should be documented in the plan review, and the goal and/or objective updated if needed. If the resident has not previously established a goal in this area but is doing so for the first time, a relevant goal and objective should be included in the service plan review. **Note:** if the resident is not ready or willing to establish a goal in this area, one need not be included in the plan; however, it should be evident that all residents receive an opportunity to re-assess their employment/vocational preferences and interests, at minimum, every six months.

For Supported SRO (Congregate) and Shelter-based On-Site Rehabilitation Programs Only

A. Provide timely services to the residents that are consistent with those recommended and described in the HRA-approved application (as applicable), and documented in service plan and reviews.

B. Develop service plan reviews with the resident that contain relevant and measurable goals and objectives, including the resident's expressed goals, based upon strengths, problems, and expressed needs of the resident.

C. Complete reviews that contain recommended services and/or service interventions and frequency of each service or service intervention.

D. Demonstrate collaboration with the resident in the service plan review process.

E. Complete service plan reviews within the required time frames. (In NYC 15/15 congregate housing, service plan reviews are completed every 90 days)

F. Have signatures of the supervisor and other staff who participated in the development of the service plan reviews.

G. Demonstrate in contact notes that services and interventions are related to the goals and objectives of the resident, as documented in the service plan reviews, and indicate the resident's progress toward the stated goals and objectives. Contact notes shall also include the date of contact, a description of the services provided, and the name and title of the person providing the services.

H. Document changes in recommended care or services in the service plan reviews and other case record documentation.

I. Engage the resident to participate in program services and activities. At least monthly, document the resident's contacts with the program, the types of activities participated in, and the services received. Documentation should demonstrate that services and activities provided are consistent with the program's goals and objectives and the identified needs of the resident.

J. Coordinate services with the resident's treatment and other service providers and make referrals and linkages to additional services for the resident when necessary.

K. Maintain current information on all psychotropic medications prescribed to the resident by qualified health professionals outside of the program, and include: the name and telephone number of the qualified health professional, list of prescribed medications, dosages and dosing intervals of each medication.

L. Maintain continuity of services to the resident who is absent or stops participating in services, by conducting appropriate outreach based on the resident's needs.***

***<u>**Guidance On Diligent Search Applicability:**</u>
All housing programs are expected to conduct a diligent search for any absent/missing resident. Please see Guidance on p. 19.

M. (Not applicable to Shelter-Based On-Site Rehabilitation programs). For all residents under the age of 62, update the employment/vocational assessment at least every six months prior to, or upon completion of the service plan review. If the resident has previously established a vocational goal, a review of the resident's progress should be documented in the plan review, and the goal and/or objective updated if needed. If the resident has not previously established a goal in this area but is doing so for the first time, a relevant goal and objective should be included in the service plan review. **Note:** if the resident is not ready or willing to establish a goal in this area, one need not be included in the plan; however, it should be evident that all residents receive an opportunity to re-assess their employment/vocational preferences and interests, at minimum, every six months.

For Transitional Living Community (TLC) Programs Only

A. Provide timely services to the residents that are consistent with those recommended and described in the HRA-approved application (as applicable), and documented in service plan and reviews.

B. Develop service plan reviews with the resident that contain relevant and measurable goals and objectives, including the resident's expressed goals, based upon strengths, problems, and expressed needs of the resident.

C. Complete reviews that contain recommended services and/or service interventions and the frequency of each service or service intervention.

D. Demonstrate collaboration with the resident in the service plan review process.

E. Complete service plan reviews within the required time frames.

F. Have signatures of the supervisor and other staff who participated in the development of the service plan reviews.

G. Demonstrate in contact notes that services and interventions are related to the goals and objectives of the resident, as documented in the service plan reviews, and indicate the resident's progress toward the stated goals and objectives. Contact notes shall also include: the date of contact, a description of the services provided, and the name and title of the person providing the services.

H. Document changes in recommended care or services in the progress notes and service plan reviews.

I. Coordinate services with the resident's treatment and other service providers and make referrals and linkages to additional services for the resident when necessary.

J. Maintain current information on all psychotropic medications prescribed to the resident by qualified health professionals outside of the program, to include: the name and telephone number of the qualified health professional, list of prescribed medications, dosages and dosing intervals of each medication.

K. Maintain continuity of services to the resident who is absent or stops participating in services, by conducting appropriate outreach based on the resident's needs.

Program Type	**Service Plan Review is Due:**
Supported Housing (Scattered-site including JISH) Supported SRO (Congregate)	Every 6 months from the date of the service plan and the previous service plan review
NYC 15/15 Housing (Scattered-site and Congregate types)	Every 90 days from the date of the service plan and the previous service plan review
On-Site Rehabilitation (Shelter-based) Transitional Living Community	Every 3 months from the date of the service plan and the previous service plan review

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Evidence of Implementation: Documentation in case records and other service delivery documentation. Written supervisory notes demonstrate staff are supervised around case management and other related resident-care issues.

Scoring:

1. 0 - 39% of the case records reviewed are rated acceptable.
2. 40 -59% of the case records reviewed are rated acceptable.
3. 60 - 79% of the case records reviewed are rated acceptable.
4. 80 - 99% of the case records reviewed are rated acceptable.
5. 100% of the case records reviewed are rated acceptable.

ST.1105 **ASSISTANCE WITH SELF-ADMINISTERED MEDICATIONS (Applicable to Supported SRO (Congregate) and Transitional Living Community programs <u>in which the provider allows Assistance with Self-Administered Medication</u>)**

Standard ST.1105 The provider assists residents with self-administered medications to maximize independent functioning.

Requirements: The provider shall:

A. When assistance with self-administered medication is **<u>allowed</u>** by the program, have written policies and procedures to assist residents in self-administration of medications.

B. Designate and train appropriate staff in assistance procedures.

C. For residents needing assistance with self-administration of medication, address this area in the resident's service plan and the service plan reviews.

Example of Evidence of Implementation: Written policies and procedures on assisting residents with self-administration of medications, documentation in resident case records, staff interviews, medication logs, evidence that only the resident and/or professionally licensed medical staff are allowed to administer medications and remove medications from the resident's individual prescription bottles or containers.

Scoring:

1. The provider meets none of the requirements, and/or allows non-professionally licensed medical staff to administer medications and/or remove medications from the residents' individual prescription bottles or containers.

2. The provider meets requirement A and/or 0-59% of the case records reviewed for requirement C are rated acceptable.

3. The provider meets requirement A and 60-79% of the case records reviewed for requirement C are rated acceptable.

4. The provider meets requirement A and 80-99% of the case records reviewed for requirement C are rated acceptable.

5. The provider meets requirement A and 100% of the case records reviewed for requirement C are rated acceptable.

ST.1106 DISCHARGE PLANNING AND IMPLEMENTATION

Standard ST.1106 Residents are discharged appropriately from program services in accordance with their assessed needs, conditions and preferences, and the program's goals and objectives.

Requirements: The provider shall implement a comprehensive discharge process that demonstrates:

A. Collaboration with the resident by actively engaging the resident in the discharge process. For programs serving chronically homeless families, when the head of household is discharged, discharge planning shall include planning for the remaining family members.

- For Supported Housing for Young Adults (SHYA) programs, discharge planning to assist individuals to move towards discharge-readiness is expected to begin at least one year before the resident's 26th birthday. **Note:** When circumstances or obstacles impacting on the individuals' discharge readiness are identified, clear and periodic documentation of such circumstances/obstacles and their status in the case record, will substantiate an acceptable basis for a delay in implementing discharge planning processes, and/or discharge of individuals from the program.

- For Transitional Living Community (TLC) residents who remain in the program longer than 9 months, the provider must document at least monthly, the rationale for discharge delay and actions taken to facilitate discharge.

- In JISH programs, as well as in NYC 15/15 Supportive Housing programs, when residents are missing and cannot be located following diligent search procedures, discharge plans are determined in collaboration with DOHMH Office of Housing Services.

B. The resident is discharged appropriately based on progress towards achievement of goals and objectives.

C. The resident's needs for additional services and supports were identified and addressed as evidenced by appropriate linkage or referrals made for any services needed to support the resident's continued care and integration into the community. Linkages and referrals may include, but are not limited to, mental health and substance abuse treatment services, medication services, health and wellness services, community services, and any other necessary services.

D. For all successful non-administrative** discharges, the program conducts follow-up by contacting the resident and/or the new service provide for one year post-discharge, at 3-month intervals, to ensure the resident remains linked to appropriate housing and other services. (Only applicable to housing programs in contract/agreement as of 9/1/07.)

** Administrative discharges may include: eviction, moving out of NYC, long-term hospitalization or imprisonment.

Evidence of Implementation: Documentation in case records

Scoring:

1. 0 - 39% of the case records reviewed are rated acceptable.
2. 40 -59% of the case records reviewed are rated acceptable.
3. 60 - 79% of the case records reviewed are rated acceptable.
4. 80 - 99% of the case records reviewed are rated acceptable.
5. 100% of the case records reviewed are rated acceptable.

ST.1107 **HEALTH CARE AND MEDICATION SERVICES**
(Applicable to residents in any housing program who are prescribed or administered medication by housing program staff)

Standard ST.1107 Residents receive health care and medication services that are appropriate to their assessed needs and conditions.

Requirements: The provider shall:

A. Complete a health assessment between the date of initial service/face-to-face contact and the date of completion of the comprehensive service/ treatment plan, and update annually.

The health assessment describes the health status of the resident, and includes a determination of the resident's need for a physical examination.

- If it is determined that the resident needs a physical examination, a referral is made for such an examination, and at least one follow-up referral is made within 3 months of the original date of referral.

OR

- The resident had a physical examination dated within the past 12 months.

B. Utilize only qualified health professionals to prescribe and administer medications.

C. Maintain current information on all psychotropic medication prescribed for the resident by qualified health professionals in the program and evaluate the resident for current clinical signs and symptoms and any adverse side effects of medications.

Evidence of Implementation: Documentation in case records

Scoring:

1. 0 - 39% of the case records reviewed are rated acceptable.
2. 40 -59% of the case records reviewed are rated acceptable.
3. 60 - 79% of the case records reviewed are rated acceptable.
4. 80 - 99% of the case records reviewed are rated acceptable.
5. 100% of the case records reviewed are rated acceptable.

ST.1108 TOBACCO-USE PREVENTION AND TREATMENT

Standard ST.1108 Residents receive tobacco-use cessation and prevention services to enhance their health and well-being.

Requirements: The provider shall:

A. Provide all residents with educational information about the health risks of tobacco-use and available treatment and/or referral resources for assistance with tobacco-use cessation. Tobacco-related education may be in the form of counseling, posted materials, brochures, waiting room videos, or other media.

B. Assess the resident's current and recent use of tobacco products and treatment readiness. (For residents who have used tobacco products recently, within the previous 12 months, this assessment will include documentation of when the resident last smoked.) This is to occur between the date of the first face-to-face contact and the date of completion of the first comprehensive service plan review, and at least annually thereafter. Preferably, the initial assessment is conducted on or prior to the date of completion of the first comprehensive service plan.

C. Provide tobacco-use cessation treatment if the resident is suitable OR refer suitable resident (who agrees to participate) to a cessation program. For the referred resident, the date of referral and name of the cessation program will be documented in the resident's case record. If the resident is not referred or treated, reasons for not referring or for postponing the referral or treatment will be documented in the case record.

D. Integrate clinically appropriate tobacco-use cessation and/or prevention strategies within the comprehensive service plan and service plan reviews of the resident who currently smokes or who has smoked within the past 12 months. Service plan reviews will also include monitoring of the resident for at least a 12-month period following successful completion of tobacco-use cessation treatment.

Examples of Evidence of Implementation: Interviews with staff and/or residents or any documented evidence demonstrating that these services are being provided to all residents; case records and any other service delivery documentation.

Scoring:

1. The provider does not meet requirement A.
2. The provider meets requirement A and 0-59% of case records reviewed meet all other requirements.
3. The provider meets requirement A and 60-79% of case records reviewed meet all other requirements.
4. The provider meets requirement A and 80-99% of case records reviewed meet all other requirements.
5. The provider meets requirement A and 100% of case records reviewed meet all other requirements.

ST.1109 **24 - HOUR COVERAGE**
(Applicable to all Scattered-site programs)

Standard ST.1109 The provider implements 24-hour coverage, 7 days per week to residents in the program.

Requirements: The provider shall:

A. Implement a mechanism for ensuring the provision of 24-hour coverage, 7 days a week by staff.

B. Demonstrate a prompt response to residents by trained staff during non-business hours by documenting:
- date and time of call
- date and time of response to the call

C. Demonstrate that all of the provider's residents are informed in the use of the provider's services during non-business hours.

D. Demonstrate an effective procedure by documenting:
- name of resident/caller
- staff persons who respond to the call and provide services
- disposition of the call

Evidence of Implementation: Documentation in the non-business hours service contact log, on-call log, resident case records, staff interviews, resident interviews.

Scoring:

1. The provider does not meet requirements A and B.

2. The provider meets requirements A and B but does not demonstrate that residents are informed in the use of the provider's services during non-business hours.

3. The provider meets requirements A, B and C, and less than 80% of the documentation required for contacts during non-business hours meets requirement D.

4. The provider meets requirements A, B and C, and at least 80% of the documentation required for contacts during non-business hours meets requirement D.

5. The provider meets all requirements.

CR.1101 RESIDENT RIGHTS

Standard CR.1101 The provider respects the rights of residents and informs all residents of their rights as participants in the program.

Requirements: The provider shall:

A. Inform all residents of their rights,* the process by which grievances can be filed and the process by which a grievance disposition can be appealed.

> *__Note__: Information provided to residents to inform them of their rights shall also include instructions for tenants to call 311 with their complaints or concerns with regard to building or housing maintenance issues that are not addressed within the program, or when they have complaints or concerns with any other city services.

B. Demonstrate a timely and efficient resolution of both resident grievances and appeals.

Examples of Evidence of Implementation: The provider has written policy and procedure pertaining to the rights of residents. Resident rights, including instructions on how to file a grievance and the process to appeal a grievance disposition, as well as instructions to call 311 for reporting complaints or concerns regarding housing or other city services, are posted and/or signed by the resident. If resident rights are discussed with residents, the discussion is substantiated in the case record. Grievance documentation demonstrates timely and efficient resolution of grievances, and includes the disposition and the resident's response to the disposition. There are no occurrences of residents not receiving services in a respectful and confidential manner.

Scoring:

1. The provider meets neither requirement A nor requirement B; OR there is evidence of violation of resident rights.
2. The provider meets requirement A only.
3. The provider meets requirement B only.
4. The provider meets requirements A and B with minor inconsistencies.
5. The provider meets requirements A and B.

CR.1102 RESIDENT INPUT

Standard CR.1102 Residents have input into the operations of the program on an ongoing basis.

Requirements: The provider shall:

A. Demonstrate an ongoing process for regular review, discussion and implementation of resident recommendations and concerns.

B. Address resident concerns and recommendations.

Examples of Evidence of Implementation: Evidence of an ongoing process for residents to have input into the program's operations, such as a resident advisory board or committee that has input into the program's operation; OR residents are members of the provider's governing body. Integration of residents on provider's governing boards and committees will have minutes reflecting participation of residents, their caregivers/supporters. Results of a resident satisfaction survey are reviewed and resident concerns and recommendations are addressed.

Scoring:

1. The provider meets neither requirement A nor requirement B.
2. The provider meets requirement A only.
3. The provider meets requirement B only.
4. The provider meets requirements A and B with minor inconsistencies.
5. The provider meets requirements A and B.

CR.1103 **CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES**

Standard CR.1103 The provider provides culturally and linguistically appropriate services to the individuals in its service area.

Requirements: The provider shall:

A. Provide program services to eligible residents with limited English proficiency and inform residents of their right to receive language assistance services.

B. Have sufficient numbers of bilingual direct service staff to provide needed services to the dominant, non-English speaking populations eligible to attend the program, or demonstrate regular and on-going recruitment efforts to hire sufficient numbers of bilingual direct care staff.

C. Implement procedures, and maintain alternative resources to provide program services when staff and residents are unable to communicate effectively in a common language.

D. Have resident rights, signs or notices posted or distributed in the dominant language(s) of the residents served.

E. Provide or arrange relevant cultural diversity training for staff, at least once every 12 months, to enhance sensitivity to the cultural and ethnic background of the consumer populations served. Topic areas may include race, color, creed, gender, sexual orientation, disability and national origin.

Examples of Evidence of Implementation: Interviews with administrators and program staff and service delivery documentation and statistics indicate that program residents reflect the population of those in the program's defined service area. The program has sufficient numbers of bilingual direct service staff; if they do not, and have vacancies, there is evidence of recruitment efforts such as newspaper or internet advertisements, job fair participation, and graduate school postings. The provider has a comprehensive list of alternative resources and/or language lines to ensure that non-English-speaking residents can be linked to appropriate services, if needed. Cultural diversity training has relevance to the specific populations the program serves and this is demonstrated in staff interviews and documentation of staff training. Attendance lists indicate that staff attend training.

Scoring:	1.	The provider meets none of the requirements.
	2.	The provider meets 1 or 2 requirements.
	3.	The provider meets 3 or 4 requirements.
	4.	The provider meets 5 requirements, with minor inconsistencies.
	5.	The provider meets all requirements.

HS.1101 CHILD ABUSE AND NEGLECT POLICIES AND PROCEDURES

Standard HS.1101 The provider has policies and procedures consistent with current applicable laws for the mandatory reporting of child abuse and neglect, and reports all suspected cases of child abuse and neglect to the proper authorities.

Requirements: The provider implements child abuse and neglect reporting policies and procedures, consistent with current applicable laws for mandated and permissive reporting, to ensure that:

A. Staff are familiar with the signs and symptoms of child abuse and neglect and/or staff can readily avail themselves of detailed information about the signs and symptoms of child abuse and neglect.

B. Staff have been trained and know the provider's reporting policies and procedures, that suspicions of child abuse and neglect must be reported, and know the requirements applicable to case record documentation in cases of suspected or discovered child abuse or neglect.

Examples of Evidence of Implementation: Written child abuse and neglect policies and procedures; evidence of staff attendance at child abuse and neglect reporting training; case records reflect that assessment and case management planning include information and follow-up, as applicable, related to the resident's parenting responsibilities. Staff interviews, incident review documentation, case records and other service delivery documentation substantiate that staff appropriately report all cases of suspected or discovered child abuse and neglect, and no occurrences of unreported, suspected or discovered child abuse or neglect have been identified during the audit.

Scoring:

1. The provider does not meet the requirements.

5. The provider meets the requirements.

HS.1102 **EMERGENCY AND FIRE SAFETY PLANNING AND PROCEDURES**

Standard HS.1102 The provider plans for emergency situations and conditions and has adequate emergency and fire safety plans and procedures to provide for the safety and security of residents and program staff.

Requirements: The provider shall:

A. Conduct emergency evacuation/fire drills at least once every 6 months in program offices, held over a range of program hours to ensure that all program staff participate.

Program Guidance:

- ***When program premises are located in a hospital, school, shelter, court or correctional facility, documentation of a regular, on-going institutional emergency evacuation/ fire safety program may be acceptable if it is clear that drills include the program's premises.***

- ***All programs are expected to maintain documentation that all program staff participated in evacuation/fire drills. Documentation should include the date and time each drill was conducted. Programs are expected to schedule evacuation/fire drills to allow for attendance by all program staff.***

B. Conduct emergency evacuation/fire drills for residents in each supported SRO (congregate) unit, consistent with local Fire Code regulations.

C. Educate all congregate and scattered-site housing residents in self-preservation procedures regarding emergency evacuation and fire safety procedures.

D. Maintain written plans and procedures that provide for the safety and security of individuals in the event of a City-wide emergency or a natural or man-made disaster, including extremes of weather, blackouts, or other regional and national emergencies. The plan includes program (or agency-wide) procedures and protocols for emergencies, including, but not limited to, those for conducting emergency evacuations, fire safety training and CPR training.

E. Have written plans and procedures that address the individualized needs of residents in the event of an emergency or disaster, including weather-related emergencies, such as extreme heat conditions. Plans and procedures include, at minimum:

- A mechanism to identify, prioritize and maintain a written list of residents considered to be at highest risk in an emergency; this includes individuals who may be at risk for heat-related illness during a heat emergency or other extreme weather condition
- A protocol describing the process for conducting outreach to residents, throughout the duration of the emergency situation or condition, particularly those residents who have been identified as being "high risk" in an emergency situation or condition
- A mechanism that provides for the development and maintenance of a file of each resident's emergency contact information; the file is updated periodically (at least every six months or more often, as needed) to facilitate the program's ability to reach out to residents' designated emergency contacts in the event of an emergency
- Written plans and procedures describing the process whereby, during conditions of extreme heat, residents who are at high risk for heat-related illness are advised to use their air conditioners; advised to use air-conditioned common rooms; and are provided with information and locations of nearby designated cooling centers. Plans are also to include procedures for following up with residents who are at risk for heat-related illness, for the duration of the extreme heat condition.

Examples of Evidence of Implementation: Documentation in fire drill or emergency evacuation logs for program offices; written evacuation plan procedures consistent with the local Fire Code regulations; documentation of evacuation/fire drills (as per Fire Code) for each supported SRO (Congregate) unit; documentation of resident self-preservation education or training; a list of at-risk residents; interviews with residents, written safety and security plans.

Scoring:

1. The provider did not conduct any evacuation/fire drills in program offices in the past 12 months, and/or did not meet requirements B and/or C and E.

2. The provider conducted only one evacuation/fire drill in program offices in the past 12 months, and/or partially meets requirements B and/or C, D, and E.

3. The provider conducted two evacuation/fire drills in program offices in the past 12 months but they were not conducted at 6-month intervals, or did not conduct evacuation/fire drills in program offices over a range of program hours to ensure that all staff participate, and/or substantially meets requirements B and/or C, D, and E.

4. The provider meets all requirements, with minor inconsistencies.

5. The provider meets the requirements.

HS.1103 INCIDENT REVIEW

Standard HS.1103 The provider has incident review procedures that facilitate the timely reporting, investigation, monitoring and documentation of all incidents.

Requirements: The provider shall:

A. Document and review all incidents in a timely and efficient fashion and include a summary of the incident and the provider's subsequent actions.

B. Forward all required reports to agency administrators (as applicable; e.g. provider-wide quality improvement committee or executive officers per provider policy), and to external entities as required. All serious incidents (e.g., death, life-threatening injury to resident or staff, attempted suicide or homicide) should be reported to agency administrators within 24 hours.

C. Have an incident review committee that includes at least 2 members of the clinical staff, one of whom is a professional, and convene the incident review committee whenever the provider's policy requires*.

D. Have documentation that the incident review committee reviews all incidents as defined in provider policies and maintains minutes of its meetings which include committee findings, and a summary of the conclusions.

E. Document the incident review committee's reasons for its recommended actions, and the proposed options for prevention of a recurrence, as appropriate.

F. Document the implementation of the incident review committee's recommendations as appropriate.

*If no incidents occur within the required time period, administrative documentation must reflect that no incidents have occurred for that period.

Examples of Evidence of Implementation: Written policy and procedure, incident review committee minutes, documentation in resident case records, staff interviews, reports to appropriate state agencies and any other documentation designated by provider staff, and no occurrences of incidents that were not reviewed.

Scoring:

1. The provider does not meet requirements A and B.
2. The provider meets requirements A and B and 0 to 2 other requirements.
3. The provider meets requirements A and B and 3 other requirements.
4. The provider meets all requirements, with minor inconsistencies.
5. The provider meets all requirements.

HS.1104 PROGRAM ENVIRONMENT AND SAFETY

Standard HS.1104 The provider's program premises shall be safe, clean, and appropriate for the provision of program services.

Requirements: The provider's program premises shall:

A. Be free of physical hazards.

B. Store current, non-expired medications in a safe and secure manner, and safely store and dispose of needles and syringes.

C. Store case records centrally, in rooms or cabinets which can be locked, and ensure that only designated provider staff have access to case records.

D. Have sufficient and appropriate space, furnishings and equipment for program operations.

E. Be clean and well-maintained.

Examples of Evidence of Implementation: Program premises have sufficient space for all expected program activities (individual sessions, group sessions) and ensure resident confidentiality as appropriate. Premises are well-lit and clean, and furnishings and equipment for program activities are in good condition. Rest room facilities are functional and clean. Programs serving children have age-appropriate furnishings and materials. Programs serving children remove or store all toxic materials in locked areas out of the reach of children; children's programs, and other programs with play areas, utilize impact-reducing materials on floors, columns and other obstacles.

Scoring:

1. The provider does not meet requirements A, B and C.

2. The provider meets requirements A, B, and C and does not meet requirement D.

3. The provider meets requirements A, B, C, and D, and partially meets requirement E.

4. The provider meets all requirements with minor exceptions.

5. The provider meets all requirements.

HS.1105 **SUPPORTED HOUSING PREMISES**
Applicable to Supported SRO (Congregate) and Supported Housing (Scattered-site) programs

Standard HS.1105 The provider's supported housing units are adequately maintained.

Requirements: Supported housing units shall:

A. Be free of physical hazards.

B. Have functioning smoke detectors.

C. Have functioning fire extinguishers/sprinkler system as applicable.

D. Have functioning carbon monoxide detectors.

E. Be well-maintained.

F. Be adequately furnished.

G. Have adequate climate control

H. Have bathroom and kitchen facilities that

- are in working order
- have hot and cold running water
- have a working stove
- have a working refrigerator

Evidence of Implementation: Environmental survey of resident's living quarters and public areas of the building in which the living quarters are located.

Scoring:

1. The provider's housing units do not meet requirements A, B, C and D.

2. The provider's housing units meet requirements A, B, C and D and 1 or 2 other requirements

3. The provider's housing units meet requirements A, B, C and D and 3 other requirements.

4. The provider's housing units meet requirements A, B, C and D and all other requirements with minor problems.

5. The provider's housing units meet all requirements.

HS.1106 **MAINTENANCE OF SUPPORTED HOUSING PREMISES**
Applicable to Supported SRO (Congregate) and Supported Housing (Scattered-site) programs

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Standard HS.1106 The provider adequately maintains all of its housing units and addresses environmental health and safety concerns as needed.

Requirements: The provider shall:

A. Inspect each supported housing unit at least once every 6 months by documenting the date of inspection for each inspection visit.

B. Document each inspection to include the following:

- The address of the housing unit
- The name of the staff person(s) who conducted the inspection
- A description of all findings resulting from the inspection to include, but not limited to, the following areas:

    - Hazard surveillance
    - Smoke detectors
    - Fire extinguisher/sprinkler system as applicable
    - Carbon monoxide detector
    - All identified exits for emergency evacuation
    - Climate control
    - Bathroom and kitchen facilities
    - The general maintenance of the public areas of the building
    - Steps taken to resolve any problems identified during the inspection.

C. Demonstrate evidence of the implementation of a plan, as needed, to address environmental health and safety concerns related to infestation (including vermin and bedbugs).

Examples of Evidence of Implementation: Inspection log documentation used by the provider to document its inspections, interviews with program administrators and staff, documentation in resident case records and any other documentation designated by provider staff.

Scoring:

1. The provider does not inspect all housing units at least every 6 months.

2. The provider meets requirement A, and 0-59% of the provider's documentation meets requirement B.

3. The provider meets requirement A, and 60-79% of the provider's documentation meets requirement B, but does not fully meet requirement C.

4. The provider meets requirements A and C, and 80-99% of the provider's documentation meets requirement B.

5. The provider meets requirements A and C, and 100% of the providers documentation meets requirement B.

HS.1107 **FOOD STANDARDS**
(Applicable to programs that purchase and/or serve food to residents regardless of the funding source for that food)

Standard HS.1107 Residents are served meals and snacks that meet all NYC Food Standards Program participants are served meals and snacks that meet all NYC Food Standards* to promote a healthy balanced diet.

Requirements: The provider shall:

A. Purchase food that meets the Nutrient and Food Category requirements as indicated in the NYC Food Standards* for Purchased Food.

B. Serve all residents meals that meet the requirements as indicated in the NYC Food Standards* for Meals served.

C. Serve all residents snacks that meet the requirements as indicated in the NYC Food Standards* for Snacks served.

D. Serve all residents meals and snacks that meet the requirements as indicated in the NYC Food Standards* for Special Occasion Meals and Snacks.

*** The current NYC Food Standards ("Standards for Meals/Snacks Purchased and Served") are available online at:**

https://www1.nyc.gov/site/doh/health/health-topics/nyc-food-standards.page

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Examples of Evidence of Implementation: Food item labels indicate that Purchased Food Nutrient Standards and Food Category Standards are met; menus indicate that meals and snacks served to residents meet Nutrient and Food Category requirements; menus indicate that meals served meet Standards for adequate servings of fruits and vegetables; water is available at all meals; deep-fryers are not used in the preparation of any food; menus indicate that when Special Occasion meals and snacks are served, healthy options such as fresh fruit and leafy green salad are also available for residents.

Scoring:

1. The provider meets none of the requirements.
2. The provider meets 1 or 2 of the requirements.
3. The provider meets 3 of the requirements.
4. The provider meets all requirements with minor inconsistencies.
5. The provider meets all requirements.

HS.1108 TOBACCO CESSATION EDUCATION

Standard HS.1108 Training is provided or arranged annually for program staff to educate them regarding the health risks of tobacco-use and on tobacco cessation methods and treatments for residents who use tobacco products.

Requirements: The provider shall:

Demonstrate evidence of annual staff attendance at training provided or arranged to educate staff regarding the prevalence and health risks of tobacco use for individuals with mental health and substance use disorders; training includes information for staff on stages of change, risk reduction and tobacco-cessation treatment activities and methods, including nicotine replacement therapies (NRT).

Examples of Evidence of Implementation: Policy and procedure manual, copy of course curriculum and related training materials, sign-in sheets or other verification of staff attendance, interviews with administrators and staff, staff personnel files.

Scoring:

1. The provider does not meet the requirement.

5. The provider meets the requirement.

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