UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA, Plaintiff, v. STATE OF NEW YORK, Defendant.	Civ. Action No. 13-CIV-4165 (NGG)

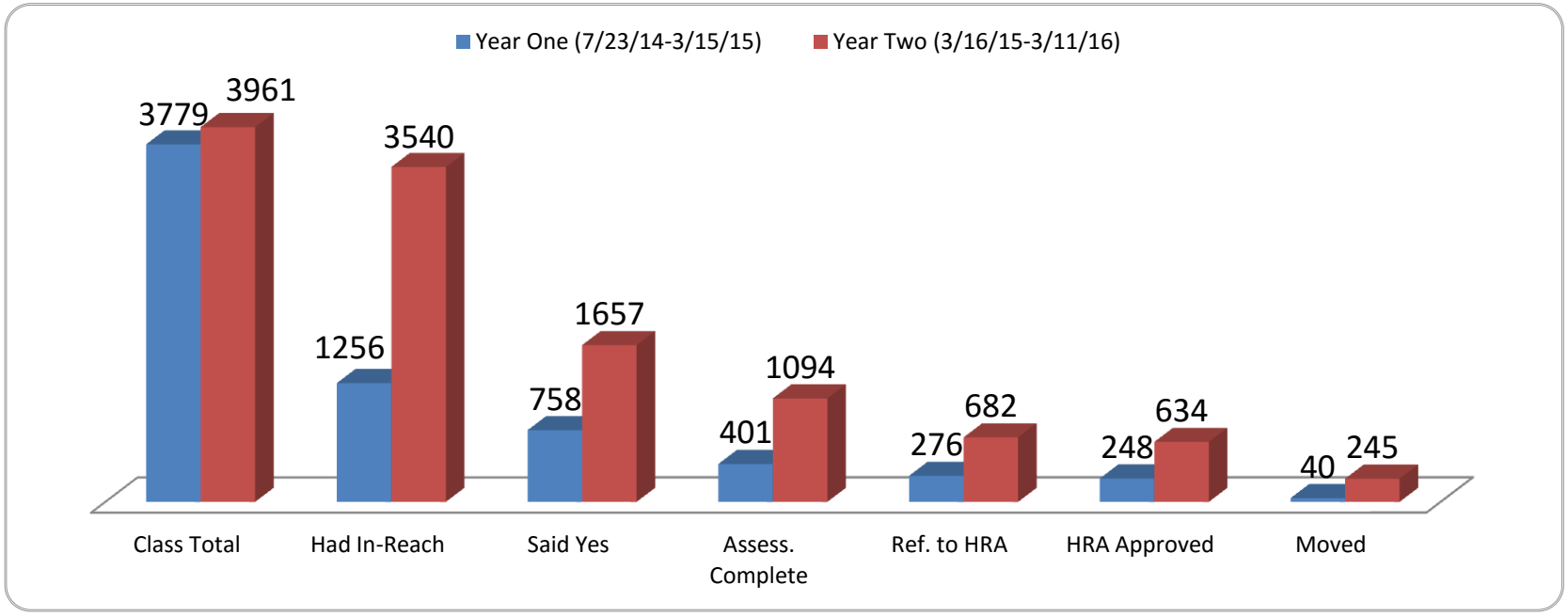
RAYMOND O'TOOLE, ILONA SPIEGEL, and STEVEN FARRELL, individually and on behalf of all others similarly situated, Plaintiffs, v. ANDREW M. CUOMO, in his official capacity as Governor of the State of New York, NIRAV R. SHAH, in his official capacity as Commissioner of the New York State Department of Health, KRISTIN M. WOODLOCK, in her official capacity as Acting Commissioner of the New York State Office of Mental Health, THE NEW YORK STATE DEPARTMENT OF HEALTH, and THE NEW YORK STATE OFFICE OF MENTAL HEALTH, Defendants.	Civ. Action No. 13-CIV-4166 (NGG)

SECOND ANNUAL REPORT SUBMITTED BY
CLARENCE J. SUNDRAM
INDEPENDENT REVIEWER*

* The members of the Independent Review team, Thomas Harmon and Stephen Hirschhorn, contributed substantially in the research and preparation of this report.

Executive Summary

Figure. 1. Overview of the Status of Implementation as of March 11, 2016[1]



[1] The data in this report are drawn from the Defendants' weekly reports up to Week 104, the most recent available at the time of finalizing the report.

Out of the 3,961 class members identified as of March 11, 2016, 3,540 (89.4%) have received in-reach by a Housing Contractor, and 1,657 (46.8%) of those class members have expressed an interest in moving to supported housing. As of March 11, 2016, 245[2] had been moved over the first 11 quarters that the Settlement Agreement has been in effect.[3]

This Second Annual Report depicts the progress made by the Defendants in transitioning class members to supported housing or other alternatives in the community pursuant to the Settlement Agreement. It is clear that the Defendants have made significant strides in conducting in-reach to almost 90% of the class and in increasing the pace of community transitions, particularly as compared to the previous year. As importantly, as described in this report, the Independent Reviewer has found that class members who have made the transition are, with few exceptions, generally doing well in their new homes and are happy to have made the move. (Report, Section II, pp. 15-27) For them, the promise embodied in the Settlement Agreement of a meaningful choice to live a more independent, self-determined life is being fulfilled. The staff of Housing Contractors, Health Homes and MLTCPs and their care managers have provided support and linked them up to medical and mental health services to keep them healthy and safe. Yet, there is more work to be done in helping them with financial planning and budgeting, and to re-connect with life in the community to assure more than re-location, to actual integration into the civic and social life of the community. (Report, Section III, pp. 27-38) The Defendants have recognized this and are embarking on a promising course of additional training for care managers in Person Centered Planning in partnerships with the New York Association of Psychiatric Rehabilitation Services, Inc. (Report, Section VII, pp. 67-72)

[2] Although 245 class members had transitioned from adult homes as of March 11, 2016, four returned to adult homes and will continue to receive in-reach as active class members. This is not reflected in the State's weekly reports, the most current of which (Week 104, ending 3/11/16) indicates that 244 transitions have occurred. This is due to two limitations in the weekly reporting system: first, it does not reflect readmissions to adult homes; and second, sometimes data concerning an individual is overwritten when a new event occurs. For example, class member R.M., was transitioned to supported housing in 2015 and returned to an adult home. In early 2016, she again expressed interest in transitioning at which point data pertaining to her 2015 transition were overwritten/deleted. Consequently, she is not counted as a transition in subsequent weekly reports, although the other three transitioned individuals who returned to adult homes but have not expressed a renewed interest in transitioning continue to be among the 244 identified as having transitioned in the Week 104 report.

[3] The State has noted that the Settlement Agreement did not come into effect until the Court's final approval was ordered on March 17, 2014, and that in-reach efforts began on the same day, and assessments on April 3, 2014. The timelines in the Settlement Agreement, however, are measured from the date of its execution on July 23, 2013.

As described in the body of this report, some concerns remain. First, although the pace of transitions has increased, it is still slower than what would be required to meet the Settlement Agreement goals for Year Four and Five. Perhaps because there are now more class members in the transition pipeline, it is taking longer cumulatively for the class as a whole to navigate the multiple steps leading to community placement in Year Two then it did in Year One. (Report, Section VIII, pp. 75-78)

Second, the problems with the assessment process described in the First Annual Report (pp. 20-28) have remained a stubborn obstacle, even past the September 30, 2015 deadline the Defendants established to eliminate the backlog, although progress has been made. (Report, Section V, pp. 53-58) The new initiatives implemented by the Defendants – Adult Home Plus, (Report, Section VII, B, pp. 72-75), changes to the requirement for a Comprehensive Psychiatric Evaluation and authorizing the use of psychosocials performed by a broader array of clinicians – are very positive developments, as are further actions under consideration. But until they are fully in place and the results can be measured, it is unclear whether they will eliminate the problems experienced to date.

Third, it is troubling that the proportion of class members saying Yes at in-reach has been falling to the extent it has, and that class members continue to drop out of the process even after they have said Yes. (Report, Section IV, pp. 38-52) This trend requires further investigation by the Defendants of the use of Motivational Interviewing during in-reach, of the training of in-reach workers and the strategies used for effective-in reach, as well as the adequacy of staffing of the in-reach teams and the use of peer advocates in this role. Here again, the implementation of Adult Home Plus and the consistent, early engagement of the care manager with a small caseload of class members may help prevent dropouts by involving them early and often in the transition planning process. This new resource may also be a critical means of addressing some of the problems, described in this report, that class members who have transitioned have experienced with delays in accessing the services and supports they require.

Fourth, there are many delays in the final step to transition following HRA approval of their applications, some of which are inherent in the process of honoring choice for class members and in the significance of the decision for the individual. (Report, Section VIII, B, pp. 81-91) Nevertheless the adequacy of staffing of the Housing Contractor teams who assist class members locate suitable apartments needs to be examined to determine if there is sufficient capacity to process the growing number of class members who are completing the earlier stages of the process.

To address these and other issues discussed in the report, the Independent Reviewer offers several recommendations for consideration. (Report, Section X, pp. 95-100) A parties' meeting has

been scheduled for April 21, 2016 to discuss these recommendations.

Introduction

Paragraph 13 of the Settlement Agreement requires the Independent Reviewer to provide five written annual reports to the parties and the Court regarding the State's compliance. Paragraph 14 of Section L of the Settlement Agreement in this matter provides:

> A draft of the Reviewer's report shall be provided to the Parties for comment each year within 30 days after the anniversary date of the Court's approval of this Agreement. The parties shall have 30 days after receipt of such draft report to provide comments to the Reviewer, on notice to each other, and the Reviewer shall issue to the Parties a final annual report within 15 days after receiving such comments; provided, however, that the parties may agree to extend such deadlines.

The Court's final approval of the Settlement Agreement was filed on March 17, 2014. Based on that date, the Independent Reviewer prepared and submitted to the parties a schedule for the preparation of the required five annual reports. For the-second year, the schedule requires that the Independent Reviewer's draft be provided to the parties by February 16, 2016, with their comments due by March 17, 2016, and the final report submitted by April 1, 2016.

A draft of this report was provided to the parties on February 16, 2016, and comments were received on March 17, 2016. The Independent Reviewer has carefully considered all comments in preparing this final report.

The Independent Reviewer's Report for Year 1 focused heavily on the preparatory steps taken by the State to implement the obligations of the Settlement Agreement and on the early implementation actions and the development of policies, procedures and practices. Consistent with the directive in the Settlement Agreement that the Independent Reviewer pursue "a problem-solving approach" (¶ L.7), the Independent Reviewer provided regular progress memos to the parties with recommendations for more effective implementation of the Settlement Agreement (see Annual Report, pp. 67-71, Doc. # 36, filed 3/30/15, hereinafter "First Annual Report"). Subsequently, at the Court's direction, the Defendants filed a report on July 1, 2015 (Doc. # 46-1), identifying the recommendations they had accepted and begun implementing, recommendations they had modified and begun implementing, and recommendations that were not accepted. The results of the actions taken by the Defendants can be assessed by the data regarding the pace of change in the performance of critical tasks that are necessary for implementation of the Settlement Agreement and transitioning interested and eligible class members to supported housing or other

less restrictive and integrated environments in the community. These data are discussed in Section VIII of this report and speak for themselves.

An important limitation regarding the data in this report ought to be noted at the outset. The Independent Reviewer and the Plaintiffs receive regular weekly reports from the Defendants on the progress being made in each of the many steps of the transition process. These reports in turn are drawn from data reported to the Defendants by the adult homes, Housing Contractors, Health Homes and MLTCPs, some of which also rely upon downstream providers to deliver services and report upon them. In addition to these weekly reports, the Independent Reviewer has requested and received from the Defendants various data reports in the course of preparation of this annual report. It has been our experience that both the weekly reports and the other data reports we have received contain missing information, anomalies and inconsistencies, and some obvious errors for a variety of reasons. These include incomplete data submission by vendors, inaccurate recording of data, and errors in compiling the reports from several different data sources. Assembling data on different dates can also result in inconsistencies, as the underlying data bases are "live" and are constantly changing due to admissions and discharges.[4] In some cases, these have been called to the attention of the Defendants. We alert the reader that the statistical analyses contained in this report, to the extent that they rely on the data provided as described above, may not be precisely accurate although we do not believe that any errors are large.

The primary focus of this report is on the experiences of class members who have gone through the in-reach, assessment, HRA approval and care planning processes, and have been transitioned to supported housing in the community which is the ultimate objective of the Settlement Agreement. The purpose of doing so is to celebrate their success, recognize the efforts of those who have made it possible, and reinforce practices that are working well to achieve this objective. In a few instances, the initial transitions did not work out as expected and modifications were required – sometimes to a different level of care and support, and sometimes resulting in a return of the class member to the adult home. Such experiences in supported housing should not be regarded as failures. With the strong presumption in the Settlement Agreement that virtually all class members are qualified for supported housing, it is not unexpected that the presumption proves incorrect in some cases. It is also foreseeable that persons who have a serious mental illness, like other serious illnesses, will experience periods when their illness requires hospitalization or a

[4] To address this issue, the Independent Reviewer has recommended that the Defendants preserve a "frozen" copy of the databases, as they exist as of the date when data is reported for the Defendants' Quarterly Reports and the Independent Reviewer's Annual Report. This practice would reduce the level of confusion and enable all parties to work with a single set of consistent data. Defendants were receptive to this recommendation.

higher degree of support than can be provided in supported housing. These events are a source of further learning about how to best support class members with intensive needs in the community. To that end, in this report we will describe in some detail our review of a sample of 28 class members (11% of all class members who had been transitioned by March 11, 2016).

Methodology

Over the past year, the Independent Reviewer and his associates (Thomas Harmon and Stephen Hirschhorn) continued monitoring the implementation of the Settlement Agreement in accord with the provisions of the Agreement and a Monitoring Plan developed by the Independent Reviewer and approved by the parties as described in detail in the Independent Reviewer's First Annual Report.

Generally, the Monitoring Plan called for reviewing training materials and tools developed for frontline staff responsible for transition-related activities; site visits; interviewing class members and reviewing their records on a sample basis; observing and participating in various transition-related activities (e.g., in-reach, assessment, care planning, etc.); and reviewing and analyzing reports by the State and its contractors concerning implementation activities.

The Monitoring Plan also called for the Independent Reviewer to provide the parties with regular reports of findings and observations as well as recommendations to facilitate the successful implementation of the Settlement Agreement. In addition to formal communications, such reports would be made in writing or at periodic meetings with the State and Plaintiffs with the goal of providing the parties with information as early as possible to enable them to act as warranted to achieve the shared objective: successful implementation of the Settlement Agreement.

Among the specific monitoring activities carried out by the Independent Reviewer and his associates during the past year which inform the content of this annual report were:

1. Participated in and observed eight training sessions sponsored by the State for Housing Contractors, Health Homes and MLTCPs. These educational sessions focused on the goals of the Settlement Agreement and the skills these frontline staff required in conducting in-reach, assessment, care planning and care management. Also, we participated in State-sponsored training for mental health providers designed to acquaint them with the Agreement.

2. Reviewed the database structures developed by the State Department of Health (DOH) and the Office of Mental Health (OMH) to capture and record data, and made recommendations regarding the same.

3. Reviewed tools and guidelines developed for use by frontline staff responsible for in-reach, assessment, person-centered planning/management and transition.

4. Participated in regularly scheduled State-sponsored meetings of all eight[5] Housing Contractors responsible for in-reach, supported housing development, transition of residents and their housing/case management following transition.

5. Met with representatives of the Coalition of Institutionalized Aged and Disabled (CIAD) and the Office of the State Long Term Care Ombudsman which provide advocacy services on behalf of adult home residents and are active in homes covered by the Settlement Agreement.

6. Met with 134 class members during educational, in-reach, assessment and care planning sessions or after their transition to supported housing.

7. Also participated in care planning and transition related conference calls for 162 class members including:

    - 68 pre-transition conference calls in which Housing Contractors, HH/MLTCP staff and DOH and OMH representatives confer to ensure that all elements of a successful transition (housing, utilities, community supports, entitlements/benefits, etc.) are in place for an individual. Such calls usually happen about three weeks before the individual moves.

    - 44 post-transition conference calls in which Housing Contractors, HH/MLTCP staff and DOH and OMH representatives discuss how an individual's transition went and any outstanding matters in need of attention following the transition. Such calls usually happen about three weeks after transition.

    - 17 "Level II" conference calls. These interdisciplinary calls involving Housing Contractors, HH/MLTCP staff and DOH and OMH representatives focus on individuals whose assessment resulted in a recommendation for transition to a level of care higher than that provided in supported housing. They are intended to revisit and probe the issues that prevented a recommendation for supported housing placement and ensure that appropriate services are put in place expeditiously to

[5] There were originally nine Housing Contractors, but FEGS went out of business and its operations were absorbed by the Jewish Board of Family and Children's Services ("JBFCS" or "JB"). In some places in the report, these are referred to as JBI and JBII.

facilitate the individual's ability to transition to supported housing and/or support his or her needs as they transition to Level II housing.

- 33 miscellaneous calls concerning individuals whose care plans or situations required special attention by Housing Contractors, HH/MLTCP staff and/or DOH and OMH representatives.

8. Conducted an in-depth review of a non-random sample of 28 class members who had transitioned from adult homes to supported housing. This involved reviews of their Housing Contractor and HH/MLTCP records as well as reports from the Psychiatric Services and Clinical Knowledge Enhancement System **("**PSYCKES"**)**; interviews with key staff; and, with their permission, visits to their apartments to observe their new environs and to hear their perspectives on their transition, their new living arrangements, the adequacy of services and matters that might be improved.

9. Conducted a special review of a sample of the 74 class members from New Haven Manor who reportedly signed a letter indicating they did not want to be transitioned. The review entailed an analysis of their status/experience in the transition process, interviews with nine class members at off-site locations and interviews with Housing Contractor and MLTCP staff supporting the majority of the individuals.

10. Follow up on complaints registered with the New York State Justice Center concerning interference or discouragement by adult homes operators or other issues referred to DOH which were brought to the Independent Reviewer's attention.

11. Through the above activities, had opportunities to observe and/or review the work of all Housing Contractors and most of the HH/MLTCPs and their downstream providers involved in the implementation process.

12. Reviewed case-specific data reported weekly by the State on implementation activities as individuals pass through the in-reach, assessment, care planning, HRA approval and transition phases of the Settlement Agreement, as well as quarterly reports and other reports prepared by the State on the status of the Settlement Agreement's implementation.

13. Maintained almost weekly contact through telephone calls and emails with DOH and OMH staff responsible for Settlement Agreement implementation and had face-to-face meetings with such staff on nearly a monthly basis to share the Independent Reviewer's observations and to discuss progress, developments and changes in the implementation process.

14. Secured a Court Order and memoranda to the field affirming the Independent Reviewer's access to facilities and records germane to the Settlement Agreement.

15. Issued several progress memos and other memos to the parties on the Independent Reviewer's activities, findings and recommendations where warranted and participated in four parties meetings to discuss the status of implementation and the Reviewer's observations. In addition, maintained regular contact with the attorneys for the Plaintiffs and the USDOJ through email and periodic telephone conferences.

16. Participated in four status conferences and hearings convened by the Court.

The Independent Reviewer and his team have relied upon the cooperation of the staff from the Department of Health and the Office of Mental Health in responding to innumerable requests for data and information. They have been generally responsive to requests for information that has been needed to perform our monitoring functions. We have also received assistance from the staff of the NYC Human Resources Administration. The staff of the Housing Contractors, Health Homes and MLTCPs, and their downstream providers, have also been cooperative with the Independent Reviewer and generous in their time and assistance. We have also had unimpeded access to the impacted adult homes to meet with class members and observe in-reach and assessment sessions. The Independent Reviewer would like to acknowledge the assistance of all of these parties, which has been of immense help.

Findings

I. Updating the Class List

The initial certified class list contained 3,867 names, to which seven additional class members were added, for a total of 3,874, which was reported to the parties and the Court on June 10, 2014 (Doc. # 30-1). The Department of Health has periodically updated the class list based on rosters that it receives quarterly from the adult homes reflecting admissions, discharges and deaths. As of June 30, 2015, 925 people were added to the list to reflect new admissions to impacted adult homes, as well as the identification as class members of persons previously admitted. Subsequently, similar adjustments have been made. [6]

The most recent class list as of March 11, 2016 requested by the Independent Reviewer contained a total of 5,007 class members. However, since this list contains all persons who have ever been identified as a class member and does not remove names as people die, are discharged or

[6] It should be noted that while the focus of the parties and the Independent Reviewer has been on transitional discharges of class members through the process established by the State pursuant to the Settlement Agreement, class members residing in the impacted adult homes are also discharged outside this process. (*See*, Fig. 8 in Section VIII)

are subsequently determined not to qualify for class status as they do not have a serious mental illness, it overstates the number of people who are eligible to be transitioned to supported housing or other alternatives pursuant to the Settlement Agreement. As such, the Independent Reviewer also asked for additional or clarifying information in order to determine a more accurate "workload" for this transition process. The additional information resulted in identifying and removing 1,046 people from the total due to death or other reasons, reducing the list to 3,961. Of these, as of March 11, 2016, 245 had been transitioned to the community, leaving 241 who continue to live in the community. The four individuals who returned to adult homes were placed back on the current active class member list leaving 3,720 "active" class members eligible for assessment and transition pursuant to the Settlement Agreement.

Grand Total class members	5007
Non-SA discharge	-707
Deceased	-302
Not a class member	-37
SA transition	-245
SA transition but returned to adult home	+4
Current active class members	3720

Table 1. Active Class members[7]

II. Visits to a sample of the class members—How are they doing?

As explained earlier, an important part of the monitoring work of the Independent Reviewer team was visiting with and reviewing the services and supports provided to a sample of 28 class members who had left the adult home between December 1, 2014 and April 28, 2015. In selecting the sample, an effort was made to review transitions that occurred early enough that class members had been living in the community for several months. The sample included class members from 11 adult homes, who were served by six different housing contractors. They were also provided behavioral health services from five Health Homes and 15 of their care coordinators, and provided managed long term care services by three MLTCPs and 11 care coordinators.

[7] There is a need to clarify the status of the 707 class members who were discharged outside the Settlement Agreement process to determine whether there is any continuing right to the benefits of the Settlement Agreement. This is an issue that should be addressed by the parties.

The sample included 11 women and 17 men. The youngest was a 34 year old woman and the oldest a 75 year old man. There were seven class members in their 40s, 13 in their 50s and six in their sixties. Six had lived in an adult home for five years or less, six had been there for 10 years or more, and the rest in between. The members of the class are a diverse group with some physically healthy and able to function independently with relatively little support, while others have significant medical and mental health problems that require on-going treatment and who need support to attend their appointments, and follow their treatment plans. These class members also have variable degrees of support in the community from family, friends and peers. Given this diversity, the development and implementation of person centered plans needs to be highly individualized.

In conducting this review, we obtained and reviewed case notes from Housing Contractor case managers, Health Home and MLTCP care coordinators, and the nurses and PCWs/HHAs who provided them with direct services. We also obtained and reviewed a summary of medical and mental health services provided to them over the past two years as compiled from Medicaid claims data in the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) maintained by the NYS OMH. We met with the class members in their homes and, as available, interviewed their case managers, care coordinators and Home Health Aides, PCWs or RNs who provided them with direct support. In some cases, we also spoke to supervisory staff at the housing contractors, MLTCPs and Health Homes, and mental health programs they attended.

Perhaps because of the length of time since their transition from the adult home, the anxiety and frustrations of the multi-stage transition process on which we reported in the First Annual Report were no longer uppermost in the minds of class members we interviewed. In fact, looking back, virtually all of them expressed the view that the process did not take too long. While some were clearly more impatient than others to leave the adult home, others also said that the length of time provided them an opportunity to adjust to the responsibility of living independently after many years of relying on the adult home for meeting their basic needs of daily living. A few said that it was a difficult step to take and having time to make the final decision allowed them to work through their doubts.

> *PG, a 60-year-old woman, who had lived in an adult home since her husband died in 2008, finally moved out with her romantic partner on April 18, 2015. She was initially interested in moving to supported housing when she heard of the opportunity, but was not in any hurry to do so. In November 2014, she told her care manager that she was not thinking of moving out for another year. In December 2014, she disenrolled from her Health Home but reenrolled in January when she decided that she wanted to move out. She began visiting apartments in March, and chose the second one she saw.*

Most of the class members in the sample live in two bedroom apartments in the community, in residential neighborhoods with a diverse population, close to grocery stores, pharmacies, banks, laundromats and other shopping. The apartments are generally close to public transportation via bus or subways. Some are close to parks, public libraries and churches. While some class members took the first apartment they were shown, most had looked at more than one apartment before accepting the place they finally chose. They considered the neighborhoods, their familiarity with it, proximity to people they knew in the community and to their service providers, safety, and easy accessibility via limited steps or availability of elevators. In some cases, after selecting an apartment they liked, they asked to change their medical provider or Mental Health program due to the distance.

All the apartments provide class members with their own bedroom furnished with a bed, dresser, night tables, lamps, sheets and pillows. Housing Contractors vary in their approach to furnishing the apartments. Some allow the residents choice in how to furnish their apartments, while others seem to have made purchases of the same furniture for the all the apartments. Typically, the living rooms are furnished with couches and love seats, end tables and lamps, and some with coffee tables. There is a dining table with two to four chairs. The kitchen has a stove, refrigerator, microwave (except for one Housing Contractor, which also later decided to provide these), and a set of dishes, flatware and cooking utensils. Bathrooms have towels, shower curtains and shower mats. Mops, brooms, garbage cans, and cleaning supplies are also typically provided. Some Housing Contractors provide additional items like coffee makers, toasters, air conditioners/fans, alarm clocks, area rugs, wall and window decorations, fire extinguishers, carbon monoxide detectors, laundry bags, hangers, flashlights and batteries, and TVs.

At the time of the move, Housing Contractors make sure that all the basic food, cleaning, toiletries and other supplies needed are present in the apartment. Most apartments did not have pictures or decorations on the walls, unless the residents had elected to put up decorations themselves, and as a result many had an impersonal feel. A few stood out in this respect. The apartment of 55-year-old AK, who moved in on April 16, 2015 had art on the living room walls, religious symbols, a crucifix and a picture of the Pope. SL & CS had decorated their living room and hallway for the Christmas season, and displayed cards they had received from friends.

Apartment of SK (Photograph by Stephen Hirschhorn**)**

Although many of the bedrooms were equally spartan in decoration, class members are more likely to decorate their bedrooms to their taste. A woman in her 30s had put up large posters of the singer Kurt Cobain on the walls of her bedroom. Another had numerous family photographs displayed on her dresser. A few had collections of stuffed animals in their rooms. A man in his 50s had hung up artistic paintings and drawings he had made, along with a handmade calendar detailing his scheduled activities. Another class member had a collection of erotica displayed on the walls of his bedroom. Many residents had added TVs, stereos or other audio equipment to their bedrooms. Several Housing Contractors now provide their residents with a flat screen TV as a standard part of the furnishings.

> "I love it! I have my ***own*** place. I am living in the ***real*** world. I've made it out. Before, I was just existing. Now I am ***living***."

A. Class members are generally happy

Virtually all class members, even those who had difficulties during the transition process, reported being happy to ecstatic to be out of the adult home and in their own apartment. The types of statements they made included:

"It took a while to adjust, but I wanted to leave so badly. . . . I wouldn't go back!"

"It's a great experience. [I would advise others] do it before you get too old or sick to do it. Go for it now."

Common themes that emerged from conversations with class members who had moved were:

- Enjoying the privacy and quiet rather than the noise that is inherent when large numbers of people live together.
- Having their own rooms.
- Being able to keep to their own schedules and eat what they wanted when they wanted (usually accompanied by loud criticisms of the food at the adult homes).
- Being able to cook their own meals, especially for those who enjoyed ethnic food.
- Not having to share a bathroom with four or more people.
- Choosing the people to interact with and having a place to invite friends and family.
- Having more spending money.
- Feeling safe in their apartments and neighborhoods.
- Not being around people who smoked all the time.
- Appreciating the assistance of Home Health Aides in cooking and cleaning.
- Meeting neighbors in their walks around the community and making new friends.
- Taking more responsibility for themselves.
- Feeling supported by case managers and care coordinators. "They believe in me," one class member said.

B. Class members are generally well supported in the community.

Class members reported making use of the resources in the community such as shopping, using laundromats, going to the movies, libraries, walking or jogging around the neighborhood, fishing off the docks and piers, learning to cook, eating out at restaurants, taking computer classes and preparing for GEDs.

Class members in the sample are well supported in the community through the efforts of the staff of Housing Contractors, Health Homes and MLTCPs. With rare exceptions, the early difficulties with coordination between the staff of housing contractors, Health Homes and MLTCPs also seem to have improved very significantly, with better and more regular communication. It was common to see plans that called for close monitoring and support of the class members at the point of transition and for the first weeks thereafter, with the intensity and frequency of visits tapering off as people settled into their new lives in the community and appeared to be managing well. As this happened, there was

Perhaps the most dramatic example of more spending money was a class member who had been a private pay client for eight and a half years and paid $2000/mo. to the adult home. Now he pays 1/3 of his social security income as rent, which works out to $238/mo. after the utility reduction.

greater reliance on telephone contact, monthly face-to-face visits and regular RN monitoring of medication compliance and supervision of HHAs.

A review of progress notes from the agencies supporting class members showed a high level of communication and interaction, and a clarification of their respective roles and responsibilities. Our review of the progress notes revealed frequent face-to-face meetings with class members, phone calls, and contacts with collaterals to arrange services, and to follow up on medical, mental health and other support needs.

- *RS, 46, and FM, her 58 year old companion, moved out of an adult home on January 12, 2015 after having lived there for 14 and 16 years respectively. Each is served by a different MLTCP. Although RS functions independently and manages her medications, nevertheless initially she was provided with regular nursing visits and aide services. These were weaned at her request as it became clear she did not need them and was compliant with medical and mental health appointments. Her companion, who is older and has greater medical needs, took longer to go through the transition process, slowing the discharge for both of them, as RS would not leave the adult home without him. Both are happy to be in their own apartment and FM is extremely satisfied with his current Personal Care Worker, after having asked to change the previous one whom he found difficult to work with. Following their transition to supported housing, both had their representative payee status changed from the Housing Contractor to themselves, in order to get access to their money more quickly.*

- *JC & CH, a couple in their 40s, moved out of Kings Adult Care Center on December 1, 2014 and into a two-bedroom apartment. The apartment seemed open, bright and airy, clean and odor free. Neither of them wanted to be involved in day programs. HC enjoys cooking, especially spicy Caribbean food, and JC shops at the local fish market and butcher shop. HC talked about his love of cooking, displaying a shelf full of spices in the kitchen and explaining: "I am Caribbean, I use them all!" They accompany each other on their visits to doctors and clinics, and spend their free time socializing with RS and FM, another couple who were discharged from the adult home and live in a nearby apartment.*

Perhaps reflective of the difficulty of this work and the intensity of the needs of some class members, despite this generally high level of support, four of the people in the sample as well as four other class members moved from supported housing to other housing as they (or their family members) desired or as they required a higher level of supervision and support.

- *PGD, a 64-year-old man, left the adult home on February 26, 2015 and moved to a supported housing apartment. He was provided support by the Housing Contractor,*

a Health Home care coordinator, visiting nurse services and mental health programs. He received home delivered meals while SNAP benefits were being applied for. He did not wish to participate in day/social programs and the Housing Contractor became his rep payee. This transition was uneventful and progress notes reveal frequent contacts by the care coordinator with PGD as well as collaterals such as mental health providers, VNS, medical providers, etc.

However, a few months after his transition, he developed medical problems, including a foot infection which required hospitalization, surgery and a course of IV antibiotics. Due to his difficulty with walking, and pain, the Housing Contractor secured a new first-floor apartment to which he was discharged in May 2015. Visiting nurse services were arranged, as were aides to assist him with household tasks. In June, it was determined that he needed insulin injections, in addition to his oral medications. The VNS arranged for glucose monitoring supplies and instructed him in self-administering his injectables.

Problems with recurrent infections/foot pain continued through July and August. He claimed he was losing sensation in his legs/feet and would bump into things and injure himself without knowing it. He was being followed by a podiatrist and vascular surgeon, but on occasion required emergency room care. In August, he was informed that he would require an angiogram and possibly inpatient admission for surgery to address the arteries in his legs.

At this time, he reported to staff that he wanted to live in an assisted living program…he wanted to live in a "controlled environment" following the procedure. Also in July and continuing in August a new problem emerged. PGD believed he was addicted to his benzodiazepine and needed to go to rehab. He would visit hospital emergency rooms, sometimes calling staff to say he was at an ER but not mentioning which one.

By early September when visited, PGD was hunched over in pain. The VNS reported that he was attributing it to his medication addiction, but that he appeared stable and not in danger. The nurse wasn't clear if the pain is medical or psychosomatic but, because of it, he was not keeping medical appointments and was running low on meds/scripts. It was arranged to have a doctor visit him at the apartment for an evaluation and medication renewal on September 15, 2015.

Following this, PGD's psychiatrist arranged for him to be treated at Mercy Hospital. He was escorted there by his Health Home care coordinator. PGD was admitted to a medical service for treatment of his leg(s) but followed by psychiatry daily. There was communication among OMH, DOH, the Housing Contractor and the Health Home to make sure that the latter two work with the hospital discharge planning team to ensure that everyone was aware

In most of these cases, there were diligent efforts to maintain their supported housing and OMH and DOH provided close supervision and monitoring of over the issues class members were encountering in supported housing.

of not only the wrap around services available, but also the different types of housing available so PGD could make an informed choice when ready for discharge.
At Mercy, PGD was treated for his foot/leg infection, but it was anticipated that he would require six weeks of IV antibiotic therapy following discharge. On 9/24, PGD was discharged to a rehabilitation facility for six weeks of continued antibiotics. Shortly afterwards he told his case manager that he wanted to tour supervised housing. While in the rehabilitation facility, he claimed that he was "in pain all over and no one will listen to my wails." He required admission back to Mercy at least once and returned to rehabilitation on 10/6 with a plan for three more weeks of antibiotic therapy.
Following his rehabilitation stay, PGD was admitted to a CR-SRO program operated by the Housing Contractor.

- *46-year-old ME moved to supported housing on December 8, 2014 after living in an adult home for eight years, but was transitioned on or about August 1, 2015 to a CR SRO in the Bronx. Although his mental health program, MLTCP and Housing Contractor all believed he would be an excellent candidate for supported housing, as he was intelligent, personable and independent in life skill areas, there were other factors that came into play and ultimately required a second move. He expressed a strong desire for more choices and independence. During care planning, he accepted the services of an aide and a nurse to monitor his medications but refused Meals on Wheels. While there were a number of issues that arose following his transition from the adult home that were common to other class members as well (delays in enrolling him in a Health Home due to issues with an Administrative Services Agreement (ASA), problems with utilities in the building, delays in delivering medical supplies like adult diapers, etc.), his tenure in supported housing was undone by many decisions that he himself made, despite the support he received from the staff of the Housing Contractor, MLTCP and Health Home care coordinating agency.*

  Although like other class members, his apartment was appropriately furnished and he was provided with adequate food, he seemed to be taken advantage of by "friends" who hung out in his apartment. Furniture was found to be missing from his apartment and he was often short of food. While awaiting full SNAP benefits, the Housing Contractor would buy him groceries to last two weeks at a time, but the food would be gone within days. He also ran up a bill at a local bodega by buying items on credit. He ran into problems with managing his money by buying expensive things like steaks to feed his "friends." About six weeks after his transition, he started missing therapy appointments, and refused an offer to use a pillbox or blister pack medications, which would have facilitated pill counts. His behaviors began to change as he was selling items, including his phone, to buy cigarettes. He began experiencing urinary incontinence, but refused to wear the adult diapers

when they were made available. Although he was offered aide services seven days a week, he limited them to five days and would not change the schedule to the mornings so they could assist him get ready to go to appointments. While he continued to attend the mental health clinic for his monthly injections, he would not go to the therapy sessions. He was often soiled and malodorous, claimed he had no money to do laundry even though he was receiving $50 per week from the Housing Contractor in addition to his full SNAP benefit.

By March 2015, he was experiencing bowel incontinence and was found naked in his apartment with feces smeared around. His mental health program recommended a more supervised setting. In April, the Housing Contractor visited in response to complaints from neighbors that he was yelling, panhandling in the street, urinating/defecating in the building's hallway. He was admitted to the hospital for hyperglycemia and disorganized speech. When he was discharged on April 8, the plan was for him to enroll in a day program but he refused. Progress notes for the following weeks described ME missing appointments with providers, canceling aide services or not being home when the aides arrived, giving his possessions away, chain smoking, eating and drinking unhealthily, and "friends" using the apartment as a hangout. The apartment itself was described as malodorous, with soiled diapers on the floor and flies. (All through this time from February 5 to April 14, the enrollment into a Health Home remained "in progress.")

ME was offered more intense community services and peer support services but refused. Eventually, on June 3, he was admitted to a psychiatric unit for a stay of approximately two weeks. A plan was developed to transition him to level II housing, although he wanted to stay in his apartment. The developments in this case were closely monitored by the MLTCP, Housing Contractor, OMH and DOH, and as his care approached crisis levels, the Independent Reviewer and Plaintiff's counsel were notified as well. Eventually he was transitioned to a CR-SRO in the Bronx and since then has been doing well, attending a day program five days a week and living in his own studio apartment with a fully equipped kitchen and private bathroom.

C. Attending Mental Health and Social Programs

Class members have the opportunity to and are encouraged to attend mental health clinics, social day programs, clubhouses or PROS programs and most attend one of more such programs at least several times a week. Thirty-one class members who have transitioned to supported housing, including 11 of the 28 in our sample, had received PROS services in the past year. Some of them spoke positively of the opportunity to go to group programs where they could "let their hair down" and discuss their concerns with therapists and peers who could provide support. One who attended a PROS program liked that "you set goals for yourself," and attended and found helpful groups on

Understanding Depression and How to Deal with Anxiety. However, eight of the 28 class members in our sample chose not to attend any day program but instead opted to spend their day as they wished. For most of them, this meant spending long stretches of time in their apartments, watching TV, listening to music, reading, shopping and taking the occasional walks in the neighborhood. A few complained of loneliness but also seemed disinclined to taking advantage of available community resources such as public libraries, senior citizen centers, or clubhouses that would provide them the opportunity for social interaction.

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D. Medications

Recognizing that an important element of successful community living for many class members is keeping their symptoms under control and maintaining compliance with their medication regimen, registered nurses provide medication education to class members and, for those who needed assistance with their medications, they arranged for mediation doses to be pre-pored or delivered in blister packs. They also made regular visits to monitor medication compliance, do pill counts and also enlist the assistance of HHAs to provide reminders to class members about taking their medication.

Despite these efforts, some class members (like ME, discussed above) ran into difficulty.

- *SK, a 42-year-old class member who transitioned January 27, 2015, experienced problems with managing her medications following discharge from the adult home. Within a month of her discharge, she was also disenrolled from the MLTCP which had been providing her service during her stay in the adult home. Starting in March 2015, there were continual problems noted in the area of medication management. She took 14 medications but was constantly running out of Klonopin, which she apparently used more than prescribed when she was feeling anxious. Concerns about her running out of medication resulted in ER visits on March 16, 2015 and April 21, 2015. Three days later, she had run out of medication again and called 911. When EMS arrived, they found her barefoot in the street and she was taken to Coney Island Hospital and admitted to psychiatry, where she remained until May 5, 2015. The dosage of her Klonopin was reduced. A month later, she again called EMS and was once again admitted to Coney Island Hospital until June 17, 2015. Upon her discharge, as a*

strategy to deal with the medication management problems, it was arranged for her to receive a weekly supply of her medications from the pharmacy in blister packs.

- *GG, 55, also had issues with self-medicating to aid sleep and ran out of his medications on several occasions, requiring emergency replenishment.*

E. Seeking Employment or Volunteer opportunities

In some cases, class members who expressed an interest in working were getting assistance from the PROS program in developing plans for necessary education or training (e.g. attending a program to become a peer advocate, learning to use a computer, etc.). Others who had expressed an interest in working were not yet ready to follow through on their plans, such as preparing to teach driver's education.

- *AF had secretarial training and wanted to freshen up her Microsoft Office skills and get employment. Through PROS, she was being referred to Access VR to pursue this. Her housemate, RG, who had never graduated high school, wanted to get her GED through PROS. AF had a laptop and an e-mail account and said she would teach RG how to use it.*

- *PC wanted to work on her GED but felt that her care manager was not being helpful and reported that to her care coordination agency. The agency contacted the care manager to offer assistance in helping him find a GED program, which he agreed to do, since it might be good for them all to work on this goal.*

- *JL, a 52-year-old man, wanted to work, and the AHRAR reflected his desire for supported employment. A review of the case notes of the care management agency showed no further references to his interest in employment. However, he was enrolled at a PROS program, and this was identified as a goal for him. He attends regularly and still wants to get a job doing office work.*

F. Housemate match

Many class members are offered and accept two-bedroom apartments, and some three-bedroom apartments, where each have their own bedroom, but share a common living room, kitchen, dining area and bathroom. The economics of the housing market are such that there is more two-bedroom and three-bedroom housing stock available within the price range for supported housing than one-bedrooms and studios which some class members prefer. Although most Housing Contractors responding to the OMH RFP envisioned offering a choice of studio/one bedroom

apartments, the reality has unfolded differently.[8] In many cases, class members select someone they know with whom to share an apartment. Many class members who are friends and romantic partners have taken advantage of the availability of a two-bedroom supported apartment to move in together. In other cases, the Housing Contractor arranges a pairing of class members who were both interested in leaving an adult home for a supported apartment, but may not have known one another previously. Some class members are more active in this selection process than others, and the results have been variable.[9]

- *A pairing that has worked well is that of 48-year-old BS and 60-year-old HC who moved within days of each other in January 2015 from two different adult homes. They did not know one another prior to moving in together. Both are served by the same MLTCP and have the same home health aide during the week who helps maintain the apartment and occasionally cooks for them. On weekends, a second home health aide provides assistance to HC. The same nurse who supervises the home health aide visits the apartment once a month.*

  BS, who had lived in an adult home for 12 years, is the more independent of the two, happy to do things for himself including managing his own medications, shopping and preparing his own meals. He attends weekly therapy appointments on his own but otherwise spends his time in his room, watching TV or reading the Bible.

  HC had lived in an adult home for three years and was at a Men's Shelter for two years before that. He is under legal guardianship and is in need of much more intensive support in areas of medication compliance, and budgeting and managing his money. Due to his failure to keep appointments with his therapist and psychiatrist, he was discharged from his mental health program for noncompliance three months after leaving the adult home and later had to reenroll. The HHA assists him with shopping and taking his morning medications. She accompanies him to his medical and psychiatric appointments when he agrees to go.

Some class members are more active in this selection process than others, and the results have been variable.

[8] For example, CommuniLife's proposal asserted: "All of our apartments are for single individuals; we do not match clients as roommates in shared apartments unless two or more clients request to share an apartment." See the discussion in Section VIII (A), Choice of Housing, and Table 5 on p. 90.

[9] One Housing Contractor responding to the RFP had envisioned a more thorough matching process than has been implemented. "Potential roommates meet in the apartment, dine with each other and have a sleepover to assess their compatibility. If after this process the consumers feel that the match is not a good one, the process will begin again."

The progress notes reflect intense and comprehensive follow-up by the MLTCP, a nurse who monitors his medications and supervises the aide, monthly social worker visits, the care management by multiple staff including periodic joint visits by the Nurse care manager and social worker, and the engagement of the director of the MLTC when HC appeared to be in crisis. With all this support, and despite the differing functioning abilities and level of needs of the two housemates, they get along well in their supported apartment.

- *Another class member we visited, AF, was discussed in the First Annual Report (Doc. #36, pp. 23-24). She moved to a supported apartment with her friend RG on March 24, 2015. They are well settled and happy in the new apartment, where they share food, the cable bill and utilities. Unlike many other housemate situations where people lead separate lives under the same roof, they shop together and take turns cooking. They also socialize with another couple who were discharged from adult homes and live in a nearby supported apartment. AF gets a low amount of SNAP benefits ($30 a month) due to her high SSD income, while her housemate is still working on getting her SNAP benefits. They have a Nurse Practitioner visit them both once a month in their home to check them medically and fill their prescriptions.*

- *A match that did not work as well was that between VL and GGT. VL was a woman in her 60s who left Surf Manor on December 23, 2014, and moved to a two bedroom apartment. On January 6, 2015, a housemate, GGT, a woman in her 40s, moved into the apartment. It is not clear how this match was arranged. GGT was a much younger woman. The two women seemed incompatible in many respects. VL was clean and neat, while GGT kept the apartment in a state of disarray, with clothes strewn all over the common living areas, the kitchen filthy and piled with unwashed dishes, with burnt and crusted food. VL's daughter reported that VL often stayed in her room due to the condition of the rest of the apartment. Her house mate reportedly smoked marijuana. According to VL's daughter, a cousin once observed a male visitor walking about the apartment naked.*

  Both her daughter and VL complained that the apartment was dirty primarily because her housemate, GGT, was not clean. This had come up during the Housing Contractor staff's visits to the apartment in February and March when clothing was left around or food was out. A staff person said she would talk to GGT and encouraged VL to do so as well but on a later visit in April, the same conditions were observed. When asked about it, VL said that GGT was still refusing to clean. Both women had aides who were in the apartment for 4 hours/day, but their presence did not address the state of the apartment. This arrangement came to an end when VL decompensated and was hospitalized and decided to return to the adult home on the day she was discharged from the hospital.

III. Issues that have arisen following transition

A. Delays in the delivery of services

1. SNAP benefits.

SNAP benefits can be applied for once the class member's community address is known, which is typically around the time 30 day notice of discharge is given to the adult home. The application requires proof of identity, which is usually in the form of a government issued photo ID; a Social Security card; Medicaid benefits card, if available; proof of income (typically SSI); and expenses (rent, utilities, etc.). Assembling this information has proved challenging for some class members. In many cases, the application process is not commenced until well after the discharge from the adult home due to problems with one or the other elements of the application.

a) *ID Issues*

Class members require a government picture ID for many important services in the community, including banking, applying for SNAP benefits, reduced fare MTA cards, etc. The lack of an ID has delayed processing applications for SNAP benefits for several class members. At least 10 of 28 class members in our sample experienced this type of difficulty.

At least 10 of the 28 class members in our sample experienced difficulties and delays in receiving their full allotment of SNAP benefits.

SL is a 34 year-old woman who moved from her adult home to supported housing with a 61 year old male friend on March 12, 2015. Her care coordinator from her Health Home noted seven months earlier that she required a valid ID to obtain a birth certificate and a birth certificate to obtain a valid ID – a Catch-22! This need was again discussed at a transitional case conference on February 19, 2015. On April 12, 2015 she went to the Housing Contractor office to discuss becoming her own rep payee. She was given a form to be filled out by her psychiatrist, which had to be taken to the SSI office. After several earlier attempts to schedule a visit, on May 28 her care manager went to DMV with SL to obtain a government ID, armed with utility bills, a letter from the Housing Contractor and a Social Security card, but was denied due to the lack of a valid government photo ID and birth certificate. She could not get a birth certificate without a government ID, which she does not have. The DMV supervisor recommended going to HRA to apply for a free New York City ID, which apparently has less strict requirements. She went there, but ran into the same problem of a lack of adequate documents. HRA recommended that she obtained a gym membership ID from Parks and Recreation, which would then allow HRA to issue a New York City ID. Since she

has a fear of traveling by subway, she took a two hour bus trip to Parks and Recreation which also requested a government photo ID in order to finalize a gym membership!

On June 25, the care coordinator made a follow-up call to make arrangements to go to HRA to apply for SNAP benefits and obtained a benefit card with a photo ID. Although she made several attempts to schedule this meeting, SL canceled them for fear of her Medicaid being cut off due to being over resourced. Although she was offered the opportunity to take advantage of a Special Needs Trust to shelter some of her resources, she declined and was eventually terminated from the Medicaid program, losing her Health Home care coordination in the process and the assistance that she had been receiving to obtain her government ID. As this report is being drafted (in January 2016), she still does not have her ID and the Housing Contractor case manager has picked up this responsibility to assist her.

b) Proving income –issues with SSI benefits

After the ID issues are addressed, the next issue is proving income, which is typically done by producing an SSA award letter. While in the adult home, the SSA award is at the Congregate Care Level III (approx. $1427/mo.), which is substantially higher than the SSA award for community living (Approx. $756/mo.). If this letter is used, it generally results in a minimal award of SNAP benefits. It usually takes some period of time after the notification to SSA of a move to supported housing for the appropriate adjustment to the income level to be provided, which would support a higher SNAP benefit award. It also takes time to change the representative payee (where there was one) from the adult home to the Housing Contractor or another rep payee or to the individual. If a change from rep payee to the individual is requested, there is an additional step of producing a physician's certification of ability to manage one's own finances.

c) Proving expenses

Typically the major expenses are rent and utilities. In some cases the utilities are paid for directly by the housing contractor. As a result, the class member does not have a utility bill with his or her name on it. The inability to prove this expense affects the amount of the SNAP benefit award which can be adjusted later when appropriate documentation of the expense is available.

As a result of these issues in the application process, class members experience significant delays in obtaining the full amount of their SNAP benefits. For people who live on a fixed and limited income, these delays have a substantial adverse effect on their lives.

- *JL, a 52-year-old man was discharged from the adult home on December 30, 2014. The pre-transition call identified the need for SNAP benefits, which was also identified on*

the care plan, as was obtaining a New York State ID and Medicaid Card, which were not done prior to the move. The progress notes of the care manager document ongoing difficulties with getting the occupancy agreement from the Housing Contractor to help him apply for the SNAP benefits and an ID. The efforts to get him these benefits extended over many months and many visits with him, and involved his brother as well. He finally received his SNAP benefits in April 2015, but only $15 a month. It was not until June 26, 2015 that he was approved for full benefits of $194 a month, retroactive to May. Once he got his SNAP card, he was able to get a DMV ID, and his care manager helped him obtain a library card.

- *VL's daughter helped apply for food stamps and tried to obtain ID for her mother following her discharge from the adult home on December 23, 2014. She went to the Social Security office and to the Housing Contractor to get proof of rent and income, but continued to have difficulty getting her mother an ID, which had still not been obtained as of March 4, 2015. The last note regarding SNAP by her MLTCP on March 11, 2015 is that she got approved but still did not have an EBT benefits card she could use. She finally got her full amount of SNAP benefits after she had moved back to the adult home in June 2015 when it was finally raised to $194 in August.*

- *PG & EK moved out of the adult home on April 18, 2015 and SNAP benefits were apparently applied for on April 14, 2015, but as of a site visit in late December 2015 they still had not received their full SNAP benefits. There were apparent difficulties with processing her boyfriend's application due to confusion created by alternate spellings of his name. In the meantime, they have been receiving assistance from the Health Home in purchasing food. PG would like to invite people over to her apartment, but her partner wants to wait until they have enough money to "entertain properly" and this awaits approval of their full SNAP benefits.*

- *BS gets SNAP benefits of $174, while his roommate HC receives $16 and is frequently running short of food, and having to rely upon food pantries, and emergency financial and food assistance from his Health Home and Housing Contractor.*

- *Despite going to the SNAP office many times himself, HC still did not have his full SNAP benefits more than six months after his discharge from the adult home.*

- *PC, a 40-year-old woman, moved out of the adult home on April 13, 2015 was denied SNAP benefits, but with the assistance of her Health Home, went to a fair hearing and received her award, but at a reduced level.*

Recognizing that applying for and securing SNAP benefits is a complicated process, the State has partnered with Hunger Solutions to connect care managers with a Nutritional Outreach and Education Program Coordinator. A NOEP Coordinator is able to assist in identifying the

necessary documentation, completing the application, calculating the maximum allowable benefits and coordinating with HRA on behalf of clients. As this report is being written, there is no information available to indicate how this resource has been used to assist class members or what effect it has had in improving their experience in applying for and receiving SNAP benefits.

2. Other Services

Part of the enrollment process for MLTCP services such as a Personal Care Worker ("PCW) or Certified Home Health Aide ("CHHA") is conducting a UAS assessment in the apartment following the move as the class member's housing status has changed. As a result, there are inevitable delays in arranging for the delivery of the services that are determined to be necessary. This structural problem with the timely delivery of services is compounded by the inclination of some class members to oversell their capabilities for independent functioning during the pre-transition assessment process, and their real abilities only become evident once they are in their own apartments.

- *PG & EK -- during the initial transitional planning, enrollment in the MLTCP was not completed. In this case, the application for MLTCP and eventual enrollment did not occur until after the post-transition call three weeks following their move to the apartment on April 18, 2015. Following the move, both class members were upset that they were not receiving the personal care aide services they had thought they would receive. PG was having a particular problem with showering, fearing a fall. But cooking and cleaning were also problem areas. Their concerns grew more frantic as the days passed, and they called complaining about not having bathed in a week and having no food and wanting to return to the adult home. At this point, the Housing Contractor, Health Home and DOH intervened aggressively to expedite the enrollment into an MLTCP and the delivery of personal care services by making the application retroactive.*

- *GP experienced delays in getting CHHA services which she needed for help with medication management, cleaning and shopping following her transition on January 21, 2015. Three months after discharge, she still did not have the service because her care manager, in her words, had "dropped the ball." A new care manager was assigned and subsequently made the application for this service, which, as of September 22, 2015—nine months later-- had been approved but had not yet started.*

- *For a 55-year-old AK, an issue that has not been resolved is aide services. Although a M11Q (a form to be filled out by a physician) was supposed to have been completed prior to the move, it does not appear this happened. In June, the housing case manager arranged for AK's PCP to complete the M11Q. A nurse, through CASA-Home Care Services, visited and assessed AK in mid-May. She was approved for 6-8 hours of aide*

services three-days per week. A vendor was identified and services were to start on July 23, 2015. However, the vendor reported that they could not find an aide who is willing to work with a heavy smoker. As of the December 15 site visit, this situation still was not resolved.

B. Financial Issues

1. Getting money –SSI and money upon discharge

As noted earlier, when a class member leaves the adult home, SSA must be provided with a change of address. Since supported housing is a different level of care than the adult home, the move also affects the amount of SSI benefits that will be payable. Moreover, it takes time for SSA to process the change of address and level of care. It is sometimes the case that SSI checks continue to be sent to the adult home, which must then return them to SSA for reissuance to the correct address and at the correct benefit level, causing delays in the receipt of these funds by the class member.

Also, when a class member transitions to the community, he or she is entitled to a refund of any SSI funds that have been paid in advance to the adult home for the days following the transition. In order to be eligible for this refund, the class member must provide a 30 day notice of termination of the admission agreement with the adult home. Although state regulations require that such refund be made at the time of discharge or termination of the admission agreement, but in any case no later than three business days after the resident leaves the facility, (18 NYCRR §487.6 (f) (1)), some class members have encountered delays in receiving their refunds on a timely basis.

- *GGT left the adult home on January 6, 2015 but did not receive the balance of her SSI payment from the adult home upon her discharge. Her SNAP benefits were not in place until February 25, 2015 ($53). The Housing Contractor case manager tried to get the money for her, but as of February 18 still had not received the refund from the adult home. In the meantime, the Housing Contractor was assisting with obtaining her SSI check for February. She continually complained about having no money.*

- *JL moved into his supported apartment on December 30, 2014 but case notes document that it took several months for him to get his money after his transition, as the process to make the Housing Contractor his representative payee were delayed. Fortunately, he had a very involved brother-in-law who was of great help.*

2. *Budgeting and managing money*

One of the more challenging responsibilities class members encounter upon transitioning to the community is budgeting and managing their money. Unlike the adult home, where most of their SSI income covers room and board, leaving a relatively small portion for a Personal Needs Allowance ($193/mo.), class members pay only a third of their income for rent, leaving the balance to cover all of their personal needs, including food, clothing, utilities, transportation, entertainment, etc. For class members who have not been used to budgeting and managing this larger sum of money, these new responsibilities can prove difficult, and some have run into problems by overspending their funds early in the month, and having too little left over to meet their needs until their next benefit check arrives. In the Person Centered Planning process, education and training in managing money and budgeting are often identified as needs, and class members are referred to PROS and other programs for assistance. In cases where Housing Contractors serve as representative payees, some have helped the class members by giving them the money left over after deducting the cost of rent in smaller periodic payments weekly or biweekly.

One of the more challenging responsibilities class members encounter upon transitioning to the community is budgeting and managing their money.

- *SK, a 42 year-old woman, experienced problems with money management and budgeting, which were identified as needs by the Housing Contractor case manager in the functional assessment that was completed on March 2, 2015. She was constantly running out of food, no matter the amount purchased. She frequently went to the Housing Contractor office seeking emergency money to purchase food. To help her manage, the case manager resorted to giving her an allotment of money one week at a time. Both the Housing Contractor case manager and the Health Home care coordinator provided intensive support, with almost daily contact with SK, and many more visits than the required monthly contact. This level of support is impressive, especially considering that the Health Home care coordinator had a caseload of 60 clients at the time and welcomed the prospect of the implementation of Adult Home Plus, which would provide for a maximum caseload of 12. He observed that having a client like SK on his caseload was like having five clients.*

- *HC frequently runs out of food and has to rely on food pantries, emergency money and emergency food supplies until his next check from his Guardian arrives. He receives $16 a month from SNAP, despite an appeal and subsequent denial. He has problems with budgeting his money, spending on Chinese food, phone cards and cigarettes. This resulted in his inability to pay his share of the cable bill in July, and*

needing to borrow money from his housemate, which he later repaid.

- *See also, ME, described above who overspent his funds entertaining "friends" who appeared to exploit his generosity.*

C. Loneliness

Class members who leave an adult home where there are always other people around generally relish the peace and quiet of living in their own apartment, where they are no longer exposed to the noise that is inherent in large numbers of adults congregating in the same common space, sharing bedrooms and bathrooms. But, unless they make the effort to attend mental health clinics, PROS programs, social day programs, club houses, or otherwise build a social life for themselves in the community, some of them complain of loneliness.[10]

- *Despite not having any of these social outlets and refusing suggestions to engage in them, 55-year-old AK relies on visits to her daughter and new grandchild, and the companionship of her pet cat. She also enjoys the people she meets on the street as she wheels herself to nearby stores to shop. People strike up conversations with her and help push her on her way.*

- *CL is a 66-year-old man who moved to supported housing in March 2015, along with a roommate, who later returned to the adult home and CL has been living by himself in this two-bedroom apartment. He appears to have a mild developmental disability, and said that he had been in special-education when he was a child, was bullied by other students, and had no friends. In fact, he said he has been a loner all his life, never knew how to make friends. CL has a close relationship with an aide who assists him five days a week and has alternating staff on Saturday and Sunday. Although the apartment*

Unless they make the effort to attend mental health clinics, PROS programs, social day programs, club houses or otherwise build a social life for themselves in the community, some of them complain of loneliness.

[10] The Independent Reviewer has provided OMH/DOH with information and training materials to address the issues of loneliness, which they in turn have shared with Housing Contractors, Health Homes, and MLTCP staff.

was neat and clean, it seems that the most important function that the aide performs is keeping CL company. In the afternoons, after the aide leaves, he goes to a Social Day program called Genesis, where he reports that he has no friends. Although he is lonely and bored being in his apartment, he does not seem motivated to explore other interests, other than a love of movies. He does not go out on his own, seems to have no interests that he wants to pursue, doesn't like the neighborhood and in general seems depressed. While he goes on occasional walks in the neighborhood with the aide, he does not explore it on his own. CL often cancels his aide service on weekends and goes into the city to see several movies each day with gift cards provided by a Community trust in his name. However, he always goes alone. Nevertheless, he prefers the apartment to living at the adult home where he had lots of problems with other people, and with bedbugs.(As of the writing of this report CL was in process of moving to a new 2 bedroom apartment in an area that, according to the Housing Contractor "he loves!").

- *GGT's roommate returned to the adult home following a hospitalization, leaving GGT alone in this two-bedroom apartment. She expressed her loneliness, and desired another housemate, but ongoing issues with her maintaining the cleanliness of the apartment, which had been an issue with her prior housemate, resulted in deferring action on this request.*

D. Limited PCPs and sharing

There is still room for improvement in the development of PCPs, especially in commencing the process earlier, and engaging the class members and family members who are involved in their lives and on whom they rely for important decisions. Too many PCPs are developed solely by case managers, care coordinators and the class members, without any involvement from mental health program staff that may have been serving the person for many years, or from involved family members. In a number of cases, the plan is developed by the Health Home or MLTCP but the content of the plan and the plan itself is not shared until the move, or even later with the Housing Contractor staff, who are an important source of support for the class members,. In some of these cases, the reason given for not doing so was the failure to complete an Administrative Services Agreement (ASA) that would permit the sharing of protected health information or the failure to obtain consent to share information with an involved family member.

- ***VL****- Mental Health Services were never finalized by the MLTCP during the almost six months in supported housing from 12/23/14-6/17/15 (when she returned to Surf Manor) for the following reasons. Her first mental health appointment following admission to supported housing on 12/23/14 was for 1/16/15 at JB, based on the client calling a central intake number. This appointment was not kept as the Aide and VL forgot the appointment.*

It took several weeks for her to make another appointment, as she had to call the intake number. An intake appointment was made for 3/12/15, which she kept as well as another intake appointment on 4/14/15. However, on this date she informed JB that she only wanted to see a psychiatrist monthly and refused to see a therapist weekly. It was then that she and her care manager were given a list of neighborhood psychiatrists by JB Clinic. Her CenterLight care manager, made an appointment for her to see a psychiatrist on 6/11/15, almost six months from the date of her discharge from the adult home. She never kept this appointment as she was hospitalized at the time, and returned to Surf Manor on 6/17/15.

Because of the difficulty in linking her with mental health services, she was running out of her psychiatric medications. On 3/20/15, she went with the case manager of JB to Coney Island Hospital, but only got a one-week supply of medications. Thereafter, CenterLight arranged to have a Nurse Practitioner visit her and prescribe medications, first for a month and then for three months (on 3/26, and then on 4/24/15, respectively).

There were on-going issues with VL's willingness to comply with recommendations and the care manager enlisted the assistance of her daughter to encourage her to follow up.

- *GGT was enrolled in both a Health Home and an MLTCP. However, the Health Home and its downstream care coordination provider were not involved in planning her transition to supported housing, despite being approached by the MLTCP to do so following in-reach by the Housing Contractor. The Health Home that had been "loyalty matched"[11] to the class member refused to provide any information to the MLTCP, and would not accept the in reach package or direct them to the care coordination entity. The apparent reason was the lack of an ASA permitting the MLTCP and Health Home to share information with one another.*

This concern about the lack of ASAs impeding the sharing of information was also raised in the First Annual Report (pp. 37-38). Although there has been progress in getting Health Homes and MLTCPs to execute ASAs, as of early February 2016, seven Health Homes still had not completed ASAs, including one with an MLTCP that serves 71 class members, 17 of whom have enrolled.

[11] Loyalty Match is a DOH Health Home assignment process that matches the Health Home eligible members' Medicaid claims and encounter data to providers that are in each Health Home's network. A member is assigned or loyalty matched to a Health Home based on the member's Medicaid utilization of providers within a Health Home network. The member's Health Home assignment is generally the Health Home with the greatest number of "matched" claims.

E. Repairs & Maintenance

Eight of the 28 class members in our sample reported minor repair and maintenance issues in their apartments such as beeping smoke alarms, broken intercoms and lights, malfunctioning door locks, elevators out of service, broken drawers and cabinet fronts, stopped up toilets, sinks and drains. In most cases these were repaired within a reasonable time after either notifying the landlord or the case manager from the housing contractor. Some problems persisted for a lengthier time, and some – like a persistent problem with lack of heat and hot water – resulted in the relocation of class members.

- ***VL-*** *There were initial problems following the move – no heat in the apartment from date of move on 12/23/14 until 1/9/15, when the Housing Contractor staff called 311 and it was fixed. Reportedly, the Housing Contractor had called the landlord to no avail. It also offered respite due to the lack of heat, in presence of her daughter on 1/2/15 (Rockaway) and on 1/5/15 (Coney Island), but she refused both and they had her sign a statement to that effect. VL used a space heater for much of this time. There were also problems with the electrical system when the service went out. The daughter said she went out and got a fuse and turned it back on.*
  The daughter said that there was no light in the entryway of the building and at night it was very dark, which her mother had said made her very fearful. Her daughter reported that she had complained to the Housing Contractor about it, but it was not fixed and the light was out for a long time. When a member of the Independent Reviewer team visited the apartment on 9/25/15 and 10/13/15, the lights in the entryway and in the first floor hallway were both still out. The Housing Contractor informed him on 10/21/15 that the landlord had repaired the fixtures and Housing Contractor staff verified that both lights were now working.

- *JC and CH-- The problem had to do with utilities in the apartment, which periodically had no heat or hot water, and occasional problems with electricity, and front doorbells that didn't work, resulting in building residents leaving the front door propped open, compromising the safety of the building. When it became evident that the landlord could not resolve the utility issues dependably, the Housing Contractor relocated them to another apartment which they found to be much nicer. Similar problems with utilities were experienced by ME, who was also relocated but to a level II program in light of other issues indicating the need for a higher level of care.*

F. Post Transition Events including Hospitalizations and Emergency Room Visits

In addition to following up on 28 individuals in our sample, in December 2015, the Independent Reviewer asked Housing Contractors to complete a survey on all 170 individuals who had transitioned as of December 11, 2015.

The survey asked for:

- The number of times since transition the individual had been admitted to a hospital for inpatient psychiatric care.
- The number of times the individual had visited an emergency room for psychiatric reasons but was not admitted for inpatient care.
- The number of times the individual had been admitted to a hospital for inpatient care for medical reasons.
- The number of times the individual the individual had visited an emergency room for medical reasons but was not admitted for inpatient care.
- Whether the individual had returned to live in an adult home.
- Whether the individual was discharged from supported housing and transferred/admitted to other OMH Housing (e.g., CR-SRO, apartment treatment program, etc.).
- Whether the individual was discharged from supported housing and transferred/admitted to other non-OMH Housing (e.g., Senior Housing, a nursing home, etc.).
- Whether the individual had been discharged from supported housing and their whereabouts is unknown.

The Independent Reviewer received completed surveys on 169 of the 170 individuals who had transitioned as of December 11, 2015 including completed surveys on all 28 individuals included in our sample.[12]

Of the 169 people who had transitioned between September 9, 2014 and December 11, 2015:

- 21 (12%) had 1 – 5+ reported psychiatric inpatient hospitalizations;
- 15 (9%) had visited emergency rooms 1 – 15 or more times for psychiatric/substance abuse reasons, with three having more than 10 such emergency room visits;
- 19 (11%) had 1 – 6 inpatient hospitalizations for medical reasons;
- 14 (8%) had visited emergency rooms 1 – 3 times for medical reasons;
- Three (2%) were readmitted to an adult home;
- Three (2%) were admitted to other OMH housing;

[12] In one case, the Housing Contractor identified in the Weekly Reports issued by the State was inaccurate and thus the survey was not completed.

- Two had been discharged from supported housing: one to live with her son out-of-state and the second for long term psychiatric hospitalization;
- None had left or been discharged from supported housing and their whereabouts is unknown; and
- One died within three months of transition reportedly of natural causes; the State has informed the parties that the death is under investigation by State agencies.

One hundred twenty-two (72%) of the 169 individuals who had transitioned as of December 11, 2016 experienced none of the above post-transition occurrences.

Of the 28 people in the sample the Independent Reviewer followed up on who were transitioned between December 1, 2014 and April 28, 2015:

- Six (21%) had 1 – 5+ reported psychiatric inpatient hospitalizations;
- Four (14%) had visited emergency rooms 1 – 15 or more times for psychiatric reasons, with two having 10 or more such emergency room visits;
- Six (21%) had 1 – 4 inpatient hospitalizations for medical reasons;
- One had one emergency room visit for medical reasons not resulting in hospitalization;
- Two were readmitted to an adult home;
- Two were admitted to other OMH housing;
- None were admitted to other non-OMH housing; and
- None had left or been discharged from supported housing and their whereabouts is unknown.

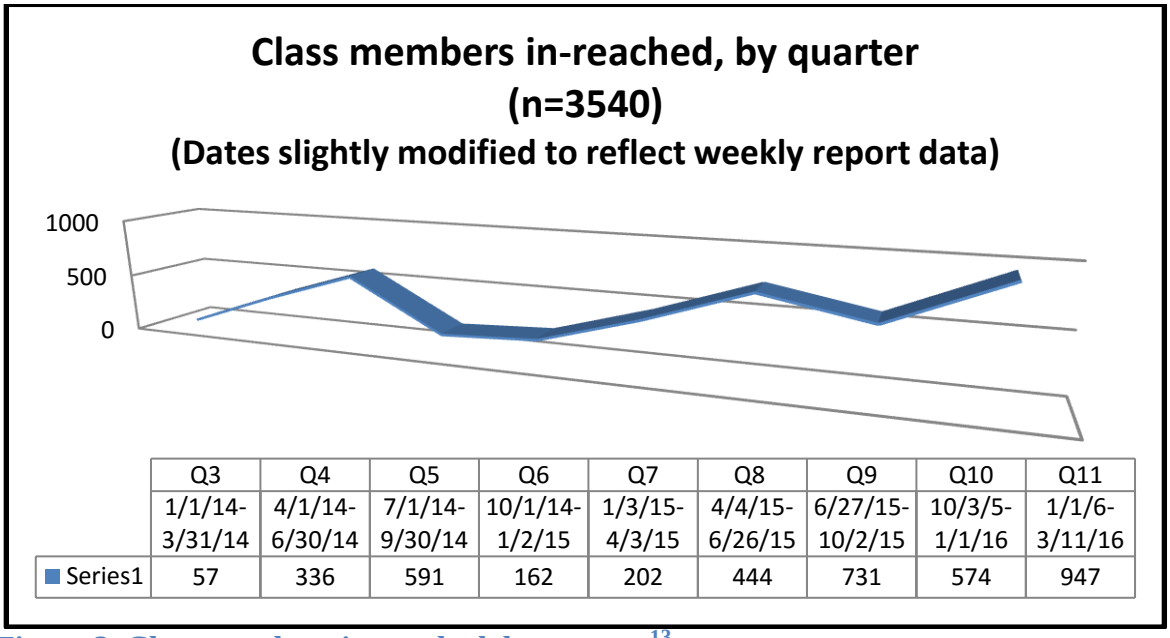
Sixteen (57%) of the 28 individuals whom the Independent Reviewer included in a sample for in-depth review had experienced none of the above post-transition occurrences.

IV. In-reach.

The Settlement Agreement requires the State to arrange for the entities that provide supported housing to conduct in-reach in the NYC Impacted Adult Homes on a regular and continuing basis to provide information about the benefits of supported housing and discuss any concerns that class members may have about moving to supported housing. (Settlement Agreement, ¶ E. 1) It also identifies some strategies for effective in-reach, including conversations with persons who already live in supported housing, visits to apartments, and the use of photographs and virtual tours. There are also provisions requiring adult homes to provide reasonable access of Housing Contractors to class members, and requiring that they not discourage class members from meeting with the Housing Contractors. (*Id.* ¶ E. (3) (4))

During March 2014, Phase I began with in-reach at three of the impacted adult homes, under one Housing Contractor. Phase II extended in-reach to 14 additional homes on July 1, 2014, served by five additional Housing Contractors. As of March 13, 2015, Week 52, 30% of the Class

had received in-reach, and 60% had expressed an interest in supported housing. The positive responses were aided by initiation of a "fast track" process within the three pilot homes for class members who had previously expressed an interest in supported housing, which was subsequently expanded to all homes included in the initiative. On April 27, 2015 Phase III began and in-reach was extended to the three homes in Staten Island and the two homes in the Bronx, served by three additional Housing Contractors.



	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11
	1/1/14-3/31/14	4/1/14-6/30/14	7/1/14-9/30/14	10/1/14-1/2/15	1/3/15-4/3/15	4/4/15-6/26/15	6/27/15-10/2/15	10/3/5-1/1/16	1/1/6-3/11/16
Series1	57	336	591	162	202	444	731	574	947

Figure 2. Class members in-reached, by quarter[13]

As of March 11, 2016 in-reach had been offered to 3,540 of the 3,961 class members, or 89.4%, and 1,657, or 46.8% of the class had said Yes (See Fig. 3)

The numbers of class members receiving in-reach at the 22 impacted adult homes had increased significantly during this period (See Fig. 2), while the percentage of class members expressing an interest had decreased from 60% to 46.8%.

[13] The quarterly totals exceed 3,540 as some class members received in-reach more than once. It should also be noted that of the 3,540 people in-reached, 173 class members died or were discharged from the adult home outside the transition process created pursuant to the Settlement Agreement and one was determined not to be a class member.

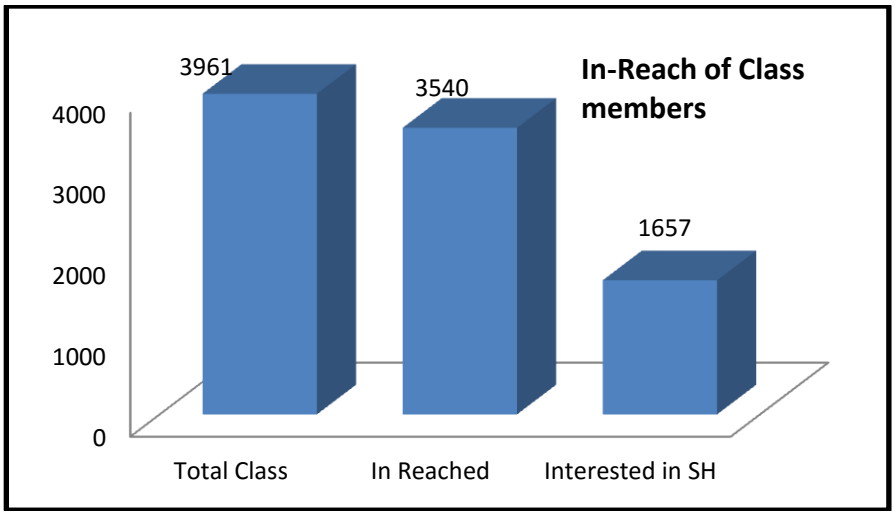


Figure 3. Class members expressing initial interest in supported housing

One obvious reason is the expected decline of interest as efforts moved away from the Fast Track, those identified as eager to transition, some who had been waiting many years. During 2015, the State added many new names to the Fast Track lists as a result of its LEAN Improvement Process, reportedly based on "use of services." Review of the Color Coded In-reach Tracking Report ("CCITR") and discussions with Housing Contractors reveal that most of those placed on the Fast Track by LEAN were initially not interested. Under the terms of the Settlement Agreement, all class members who are initially not interested, or who are initially interested and subsequently change their minds at any point in the process (including during assessment, after HRA approval, or even after seeing and accepting an apartment), will have at least an annual opportunity to receive additional in-reach to discuss their option to move to supported housing or another less restrictive community living arrangement. This is documented for each adult home on the CCITR that is updated bi-weekly, and monitored by OMH staff that have weekly calls with each Housing Contractor.

The numbers of class members receiving in-reach at the 22 impacted adult homes had increased significantly during this period (See Fig. 2), while the percentage of class members expressing an interest had decreased from 60% to 46.8%.

The Independent Reviewer anticipated that the rate of positive response at in-reach would have increased as adult home residents had greater opportunities to learn about the successful transitions to supported housing of people they know, and as the recommendations made in our first report regarding the method of in-reach and care planning were implemented. While progress in each of these areas has been made, many factors have been in play that have resulted in more class members reporting as not interested, undecided/uncertain, or just not wanting to talk about it.

A. Reasons for lack of interest

In speaking with Housing Contractors and observing in-reach at several of the homes, many factors appear to be contributing to the lower response. Many of the residents who have been at the home for many years report being "comfortable" where they are, and fear the unknown of supported housing. Many recall what it was like when last they tried living independently, or in programs similar to supported housing, and had a bad experience. Some didn't want to leave without a boyfriend/girlfriend, and their partner was "definitely not interested," as discussed in Section VIII, 2 below.

During in-reach we have observed class members ask about the ability to live in supported housing with their romantic partner currently in the adult home who is not a class member, or others who want to live with a family member, or another who is not affiliated with the adult home or the Settlement Agreement at all. In these instances, the in-reach staff have not been able to clearly answer or address the questions about how such arrangements would work and the respective financial obligations of the parties.

It is possible that an expression of ambivalence or uncertainty is sometimes treated as disinterest or a refusal.

Some class members no doubt have been influenced by what they hear in the home from staff or other residents about the few class members that "didn't make it." These class members had reportedly returned to their or another adult home. Others have heard stories of some of their peers who have struggled when they first moved due to delays in setting up dependable arrangements to get them their money or SNAP benefits. The length of time that it has taken some to move out may have affected others who decide not to move. We continue to hear complaints that residents do not know where in the process their cases are. Some report that when they say they are undecided, or reluctant to sign the papers needed to begin the process, it sometimes takes months for someone to speak to them about it again. It is possible that an expression of ambivalence or uncertainty is sometimes treated as disinterest or a refusal. It is difficult to ascertain the extent to which each of these and many other factors impact a class member to express an interest, declare they are not interested at this time, or uncertain/undecided. Some class members have been unwilling to even discuss it when approached or called down to the front desk of the adult home, and that also has been captured as "not discussed during visit" on the weekly reports (See Fig. 4).

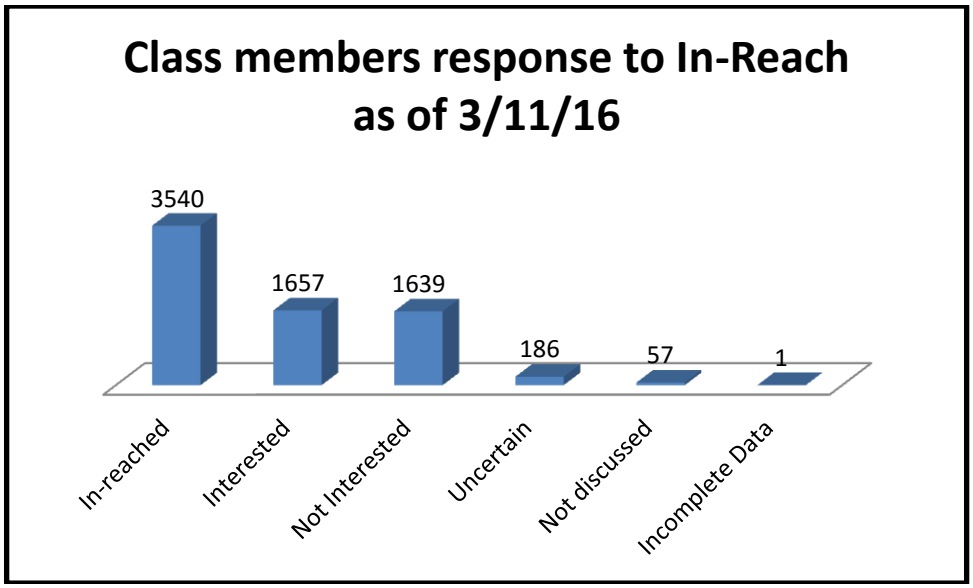


Figure 4. Class members' response to In-Reach as of 1/1/2016

Below are some excerpts from in-reach sessions observed by the Independent Reviewer's Team, where some of the reasons for refusing or being uncertain are offered.

- *PB, 61 year-old male has been at adult home for 6 years. PB had never lived on his own and came here "from living with my mother." The in-reach provided a very comprehensive explanation of the Settlement Agreement and the wrap around support services that would be available to him. PB very thoughtfully explained that he had not been comfortable here the first few years and it had something to do with the medications he was taking. But now he "had reached a level of comfort here," and that "I get along well with my roommate." He said he had a small refrigerator in his room. PB is a vegetarian who reportedly gets $200 a month in food stamps because of his medical needs around diet/food. He said he had lost 50 pounds and now weighed a little under 200 lbs. He said he has "never been responsible for myself before" and had concerns about cooking his meals. He said "I have everything I could ever want and have the full support of everyone here." He also said, "I can't deal with getting shaken up again" and was afraid of "getting right back to ground zero."*

- *CH is a 69 year-old African American woman who had lived at the adult home in Staten Island since Hurricane Sandy forced her to leave her adult home in Far Rockaway, after 11 years. The in-reach session included a trip to a nearby model apartment, a group presentation including the showing of Coco's video of a successful transition, and then individual meeting. She said she had lived on her own, but got sick and was hospitalized. She talked of growing up in the Bronx and when asked where she wanted to live she said*

she wanted to live in a three-room apartment in the Bronx, where she had some cousins, but thought family and friends would visit. Although she would consider SI, she preferred the Bronx. In terms of her goals she wanted "to be doing better" when she moves, and mentioned taking her meds and shopping. She hoped she would move to a nice area "where I would say good morning to the people." The in-reach worker spoke of the Care Coordination team that would link her to Transportation and other services. When asked if she was interested, CH said she "needed time to think about it." Follow-up with the in-reach worker found that C.H. said she was not interested in moving at this time, as she was adamant she wanted a three-bedroom apartment to move in with her children. He reported that he informed her of the apartment guidelines and later she stated she was only interested in a large house with her children.

- *BR, 58 year-old male, has been at the adult home since 1999, more than 15 years. The in-reach was comprehensive and he was shown a video on a tablet of an unfurnished apartment and the nearby neighborhood. BR said he was not interested in moving right now. He is interested in his girl friend moving with him, and she was not interested in moving now either. He said he liked it at the home and didn't want to leave now. No matter what the in-reach worker said, BR repeated he did not want to move, so the presentation did not last very long. He was reminded that he could change his mind and they may speak to him again in the future.*

- *BB is a 76 year-old male who had been the adult home for "20-30 years." During the presentation he reported that he lived on his own "15 years ago" and "didn't like it." During the presentation he asked, "Can I stay here?" Although in-reach worker tried to continue talking about SH, BB said it was "too much" and ended the discussion.*

B. Discouragement

The Settlement Agreement (¶ E. 4) notes "The State shall advise NYC Impacted Adult Homes that they may not interfere with the reasonable access of housing contractors to the NYC impacted adult homes and may not discourage NYC Adult Home residents from meeting with Housing Contractors." Nevertheless, Housing Contractors talk of the subtle and not so subtle influences that they feel the adult home Administrators and staff have on the process. For many of those to be in-reached it is reportedly harder to get them to come to the session. In one adult home at which the Independent Reviewer's Staff was present, the in-reach staff were only allowed to see class members that were on the list they provided in advance and could not speak with class members outside in front of the home or anywhere else in the home. (This was reported to the State by the Independent Reviewer's staff, and the practice has reportedly since stopped).

In speaking with the in-reach teams many mentioned that the adult homes "had their good days and their bad days." At one recent in-reach session where the in-reach staff were there before

10 a.m., the staff at the front desk did not call anyone down until 11:10 a.m., leaving them time to only meet with one person. Many Housing Contractors are now sending letters and trying to arrange for dates and times to meet, while another is offering vouchers for a free lunch; getting the mail to the residents does seem to be a problem for some, when there has been absolutely no response to a planned event.

Although Housing Contractors have been encouraged to meet with class members at programs, those efforts have often met with mixed results. While a few in-reach staff are allowed, most are not permitted to go to class member's rooms, and some have difficulties trying to call residents themselves from the front desk, rather than having the adult home staff do so, or resorting to calling on their cell phones from outside of the facility. We were informed that the Administration at New Haven Manor had "closed the doors" to the in-reach team for several weeks, and they were only able to regain access after scheduling a meeting with the MLTCP that serves the home. In addition, during September 2015 New Haven Manor developed a form letter for residents to sign expressing a desire not to be placed on any list for community housing and professing their lack of readiness to leave the adult home. Seventy-four of the letters were submitted to the Housing Contractor. While some of these letters accurately reflected the feelings of the residents, in other cases the residents still wanted to move, some of them believing that the letter they signed simply expressed their opinion about their unwillingness to move immediately, not their lack of interest in the option of supported housing. The percentage of class members expressing an interest in moving from this home between July 31, 2015 and March 11, 2016 dropped significantly from 79% to 52%.

The conditions under which some of the Housing Contractors conduct in-reach are still less than desirable, and do not provide an adequate private space.

The conditions under which some of the Housing Contractors conduct in-reach are also still less than desirable. The State DOH's letter to Adult Home Administrators (DAL) of June 6, 2014 stressed the importance of providing the Housing Contractor with a "quiet, private, space, where either group or individual in-reach sessions can take place," and to "make every effort to avoid rooms where frequent interruptions may occur." Many of the Housing Contractors were provided with conference rooms, unused activity areas, and unused staff offices that clearly met the criteria noted in the DAL. Others were satisfied conducting in-reach in the adult home's dining room, with some staff present setting up for the next meal or cleaning up after the last one. However, the conditions under which some of

the Housing Contractor's conduct in-reach are still less than desirable, and do not provide an adequate private space, described above.

At one adult home the in-reach team uses the laundry room, which they chose as preferable to the previous extremely small space that that they were provided, which reportedly contained a camera and the ability to hear what was being said in the room. While we were told that efforts are made by that home to not have laundry done during the in-reach sessions, it is not consistently adhered to, as the Independent Reviewer's staff observed during a recent visit. At another home where we have observed in-reach, the room is a narrow small space that includes three tables, computers and filing cabinets; again this was better than the even smaller space they were given, that reportedly resulted in a call to the State.

In looking at the statistics by adult home and Housing Contractor it is not easy to point to one reason or factor. Is it the quality and nature of the in-reach being offered, or everything else that occurs in and out of the adult home that may impact a class member?

Instances of discouragement by family/guardians, as well as by therapists, are also commonly reported by Housing Contractors. Some family members believe that their loved one would be "safer" in the adult home and find support from their relative's therapist, who may also question the individual's readiness for independent living. (*See* section VIII, (B) (5)), Influence of family members and therapists)

- *MB changed her mind and refused assessment because her daughter felt that she was new to the adult home and this was not the best time for her to move to the community, regardless of the wraparound services that may be available.*

- *SE was very interested in moving to the community. However, after his mental health program informed his brother of his intent to move, he influenced SE to withdraw his consent, and SE refused assessment.*

However, discouragement, subtle or otherwise, undoubtedly plays a role. Some of these instances have been reported to the Justice Center and have been followed up by DOH.

Housing Contractors vary substantially in how they carry out their in-reach functions, and the data indicate that they have varying rates of reaching the class members in the adult homes to which they are assigned, and in the percentage of class members who respond positively to their efforts.

- *SL who moved to supported housing in March 2015 said that the staff at her adult home told her they "felt sorry that you are moving, you'll probably be homeless in two days, but you can always come back here.*"

- *EK, who was one of the 28 class members visited and discussed in Section II, above, changed his mind about moving from Mermaid Manor at one point. According to Care Coordination progress notes, he told her that his adult home administrator scared him about going out on his own telling him "no one will care about him and no one will take care of him."*

In the State's Quarterly Report #7, five of the six allegations of discouragement, received between 9/17/15 and 11/18/15, investigated and completed by the Department of Health- Division of Surveillance were substantiated. Four of these were at Mermaid Manor.

C. Performance by Housing Contractors

While, as discussed below, there are many factors that help explain these results, the high rate of turnover in the Housing Contractor staff assigned to this function, and other duties that are assigned to them, probably have a significant effect.

Because of staffing issues, in-reach and housing functions were not always kept separately, as intended in the original RFP of August 10, 2012 for this initiative which has been noted and reiterated at OMH Housing Contractor meetings. It is unclear to what extent the staffing levels, or need to share staff between in-reach and housing, impact the bottom line of the quantity and quality of in-reach and the number of community placements. As of 3/11/16, St. Joseph's Medical Center has vacancies in supported housing staffing of 4 FTE; FOO, 3 FTE; CommuniLife, 2.25 FTE; and SI-BN, 2 FTE, while the other five Housing Contractors have between .5-1.5 FTE vacancies. The backlog of class members who have received HRA approval of their applications for community living but who remain in the adult home for a substantial period of time suggests that the lack of adequate housing staff to perform the myriad tasks associated with successful transitions probably contributes to this result. To the extent that Housing Contractors attempt to cope with vacancies and inadequate staff

by relying upon the same staff to perform in-reach and housing tasks, both functions probably suffer while also contributing to the stress and burnout that leads to staff turnover.

In-reach numbers reflect the number of unique individuals who had an in-reach session, not the number of in-reach sessions conducted. An individual may have had multiple in-reach visits, but the Weekly Report only reflects one: the most recent session. In looking at Fig. 5 below, one is struck that ICL lags significantly behind other Housing Contractors that started in-reach during Phase II (July 1, 2014) in terms of percentage of class members that have received in-reach. Surprisingly, Pibly and SIBN, in Phase III, which started nine months after Phase II, have already in-reached 87% of their class members as of March 11, 2016 compared to ICL's 77%.

HC	Class	IR'd	%IR'd	Yes	%Yes
Phase I (4/1/14)					
JBFCS	525	550	100+%[14]	250	45%
Phase II (7/1/14)					
CommuniLife	602	530	88%	230	43%
JBFCS 2 (FEGS)	395	376	95%	161	43%
FOO	528	522	99%	220	42%
ICL	489	377	77%	241	64%
TSI	438	402	92%	156	39%
Phase III (4/27/15)					
Pibly	371	323	87%	177	55%
SIBN (6/16/15)	308	269	87%	127	47%
St. Josephs'	305	191	63%	95	50%

Figure 5. Variable Performance of Housing Contractors

Also of note, the four housing contractors with the highest percentage of class members in-reached, JB1 (100+%), FOO (99%), JB2 (95%) and TSI (92%) had some of the lower rates of people saying Yes, 45%, 42% 43% and 39%, respectively.

[14] The number of people in-reached is greater than the number of class members due to the fact that some of class members initially in-reached subsequently died or were non-transitional discharges.

Adult Home	Housing Contractor	In-Reached as of 3/11/16	Said Yes	Current %	Transitions
Belle Harbor	CommuniLife	104	63	61%	3
New Gloria Manor	CommuniLife	114	46	40%	2
Park Inn Home	CommuniLife	162	67	41%	8
Surfside Manor	CommuniLife	150	54	35%	6
Central Assisted	FOO	169	53	31%	0
New Haven Manor	FOO	122	63	52%	11
Seaview Manor	FOO	115	50	43%	4
Wavecrest HFA	FOO	116	54	47%	7
Brooklyn ACC	ICL	174	105	60%	26
Queens ACC	ICL	203	136	67%	22
Mermaid Manor	JB 1	176	70	40%	15
Oceanview Manor	JB 1	169	84	50%	14
Surf Manor	JB 1	205	96	47%	25
Garden of Eden	JB II	183	66	36%	10
Kings ACC	JB II	193	95	49%	17
Parkview HFA	Pibly	123	46	37%	2
Riverdale Manor HFA	Pibly	200	131	66%	16
Lakeside	SI-BN	176	77	44%	8
Mariner's	SI-BN	93	50	54%	3
Harbor Terrace	St. Joseph's MC	191	95	50%	24
Elm York	TSI	212	75	35%	14
Sanford Home	TSI	190	81	43%	8
TOTALS		**3540**	**1657**	**46.8%**	**245**

Table 2. In-Reach & Transitions by Housing Contractor as of 3/11/16

To date, 46.8% of the class members in-reached have said Yes. In looking at the adult homes where 40% or less of people said yes at in-reach, they were: New Gloria Manor and

Surfside, two of four of CommuniLife's adult homes; Garden of Eden, one of two homes handled by JBII; Central Assisted Living, one of the four homes handled by FOO; Mermaid Manor, one of the three homes handled by JB1; and Parkview, one of two homes covered by Pibly. Is it the Housing Contractor's approach/ in-reach style? Or does the adult home influence the low rate of people saying they are not interested?

Looking at FOO, while 31% said Yes at Central and 44% said Yes at Seaview, 52% said Yes at New Haven (down from 79% as of 7/31/15) and 47% said Yes at Wavecrest (down from 66% as of 7/31/15), yet it is the same FOO team doing in-reach at all four homes. The recent drop in those saying Yes at New Haven may be the result of aggressive efforts by the adult home to have residents sign a form letter saying they were not interested in moving, as discussed above.

Ironically, despite questionable conditions for in-reach staff at Queens ACC, their percentage of class member's saying Yes, at 67%, is among the best of the Housing Contractors. However, later in the process, Queens ACC had the second highest percent of the 164 withdrawn housing referrals following HRA approval at 15.8%, trailing only Surf Manor at 16.4%.

Mermaid Manor, at 39% of class members expressing interest, may accurately reflect problems of interference and discouragement by the Administrator. As noted in the State's Quarterly Report #7, discussed above, four of the five allegations of discouragement which were received between 9/17/15 and 11/18/15 and which were investigated and substantiated by the Department of Health, Division of Surveillance, were made at Mermaid Manor.

D. Robust In-reach

The Independent Reviewer's staff visited with the St. Joseph's Medical Center in-reach team during August 2015 about three months after they began providing in-reach at the only adult home on Staten Island they serve. The St. Joseph's team was incorporating many of the components mentioned in the Settlement Agreement and recommended previously by the Independent Reviewer, but not consistently practiced by most Housing Contractors at that time.

The in-reach began with a short trip in a van with the in-reach worker and a peer, and five class members, two of whom had previously received in-reach but had not seen the apartment. The model apartment was a two-bedroom unit on the ground floor of a two-storey building that was less than five minutes away from the adult home. Although the apartment was not furnished at the time, it allowed the class members to see what they might be able to have if they decided to move. There

was a nice sized living room with a non-working fireplace with exposed brick, a kitchen, dining area and two bedrooms, as well as a full bathroom, and a large walk-in hall closet. When in the apartment, the St. Joseph's peer, in a very animated and open manner, explained that she lives in one of their supported apartments on Staten Island and explained everything that comes with the apartment when you move in, including a flat screen TV that caught the attention of the five residents. Two of the men stated their intention to live together during the session. Most seemed to like the apartment and were interested in moving, and several wanted *this* apartment.

After about 20-30 minutes the group returned to the adult home. At the adult home three of the group met again in the conference room where they listened to a brief presentation. The others had previously received in-reach and agreed to move forward in the process. The presentation included a viewing of a successful community transition from an adult home produced by CIAD (Coco's Story) on the in-reach worker's tablet, and then an overview of the Settlement Agreement and supported housing, and personal experiences of the peer. They each received a folder of materials including the adult home Pamphlet and the Nathan Kline Institute's Guide to Supported Housing, both also being used by all Housing Contractors. Two of the three expressed an interest in supported housing and one "needed more time to think about it," as described above. Subsequently, two of the class members who visited and wanted the model apartment that day have subsequently moved into it. St. Joseph's developed a new fully-furnished model apartment, also in close proximity to the home.

Currently, the in-reach team conducts in-reach at the model apartment, while, in addition, the peer meets at the adult home with those class members who have said "No" or are uncertain/undecided. In addition, another peer conducts groups every Friday at the model apartment for those preparing to move, to discuss budgeting, meal preparation and other aspects of the transition. St. Joseph's has also hired several of those class members who have transitioned to work as peers in other of their programs, which was also presented as possible motivation during in-reach.

In response to guidance by OMH, "robust in-reach" as described above is reinforced in their regular meetings and conversations with the Housing Contractors. It was also discussed and encouraged during the most recent OMH Training for Housing Contractors on January 6, 2016. The various contractors shared what they were doing, as they did subsequently in speaking with the Independent Reviewer's Office. There is increased evidence that Housing Contractors are exploring varied ways to enhance their in-reach efforts, particularly as they approach those that have been undecided or had said no in the past. There is more evidence that contractors are showing videos of the model apartments or those actually in use, with permission; holding special

events to gather class members to meet with those who have already transitioned; developing picture books of the supported apartments; providing testimonials of class members who have moved out; extending invitations to those considering moving to parties and other events sponsored by the Housing Contractors; and visits to their model apartments, that some spoke of making more attractive and inviting.

However, for some Housing Contractors who do not have an agency car or van, transporting class members to the model apartment, including using taxis, is challenging and is not done as frequently. In addition, many do not have their model apartments in proximity to the adult homes. Pibly reported that they are in process of developing a model apartment close to Parkview HFA, which will permit more frequent use of the unit. Most housing contractors do not show their model apartments during in-reach, and wait for receipt of the housing referral. One Housing Contractor said they don't want to show it to someone during in reach, as they may later be approved for a more restrictive level of housing (Level II), which they felt would be misleading. However, the model apartments are being used in various ways to aid in the process. One contractor uses their model apartment for those that were already in-reached, to provide skill training groups and keep them engaged while they are going through the process, while several reported using, or planning to use, the model apartment to hold socials. Another Housing Contractor is scheduling trips to the model apartment with their peer, who also takes the class members on a tour of the neighborhood, where many of their apartments are. In addition, some are making efforts to use class members who have moved out to speak to those that are considering it or are getting ready to move, which has been proving to be very effective.

Pibly is taking advantage of offers by CIAD, which already conducts housing readiness groups at five transitional adult homes, to offer training on budgeting and money management at their two Bronx adult homes.

As will be discussed later in this report, according to Week 104 data, 181 (10.9%) of the 1,657 class members who expressed an interest in moving at in-reach changed their minds during the assessment phase, and additional individuals changed their minds afterwards.

V. Assessment

The Settlement Agreement sets forth a schedule that within four years of its execution (July 23, 2013), at least 2,500 class members shall be assessed by Health Homes or MLTCPs and, if appropriate under a person-centered care plan developed pursuant to ¶ G, transitioned from NYC Impacted Adult Homes. Within five years of the execution, *all* class members shall be assessed by Health Homes or MLTCPs pursuant to ¶ F and, if appropriate under a person-centered care plan, transitioned from NYC Impacted Adult Homes. (Settlement Agreement, ¶ I)

The current practice is that each class member who expresses an interest in supported housing must undergo a comprehensive assessment conducted by a registered nurse from a Health Home or MLTCP to determine the person's housing and service needs and preferences for the purpose of transitioning from an adult home. (Settlement Agreement, ¶ F (1) (2)) There is a presumption in the Settlement Agreement that class members can live in, and will be considered appropriate for supported housing if desired by the resident, unless the assessment discloses a disqualifying condition. (*Id*. (4) (5)) If the assessment concludes that a class member is not appropriate for supported housing, it must specify the reason and the class member must be provided the opportunity to live in the most integrated setting desired that is appropriate to his or her needs. (*Id.* (7))

Initially, the assessment phase of the transition process was designed to consist of three components: a face-to-face assessment of the individual by a registered nurse who completes the mandated report: UAS-NY; securing and reviewing a comprehensive psychiatric evaluation conducted by the individual's psychiatrist within the past six months; and formulating recommendations for housing and community services, based on the UAS-NY assessment and the current comprehensive psychiatric evaluation, which are recorded on an Adult Home Resident Assessment Report (AHRAR). The State initially planned on conducting a quality assurance review of 10% of the assessments for six months, but due to the issues the DOH encountered in the course of their review of the Adult Home Resident Assessment Reports (AHRAR) which summarize the results of the assessment conducted by a registered nurse, in August 2014, this plan was altered to review 100% of the AHRARs, and later, at the recommendation of the Independent Reviewer, extended to review additional supporting documentation underlying the AHRAR.

Upon DOH's approval, a final AHRAR is prepared by the assessing entity and distributed to DOH, the Housing Contractor, the care manager and other appropriate parties. The final AHRAR, UAS-NY and psychiatric evaluation are forwarded to the HRA along with an HRA application by the assessing entity, thus beginning the HRA review phase of the transition process.

A. Delays in the Assessment Process

As documented in the Independent Reviewer's First Annual Report (pp. 20-28,), many factors contributed to the delays in completion of the assessment process, as such is indicated by the distribution of a final AHRAR. These included difficulties in assembling all the documents necessary to formulate housing and service recommendations, particularly a current comprehensive psychiatric evaluation by the treating psychiatrist. In many cases, the psychiatrist was a private practitioner working under contract with the Adult Home and not affiliated with OMH certified/regulated programs; evaluations that were completed were found to be incomplete requiring supplementation or revision; and incomplete UAS-NY or AHRAR reports submitted by assessors required repeated re-submissions. Some class members who had initially expressed interest in transitioning at the time of in-reach were ambivalent about such at the time of assessment and declined either assessment or interest in moving at the time of assessment.

Delays in completing the assessment phase of transition continued through the first half of 2015 creating a sizeable backlog.

Delays in completing the assessment phase of transition continued through the first half of 2015 creating a sizeable backlog. This was of concern to Plaintiffs' counsel and the Independent Reviewer who had previously recommended strategies to address the issue including creating a pool of trained assessors, establishing reduced and manageable caseloads for care managers and setting performance expectations.

As of July 1, 2015, 986 individuals had expressed interest in moving during in-reach, yet 449 of the individuals (46%) had not completed the assessment process with a Finalized AHRAR.[15] While the median length of time from when an individual expresses an interest in transitioning to when the case is referred to an HH/MLTCP for assessment has consistently remained at one day, as indicated, below many of these 449 individuals (32.7%) had not completed the assessment process six month or more after in-reach, some more than one year.

[15] It should be noted that in this and other analyses of the backlog issue, cases in which individuals who initially expressed an interest in moving but subsequently died or were discharged outside the SA process were not included.

Cases Backlogged in Assessment Process as of 7/1/2015

Number of Cases Referred for Assessment	986
Number of Referrals without a Finalized AHRAR as of 7/1/2015	449
Percentage of Referrals without a Finalized AHRAR	45.5%
Range of Days from In-reach to 7/1/15	0 - 470
Median Number of Days from In-reach to 7/1/15	79

Number of Days	Number of Cases	Percent of Total Cases
From in-reach to 7/1/2015		
0 – 60	**174**	**38.8%**
61 – 120	**96**	**21.4%**
121 – 180	**32**	**7.1%**
181 – 240	**17**	**3.8%**
241 – 300	**15**	**3.3%**
301 – 360	**96**	**21.4%**
More than 360	**19**	**4.2%**

Table 3. Referrals without a Final AHRAR as of 7/1/2015 (N=449)

In the Summer of 2015, the State announced initiatives designed to address the assessment issue, as well as the rate and pace of transitions overall.

- With the agreement of the HRA, a psychosocial history assessment (psychosocial) could be completed and submitted in lieu of a comprehensive psychiatric evaluation as a component of the assessment package submitted to HRA. Whereas a comprehensive psychiatric evaluation must be completed by the treating psychiatrist or a psychiatric nurse under the psychiatrist's supervision, a psychosocial can be completed by a broader array of licensed clinicians including social workers and psychologists. The State also developed a format for the completion of psychosocials. The target for completion of the psychosocial was set at 30 days. (Defendants' Report to the Court, July1, 2015, p. 3, fn. 2, Doc. #46-1)

- The State established a new Health Home reimbursement rate to allow funding for additional staff to complete assessments (UAS-NY and psychosocials) as well as for reducing the caseloads of care managers to no more than 1:12. Care managers would be the single point of contact for each class member and would be responsible for coordinating the completion of the psychosocial. This initiative, referred to as Adult Home Plus, also set forth educational and experience criteria for care managers. It was expected to roll out and be ramped up beginning in July with training in psychosocial completions and on other topics, which would continue as more care managers were recruited and hired by Health Homes to incrementally reach the goal of 1:12 caseloads. It was anticipated to be fully implemented by February 29, 2016 *(Id.*, p. 7), although at a status conference Judge Garaufis urged the State to make its best efforts to implement this change by the end of 2015.

- The State would hire supplemental staff (nurses, LCSWs, Psychiatric Nurse Practitioners) through an existing State temporary services contract to assist in addressing the backlog with the expectation that 22 staff being recruited would be in place by August 15, 2015.

In a July 1, 2015 report to the Court, the State indicated that it anticipated these actions would address the entire backlog by September 30, 2015. (*Id*. p. 5) However, the State experienced difficulty hiring the staff as planned. The Independent Reviewer was informed in early December that Nurse Practitioners and LCSWs did not apply for the positions and only two RNs had been hired, with two more pending.

Week 104 data, cumulative through 3/11/16, indicate that these efforts have had some positive impact. In the period 7/1/15 through 3/11/16, 626 AHRARs were finalized, an increase of 79% over the 349 AHRARs finalized in the preceding eight-and-a-half months (10/15/14-6/30/15). And the proportion of class members who have expressed an interest in transitioning but have not completed the assessment phase has declined slightly from 45.5% on 7/1/15 to 44.5% on 3/11/16, although the absolute number has increased from 449 to 683 individuals awaiting completion of the assessment phase as indicated in the Table below.

Cases Backlogged in Assessment Process as of 3/11/16

Number of Cases Referred for Assessment	1535
Number of Referrals without a Finalized AHRAR as of 3/11/16	683
Percentage of Referrals without a Finalized AHRAR	44.5%
Range of Days from In-reach to 3/11/16	0-695
Median Number of Days from In-reach to 3/11/16	87

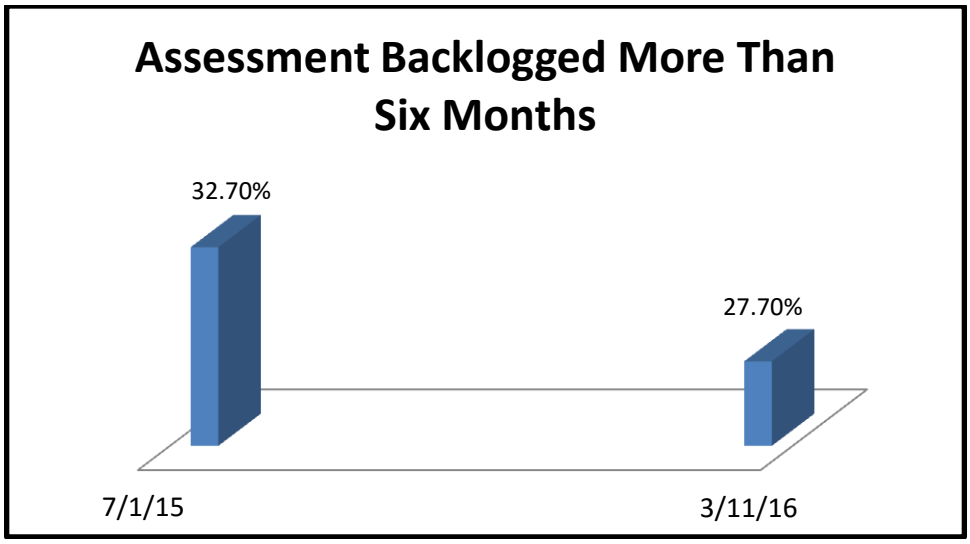


Figure. 6. Change in Percentage of Assessments Backlogged More than Six Months

Although the percentage of people in the backlog waiting more than six months has decreased from 32.7% on 7/1/15 to 27.7% on 3/11/16 (Fig. 6), the median length of time in this "limbo" of awaiting completion of the assessment phase has grown slightly from 79 days in mid-2015 to 87 days on 3/11/16. The State anticipated addressing the backlog by September 30, 2015, but the data show it was not eliminated. On March 11, 2016, 16.2% of the 683 people awaiting completion of the assessment process had been waiting at least eight months and seven percent for nearly a year or more.

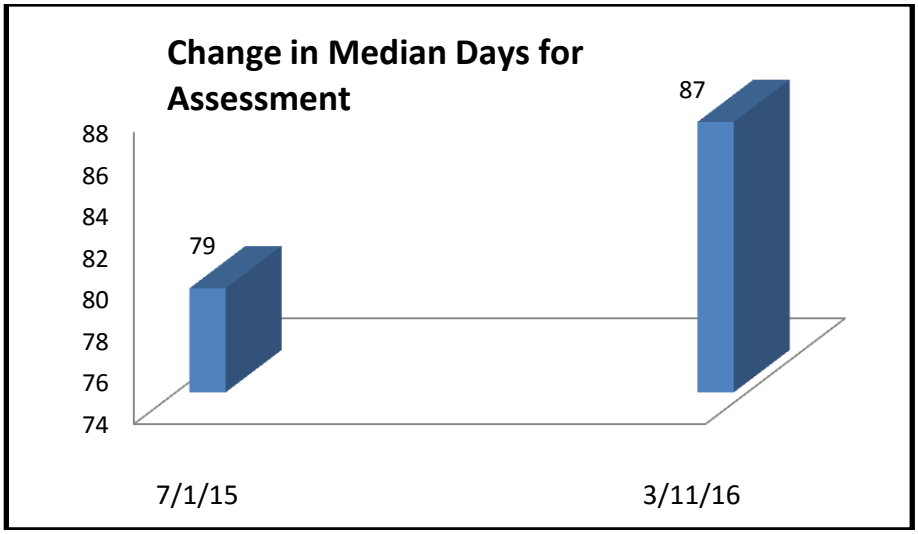


Figure. 7. Change in Median Number of Days for Class Members Awaiting Assessment

In the months prior to 3/11/16, the full effect of Adult Home Plus and other reforms,

announced in the Summer of 2015, had not yet come to fruition as staff were still being recruited, trained and deployed. But the data suggests some progress. The number of assessments completed (626) in the eight-and-a-half months since 7/1/15 had nearly doubled compared to the preceding eight-and-a-half months. However, the backlog of class members awaiting completion of assessments has grown by 52%, from 449 to 683.

This appears to be due to the fact that assessment completion is still not keeping pace with the number of people saying Yes to transition and being referred for assessment. While the number of assessments completed in recent months has increased significantly, so has the number of people being referred for assessment, and the backlog grows.

In the eight-and-a-half month period prior to 7/1/15, 391 class members were referred for assessment, but only 349 completed the assessment phase. Although in the eight-and-a-half month period following 7/1/15, 626 class members completed the assessment phase, 837 were referred for assessment.

Number of Days	Number of Cases	Percent of Total Cases
From referral to 3/11/16		
0 – 60	**273**	**40.0%**
61 – 120	**124**	**18.2%**
121 – 180	**99**	**14.5%**
181 – 240	**76**	**11.1%**
241 – 300	**30**	**4.4%**
301 – 360	**33**	**4.8%**
361-- 460	**11**	**2.0%**
461—560	**8**	**1.2%**
561—660	**29**	**4.2%**

Table 4. Referrals without a Final AHRAR as of 3/11/2016 (N=683)

More needs to be done to address the assessment phase of transition.

The lengthy time it takes for individuals to complete the assessments and learn of what housing and service options are available to them after they have expressed an interest in transitioning undoubtedly contributes to their frustration with the process, and ambivalence and uncertainty about moving further.

B. Declinations of Assessment or Transition

As of March 11, 2016, 181 (10.9%) of the 1,657 class members who expressed interest in transitioning during their most recent in-reach session declined assessment or the opportunity to transition during the assessment phase of the transition process.

As reported in the Independent Reviewer's First Annual Report, follow up on individuals who had changed their minds at this juncture revealed a variety of reasons. (First Annual Report, pp. 27-31) In some cases, there appeared to be a misunderstanding between the individual and assessor, due to language or other difficulties; in other cases, it appeared that an assessor's comments may have swayed the individual's choice at that time; and in other cases, there seemed to be well founded reasons on the individual's part – a desire to reunite with a spouse at home or the need to attend for the time being to a serious medical issue that had recently emerged.

In cases where individuals change their mind about transitioning during the assessment phase, the Housing Contractor is informed and the individual is rescheduled for additional in-reach activities. Over the past year, Independent Reviewer staff have observed that additional in-reach is done with these individuals and some re-express interest in moving. This underscores both the weighty nature of major life decisions, such as moving, and the need for continual in-reach and support when people are ambivalent or unsure.

C. Inappropriate for Supported Housing

As of March 11, 2016, 61 (5.6%) of the 1,094 individuals who had completed the assessment process were found inappropriate for supported housing. The reasons cited in the weekly data reports were as follows:

- In 50 cases, it was the assessor's opinion that the resident would be a danger to self or others in supported housing even if receiving services currently provided under the New York State Medicaid Program;

- In nine cases, it was the assessor's opinion that the individual needs a type and/or frequency and duration of service on an ongoing and sustained basis in order to live in supported housing that is not available under the New York State Medicaid Program; and

- In two cases, the assessor opined the individual had significant dementia.

Most of the individuals found inappropriate for supported housing - 47 of the 61 individuals (77%) – were recommended for OMH certified housing: Apartment Treatment (one case), Congregate Treatment (23 cases), Community Residence-Single Room Occupancy (22 cases), and Family Care (one case). It should be noted that in an additional case, the assessor found that the individual *was* appropriate for supported housing but recommended a Community Residence-Single Room Occupancy placement; the weekly reports indicate this class member desired Level II housing.

In the remaining 14 cases found inappropriate for supported housing, Senior Housing was recommended in one case and one case was recommended for "OASIS" (sic), presumably a program overseen by the State Office of Alcohol and Substance Abuse Services (OASAS). In the remaining 12 cases, an adult home placement was recommended. It is difficult to reconcile this last recommendation in light of the reasons given. In two of the cases, the reason was "significant dementia." But in 10 of the cases, the reason was that "the resident would be a danger to self or others in supported housing even if receiving services currently provided under the New York State Medicaid Program." Considering the individual's desire to transition from an adult home and the types of certified and supported housing options and services available, one must question the basis for this recommendation and the assessors' knowledge of housing options.

Of the 48 recommendations for OMH certified housing, HRA has approved 40 for Level II (i.e., certified) Housing only. In eight cases there has been no application or decision by HRA.

As detailed in the Independent Reviewer's last Annual Report, class members' referrals to OMH certified housing raises concerns. (Annual Report, pp. 32 - 33)

First, referrals to this type of housing are a bottle neck because there are not a lot of vacancies and a high demand for those that do exist.

When it is determined that class members require OMH housing other than supported housing, the care manager who submitted the HRA application would first send the completed referral package to the class member's Housing Contractor if that agency has a Level II housing

program. If not, the care manager is to first send the referral to other Housing Contractors in this initiative who have Level II housing, keeping in mind the class member's preference for borough etc. If there are no beds available at those programs, or if the class member is requesting another borough, the OMH New York City field office provides assistance in identifying available Level II housing, as was the case for several class members who required a higher level of supervision than was being provided in supported housing. When no vacant Level II beds are available within this initiative, class members are referred by their care managers to the Center for Urban Community Services ("CUCS"), which is an OMH-funded referral program for various housing programs and provides administrative support for the NYC Single Point of Access housing program.[16] CUCS receives referrals from various sources which are searching for housing, including the NY/NY program, the nursing home settlement, prison discharges, Assisted Outpatient Treatment, psychiatric center discharges, etc., including this Settlement Agreement. While the adult home referrals are supposed to get priority, so too do all the other referrals.

Unlike supported housing which is permanent and for which there is a specific commitment for bed development under this Settlement Agreement, most of the alternate housing is transitional (e.g., CR-SRO has an anticipated length of stay of two to five years, while Apartment Treatment is generally 18 months), and there is no specific requirement to develop additional beds to meet class members' needs. The anticipated difficulty of transitioning adult home residents after a temporary stay may also play a role in the providers being reluctant to serve them. Such placements also raise the question of what will happen to these class members when their transitional period expires and they are still in need of housing. This is an issue that requires the attention of the parties, and is related to a similar issue that arises when there are non-transitional discharges of class members from adult homes to non-permanent placements (e.g., admissions to nursing rehabilitation, medical or psychiatric hospitalization).

Class members placed in Level II housing also receive a smaller PNA of $163/mo. compared to $193/mo. in an adult home which is funded at the higher Congregate Care Level III. For persons living on small and fixed incomes, this is a significant reduction in available spending money for personal necessities.

[16] In its response to a draft of this report, the State offered some clarifying information about this process. According to the response, the care manager does not always submit the HRA application. Rather the care manager is responsible for ensuring the application is submitted. The care manager does not send the referral to other housing contractors in this initiative unless directed to do so by CUCS or the OMH New York City Field Office, or the class member desires a different borough.

The Independent Reviewer is concerned about the class members who are referred to CUCS to find housing because there seems little likelihood that they will get housing anytime soon, as there is no dedicated allocation of beds other than for supported housing. The Independent Reviewer has recommended that notice be provided to class counsel prior to referring any class members for alternate housing. This recommendation recognizes that in the early phases of implementation there have been several such referrals for alternate housing that were poorly supported by the assessor, and later changed to supported housing.

D. MLTCP Enrollments and Disenrollments

Another factor impacting the assessment phase of transition, as well as care planning phase, is an individual's disenrollment from his or her MLTCP. Individuals can disenroll voluntarily – e.g., they opt to join another organization/plan; or involuntarily – e.g., they no longer meet enrollment criteria. In late 2014, for example, approximately 90 class members were disenrolled from the CenterLight MLTCP, most involuntarily because they did not meet the enrollment criteria of need for 120 days of long-term care services.

Disenrollment, whether voluntary or involuntary, can result in delays in assessment. For example, if an individual is disenrolled after in-reach but before the HH/MLTCP begins the assessment process, the in-reach form and referral must be sent to a new care management entity, once identified. If the individual is disenrolled in the midst of the assessment process before the assessor has gathered all the information (e.g., comprehensive psychiatric evaluation or psychosocial history) necessary to reach conclusions and make recommendations in the AHRAR, the assessment process (including the completion of a UAS-NY assessment, even if one had been completed) must be re-initiated by the new assessment entity because the assessor's recommendations must be based on their own in-person assessment and review of documentation.

It is expected that when an individual is disenrolled, the MLTCP will refer the individual to the Health Home that he has been matched with through DOH's loyalty match process. The MLTCP must also inform the Health Home where the individual stands in the assessment process and share any applicable documentation. Also, the MLTCP must notify the Housing Contractor of the change and the contact information of the Health Home. Sharing of information by the MLTCP is complicated when there is not an Administrative Services Agreement between the MLTCP and the Health Home, as was reportedly the case with CenterLight and some of the Health Homes involved in this initiative. (*See*, Section III (D) above) In addition, the consents signed by the individual do not routinely include the DOH or OMH. So in instances of disenrollment, while DOH

may have all of the prior documents, including psychiatric evaluations that took months to acquire, they cannot share them with the new Health Home, which may have difficulty obtaining them from the MLTCP. Moreover, the delays caused by disenrollment may also render a prior psychiatric evaluation too dated to be used even if obtained.

On November 3, 2014, DOH directed all MLTCPs to report the disenrollment of any class members to DOH to allow the State to immediately intervene and facilitate the smooth transition to another care plan and reduce the negative impact resulting from a gap in care management services.

In preparing this Annual Report, the Independent Reviewer requested data on disenrollments from MLTCPs during the last six months of 2015. According to data provided by DOH in January 2016, twelve MLTCPs serve class members. Eight of these serve fewer than five members each, with most serving only one Class Member. Four MLTCPs, however, serve the majority of class members enrolled in MLTCPs with:

- Alpha Care serving 260;
- CenterLight serving 124;
- Elderserve serving 1044; and
- VNS serving 24.

During the last six months of 2015, there were no disenrollments from VNS. But 90 class members were disenrolled from the other three MLTCPs: 15 were disenrolled due to death; five were involuntarily disenrolled; and 70 disenrolled on a voluntary basis; as indicated below.

Disenrollments from Three MLTCPs by Type

MLTCP	Total	Death	Involuntary	Voluntary
Alpha Care	7	3	1	3
CenterLight	11	-	-	11
Elderserve	72	12	4	56

Of the five involuntary disenrollments, one person was or is incarcerated; two were enrolled in Health Homes prior to their disenrollment from the MLTCP; one was hospitalized and reenrolled in the MLTCP following the hospitalization; and one was hospitalized and placed on fee-for-service status following discharge from the hospital.

Of the 70 voluntary disenrollments, 42 (60%) were enrolled in Health Homes prior to or following disenrollment from the MLTCP as follows:

- 25 were enrolled in a HH prior to MLTCP disenrollment;
- 4 were enrolled in a HH the day after MLTCP disenrollment;
- 2 were enrolled in a HH a month after MLTCP disenrollment;
- 4 were enrolled in a HH two months after MLTCP disenrollment;
- 6 were enrolled in a HH three-six months after MLTCP disenrollment; and
- 1 was enrolled in a HH after MLTCP disenrollment, but date of enrollment was not provided.

The remaining 28 (40%) of the 70 individuals who voluntarily disenrolled from MLTCPs in the last six months of 2015 were not enrolled in Health Homes. Their status as of January 2016 is as follows:

- 8 were enrolled in other MLTCPs within one day (four cases) or one (three cases) to three (one case) months;
- 2 were enrolled in Managed Care Plans;
- 6 resided in Assisted Living Program ("ALP") beds in the adult Home;
- 10 were placed on a fee-for-service status; and
- 2 were residing in nursing homes.

Although more than half the class members disenrolled from an MLTCP in the last six months of 2015 were either enrolled in a Health Home prior to disenrollment or enrolled in a Health Home or MLTCP within a month following disenrollment, others took longer and one-quarter were not enrolled. But eventually, all class members disenrolled from MLTCPs had their health care covered through a new Health Home, MLTCP, managed care, fee-for-service, or placement in an ALP bed. Nevertheless, as discussed in the case examples in Section III, class members would benefit from a smooth and timely transition to new health coverage when they are disenrolled from a MLTCP.

VI. HRA Process and Activities

Once a complete assessment package has been approved by the DOH, the assessing entity submits an application package to HRA for approval. Prior to the Settlement Agreement, HRA

handled roughly 22,500 applications for housing arising out of mental health sectors and the NY/NY agreement. Major referral sources are psychiatric hospitals, shelters and correctional facilities. Many applicants are repeat HRA customers and their prior applications/histories are retained by HRA and reviewed as part of the process of reviewing a current application. According to HRA representatives with whom the Independent Reviewer met in 2014, applications are reviewed and generally turned around within 1-3 business days.

In anticipation of the Settlement Agreement, in mid-2013, HRA and DOH/OMH began discussions on the role of HRA in the Settlement Agreement process. Consistent with the State's work plan, HRA developed a streamlined application process, specifically to be used when applying for housing for the adult home residents included in the Settlement Agreement. HRA participated in DOH/OMH training sessions for partners in the Settlement Agreement initiative and training was initiated and is ongoing for those responsible for completing the HRA application.

An application package to HRA includes an abbreviated HRA application, the finalized AHRAR, the UAS-NY nursing assessment and a comprehensive psychiatric evaluation or, beginning in the summer of 2015, a psychosocial history assessment (psychosocial) in lieu of a comprehensive psychiatric evaluation. Applications are approved for Community Care (i.e., supported housing) and/or Level II Housing. Level II Housing refers to other types of OMH Housing, including Community Residence-Single Room Occupancy (CR/SRO); Congregate Treatment; Apartment Treatment; Family Care; or Senior Housing.

At times, the HRA classifies applications as "Unable to Complete" (UTC) due to insufficient or inconsistent information or other reasons and the applying entity is informed of this so it can rectify the situation. As of March 11, 2016, 682 applications had been submitted to HRA of which 634 (93%) were approved and 48 (7%) were classified as UTC.

The median length of time from submission to HRA approval was two days. It should be noted that in the initial stages of implementation, the median length of time for HRA approval was seven days. However, as noted earlier, in August 2014, DOH expanded its quality assurance reviews of AHRARs (and supporting documents) prior to HRA submission by assessing entities from 10% to 100%. Subsequently, there was a reduction in the number of days it takes HRA to complete a review of an application.

At the time of the Independent Reviewer's First Annual Report, the rate of UTCs was 10%. (Annual Report, p. 40) At present, with 48 UTCs, there appears to be a slight reduction with 7% of submissions falling into this category.

In January 2016, the HRA provided the Independent Reviewer information explaining the reasons for the 48 cases falling into the UTC category. Below is a summary of the information provided including the determination reason (and a definition of terms), the number of cases and the length of time cases have been in this category at the time the HRA provided the information.

Determination Reason	Applications	Average # of Days
Missing/Incomplete Supporting Docs.	17	92
Requested Additional Information	16	285
Assessment Discrepancy	9	199
Timeline of Assessments	2	75
Axis I unsubstantiated	2	301
Other	1	333
Outdated Documents	1	168
Grand Total	**48**	**191**

Determination Reasons Defined

Missing/Incomplete Supporting Documentation: Incomplete/missing sections of AHRAR, UAS and/or other clinical documents. Missing required forms such as AHRAR, Psychosocial and/or UAS.

Requested Additional Information: More information is needed in order to make a determination, such as fire setting/arson behavior, detailed description of violent behavior, or recent psychiatric hospitalization.

Assessment Discrepancy: The level of housing recommended in the clinical documentation (i.e. psychiatric evaluation, UAS, AHRAR or psychosocial) is inconsistent.

Timeline of Assessments: Date of completion for the AHRAR doesn't include the most recent significant clinical event to inform an appropriate recommendation for the level of supportive housing.

Axis I Unsubstantiated: More information needed to substantiate the psychiatric diagnosis in the clinical assessment.

Other: Application contained documentation for another client (non-HIPAA Compliant).

Outdated Documentation: Documentation exceeds required time frame.

It should be noted that in six of the above cases it appears that the current application for housing will not be pursued. In these cases, according to the State's weekly report, the individuals had either died or had been discharged from the adult home to live at home with family members or to an inpatient psychiatric or rehabilitation facility.

The Assistant Commissioner for HRA, who oversees the unit responsible for the review of these applications, provides regular training to staff from the Health Homes and MLTCPs on the proper completion of the application in order to reduce the need for repeated submissions. Since the Independent Reviewer's First Annual Report issued in March 2015, as of January 14, 2016, it has conducted 10 training sessions for more than 150 staff. Nevertheless, the data suggests the need for the State to redouble its quality assurance review efforts to limit the number of cases referred to HRA with missing, inconsistent, outdated or otherwise flawed application packages and to remedy cases that have lingered in the UTC category for unacceptable periods of time.

The underlying presumption of the Settlement Agreement is that any adult home resident with a Serious Mental Illness would be eligible for supported housing. The four exceptions were detailed in the Settlement Agreement (Para. F(5)), with the stipulation that if an assessor determined that a resident was inappropriate for supported housing the reasons would be clearly documented, and the resident would be given an opportunity, if interested, to seek other appropriate community placement. Of the 634 applications approved by HRA as of March 11, 2016, 577 (91%) were approved for supported housing and 57 (9%) for Level II, or other than supported housing.

As reported in the Independent Reviewer's First Annual Report, as of March 13, 2015, HRA had differed with the Assessor's opinion in 21% of the cases and approved Level II when supported housing had been recommended. (Annual Report, p. 42) Since then, the rate of disagreements has dropped.

In five of the 57 cases that HRA approved for level II, the Assessor had recommended Supported Apartment, but HRA approved the resident for Level II only. HRA maintained that information that it had received during the application process, often in the psychiatric evaluation or UAS, led to a determination that the resident would not be safe in supported housing, and the class member was approved for Level II only. The following examples of reasons provided by HRA for more recent determinations which countered the Assessor's recommendation are illustrative.

- Reason in the case of ED: *Client hospitalized/ER visits 12 times in last 2 years for medication/treatment noncompliance and violent behavior/command AH (auditory hallucinations).*

- Reason in the case of RD: *Psychiatric Evaluation (PE) and AHRAR recommends Level II.*

- Reason in the case of FC: *PE states client requires supervised setting.*

- Reason in the case of RR: *Psychosocial details ongoing daily drinking/intoxication and resulting disruptive/violent behavior with recommendation for further psychiatric evaluation; history of violence and suicide attempt.*

Cases wherein the HRA disagrees with the Assessor's recommendation for supported housing are reviewed in telephone conversations between the State and HRA representatives designed to reconcile the differences.

Additionally, in the Fall of 2015, the State initiated conference calls to discuss cases where the Assessor has recommended Level II housing before an application is submitted to the HRA. Referred to as "Level II Calls," these conference calls include the Housing Contractor and Assessors and Care Coordinators/Managers from the HH/MLTCP involved as well as representatives from DOH and OMH. They are designed to ensure that the rationale for a Level II recommendation is sound, that all parties – including the class member – are in agreement with the recommendation and whether any services, such as enrollment in a PROS or other program, can be put in place now, while the individual still resides in an adult home, which would enable him or her to transition to supported housing.

VII. Person-Centered Care Planning Process

The Settlement Agreement requires that for each class member assessed, the Health Home or MLTCP shall develop a person-centered care plan with the informed and active involvement of the class member, and include consideration of the current and unique psychosocial and medical needs and history of the individual as well as the functional level and support systems developed by the Health Home or MLTCP care manager. (Settlement Agreement, ¶ F (1) (2))

Each person-centered plan must identify the housing that is the most integrated setting appropriate for the individual and the Community Services needed to support the individual in such housing, based on the individual's needs and personal preferences. If supported housing is part of the person-centered plan, the care manager must make a referral to the appropriate Housing Contractor. (*Id*. F (3))

According to the DOH, care planning begins upon the class member's enrollment in a Health Home or MLTCP. Person-centered care plans are based on individual needs and desires, and focus on attainable goals. When a class member expresses a desire to move to the community, transition care planning should begin. Upon approval of the HRA application, the HH/MLTCP care manager should notify the Housing Contractor and send him/her a copy of the referral package and, with the class member and Housing Contractor, work toward developing a transition care plan that identifies and arranges for the supports needed by the class member to successfully move to supported housing. Care planning for transition involves numerous service providers who provide and/or coordinate the services/benefits that the class member needs, as identified in the assessment process as well as by the individual. Services to be coordinated can include SNAP benefits (Food Stamps), furnishing an apartment, setting up utilities, transportation, mental health programs, psychiatric and medical visits, aide and visiting nurse services, etc. Care planning is not a one-time event that is "completed," but is a continuous and fluid process.

Once a supported apartment is secured, the care manager with the support of the care team, which includes the class member, works to coordinate all necessary services and benefits to meet the class member's needs in the community. Care managers must coordinate care before, during and after transition, serving as the class member's point-of-contact 24/7.

Care managers must also make the final care plan available to the Housing Contractor at least two weeks prior to scheduled transition.

In addition to care planning sessions involving the individual, HH/MLTCP care manager, Housing Contractors and others as appropriate, in November 2014, DOH initiated a Quality Assurance mechanism of “Transition Calls.” The purpose of these calls is to ensure that all components of a safe transition for a class member have been adequately addressed and secured. Transition calls are made approximately three weeks (21-days) prior the class member’s identified move-in date. Participants include care managers from the Health Homes and/or MLTCP, the Housing Contractor and representatives from DOH and OMH.

Among the items discussed are: securing required documents (e.g., picture ID), medication management and the need for assistance, scheduling of medical and mental health appointments, enrollment in mental health programs, emergency contacts, arrangements for meals, furnishing, utilities, etc. To guide these conversations, the State issued the ***Adult Home Class Member Discharge Planning Tool*** which has been revised over time. A copy of the tool is attached as Appendix B.

Also, in response to the Independent Reviewer's suggestion, in February 2015, the State implemented a system of post-transition calls to monitor whether the services called for in care plans were actually in place and being delivered now that the individual has transitioned. These calls occur within three weeks following transition and involve the Housing Contractor, care managers from the Health Homes and/or MLTCP and representatives from DOH and OMH. A copy of the template developed by the State to guide these calls, ***NYC Adult Home Class Member Post Transition Call Agenda***, is attached as Appendix C.

In monitoring person-centered care planning activities, as mentioned earlier, the Independent Reviewer and associates followed up on a sample of 28 individuals who had transitioned, visiting with them in their homes, reviewing care plans and progress notes and interviewing staff. The Independent Review team also met with or followed up on several dozen other class members who had not yet transitioned; participated in 68 transition calls and 44 post-transition calls and 17 "Level II" calls; and met with all Housing Contractors and at least 75 HH/MLTCP care manager/coordinators in the course of meetings, trainings and other activities.

A. Ongoing Problems in Person-Centered Care Planning

These review activities suggested ongoing problems with care planning and delivery of needed services, as were reported in the Independent Reviewer's first annual report. (Annual Report, pp. 47-53)

1. Delays in the Delivery of Services

As discussed earlier (Section III. *Issues that have arisen following transition*, above) more than a third of the individuals who were included in the sample the Independent Reviewer followed up on experienced problems with the design and implementation of care plans and thus experienced delays in the receipt of benefits and services including SNAP benefits, government IDs necessary for a range of community services, and Health Home, MLTCP and/or CHHA services.

2. Need for Improved Communication Among Class Members and those Providing Supports

Individuals in the sample of class members the Independent Reviewer followed up on reported feeling supported by case managers and care coordinators. Also, the records of these individuals reflected frequent and regular communication among the individuals and those providing support by the Housing Contractor and HH/MLTCPs.

While this may be the case for individuals we followed, and hopefully for all who have transitioned, over the past year the Independent Reviewer's experience suggests that such is not the case for class members who have not yet transitioned.

The Independent Reviewer's team continues to meet class members who don't know who their care managers are, who don't know where they stand in the transition process and are seeking information, guidance and advice. Housing Contractor staff also report having difficulty contacting HH/MLTCP care managers to schedule care planning meetings. As recently as a January 6, 2016 Housing Contractor meeting, several expressed concern about this and also indicated that they do not consistently receive care plans from HH/MLTCPs two weeks prior to transition as is required.

A recent pre-transition call in which Independent Reviewer staff participated is illustrative:

- *In this 12/30/15 call for AH, the Health Home care manager was asked when the care planning meeting occurred. He responded, somewhat incredulously, that he thought this call* ***was*** *the care planning meeting. It was explained that the call was intended to ensure that all essential elements of a care plan, which should have been developed prior to the call, were in place now that the transition date was approaching. It was agreed that the care manager would convene a care planning meeting with the appropriate parties and a pre-transition call was rescheduled.*

Throughout the year, the Independent Reviewer continued to receive reports of HH/MLTCPs care managers having caseloads in excess of 75 individuals, with some up to more than 100 individuals. Undoubtedly, this contributes to poor communication and care planning, and class members feeling left in the dark about their transition status, uncertain about their future and whether they want to move. The Independent Reviewer continued to stress with the State, as he had in the First Annual Report, that if a care manager is truly intended to be the lynchpin in ensuring a successful transition and life in the community, the State must examine and establish expectations for meaningful assignments and caseloads that enable the care manager to fulfill his or her role. As discussed in more detail below, the State has responded to this concern by implementing a new model of care management denominated as Adult Home Plus, with a caseload limit of 12 class members.

3. Need for More Robust Care Planning and Training in Person Centered Planning

As reported in the Independent Reviewer's first annual report, HH/MLTCPs have a variety of templates for developing care plans. **(**Annual Report, p. 50**).** Most of these, however, focus on health and safety issues, much like the State's discharge planning tool; issues such as food, shelter, medical/mental health services, emergency contacts, etc. These are all vitally important issues, to be sure. But they do not address the totality of a person's life, their desires, life dreams, things they would like to accomplish upon transitioning from an adult home, or more fundamentally how they would like to spend their days once they leave an adult home. Few HH/MLTCP care plan templates address issues such as vocational, educational, spiritual, social, community/civic interests/needs which round out the total individual and complement his or her health and safety needs.

This was confirmed in the Independent Reviewer's follow up of a sample of individuals who had transitioned. Although a number of individuals were engaged in educational/vocational pursuits, in few of these cases were such life goals/interests expressed in their care plans. Two cases are illustrative:

- *In the case of SC, his AHRAR recorded his interest in wanting to work. However, the care plan developed was silent on this issue. SC is currently pursuing vocational training which appears to have been facilitated by the PROS program which he attends. This became known to his HH/MLTCP sometime after transition via his Housing Contractor who learned of it from the PROS program. So, while this worked out well for SC, the result was largely a product of his own determined self advocacy, a skill which many other class members lack.*

- *In the case of PC, at the time of her assessment as recorded in her AHRAR, she wanted to "learn"…she had only completed 9th grade. It does not appear that her interests in "learning" or continuing education were addressed until three months after her transition when she expressed to her Housing Contractor that she wanted to attend GED classes but her Health Home care manager wasn't helping her. At that point the Housing Contractor reached out to the Health Home care manager and they agreed to work on this together.*

While it is fortuitous that these individuals' life interests are being addressed due to their own advocacy or that of the programs with which they are affiliated, one could rightfully question whether other individuals' life interests will not be pursued because care planning templates do not address the totality of a person, or life domains which are as important, but perhaps not as critically and immediately vital as health and safety issues.

Throughout the year, the Independent Reviewer has advocated for care planning templates which address these other domains of a person's life and has also advocated for training for care managers in person-centered planning. Although, the State had expressed reservation about creating a care planning template that would address all life domains as this would require substantial effort on the part of HH/MLTCPs and would delay transitions, (Defendants' Report, July 1, 2015, p. 2, Doc. #46-1) it also indicated it would amend the Discharge Planning Tool Guidance to address this concern. (Appendix B)

It should be noted that the State's template for post transition calls contains an item for discussion focusing on an individual's social needs including community involvement, life goals and how the individual is spending his or her days. In calls in which the Independent Reviewer's team has participated, this item has been discussed, but the degree to which the issues are

probed/reinforced is inconsistent. Independent Reviewer staff notes on the following cases are illustrative:

- *RG's 12/2/15 post-transition call: At this time, he has no interest in day program or other organized activities…reportedly he goes out daily on his own. DOH/OMH staff reminded all involved in the call to stay on top of this issue as right now he may be getting used to a new environment and various appointments he must keep on his own, but they would like to see that his possible interests in other life pursuits and goals are followed up on.*

- *JS's 11/24/15 post-transition call: She was referred to West Brighton MHC and kept her initial appointments with her therapist and psychiatrist. She visits with family and is interested in classes at Snug Harbor in computer or art and plans to go to a gym.* Note: As opposed to the RG case above, there is no reminder or indication that interests expressed by the individual should be followed up or supported by the care team.

As a result of further discussions between the Independent Reviewer and the State, the DOH entered into a partnership with the New York Association of Psychiatric Rehabilitation Services, Inc. to provide training for care managers in Person-Centered Planning. Training sessions will begin in February and run through July 2016 and cover such topics as: Integrating Person Centeredness in Day-to-Day Practices, Looking through the Recovery Lens, Employing Successful Engagement Practices, Trauma Informed Care, Employment and Self Sufficiency, Holistic Approaches to Managing Intense Emotions, and more.

B. Adult Home Plus

As indicated earlier (Section IV**)**, in mid-2015 the State announced an initiative intended to improve the entire transition process including assessments and care planning and management. It established new, intensive care management requirements (and reimbursement rates) for class members who are transitioning to the community. The new model, referred to as Adult Home Plus ("AH Plus") had a ramp up beginning in September 2015.

The model is intended to address many of the concerns expressed by the Independent Reviewer and Plaintiffs and those learned by the State in the process of its implementation of the Settlement Agreement. All class members enrolled in a Health Home and desiring transition will automatically receive Adult Home Plus.

Under the model, the Health Home care manager will be the single point of contact for every class member enrolled in a Health Home and desiring transition, and will coordinate their transition. All eligible and consenting class members will be enrolled in a Health Home on an expedited basis and MLTCPs and Health Homes will be required to enter into an Administrative Services Agreement (ASA) delegating primary responsibility for care management for transitioning class members to Health Homes.[17] If a class member enrolled in a MLTCP chooses not to enroll in the Health Home, the MLTCP will be the care manager.

Among the highlights of the Adult Home Plus:

Early engagement. Early engagement, defined as outreach and engagement prior to in-reach by the Housing Contractor, will support the development of the relationship between the class member and care manager. It will:

- Make it possible for the class member to build a relationship of trust with the care manager and recognize him/her as the single person to go to with questions about transition;
- Allow the care manager to participate in the assessment process; and
- Provide for the development of the person-centered plan earlier.

Increased frequency of contacts. Care managers will be required to have contact with class members at a minimum on a weekly basis. This level will:

In mid-2015 the State announced an initiative intended to improve the entire transition process including assessments and care planning and management. It established new, intensive care management requirements (and reimbursement rates) for class members who are transitioning to the community.

[17] *See*, status of execution of ASAs discussed earlier at pp. 34-35.

- Allow class members to get regular updates on their transition;
- Strengthen the relationship and trust between the care managers and class members; and
- Hold care managers accountable for continuously resolving barriers to transitions.

Smaller caseload sizes. The caseload ratios for Adult Home Plus will be no greater than 1:12. Care managers will not be permitted to have blended caseloads with non-class members. The lower caseload ratio will:

- Afford the care managers the time necessary to support transition;
- Increase their accessibility to assessors and housing contractors; and
- Allow care managers to develop expertise in transitions of people with serious mental illness.

Minimum education and experience levels. The minimum education and experience requirements specified were: a bachelor's degree in a specified field or a NYS teacher's certificate for which a bachelor's degree is required; or NYS licensure and registration as a Registered Nurse and a bachelor's degree and four years' experience in providing or coordinating services for people with serious mental illness. A master's degree in one of the specified fields may be substituted for two years of experience.

A Health Home cannot bill for the enhanced Adult Home Plus funding if the above requirements are not met.

Time lines for implementation included:

- Enrolling 100% of all consenting, eligible and assigned adult home residents and beginning care planning by December 31, 2015;
- Providing weekly contacts with 100% of adult home residents by December 31, 2015;
- Ensuring that 100% of Adult Home Plus care managers have reduced caseloads of 1:12 by February 29, 2016; and
- Ensuring that 100% of Adult Home Plus care managers meet the education and experience guidelines by February 29, 2016.

As reported earlier, at a status conference in Summer 2015, Judge Garaufis urged the State to make its best efforts to implement Adult Home Plus changes by the end of 2015.

As of the State's 7th Quarterly Report for the period ending 12/11/15, over 50 Adult Home Plus care managers met the educational requirements, many of whom are "new hires" and are building their 1:12 caseloads. The number of Adult Home Plus care managers has since grown and,

as of 3/11/16, 614 class members were enrolled in Adult Home Plus. These 614 individuals are in the following phases of the transition process:

In-reach:	47 Individuals
Assessment:	250 Individuals
Housing:	215 Individuals
Transitioned:	102 Individuals

On January 13, 2016, an Independent Reviewer team member attended training for Adult Home Plus care managers at which approximately 75 care managers were present. The training touched on issues including early engagement, frequency of visits with class members and regular communication with class members, psychosocial histories/assessments, discharge and care planning, and expectations of and checklists for care manager duties (including applications for benefits, sharing care plans with housing contractors, etc.). On February 29, 2016, the New York Association of Psychiatric Rehabilitation Services, Inc. began training on person-centered planning and related issues for Adult Home Plus care managers; nearly 100 care managers were present as was a representative from the Independent Reviewer's Office.

Most of the Housing Contractors have spoken positively about the early impact of the Adult Home Plus program, which was to be in place by December 31, 2015, and started several months earlier in some of the homes. Health Homes have been seeking to enroll all class members, and in some cases, even before in-reach has occurred. According to the above numbers, 42% of the 245 class members who have transitioned have been enrolled in Adult Home Plus thus far. Health Homes have also been seeking to enroll all class members, at each phase of the process. Thus far 8% of those enrolled are in the in-reach phase. This includes class members who have never received in-reach; those who have received in-reach and have said No; and those who have said Yes, changed their mind at any point in the process, and will be offered the opportunity again, no less than annually. This has resulted in reports by housing contractors that they have been alerted that a particular class member is interested in supported housing, which prompts a visit by the in-reach team. Contractors are also seeing more rapid assessment and follow-up once the in-reach is completed and the Health Home is notified, if an Adult

Most of the Housing Contractors spoke positively about the early impact of the Adult Home Plus program, which was to be in place by December 31, 2015, and started several months earlier in some of the homes.

Home Plus care manager is assigned. Housing contractors report that it is already evident that the Adult Home Plus care managers are more readily available to work with them in getting all of the necessary pieces in place prior to transition, whereas previously care managers' case loads were so large, it is was difficult to reach them, let alone coordinate services with them.

VIII. Community Transitions

The Settlement Agreement requires the State to fund sufficient supported housing units to provide any class member for whom supported housing is found to be appropriate an opportunity to transition from an adult home. (Para. D). The State is required to make all reasonable efforts to coordinate the performance of assessments by Health Homes and MLTCPs with the development of supported housing units so that the assessments take into account supported housing units that are actually available or will soon become available. The agreement also provides that the assessment shall determine the housing and service needs and preferences of the NYC Adult Home Resident in order to transition from the NYC Impacted Adult Home. In addition, "the assessment shall identify the housing that is the most integrated setting appropriate for the individual and the community services needed to support the individual in such housing, based on the individual's needs and personal preferences." (Para. F) There is a presumption in the Settlement Agreement that most class members will be found appropriate for supported housing, with adequate services and supports to meet their needs, but some may require a higher level of care. These are generally denominated as Level II, which includes a range of housing alternatives including community residences, CR-SROs, apartment treatment, supportive apartments, etc. as discussed above in Section V.

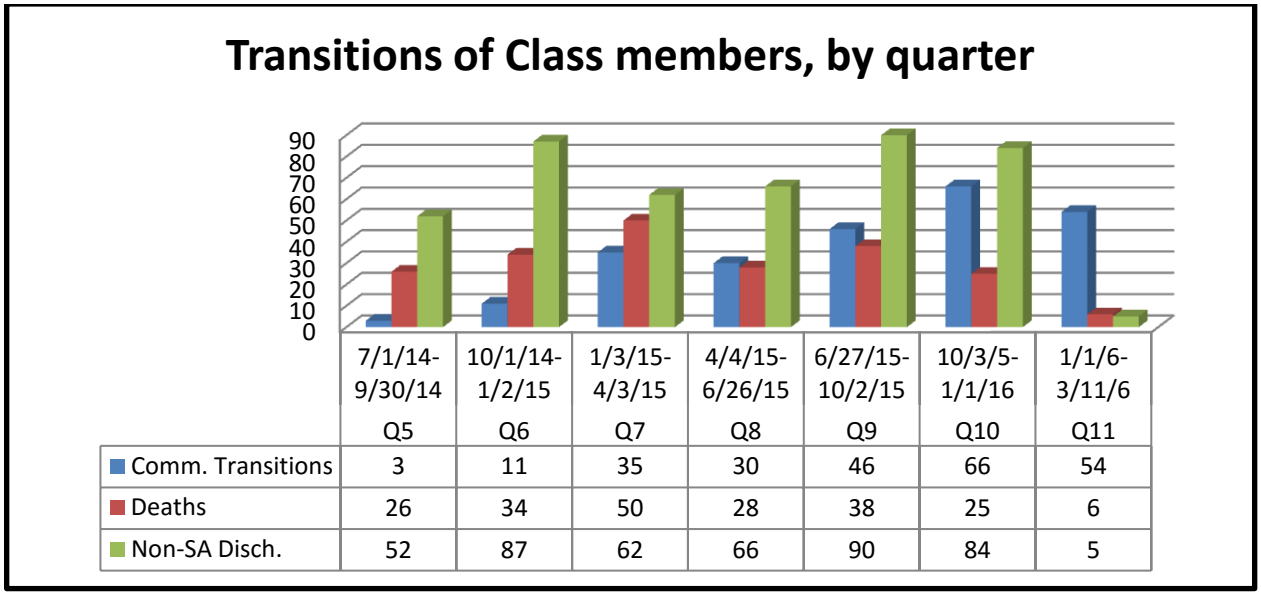
Following approval of the complete package by HRA, the care manager for the Health Home or MLTCP sends it to the Housing Contractor, who schedules an interview with the class member.

As of March 11, 2016 there were 577 housing referrals sent to the Housing Contractors, with a median of five days to forward the package from the point of HRA approval. Of the referrals sent to the Housing Contractor, 513 of the class members had dates of interviews listed, with a median number of days from receipt of the referral to the interview of 12 days.

Although the Housing Contractors' staff had previously met with the class members during in-reach to determine if they were interested in moving, the interview at this time is focused on learning more about the individuals and what their preferences are in terms of where they want to live, the type of apartment they want, and what, if any accommodations will they need for a

successful transition (e.g., first floor, elevator, or walk-up apartment). After the housing interview the process of looking for the apartment begins. Many of the residents are shown model apartments before they are shown apartments that are under lease to the Housing Contractor and available for transition. Once they are shown apartments they can either accept the apartment or ask to see another. Of the residents that the Independent Reviewer's staff met with who transitioned, most liked and accepted the first or second apartment they saw.

As noted above, as of March 11, 2016 HRA had approved 634 class members for transition: 577 (91%) for Community Care (supported housing) and/or Level II, and 57 (9%) for Level II only. As of that date, 245 class members had transitioned to the community, including eight who moved directly to Level II housing, as described in the Assessment section. Four of the 237 class members transitioned to supported housing, however, returned to an adult home and continue to be a part of the class eligible for transition. The 241 class members who have successfully transitioned to the community pursuant to the Settlement Agreement are a part of the total reduction of class members in the adult homes. In addition to these 241, 302 class members died and 707 were discharged outside the Settlement Agreement process, as depicted in the Figure below.[18]



	7/1/14-9/30/14 Q5	10/1/14-1/2/15 Q6	1/3/15-4/3/15 Q7	4/4/15-6/26/15 Q8	6/27/15-10/2/15 Q9	10/3/5-1/1/16 Q10	1/1/6-3/11/6 Q11
Comm. Transitions	3	11	35	30	46	66	54
Deaths	26	34	50	28	38	25	6
Non-SA Disch.	52	87	62	66	90	84	5

Figure 8. Transitions of class members, by quarter

[18] The data for Q. 11 for deaths and non-Settlement Agreement discharges is partial as the reports from adult homes of these data are typically not available for several weeks after the quarter ends. Also, 95 deaths and 260 non-Settlement Agreement transitions occurred prior to Q5, and one non-Settlement Agreement transition has no associated date.

As of March 11, 2016, 245 class members have transitioned.[19] It has taken a median of 277 days from in-reach to transition for these 245 class members. As noted in the First Annual Report (Doc. 36 p.53), as of March 13, 2015 it took the first 40 class members a median of 203.5 days from the point of in-reach to transition, a difference of 73.5 days. There are obviously different ways of analyzing data. From one perspective, it took 20 months from the execution of the Settlement Agreement for the first 40 class members to move. The next 205 moves were accomplished in about 12 months. The rate at which class members are currently transitioning and being prepared to move is clearly improving, but as the numbers increase, the amount of time it is taking to move through each stage of the transition process has been increasing as well, as shown in Fig. 9.

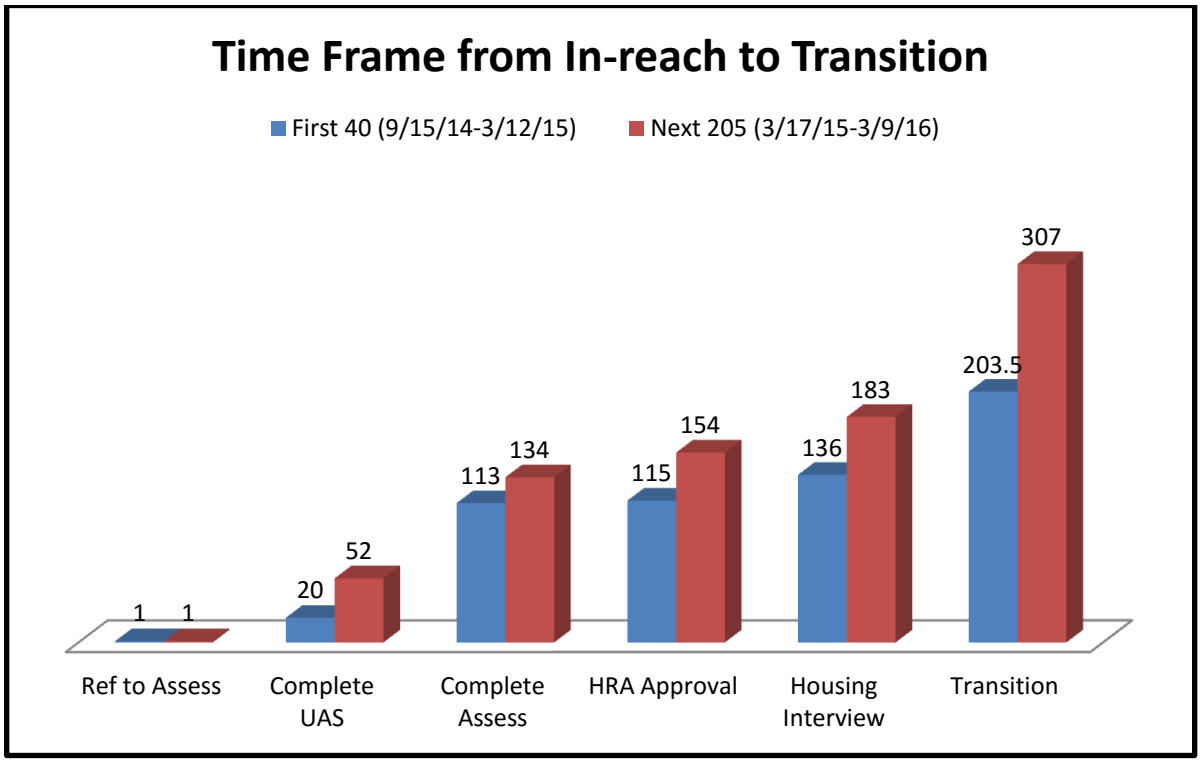


Figure 9. Change in the length of time for transition

In its response to a draft of this report, as well as in statements made to the Court, the State has noted that for 38 class members who were in-reached in Year 2 *and* who completed the transition process, the time to transition has been shorter than the overall median at 157.5 days, indicating a greater efficiency in the process. (See, Def.'s Exhibit # 3 at the Status Conference on

[19] As noted previously, four of these individuals have returned to an adult home but will continue to receive in-reach.

March 19, 2016) While that is true as far as it goes, what this analysis overlooks is that 702 class members who were also in-reached in Year 2 have not yet completed their transitions and that when they do, their transitions will inevitably have taken substantially longer. Moreover, beyond this cohort, there were 338 class members who were in-reached in Year 1 who have still not completed their transitions, and had been waiting a median of 519 days as of Week 94 which is the data used by the State in its analysis. Their experiences contribute to the growth of the cumulative median time for transitions of the class.

A. Choice of housing

An important provision of the Settlement Agreement was the element of individual choice; including that the class members' preferences would be taken into consideration, and they would have a choice about where they wanted to live; if they wanted to live alone in a studio or one-bedroom apartment, or with another class member in a two bedroom apartment, or maybe in another borough. During the in-reach process the Independent Reviewer's staff observed these questions being asked by the in- reach staff, as well as whether they would be able to walk up a flight or more of stairs, would they need a ground floor or elevator apartment, etc. Consistent with this level of choice, and as documented in the Housing Contractor's proposals in response to the original RFP, each of the nine Housing Contractors had agreed to provide apartments for class members to live alone or share an apartment with separate bedrooms.

As noted on Figures 10 and 11 below, as of March 11, 2016, 245 class members transitioned from 21 of the 22 NYC Impacted Adult Homes, with housing acquired by all of the nine Housing Contractors.

In examining the transitions by Housing Contractor and adult home, the outliers are apparent. Specifically, what is notable is the lack of any transitions at Central Assisted Living and the low numbers at New Gloria and Belle Harbor, which were part of Phase II, which began on July 1, 2014. On the other hand, St. Joseph's Medical Center which serves Harbor Terrace, with 24 transitions, and Pibly, which serves Riverdale Manor, with 16, and were included in Phase III, have as many or more moves than most of the homes that started in Phase II, almost a year earlier. Some of the homes like Belle Harbor, where 61% of those in reached said Yes, had particular problems in having the in-house psychiatrist do the psychiatric evaluation, extending the assessment to more than a year for many residents. The Staten Island Housing Contractor agencies also are downstream providers for CBC Health Home and provide care coordination to many of the class members that they serve. The administration of both agencies has stated that this makes the assessment, care

planning and transition phases much more efficient. While there are no easy answers, closer examination of the outliers, both high and low, is warranted by the State.

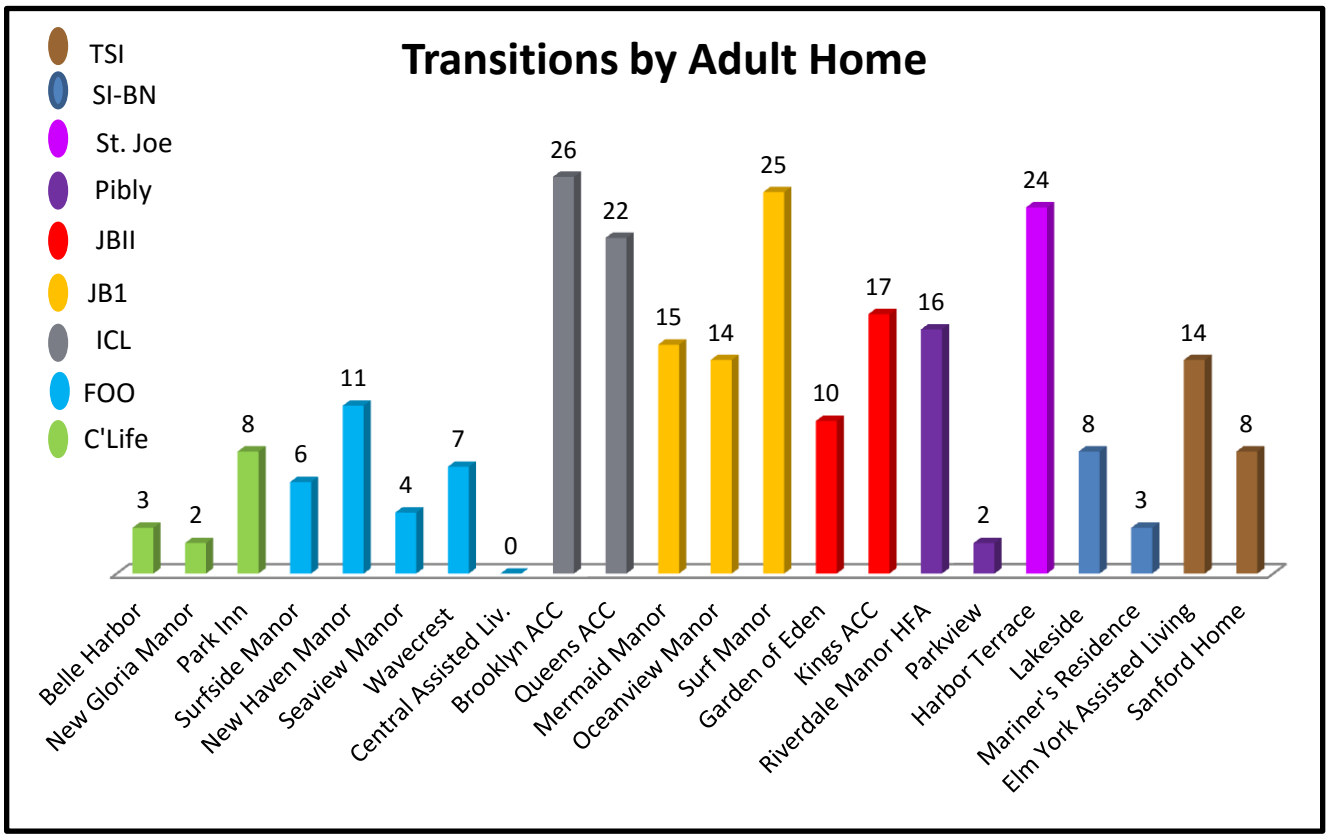


Figure 10. Class Members Transitions as of March 11, 2016

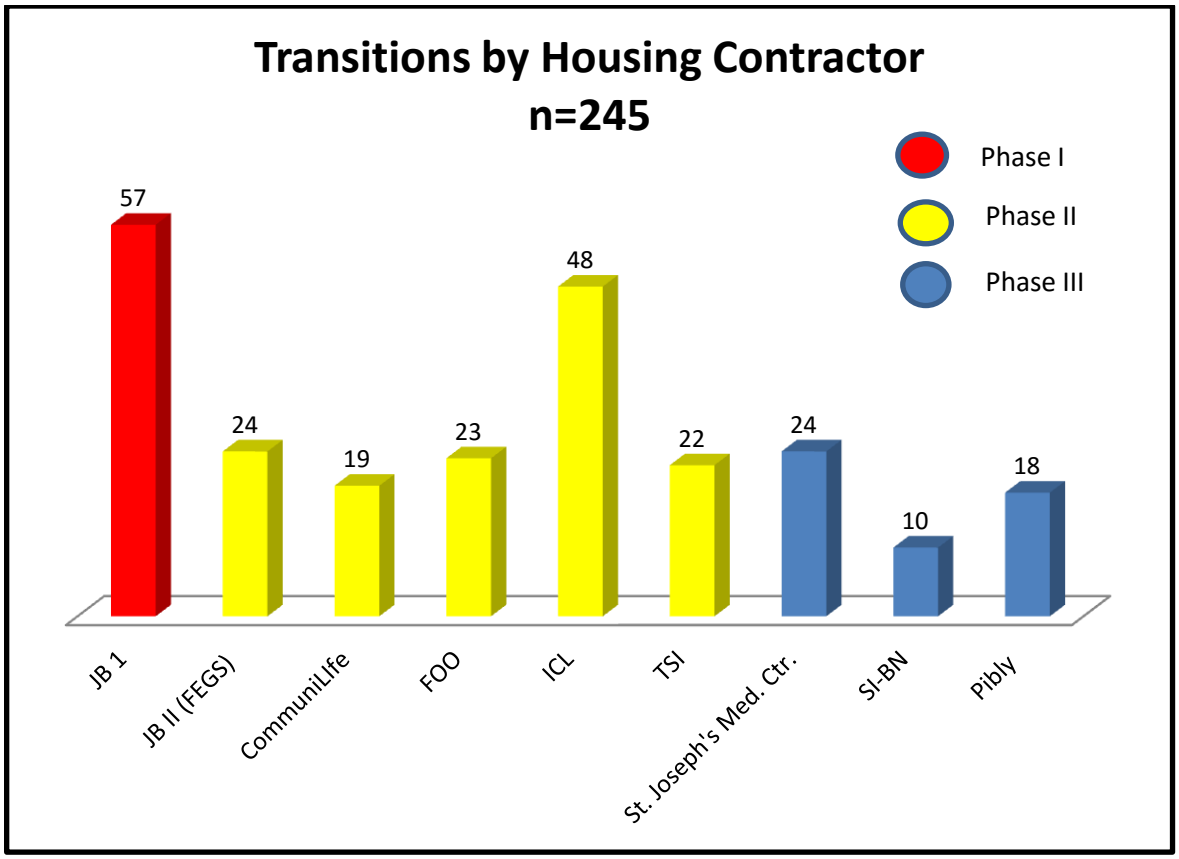


Figure 11. Transitions by Housing Contractor[20]

B. Obstacles to transitions

In Section II, the report describes the experiences of a sample of class members who had successfully moved to supported housing. Here we describe some of the challenges encountered both by class members and by the staff of Housing Contractors, Health Homes and MLTCs who work with them to achieve a transition to the community. As noted in the Assessment Section, 10.9% of those who said Yes at in-reach change their minds during the assessment process. In addition, some class members change their minds after they have been assessed and their

[20] There are discrepancies among the data sources about the distribution of class members among the Housing Contractors, as some class members have been placed by Housing Contractors assigned to different adult homes due to their preference to live in neighborhoods where these Housing Contractors have apartments, and some have been moved to Level II housing .operated by a different Housing Contractor. These discrepancies affect a handful of class members and do not significantly affect the overall distribution reflected in this Figure.

applications have been approved by HRA, but before their referral package has been sent to the Housing Contractor by the Health Home or MLTCP.

As of Week 104 (3/11/16), 62 class members had their HRA applications approved by HRA, but there is no date recorded in the field for receipt of complete housing referral. Of these, 37 were approved for Community Care & Level II; and 25 for Level II only. From the data presented we are unable to discern if the Level II referrals have been made, other than if the class member is subsequently placed in Level II Housing. Many more HRA approved applications are withdrawn after they have been referred for housing, have seen apartments, and some who have tendered their 30 day notice to the adult home. As the HRA approval is good for six months, many expire in the process, although three-month extensions are routinely granted by HRA if they are informed that the transition is in process.[21]

Many class members have seen several apartments following the approval of their HRA applications and have still not accepted an apartment, for a variety of reasons. For some, the neighborhood where the apartment is located is not where they had hoped to move; some want to live alone and will not consider a shared unit; for others, there had been a change in their condition, or they were having second thoughts, or they are waiting for a friend or significant other to also get approved so they could move together. Some have gone through cycles of changing their minds several times, even on the date of a planned move.

Examples of the varying circumstances surrounding the decision to withdraw the housing referral are included below. The Independent Reviewer's staff met with some of the class members discussed below and information was also obtained from Housing Contractors as to the reasons many of the housing referrals were withdrawn after they had received them.

1. Preference for a different borough or neighborhood

Some class members state that they wish to live in a borough other than that served by the Housing Contractor. Although this is noted at the time of in-reach, it generally does not get addressed until the care manager obtains the HRA approval and forwards it to the Housing Contractor. Of the 245 transitions as of 3/11/16, six class members have been placed in supported housing with contractors in other boroughs. As previously reported by the Housing Contractors, the specific preferences of the class members, especially the locations, have posed significant

[21] The Independent Reviewer has recently been informed that the State and HRA have reached an agreement and HRA approvals will be good for a period of 12 months.

challenges with requests to live in neighborhoods where affordable housing is not readily available. While Housing Contractors try not to tell class members that it is impossible to fulfill the member's specific requests, they inform them that it will most likely take longer to acquire, and continue to offer alternative areas for their consideration, including shared housing rather than a single unit. Those that insist on living alone or in a specific neighborhood, often wait indefinitely while their HRA approval expires.

- *A Case Conference, which included MA, the care coordinator and the Housing Contractor, was held to determine if MA wished to proceed with supported housing. She stated that she did not want to live in Queens because she is more familiar with Manhattan. Client was assured that she would be aided to become acquainted with the new neighborhood in Queens and was shown a video of a typical apartment, and supportive services were discussed. Client reiterated her preference to live in Manhattan. Her care manager agreed to try to assist her in locating housing in Manhattan. Her referral for housing was withdrawn 11/23/15.*

- *MCP wanted to move to Brooklyn to be closer to his mother who resides there. She apparently influenced his decision not to accept an apartment in Queens, after several weeks of going back and forth visiting the available apartment and exploring the neighborhood, which MCP had viewed. He currently waits in the adult home.*

- *LB, a 58 year-old female who is legally blind, was in-reached at Harbor Terrace on Staten Island, in June 2015 and said that she wanted to live in her own apartment in Queens, NY. After her HRA application was approved for supported housing in September 2015 she made it clear to the Housing Contractor that she was very comfortable and familiar with Queens, including the subway system, and felt this would be the best choice. Her Health Home care manager contacted a Queens Housing Contractor to confirm availability and sent the referral package. They received her referral on 11/3/15 and met with her on 11/10/15. She viewed and accepted the apartment and transitioned on 12/17/15 to a two-bedroom apartment but does not yet have a housemate.*

2. Fear of losing existing services or providers

An important consideration for many class members is continuity of care with their current providers of medical and psychiatric care. For many who received these services in the adult home, referral to new providers of care is necessary. But for others who can and want to

continue to see their current mental health treatment providers or their PCP, this desire also affects the distance they are willing to travel after moving to the community, and circumscribes the area in which housing must be found.

- *JCL, a 58 year-old woman, was approved for supported housing on 2/19/15, but the Health Home care manager did not send the referral to the Housing Contractor until 7/16/15. There is no date listed under "Date of Interview" on the weekly report, and the Housing Contractor withdrew the referral on 9/15/15, documenting she had "no interest in moving." When JCL met with the Independent Reviewer's staff at her adult home during January 2016 she said she didn't remember the process but confirmed that she did not want to leave the adult home. She said she was in an ALP bed and "I don't want to lose my Aide." She said she felt secure and "I love everybody here." In closing she said, "People on the outside don't treat you right. Here I can do what I want to do."*

- *DP, a 64 year-old female, has lived at the adult home since 2012. She expressed an interest in moving on September 2014 during in-reach, and her HRA application was approved in April 2015. The Housing Contractor met with her in May to discuss what she was looking for. She said she wanted to share an apartment in Far Rockaway with her former roommate in the adult home who had recently moved out. She visited the modern three-bedroom townhouse apartment in Far Rockaway, and submitted her 30 day notice with a planned moving date of 6/23/15. On 6/22/15 she reported she changed her mind saying she was unsure if her benefits would go with her. Subsequent notices to leave were submitted on 8/29/15 and 10/15/15 with a move out date of 11/12/15. On 11/9/15 there was another case conference, during which DP said she was not sure about moving and reportedly spoke of wanting to wait until after Thanksgiving. When it was mentioned she and her housemate could have Thanksgiving together in her new apartment, she spoke of waiting until after Christmas. She revoked her move out letter on 11/9/15.*
  When the Independent Reviewer's staff met with DP at her Social Day Program she said that she had originally wanted to move to "be independent and be on my own…to do cooking and cleaning for myself." She said she had last lived on her own in 2010 with her son. She said the only apartment she saw was where her former roommate at the adult home lived, and was "beautiful." She said she submitted "three or four move-out letters," all for the same apartment. When asked why she didn't move, she said, "I am adjusted to (New) Gloria, and described it as "comfortable." She said she still works with her care manager from Brightpoint, and that "I still think about moving...I have to get accustomed to something new." When asked what made her think she wouldn't change her mind again, she smiled and said "maybe, maybe not."

- *JH, a 62 year-old man, has lived at the adult home on Staten Island since 2006. He was in reached on 8/22/15 and was approved for supported housing on 10/19/15. He met with the Housing Contractor and saw two apartments on 10/22/15. He chose to accept a split-level 2 bedroom Townhome apartment, which was fully furnished at the time of the visit. He also met his roommate, who is a good friend from the adult home. He submitted notice to the adult home the same day he saw the apartment, and was to move on 11/18/15. However, on 11/12/15 he informed his care manager that he changed his mind and didn't want to move, saying he didn't want a lot of people coming to his house.*
  When the Independent Reviewer's staff met with JH, he said he liked the apartment he had chosen very much and was to live with his friend George, who was already in the apartment. When asked why he had changed his mind he said he decided not to move when transportation didn't come to take him to his new mental health clinic (11/9/15), and he feared he wouldn't have enough medication when he moved out; but acknowledged he did not tell his care manager about this.

3. Concerns over safety, accessibility or changing medical condition

Some chose to remain due to safety/medical concerns.

- *MH saw several apartments "but I feel safer in the adult home."*

- *During his housing interview on July 23, 2015, AKN informed the Housing Contractor that he "has a heart condition, is in and out of the hospital, and wants to stay in the adult home."*

- *DY expressed many safety concerns about living independently, including: extreme anxiety after every care plan meeting and apartment viewing, which had resulted in an admission to the hospital. She was offered several opportunities to discuss these concerns and did not attend three planned meetings, after which her housing referral was withdrawn.*

- *CC is a 70 year-old female who had been living at the adult home for 18 years. She was originally on the Fast Track, and said she was interested in supported housing when in-reached during July 2014. However, she fractured her hip in September 2014 and had multiple hospitalizations and extensive rehabilitation. She was reassessed in August 2015 and her HRA application was approved and referred to the Housing Contractor in October 2015. She viewed an apartment on 11/24/25 and submitted her notice to the adult home the same day.*
  When she met with the Independent Reviewer's staff at the adult home, she had with her a metal cane that she mostly used when outside the home. She said that she saw her first

apartment in Flatbush, Brooklyn and it was "just beautiful," after which she submitted her notice. She said there were six or seven marble steps in the building leading to the first floor, which concerned her, as she wanted to be independent in doing her shopping, laundry, etc. and thought it might be a problem. The building agreed to put in a rail for her, but in the end she was not confident, feared falling again, and withdrew the letter on 12/3/15. She visited another apartment on E. 96th street Brooklyn on 12/16/15, but saw seven steps going to the elevator, which she said were broken, with peeling paint, so she wasn't interested. She said that she is in Physical Therapy now and is walking much better, and if she saw the first apartment again, she might accept it. She spoke positively about her Health Home care manager and said she helped her get her NYS ID, Social Security Card, transit pass and is working on Access a Ride, noting "she does a beautiful job." CC was eager to begin looking again.

4. Waiting for a housemate to be ready to move

- *HB is a 62 year-old male living at Mermaid Manor since May 2009. He was a Fast Track member who was in reached during March 2014 at the beginning of Phase I. He was assessed in July 2014 and his HRA application was originally approved during November 2014. The Housing Contractor interviewed him on 11/24/14. HB wanted to live with his girlfriend, (MH) who is also a class member. He and MH specified areas in proximity to the Adult Home where they wanted a two-bedroom apartment, and on several occasions refused to view apartments in the Flatbush Area, where the Housing Contractor had more available units. In November 2015 they both saw a ground floor apartment in an area they were interested in. As their HRA applications had expired, an expedited HRA was requested from the Health Home, which was submitted and approved on 12/15/15. On 11/19/15 HB submitted his notice to the adult home, with a move out date of 12/21/15. On 12/16/15 he informed the Housing Contractor that he was no longer moving as MH was hospitalized for severe leg pain, and was to be transferred to Rehab where she might be for several months, and that "he didn't want to go without her." He reportedly refused further efforts to discuss housing. The Supervisor of Housing did not withdraw his referral until 1/15/16, hoping to give him time to change his mind.*

  When the Independent Reviewer's staff approached him at the adult home he ~~w~~as most concerned about changing his physicians that he had seen at the adult home, including his pain management doctor. In addition he said he didn't want to move without his girlfriend.

5. Influence of family members and therapists

Sometimes family and the opinion of the treating psychiatrist/medical provider impact the decision:

- *PF was originally approved for supported housing on 4/17/15 and met with the Housing Contractor on 4/20/15. His sister was informed he was moving and she spoke with PF's psychiatrist who subsequently submitted a revised psychiatric evaluation recommending a higher level of supervision than offered in supported housing. His referral was withdrawn on 8/19/15. At a subsequent care plan meeting PF was determined to be more appropriate for level II housing, was reassessed and approved for Level II by HRA on 10/2/15. At this time PF still resides in the adult home, and is reportedly still interested in supported housing.*

- *WR 's daughter "decided she no longer wanted her father to move," and VS felt his" relationship with his step-mother would be ruined if he moved."*

- *JH mentioned that his sister, who lives in Pennsylvania and is listed as his emergency contact, had come to see the apartment he had planned to move into, and had spoken with his Care Coordinator. She told JH she liked the apartment, and was happy about the services he was to receive, but "she was worried about me," and was "relieved when I didn't move." His other sister and brother who live in New Jersey "thought I'd be better off here…when I changed my mind they said maybe it is for the better."*

The support of therapists and family members can also be an important factor in encouraging class members to move to supported housing.

- *GS is a class member we had previously visited who was included in the First Annual Report (pp. 54-55). GS had changed her mind several times and canceled several move out dates, including once on the day of the move. Her reasons included the neighborhood, absence of a roommate at the time of the move, and overall uncertainty. After the last cancelation, her referral was withdrawn. However, she received additional in-reach and in October 2015 said she was interested in moving again, and was assessed and her HRA application approved on December 9, 2015. She subsequently accepted a two-bedroom apartment with a move-out date of January 29, 2016. Her care manager worked closely with the adult home nurse and social worker to ensure a smooth transition. When the Independent Reviewer staff spoke to her on January 20, she was excited about the move and the prospect of sharing an apartment with a friend from the day program who lives in another adult home. When asked what made her change her mind again she mentioned that her psychiatrist and therapist both felt positive about the move and that her sister in Florida told her "to get out of there!"*

6. Specific preference for one-bedroom or accessible apartments

While there are attempts to honor choice, the housing stock and availability in some areas does play a role. The responses to the original OMH RFP of August 10, 2012 submitted by Housing Contractors for this initiative included that they would offer the choice to live alone in a studio or one bedroom apartment, or to live with others. However, to date, two of the housing contractors have not offered this choice. (See Table 5.) Federation of Organizations, which serves four adult homes, does not offer its class members studio or one-bedroom apartments. To date, they have rented primarily three bedroom apartments, and mini-houses they call "bungalows" in Far Rockaway, intended for three persons. Currently, 17 of the 23 class members live in these units, but none currently houses more than two. Six other class members have moved to two-bedroom apartments. Similarly, all of the 25 class members transitioned by Jewish Board II, from the two adult homes they serve, live in two-bedroom units. While acknowledging that some class members do ask for their own apartment, Jewish Board II reports that class members usually come to accept the benefits of sharing an apartment with another class member.[22] ICL, which serve

While there are attempts to honor choice, the housing stock and availability in some areas does play a role.

[22] The Request For Proposals issued by the NYS OMH for Supported Housing for Adult Home Residents with Serious Mental Illness (August 10, 2012) provides:

> Funding for SH is a combination of resident rent payments and OMH funds. Residents of SH are required to pay a minimum of 30 percent of their net income for rent and reasonable utilities. ***However, residents can choose to pay more than 30% of their income based on a personal decision to have an apartment beyond what is affordable with the 30% applied to the agency contribution, for example, selecting a different neighborhood or a one bedroom in a neighborhood where only 2 bedrooms are affordable within the SH allocations. OMH Field Office approval is required prior to the recipient contributing more than 30% of their income for rent and utilities.*** (Sec. 5.4, p. 14, emphasis added)

However, in all of the meetings with Housing Contractors that the Independent Reviewer team has attended, and the in-reach sessions that we have observed, we have not heard any reference to this provision and are unaware of any applications being made to the NYC Field Office for prior approval of additional payments to make it possible for a class member to obtain a one bedroom apartment in a neighborhood where such is not affordable within the stipend otherwise available. An OMH representative informed the Independent Reviewer that this practice is not followed due to concerns about the class members' ability to afford and sustain such arrangements. In a response to a draft of this report, the State stated that the supported housing guidelines were updated in 2015 to state, in part: "Recipients pay no more than 30% of their adjusted gross income towards reasonable rent and reasonable utility costs." However, the State also noted that there are exceptions which would be looked at on a case by case basis.

Brooklyn ACC and Queens ACC, have also transitioned very few class members to single bedroom or studio apartments. None of the 26 class members who transitioned from Brooklyn ACC reside in a studio or one bedroom apartment, while only three of the 22 class members who transitioned from Queens ACC live in single unit housing. It should be noted that of the 237 class members who transitioned to Supported Housing, only 58, or 24.5%, reside in a studio or one bedroom apartment. It is not clear that this is solely due to the choices of the class members, rather than the economics of the Housing Contractors and the current housing market.

Supported Housing Contractor	Studio/One Bedroom	Two Bedrooms	Three Bedrooms
CommuniLife	6	11	2
Federation of Organizations	0	6	17
Institute for Community Living, Inc.	3	44	0
Jewish Board of Family & Children's Services 1	15	37	0
Jewish Board of Family and Children's Services 2	0	24	1
Pibly Residential Programs	11	4	0
St. Joseph's Medical Center	9	13	0
Staten Island Behavioral Network, Inc.	3	7	0
Transitional Services for NY	11	10	3
TOTAL 237	**58**	**156**	**23**

Table 5. Class Members Transitioned to Supported Housing Units as of 3/11/16

Of the class members who have moved: 96 are on the first floor; 66 on the 2nd floor; and 16 on the 3rd floor of walk-up housing. There are 59class members who transitioned to elevator buildings and live on the 2nd floor or above. Class members' preference for one-bedroom, accessible or apartments in specific neighborhoods sometimes means a longer wait time.

- *RP, a 58 year-old woman, received in-reach and was assessed in June 2014, and was approved for supported housing in February 2015. When interviewed in March 2015 she stated she wanted to live alone in the area close to the adult home where she attends*

a PROS program five days a week. She told the Independent Reviewer "I have been waiting forever" and "they keep showing me two bedroom apartments," and mentioned a two bedroom apartment she saw in Flatbush, but it was too far. "I rather not share anything with someone I don't know...they may be dangerous, violent or steal from me." She did see a studio apartment in Boro Park but she said, "it took 25 minutes to open the door," as there was a problem with the lock. She said she wanted it at first but "I got paranoid about being the only black person (she saw in the area)." Her HRA application expired in August 2015. The Housing Supervisor said she would keep the referral open, but added "there are a lot of people waiting for one bedrooms in this area who are ahead of her."

- *DV, a 63 year-old female, has resided at the adult home since 2009. She expressed an interest in supported housing as a Fast Track Member when in-reached during July 2014. Due to disenrollment by her MLTCP, the refusal of the psychiatrist in her adult home to do psychiatric evaluations when they were not "due," and the need for the State to arrange for a psychosocial evaluation, her HRA application was not submitted and approved until July 2015. The Housing Contractor conducted an intake interview on 8/12/15 during which she said she wanted an accessible two-bedroom apartment for her and JR, her significant other, who uses a wheelchair and a walker. She wanted to live in Rockaway Park, a very desirable and expensive area close to the adult home, but said she was willing to look at other areas in Queens.*

  When the Independent Reviewer's staff met with DV and JR, she said she "waited over a year to see two apartments." She said she has a list of what she wants in an area where she moves, like buses, trees, flowers, supermarket within 10 blocks, Laundromat, restaurants, etc., as she plans to be there a long time, and doesn't want to live in an area that would depress her. She said they saw an apartment in Jamaica that had many of the things that were on her list, but "the neighborhood was dirty with lots of garbage." She said she also turned it down because the bathroom was too narrow, and not accessible for a wheelchair, and she feared JR getting stuck in the narrow hallway. She said she saw another beautiful apartment, but she really doesn't want to live in Far Rockaway. When asked about neighborhoods she would live other than Rockaway Park, she mentioned Forest Hills and Flushing, where she "once had a rent stabilized apartment for $500." The Housing Contractor said they had showed her four apartments, but said, "it is impossible to find affordable units in Rockaway Park." DV has been given a three-month extension on her HRA application, and a meeting is planned with her housing contractor and her Adult Home Plus care manager. Complicating the matter, JR's assessment from August 2014 has never been completed (including psychiatric assessment) and it has expired; a new assessment is to be scheduled.

C. Level II Housing

Aside from class members who are initially placed in supported housing and later moved to Level II housing, there are others who are initially approved by the assessor and HRA for Level II only. As previously discussed in the assessment section (Section V), there are four accepted rationales for being inappropriate for placement in supported housing. For six of the eight class members transitioned to Level II housing as of 3/11/16, the documented rationale was: "Resident would be a danger to self or others in supported housing, even if receiving services currently provided under the New York State Medicaid Program." In reviewing the AHRAR for these class members who were all assessed by Elder Serve, the following was documented:

- *AFD's Final AHRAR dated 7/2/15 recommending Congregate Treatment noted: "Client is forgetful-extremely- has history of violence- when delusional has persecutory ideations. Requires 24/7 supervision in a structured setting to be safe in the community." He moved to TSI's Phase I Congregate Treatment Community Residence on the grounds of Creedmoor PC on 9/15/15. He lives in one of three 10-bed sections where he shares a room with another resident, and a bathroom with 3-4 others.*

- *SS's Final AHRAR distributed to the CTP on 7/16/15 recommending CR-SRO noted: "According to Psych eval SS does not currently exhibit the skills to live on her own. She has not developed skills necessary for non-supervised function." SS was transitioned to St. Joseph's Chait House on 12/2/15, where she has her own room in a shared unit with two others, in a 15 bed CR-SRO. As noted on her post transition call on 1/5/16 she has a PCW for 4 hrs/day x 3 days/wk. to assist her with her personal hygiene, laundry, and cleaning of her room.*

- *MK's Final AHRAR distributed to the CTP on 7/23/15 recommending CR-SRO noted:"Psych eval. states (he) requires supervised residence because of his tendency to act out. Has risk of losing control and hurting his girlfriend if not supervised", later adding that he tried to choke her a few months ago "but did not have any plan to hurt her." MK was transitioned to Pibly's Apartment Treatment Program on 12/29/15. There he has his own room in a three bedroom scatter-site apartment that he shares with two others. Pibly staff will typically visit from four to seven times a week to assist with restorative services and help prepare him for supported housing within the next 1 ½ to 3 years.*

When referred and interviewed for Level II by the residential program it is determined which of their programs would be most appropriate. Eight class members have transitioned to Level II housing as of 3/11/16, as follows:

- three are in Pibly's Apartment Treatment Program;
- three are in CR-SROs, including two in TSI's Hazel House, and one in St. Joseph's Chait House; and
- two are in TSI's Phase I Congregate Treatment program, which along with Hazel House, is on the grounds of Creedmoor Psychiatric Center.

As noted above, some are changed from the original recommendation. In addition, some referrals for Level II are found to not be appropriate for their program, as documented below:

- *JI from Riverdale Manor was approved for Level II housing and recommended for CR-SRO. He was interviewed by Pibly's Level II housing staff on 11/9/15, and was rejected as "he demonstrated no insight into arson behavior and presented with cognitive impairment." He was found to be a likely danger to himself in a Level II setting.*

Although not readily discernible in the data presented to the Independent Reviewer and the parties, sometimes a class member who is approved for supported housing is transitioned to Level II housing, in response to the subsequent concerns of those involved in her treatment.

VH from Riverdale Manor was approved by HRA for supported housing (Community Care and Level II) on 8/23/15 and wanted to live in her own apartment. Pibly showed her a supported apartment in November 2015, which she accepted. However, at that point, her AOT ACT team, who Pibly had not previously been aware of, became involved. The AOT care manager and his supervisor were very concerned about VH's long history of medication non-compliance and subsequent psychiatric decompensation, and did not believe that she was appropriate for supported housing. There were several conference calls arranged with all parties (e.g. housing contractor, AOT team, DOH & OMH). Ultimately, the team acceded to the concerns of the AOT care management team, who stressed that they knew her best, and it was agreed VH would require Level II housing. Although reportedly disappointed in the decision, VH accepted placement in Pibly's Apartment Treatment Program on 12/23/15, with hopes of transferring to supported housing in the future.

IX. Conclusion

This Second Annual Report depicts the progress made by the Defendants in transitioning class members to supported housing or other alternatives in the community pursuant to the Settlement Agreement. It is clear that the Defendants have made significant strides in conducting in-reach to almost 90% of the class and in increasing the pace of community transitions, particularly as compared to the previous year. As importantly, as described in this report, the Independent Reviewer has found that class members who have made the transition are, with few exceptions, generally doing well in their new homes and are happy to have made the move. For them, the promise embodied in the Settlement Agreement of a meaningful choice to live a more independent, self-determined life is being fulfilled. The staff of Housing Contractors, Health Homes and MLTCPs and their care managers have provided support and linked them up to medical and mental health services to keep them healthy and safe. Yet, there is more work to be done in helping them with financial planning and budgeting, and to re-connect with life in the community to assure more than re-location, to actual integration into the civic and social life of the community. The Defendants have recognized this and are embarking on a promising course of additional training for care managers in Person Centered Planning in partnerships with the New York Association of Psychiatric Rehabilitation Services, Inc.

As described in the body of this report, some concerns remain. First, although the pace of transitions has increased, it is still slower than what would be required to meet the Settlement Agreement goals for Year Four and Five. Perhaps because there are now more class members in the transition pipeline, it is taking longer to navigate the multiple steps leading to community placement in Year Two then it did in Year One.

Second, the problems with the assessment process described in the First Annual Report (pp. 19-31) have remained a stubborn obstacle, even past the September 30, 2015 deadline the Defendants established to eliminate the backlog, although substantial progress has been made. The new initiatives implemented by the Defendants – Adult Home Plus, changes to the Comprehensive Psychiatric Evaluation and authorizing the use of psychosocials performed by a broader array of clinicians– are very positive developments, as are further actions under consideration to implement a recommendation to establish a dedicated pool of assessors. But until they are fully in place and the results can be measured, it is unclear whether they will eliminate the problems experienced to date.

Third, it is troubling that the proportion of class members saying Yes at in-reach has been falling to the extent it has, and that class members continue to drop out of the process even after they have said Yes. This trend requires further investigation by the Defendants of the use of Motivational Interviewing during in-reach, of the training of in-reach workers and the strategies used for effective-in reach, as well as the adequacy of staffing of the in-reach teams and the use of

peer advocates in this role. Here again, the implementation of Adult Home Plus and the consistent, early engagement of the care manager with a small caseload of class members may help prevent dropouts by involving them early and often in the transition planning process. This new resource may also be a critical means of addressing some of the problems, described in this report, that class members who have transitioned have experienced with delays in accessing the services and supports they require.

Fourth, there are many delays in the class members' final step to transition following HRA approval of their applications, some of which are inherent in the process of honoring choice for class members and in the significance of the decision for the individual. Nevertheless the adequacy of staffing of the Housing Contractor teams who assist class members locate suitable apartments needs to be examined to determine if there is sufficient capacity to process the growing number of class members who are completing the earlier stages of the process. The first step is to ensure that all positions currently funded are filled with qualified and trained staff.

To address these and other issues discussed in the report, the Independent Reviewer offers the following recommendations for consideration. A meeting of the parties has been scheduled for April 21, 2016 to discuss these recommendations.

X. Recommendations

Consistent with the requirement in the Settlement Agreement that the Independent Reviewer take a "problem-solving approach" (¶ L [7]), during the past year, the Independent Reviewer has shared his observations and recommendations on the progress of implementation with the State, sometimes in writing and sometimes informally during meetings.

A. In-Reach

- Housing Contractors continue to express concerns on limitations to the in-reach process placed upon them by some adult homes, both in terms of the conditions in which in-reach can be conducted and the hours in which it may be performed. The State DOH's has already been proactive in communicating with adult homes their obligation to provide access to in-reach teams and has issued Dear Administrator Letters ("DAL") of March 12, 2014 and June 6, 2014 which stressed the importance of providing the Housing Contractor with a "quiet, private, space, where either group or individual in-reach sessions can take place," and to "make every effort to avoid rooms where frequent interruptions may occur." The DOH has also conducted investigations when complaints have been made about interference with Housing Contractors' performance of their in-reach functions and has

substantiated some of these reports at individual homes. Beyond this formal and regulatory process, the Independent Reviewer recommends that DOH monitor a sample of the impacted adult homes to assess their compliance with the expectations contained in these DALs and to reinforce the importance of doing so.

- The uneven performance of Housing Contractors with respect to rates of in-reach and in-reach outcomes (whether or not one is interested in transitioning), warrant closer scrutiny by the State. Some Phase III Housing Contractors, which started in-reach nine months after Phase II, have in-reached a greater percentage of class members than some Phase II Housing Contractors. Some Phase II Housing Contractors have had only two or three class members transition from some adult homes; none have transitioned from Central Assisted Living. It is also noted that while class members' rates of interest in transitioning vary among Housing Contractors, overall the rate is declining. The rate of positive responses at in-reach seems to be declining as time goes on. At Week 24 (8/19/14), for example, when in-reach had been expanded to all of Brooklyn and Queens, the overall rate of positive responses was at 63.9%. The overall rate as of week 73 was 52.3%. If one considers only the most recent three month period, the rate of positive responses is 34%. This is a troubling trend, the reasons for which require further analysis, explanation and remediation. Among the issues requiring further investigation by the Defendants is the use of Motivational Interviewing during in-reach, the training of in-reach workers and the strategies used for effective-in reach, as well as the adequacy of staffing of the in-reach teams and the use of peer advocates in this role.

- The strong influence of family members upon class members and their decision to move to supported housing also suggests that consideration should be given to expanding in-reach efforts to educate guardians and family members about supported housing and the wrap around services available, and engage them in the personal planning process, especially as the roll out of the Adult Home Plus program would provide case loads that make such engagement feasible.

- Housing Contractors play a unique role in the transition process, serving almost like book ends. At the onset of the process, Housing Contractors are responsible for in-reach, which paves the way for assessments and reviews by other entities, after which, at the tail end of the process, they become responsible for finding housing and supporting individuals in their supported housing units. In the initial stages of the Settlement's implementation, many people interested in transitioning to supported housing were "stuck" in the assessment

phase. With the advent of Adult Home Plus, and the increasing numbers of individuals passing through the assessment phase of the process, Housing Contractors' workloads at the backend have increased. A critical question that must be addressed in the State's review of Housing Contractors' staffing patterns is whether they have sufficient resources to expeditiously facilitate the transition of individuals, and support them, once they are approved for supported housing.

- A frequent question of class members, when offered the choice of supported housing during in-reach, is: "What will happen if it doesn't work out? Where will I go?" This uncertainty probably contributes to the decreasing rate of Yes responses, as well as to the dropout rates later in the process and the changing decisions of class members right up to moving date. The message thus far has been that once you leave the adult home, you cannot return. Staff of the adult homes have sometimes amplified this message and raised the specter of homelessness which may have had the effect of discouraging individuals from moving. The reality is that class members ***can*** return to adult homes which have DOH waivers in effect and, as described in this report, have done so in a few cases. Simply helping them understand that reality may allay some of the fears and uncertainties class members confront when making the decision of this significance.

B. Assessment

- As early as June 2014, the Independent Reviewer has been recommending that the state arrange for the performance of assessments under the Settlement Agreement be assigned to a dedicated team of experienced assessors to promote consistency, quality and timeliness of this critical function. (Progress Memo #3, July 31, 2014, First Annual Report, p. 70). As the State has continued to struggle with eliminating the backlog of assessments and improving the timely performance of this function, that recommendation is renewed. The Independent Reviewer understand that the State is considering further actions to implement this recommendation and awaits further information regarding its progress in doing so..

- As noted in the report, the assessment process has resulted in six percent of class members being recommended for Level II Housing which, as opposed to supported housing, is temporary and at a premium, given the limited number of beds. The Independent Reviewer recommends that when a class member is recommended for level II housing, the Person Centered Plan developed needs to be reviewed to ensure that it addresses the need for services and supports that may better prepare the class member for eventual transition to supported housing.

- As also described in the report, approximately seven percent of cases referred to HRA for review/approval following assessment were classified as "Unable to Complete" (UTC) due to incomplete or inconsistent information or other reasons. In some cases, this is because HRA has access to information in prior applications which may not have been available to the assessor. A small number of cases are in this category due to the death of the class member or the abandonment of the application. While the number of UTC cases is slightly lower than that in the first year of the Independent Reviewer's monitoring activities, it nonetheless warrants attention. The Independent Reviewer recommends that the State DOH: 1) examine whether changes in the Quality Assurance reviews are necessary with an eye toward identifying and addressing issues that may lead to UTC determinations, their underlying causes and any patterns of less than adequate performance by assessing entities; and 2) take action to correct the deficiencies in information/documentation that has led to more than 40 cases lingering in the limbo of UTC, many for extended periods of time.

C. Person Centered Planning

- The Independent Reviewer has expressed concern over the need for additional training in person-centered planning and a template which ensures that the total needs and desires of class members - including vocational/educational, religious, leisure/social, civic interests and the like – are addressed in care plans in addition to the health and safety issues which are typically addressed in plans. The Independent Reviewer applauds the State's initiative to arrange for person-centered planning training for the Adult Home Plus care mangers by the New York Association of Psychiatric Rehabilitation Services, Inc. and is optimistic that this training will address the concerns that have been expressed in this report about person centered planning. It is important that training reinforce the central principle that the class member is at the heart of the plan and can determine who is invited to participate in the development of the plan and whether to invite family members, friends, allies and others into the process.

- It was noted that in the Independent Reviewer's follow up of sample class members who had transitioned, a number who were not involved in programs or structured social activities complained of loneliness following transition. In training sessions, the State should continue to stress the importance of exploring individuals' interests in social activities during care planning sessions and means of addressing these interests through involvement in PROS programs, psycho-social clubs or drop-in centers.

- Considering that individuals often experience budgeting and money management problems upon transition, more attention should be paid in the care planning process to identify means of assisting individuals to learn budgeting skills either through enrollment in programs like PROS or through direct hands-on teaching by Housing Contractors or others.

- Contributing to budgeting problems are delays in securing SNAP benefits or full SNAP benefits upon transitioning. Efforts to ensure timely pre-transition applications for SNAP benefits and setting up expenses so that individuals receive maximum benefits upon transition need to be stepped up in the care planning process. Related to this is the need to secure proper IDs which are needed to apply for SNAP and to use community resources upon transition, such as banks, etc. With the implementation of Adult Home Plus, more attention ought to be given to securing essential documents while class members are still in the adult home, and commencing applications for services and benefits at the earliest possible time.

- PSYCKES data can be a useful tool in care planning and monitoring as well as the assessment phases of transition. These summaries of Medicaid claims data maintained by OMH offer insights into health and behavioral health providers class members have utilized as well as utilization patterns. They also flag certain issues one should be aware of and attend to, such as polypharmacy, frequent hospitalizations and emergency room utilization, diabetes needs and monitoring, etc. At the Independent Reviewer's suggestion, PSYCKES data has been made available to HH/MLTCPs. It is recommended that the State provide training to HH/MLTCP assessors and care managers and assessors to assist them in their use of the data in assessments and care planning/monitoring activities.

D. Transition

- The Independent Reviewer understands and appreciates the balance between choice and affordability that Housing Contractors are trying to strike in accommodating choice of housing for class members who express a strong preference for a studio or one-bedroom apartment. At present, two Housing Contractors have not placed any class member in single occupancy apartments. The Independent Reviewer recommends that, consistent with the Supported Housing RFP issued by the OMH in 2012, more attention to be given to developing the capacity to offer meaningful choice to those class members whose preference is to live alone, or with family members or friends who are not class members, or in another borough –as has already been done in a few cases.

- In the review of sample class members who had transitioned, the Independent Reviewer encountered individuals who experienced difficulties with housemates or guests the housemate invited to stay in the shared apartment. It is recommended that OMH develop guidance for Housing Contractors and class members on how to best deal with and resolve such situations as they arise.

- As detailed in the report, individuals sometimes experience crises which jeopardize their continued stay in Supported Housing. As the Independent Reporter has pointed out, these occurrences present learning opportunities about how best to support individuals with intensive needs in the community. These opportunities need to be seized and capitalized on in a more formal way. Toward that end, the Independent Reviewer recommends that:

    - When individuals begin experiencing difficulties which are likely to jeopardize their placement, the State convene a special review mechanism involving all current providers as well as objective, clinical outsiders with experience in supported housing to discuss and plan a course of intervention and services to support the individual where they are living.

      A mechanism be put into place whereby when an untoward event – such as an elopement, a crisis hospitalization, etc. – occurs, the individual's support team – including the Housing Contractor, HH/MLTCP, mental health provider and others as appropriate – should promptly conduct a thorough review of the circumstances of the event with an eye toward determining if anything in, or missing from, the care plan may have contributed to the event and what actions should be taken to reduce the likelihood of a recurrence. The findings, recommendations and actions taken stemming from this internal review should be reported to OMH, DOH, the Independent Reviewer and Plaintiff's Counsel within 30 days of the event. The lessons learned from such reviews should be shared with all HCs, HH/MLTCPs involved in this initiative.

- In following a sample of class members, the Independent Reviewer also noted that a number had been disenrolled from their MLTCPs shortly after transitioning. It is recommended that class members not be disenrolled from an MLTCP until the individual is enrolled in another MLTCP or Health Home and a care plan put in place, unless the individual freely chooses otherwise. Understandably, the time of transition and the weeks that follow is one of change and possibly turmoil in the individual's life; all efforts should

be made to ensure a smooth transition of care management and continuity of services at such a time.

- The parties should discuss and clarify the obligations under the Settlement Agreement to class members: a) who have been placed in non-permanent Level II housing or other time-limited housing following the assessment and HRA approval process; and b) who have been discharged from the adult home outside the transition process of the Settlement Agreement.

- In addition, there are a number of class members who are not Medicaid eligible, most often due to excess resources. They are thus ineligible for Medicaid funded programs like Health Homes and MLTCPs, and the care management services they provide. The Settlement Agreement provides that if a class member "is not enrolled in a Health Home or MLTCP, then the State shall provide the person with a care coordinator who shall carry out the functions in this Agreement that would otherwise be assigned to a Health Home and MLTCP." (Paragraph F (1)) There is a need to operationalize this provision of the Settlement Agreement so that class members who are no Medicaid eligible are not excluded from the benefits of the Settlement Agreement.

Appendix A. List of Acronyms/Abbreviations

AHRAR	Adult Home Resident Assessment Report
CHHA	Certified Home Health Aide
CIAD	Coalition for the Institutionalized and Aged
CTL	Community Transition List
CDTP	Continuing Day Treatment Program
CBC	Coordinated Behavioral Care
FTL	Fast Track List
FEGS	Federation Employment & Guidance Services
FOO	Federation of Organizations
HHC	Health & Hospitals Corporation
HCS	Health Commerce System
HH	Health Home
HC	Housing Contractor
HRA	Human Resources Administration
ICL	Institute for Community Living
JBFCS	Jewish Board of Family and Children's Services
LHCSA	Licensed Home Care Service Agency
MLTCP	Managed Long Term Care Plan
MHC	Mental Health Clinic
MFY	Mobilization for Youth
PCS	Personal Care Services
PER	Personal Emergency Response
PROS	Personalized Recover Oriented Services
TSI	Transitional Services Inc.
UTC	Unable to Complete
UAS-NY	Uniform Assessment System for New York

Appendix B. Discharge Planning Tool

Adult Home Class Member Discharge Planning Tool

Guidance

The development of the care plan for transition must begin as soon as the resident is enrolled in the Health Home or MLTC Plan and express they wish to transition out of the Adult Home. The Adult Home Plus (AH+) Care Manager must collaborate with primary care, specialists, and behavioral health providers to schedule regular care plan meetings with all members of the multidisciplinary team. The AH+ Care Manager is responsible for updating and reviewing the person-centered care plan. Once the resident completes in-reach and wishes to transition to the community, the Housing Contractor needs to be included as a member of the multidisciplinary team.

The person-centered care plan should reflect the UAS-NY assessment, the AHRAR, and HRA recommendations as well as additional needs identified through the progressive care management work with the resident. This person-centered care plan must be updated as needed and reflect the resident's changing needs.

The person-centered care plan:

1. Identifies the programs that address the resident's primary, specialty, behavioral health care and social service needs;
2. Reflects the resident's, family's and guardian's (if applicable) input on identified services/programs;
3. Lists the goals and interventions for improving the resident's health and health care status;
4. Demonstrates the periodic reassessment of the resident's needs and progress based on changes in the resident's status; and
5. Reflects the resident's psychosocial/spiritual needs and interests (e.g., continuing education, culturally relevant social opportunities and faith communities, civil/civic community activities, etc.)

The Office of Community Transitions will schedule a call approximately three weeks prior to the resident's transition to the community. The AH+ Care Manager **is required** to complete the Discharge Planning Tool and forward it to the assigned Community Transitions Coordinator at least two business days prior to the pre-transition call. The AH+ Care Manager should come prepared to discuss the person-centered care plan for transition. Housing Contractors need access to a copy of the care plan no later than two weeks prior to the scheduled move in date.

Please note that it may take the Housing Contractors upwards of 40 days from the day they conduct a housing intake interview with a resident, to find an apartment for the resident. During this waiting period, please be sure to continue to work with the resident to prepare the resident for transition.

Adult Home Class Member Discharge Planning Tool

AH+ Care Manager Checklist

The Adult Home Plus (AH+) Care Manager is the single point of contact and will be responsible to:

☐	Confirm that class member is enrolled in the Health Home
☐	Advise Adult Home + Care Manager (CM) Supervisor to record the date the class member was enrolled in Adult Home Plus on OCT's weekly tracker
☐	Begin completion of the Discharge Planning tool
☐	Check for guardianship
☐	Establish the multi-disciplinary team, which must include, but not be limited to, the Housing Contractor, Mental Health Provider, the MLTCP Care Manger (if applicable), the class member, and guardian (if applicable).
☐	Complete and update the HH Consent Form (DOH-5055) to obtain all consents for release of Protected Health Information (PHI) including the class member's psychiatric records and HRA application
☐	Contact and inform the Mental Health Provider that their client has expressed an interest in transitioning to the community
☐	Request a Comprehensive Psychiatric Evaluation (CPE) or a Psychosocial History from the Mental Health Provider and follow up as needed for timely completion; The AH+ Care Manager may arrange for alternative means to obtain a CPE or Psychosocial History if needed, through qualified clinicians
☐	Advise CM Supervisor to record on OCT's weekly tracker the date the CPE or Psychosocial History was requested and the date the CPE or Psychosocial History was obtained
☐	Forward a copy of the completed CPE or Psychosocial History to the RN assessor and the Office of Community Transitions via the Health Commerce System (HCS) Community Transition Upload
☐	Coordinate completion of the UAS-NY assessment with appropriate RN Assessor based on class

	member's enrollment (MLTCP or HH)
☐	Advise CM Supervisor to record the date the UAS-NY assessment was completed or refused on OCT's weekly tracker
☐	Distribute the finalized AHRAR (per the distribution list) immediately upon receipt from the RN assessor
☐	Submit completed Impacted Adult Home Supported Housing Application (IAHSHA) to the Human Resources Administration (HRA) via the WinSCP program *The HRA IAHSHA includes:* ☐Finalized Adult Home Resident Assessment Report (AHRAR) ☐UAS-NY comprehensive assessment ○ Community Assessment ○ Mental Health Supplement ○ Functional Supplement ☐Comprehensive Psych Evaluation (CPE) or Psychosocial History
☐	Once HRA completes their review of the IAHSHA: ☐ A. If the HRA housing recommendation aligns with the housing recommendation listed on the AHRAR, forward the HRA determination letter and the completed HRA IAHSHA packet (components listed above) to the assigned Housing Contractor and MLTCP Care Manager (if applicable) ☐ B. If the HRA housing recommendation does not align with the housing recommendation listed on the AHRAR contact OCT via email at CommTran@health.ny.gov
☐	Send completed Discharge Planning Tool to assigned Community Transition Coordinator (CTC) at least 2 business days prior to the scheduled three-week pre-transition call and forward a copy completed care plan to the Housing Contractor.
Early Health Home Enrollment: ☐ Within 24 hours of the class member consenting to Health Home and AH+ enrollment the AH + Care Manager must e-mail the Housing Contractor and copy CommTran@health.ny.gov to request that the class member is given in-reach ☐ Advise AH + Care Manager (CM) Supervisor to record the date the class member was enrolled	

in Adult Home Plus on OCT's weekly tracker
AH+ Care Manager Best Practice: • Keep the class member informed throughout the assessment process and reinforce that the AH+ care manager is the single point of contact and leader of the transition process • Utilize your supervisor on an on-going basis to discuss any questions or challenges that you have that need to be resolved • Coordinate with the RN assessor to be present during any assessments, if possible • Introduce self and role as the AH+ Care Manager to the multi-disciplinary team and maintain rapport and communication throughout the transition process

Adult Home Class Member Discharge Planning Tool

Date of Meeting: Click to enter date.

Completing this required form will assist you, the AH+ Care Manager, to prepare for the Office of Community Transitions' (OCT) call held approximately three weeks prior to the resident's discharge. Completing this form will also allow you to provide a summary of the services that have been arranged, the name of the service providers, and when services are scheduled to begin, to ensure that everything is ready for a safe transition. **This form must be submitted to the assigned Community Transitions Coordinator (CTC) at least two business days prior to the pre-transition call.**

Date Discharge Planning Tool Sent to CTC (*2 business days prior to call*): Click to enter date.

Conference Call Participants (*to be completed on date of meeting by participants*):

Click here to enter text.

1. **Resident name:** Click here to enter text.
2. **Name of resident's guardian (if applicable):** Click here to enter text.
3. **Roommate (if applicable). Include whether the roommate is currently residing in apartment:** Click here to enter text.
4. **Address of apartment resident is moving to:** Click here to enter text.
5. **Apartment type (level, walk-up stairs/elevator and number of bedrooms):** Click here to enter text.
6. **Projected date and time of move:** Click here to enter a date. Click here to enter time.
7. **The care plan must be shared with the Housing Contractor by the 3-week pre-transition call:** Click here to enter a date.
8. **Has the 30-Day notice to adult home been submitted by the Housing Contractor?**

   □ Yes. *Please provide date of submission*: Click here to enter a date.

   □ No - *Explain*: Click here to enter text.
9. **Is the resident currently in an Assisted Living Program (ALP) bed at the Adult Home?**

   ☐ Yes. *Please list the identified ALP services being provided:* Click here to enter text.

   □ No
10. **Has the local Department of Social Services been contacted by the Health Home (HH)/MLTC Plan Care Manager, on behalf of the resident, to verify eligibility for the Special Income Standard Program** (*Please refer to* ***FAQs Document***)**?**

    ☐ Yes ☐ No - *Explain*: Click here to enter text.
11. **Date of discharge care planning meeting:** Click here to enter a date.
    a. Participants in the care planning meeting: Click here to enter text.
12. **Name of HH and/or MLTC Plan:** Click here to enter text.
13. **Name of HH and/or MLTC Plan Care Manager:** Click here to enter text.
14. **Housing Contractor Agency and Name of Housing Contractor:** Click here to enter text.

15. **Resident's emergency contact(s):** Click here to enter text.
16. **Representative Payee** *(if applicable, apply for representative payee status by the 13th of the month to allow for the receipt of the SSI/SSD check by the next consecutive month*): Click here to enter text. □ N/A
17. **Discuss whether the resident will have sufficient cash after being discharged from the Adult Home and whether the Adult Home Administrator will be refunding the remaining rent and personal needs allowance to the resident:** Click here to enter text.
18. **Required documents provided to the Housing Contractor:**
    a. SSA Award Letter □ Yes □ No - *Explain*: Click here to enter text.
    b. Medicaid benefits card □ Yes □ No - *Explain*: Click here to enter text.
    c. State Picture ID □ Yes □ No - *Explain*: Click here to enter text.
    d. Most recent copy of Assisted Living Residence Medical Evaluation Form (DOH 3122) □ Yes □ No - *Explain*: Click here to enter text.
    e. Other: Click here to enter text.
19. **Secured essential benefits and entitlements:**
    a. SNAP

       □ Yes. *Submit application for SNAP benefits no more than 30 days prior to transition. Date application was (or will be) submitted:* Click here to enter a date.
       □ No – *Explain*: Click here to enter text.

    b. Other: Click here to enter text.
20. **Medical and psychosocial review:**
    a. Summary of medical diagnoses: Click here to enter text.
    b. Summary of mental health diagnoses: Click here to enter text.
    c. List resident's primary concerns relating to the move (*e.g., fear of being alone, not getting along with roommate, emergency needs, afraid of making meals on their own, etc.):* Click here to enter text.
21. **List of service recommendations from AHRAR, HRA Decision, and care plan meetings:** Click here to enter text.
22. **Medical treatments:** Click here to enter text.

a. Medications: Click here to enter text.

b. Special dietary needs: Click here to enter text.

c. Name and phone number of PCP in the community: Click here to enter text.

d. Name and phone number of pharmacy in the community: Click here to enter text.

e. Name of any other medical specialists (*if applicable*) in the community: Click here to enter text.

f. Next scheduled appointments in the Community:

i. Medical: Click here to enter a date.

ii. Other: Click here to enter a date.

23. Behavioral health treatments: Click here to enter text.

a. Enrollment in mental health programs: Click here to enter text.

b. Name of mental health clinic/psychiatrist: Click here to enter text.

c. Next scheduled appointment for behavioral health in the community: Click here to enter a date.

24. Activities of daily living:

a. Medication management: Is the resident able to manage and self-administer his/her medication?

□ Yes. *Choosing this response indicates prior to transitioning the care manager arranged to have the resident's self-medication abilities assessed by an RN for each objective identified in* ***FAQs Document****, and a plan of care was developed to address specific needs and the nurse determined the resident is able to manage and self-administer his/her medication.*

☐ No. *Please explain the plans for medication management of the individual, including any planned medication training*: Click here to enter text.

For those residents who are insulin dependent diabetics, please make sure that prescriptions are obtained from the PCP/endocrinologist for insulin (pen or vial), pen tips with needle (if required) for the insulin pen; syringes (if needed) to draw insulin from the vial; glucometer, glucometer strips, lancets, alcohol pads.

b. Medications for transition: Will the resident have a 30 day supply of medications?

□ Yes.

□ No. *Please explain the plan for ensuring there is no lapse in medication:* Click here to enter text.

c. Meals: Plan for access to food at transition and following transition: Click here to enter text.

1. Is the resident capable of preparing his/her own meals?

□ Yes.

□ No. *Please indicate which of the following services have been secured:*

i. Meals on Wheels (*if qualified)* □ Yes □ No

ii. Congregate Meals Program □ Yes □ No

iii. Home Health Aide □ Yes □ No

iv. Personal Care Worker □ Yes □ No

v. Other: Click here to enter text.

25. **Furniture and household items:** Click here to enter text.
26. **Telephone services:** Click here to enter text.
27. **Utility set-ups:** Click here to enter text.
28. **Transportation/Assistance with moving resident:** Click here to enter text.
29. **Transportation for medical appointments in the community:** Click here to enter text.
30. **First scheduled meeting with AH+ Care Manager following transition:** Click here to enter a date.
31. **First scheduled meeting with Housing Contractor following transition:** Click here to enter a date.
32. **Other comments:** Click here to enter text.
33. **Date of Post-Transition Call:** Click here to enter a date.

Appendix C. Post Transition Call Checklist

NYC Adult Home Class Member Post Transition Call Agenda

Date/Time: Click here to enter text.
Class Member Name: Click here to enter text.
Attendees:
Housing Contractor Staff/Agency: Click here to enter text.
HH Care Manager Staff/Agency: Click here to enter text.
Name of Health Home (if CM is downstream provider): Click here to enter text.
MLTC Care Manager Staff/Agency: Click here to enter text.
OMH/DOH Oversight Staff: Click here to enter text.

1. Move/Apartment (ex. condition of apt; utilities, phones, bed bugs)	☐ No Concerns	☐ Yes Concerns Notes (list concerns and how addressed or will be addressed): Click here to enter text.
2. Financial (ex. Has money, switched payee)	☐ No Concerns	☐ Yes Concerns Notes (list concerns and how addressed or will be addressed): Click here to enter text.
3. Food (ex. Has food stamps/date to start, able to prepare meals)	☐ No Concerns	☐ Yes Concerns Notes (list concerns and how addressed or will be addressed): Click here to enter text.
4. Psychiatric/Medical (ex. Follow up with providers, compliance)	☒ No Concerns	☐ Yes Concerns Notes (list concerns and how addressed or will be addressed):

		Click here to enter text.
5. Medications (ex. Received 30 day supply/script, support services for med mgmt. if indicated)	☐ No Concerns	☒ Yes Concerns Notes (list concerns and how addressed or will be addressed): Click here to enter text.
6. ADL services (ex. CHHA, PCW, nurse services in place)	☐ No Concerns ☐ Not applicable	☐ Yes Concerns Notes (list concerns and how addressed or will be addressed): Click here to enter text.
7. Social needs (ex. Roommate relationship, community involvement, life goals; how is the class member spending his/her day)	☐ No Concerns ☐ Not applicable (no roommate)	☐ Yes Concerns Notes (list concerns and how addressed or will be addressed): Click here to enter text.
8. Communication (ex. With Class Member, between HC and CM)	☐ No Concerns	☐ Yes Concerns Notes (list concerns and how addressed or will be addressed): Click here to enter text.

Additional concerns/positive aspects to share	
