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)

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

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

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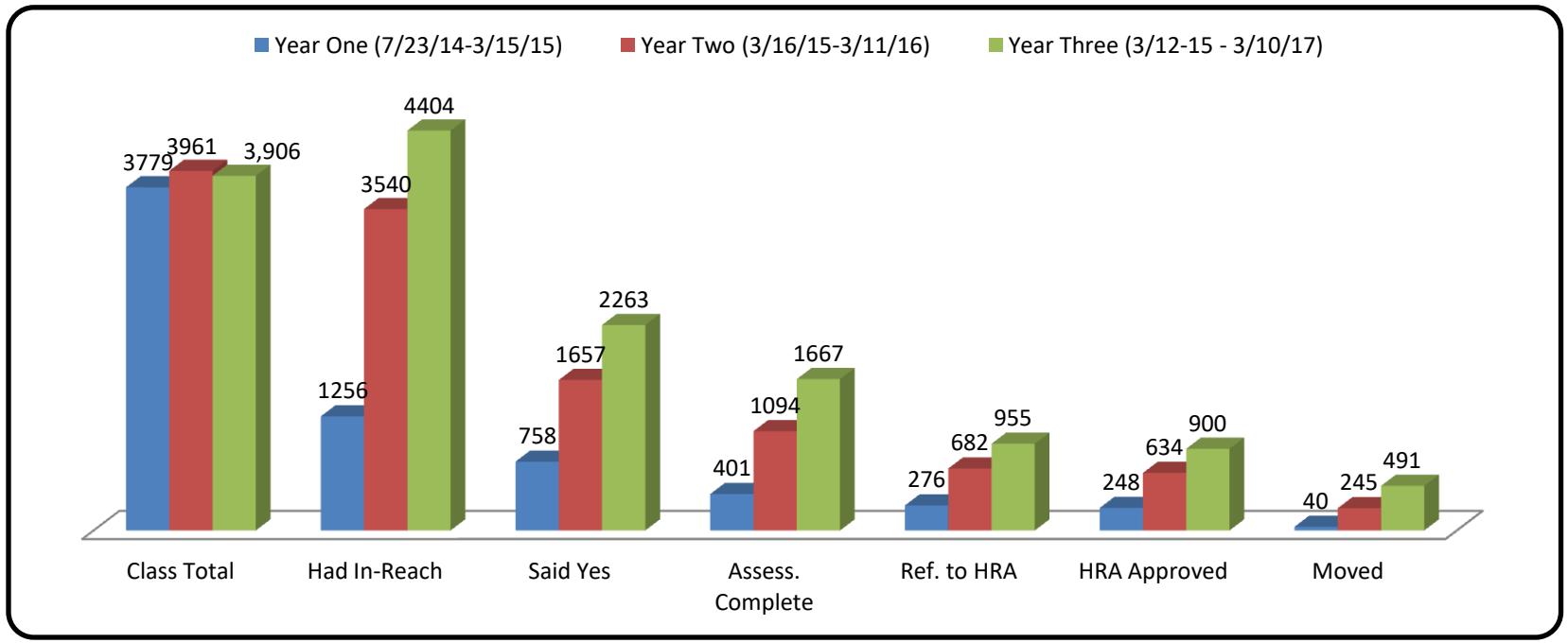
Executive Summary

Figure. 1. Overview of the Status of Implementation as of March 10, 2017[1]



[1] The data in this report are drawn from the Defendants' weekly reports up to Week 156, ending on March 10, 2017.

Out of the 3,906 class members identified as of March 10, 2017, 4,404 have received in-reach by a Housing Contractor, and 2,263 of those class members have expressed an interest in moving to supported housing.[2] As of March 10, 2017, 491[3] had been moved over the first 15 quarters that the Settlement Agreement has been in effect.[4]

There continues to be progress towards the goals of the Settlement Agreement in year three. However, the flaws in the transition process described in previous reports continued to hobble the pace of progress. The bottleneck that is the assessment process continues to be a significant impediment to quicker movement through the process, and it may be having an effect on the interest of class members in taking advantage of the opportunity offered by the Settlement Agreement to transition to supported housing or other suitable alternatives in the community. It is taking longer cumulatively for the class as a whole to navigate the multiple steps leading to community placement in Year Three than it did in Year One and Two.

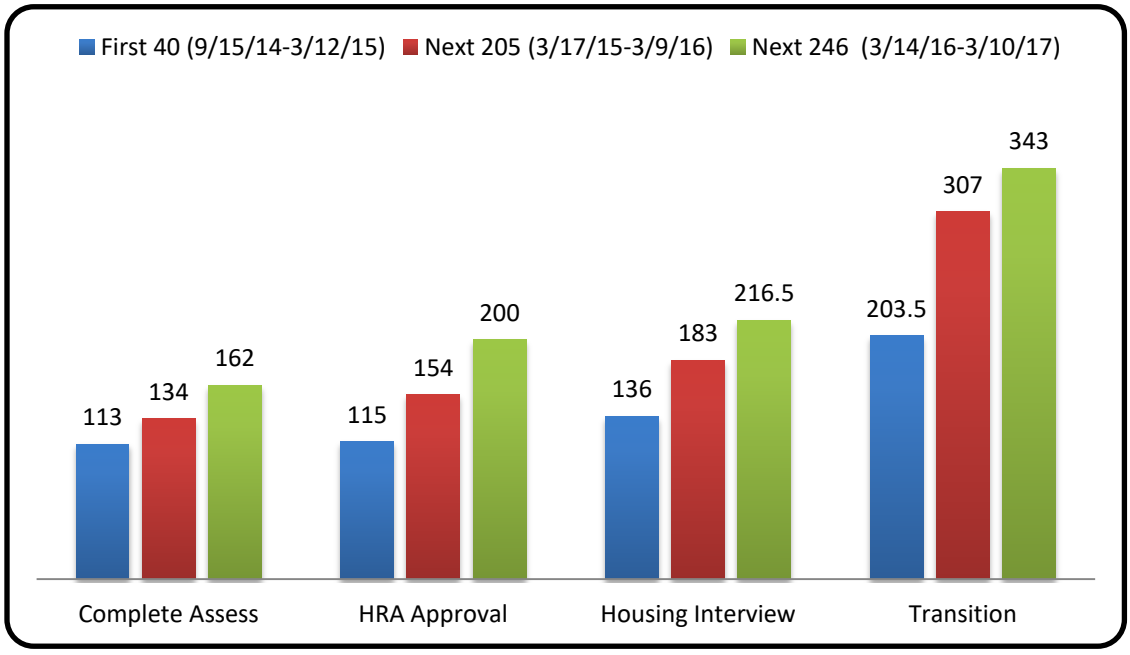


Figure 2. Median Days from in-reach to transition as of March 10, 2017

[2] As explained in more detail below, the 3,906 class members represent a snapshot at a point in time. Due to admissions and other additions to the class list, there are more people in a year who are eligible to receive in-reach.

[3] Although 491 class members had transitioned from adult homes as of March 10, 2017, 10 had returned to adult homes and will continue to receive in-reach as active class members. .

[4] 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.

The pace of transitions is still slower than what would be required to meet the Settlement Agreement goals for Year Four and Five.

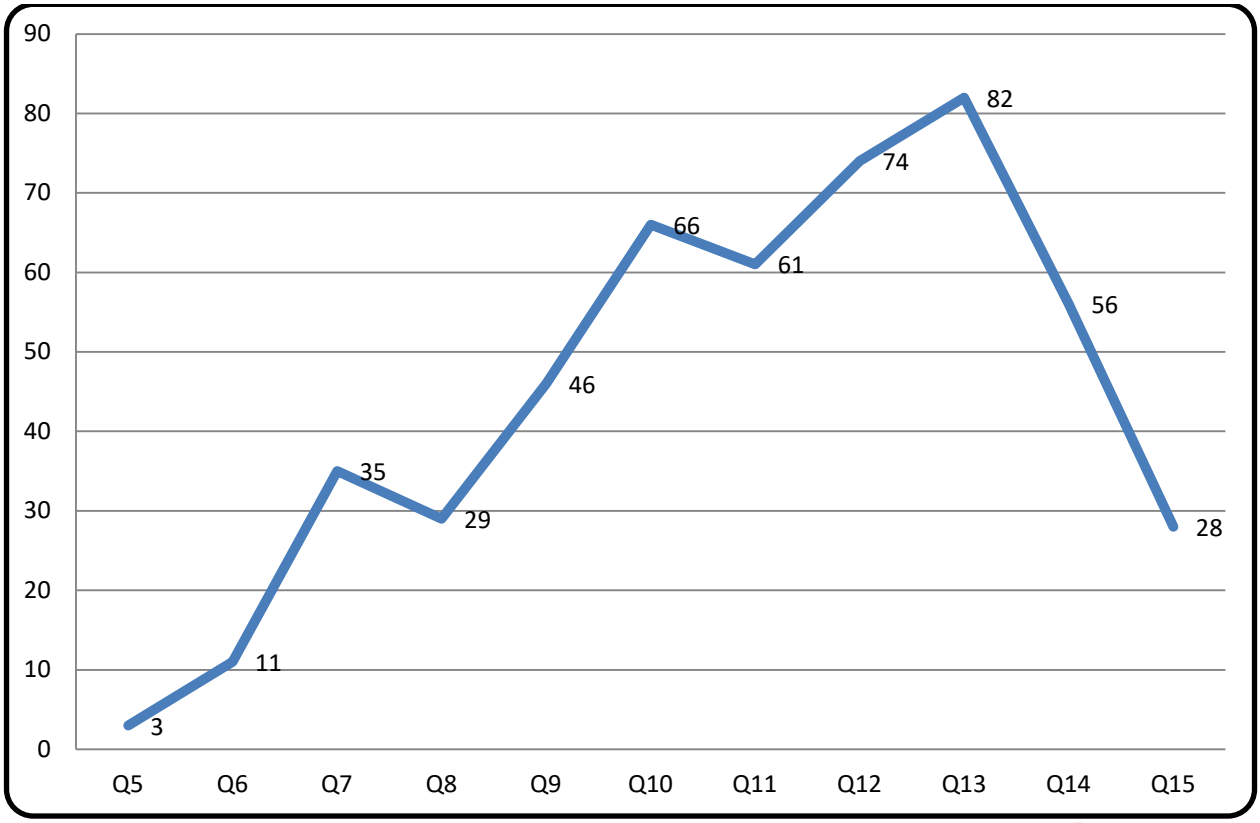


Figure 3. Transitions of class members, by quarter as of March 10, 2017[5]

The problems with the assessment process described in the First Annual Report (pp. 20-28) have remained a stubborn obstacle. The new initiatives implemented by the Defendants – Adult Home Plus, changes to the requirement for a Comprehensive Psychiatric Evaluation and authorizing the use of psychosocials performed by a broader array of clinicians – and the decision to vest responsibility for assessment in a single entity – Transitional Services Inc. (TSI) - are all positive developments. But thus far, they have not eliminated the problems experienced to date and by several measures, the problem has become more severe. (Report, Section VI) By March 10, 2017, the number of cases in the assessment process had grown from 449 on July I, 2015 to 811. The median number of days in assessment increased from 79 to 269. The number of cases that remained in the assessment phase for more than six months rose from 32.7% to 58.5%.

Not only is the pace of assessments a matter of significant concern but so too is the changing outcome of the assessment process, especially since TSI took over responsibility for assessments. Since then:

[5] The data for Q 15 is partial, as the Quarter does not end until March 31, 2017.

- the percentage of class members recommended for Level II housing has increased significantly;
- the percentage of class members recommended for supported housing has declined significantly;
- there has been a sharp increase in the percentage of class members who are determined not to have a serious mental illness; and
- the percentage of assessments with an outcome of "declined assessment" has increased substantially. (Report, §V (B))

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 V) As the Independent Reviewer has previously recommended, 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.

It is apparent as the implementation of the Settlement Agreement has not proceeded as originally anticipated and that the pace of transitions of class members who are interested in moving to supported housing or other community residential alternative has been slower than envisioned. In each of the annual reports and periodic progress memos to the parties, the Independent Reviewer has offered recommendations to address the obstacles that have been encountered. While the state had disagreed with or not adopted several of these recommendations, it has eventually adopted others (e.g., smaller caseloads for care coordinators through the Adult Home Plus program, and more recently, relying on a single contractor to perform assessments), but the time lag in doing so has been too great to overcome the cumulative effects of the initial slow progress.

As this report is being drafted, the parties have agreed to review provisions of the Settlement Agreement to consider revisions that might be warranted to streamline the implementation process as well as to facilitate the achievement of the goals of the agreement.

I. 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 third year, the schedule requires that the Independent Reviewer's draft be provided to the parties by February 15, 2017, with their comments due by March 17, 2017, and the final report submitted by April 1, 2017.[6]

A caveat noted in last year's annual report regarding the data contained herein bears repeating. 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 Managed Long Term Care Programs (MLTCP), 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. 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.

[6] Annual reports have been filed previously as follows: Independent Reviewer's First Annual Report, Doc. # 36, filed March 30, 2015, hereinafter "First Annual Report"; Independent Reviewer's Second Annual Report, Doc. # 63, filed April 1, 2016, hereinafter "Second Annual Report."

The primary focus of this report is on the experiences of class members who have gone through the in-reach, assessment, approval by the New York City Human Resources Administration (HRA) and care planning processes, and have been transitioned to supported housing in the community which is the ultimate objective of the Settlement Agreement. To that end, in this report we will describe in some detail our review of a sample of 28 class members who left or had been scheduled to leave the adult home between March 25, 2016 and July 2016. In addition, we will report on each of the stages of the transition process – in-reach; assessment; HRA approval; Housing Contractor placement process; services provided by Housing Contractor case managers, care coordinators from Health Homes (HH) and MLTCPs, and the Adult Home Plus Care Managers;[7] person centered planning and quality assurance.

II. Methodology

Over the past year, the Independent Reviewer and his associates (Mindy Becker, 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:

[7] There are many different terms used to refer to these staff who assist class members during various phases of the transition process. For the sake of consistency and clarity, in this report we will refer to the Housing Contractor staff as case managers, to the staff of the Health Home and MLTCPs as care coordinators, and to the Health Home Adult Home Plus Care Managers by the shorthand AH+CM.

1. Participated in and observed 17 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.

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[8] Housing Contractors responsible for in-reach, supported housing development, transition of residents and their housing/case management following transition, as well as in periodic meetings of the Housing Contractor supervisors.

5. Met with representatives of the Coalition of Institutionalized Aged and Disabled (CIAD), the Mental Health Association in New York State (MHANYS), the New York Association of Psychiatric and Rehabilitation Services (NYAPRS) and the Schuyler Center for Analysis and Advocacy (SCAA) which provide advocacy services on behalf of adult home residents and are active in homes covered by the Settlement Agreement.

6. Met with HRA and TSI about the new assessment process;

7. Attended a meeting with a Housing Group at an adult home coordinated by CIAD and a Housing contractor

8. Met with 171 class members during educational, in-reach, assessment and care planning sessions or after their transition to supported housing.

9. Also participated in care planning and transition related conference calls for 182 class members including:

    - Seventy five 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.

[8] There were originally nine Housing Contractors, but one, Federation, Employment and Guidance Services (FEGS), went out of business and its operations were absorbed by the Jewish Board of Family and Children's Services. The FEGS services are referred to in this report as "Jewish Board II" or "JB II."

- Fifty six 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 happened about three to four weeks after transition.

- Fifteen "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.

- Five calls in which the assessment process resulted in a recommendation that the individual remain in an adult home.

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

10. Conducted an in-depth review of a 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.

11. Conducted a special review of a sample of the 20 class members whose assessment resulted in a finding that they were not Seriously Mentally Ill (SMI) or that their needs warranted placement in Level II housing. This entailed a review of their assessment related documents and discussions with DOH and the assessing entity's staff.

12. Followed up on complaints registered with the New York State Justice Center or DOH concerning interference or discouragement by adult homes operators.

13. 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.

14. 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.

15. Maintained regular contact through telephone calls and emails with DOH and OMH staff responsible for Settlement Agreement implementation and had periodic face-to-face

meetings with such staff to share the Independent Reviewer's observations and to discuss progress, developments and changes in the implementation process.

16. Issued several progress memos and other memos to the parties on the Independent Reviewer's activities, findings and recommendations where warranted and participated in three 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 United States Department of Justice through email and periodic telephone conferences.

17. 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.

III. 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 December 16, 2016, 1,494 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. [9]

The most recent class list as of March 10, 2017, requested by the Independent Reviewer contained a total of 5,533 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 are subsequently determined not to qualify for class status as they do not have a serious mental

[9] 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.

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 1,627 people from the total due to death or other reasons, reducing the list to 3,906. Of these, as of March 10, 2017, 491 had been transitioned to the community. The 10 individuals who returned to adult homes were placed back on the current active class member list leaving 3,425 "active" class members eligible for assessment and transition pursuant to the Settlement Agreement.

Grand Total class members	5533
Non-SA discharge	-1061
Deceased	-432
Not a class member	-134
SA transition	-491
SA transition but returned to adult home	+10
Current active class members	3425

Table 1. Active Class members[10]

IV. Review of a Sample of Class Members in Transition

As was done last year, the Independent Reviewer team conducted an in-depth review of a sample of 28 class members who had expressed an interest in transitioning from adult homes to supported housing, and who had left or had been scheduled to leave the adult home between March 25, 2016 and July 19, 2016. In selecting the sample, an effort was made to review class members who would have been in the community for several months to capture their experience through the transition and settling in to their new residences. The sample included class members from 18 of the 22 adult homes who were served by all eight Housing Contractors. They were also provided behavioral health services from eight Health Homes and managed long-term care services from seven MLTCs. Sixteen of the 28 were selected at random, two from each housing contractor. Nine were selected based on pre or post transition calls in which the Independent

[10] As previously noted by the Independent Reviewer, there is a need to clarify the status of the 1061 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 for any of them. This is an issue that it is being discussed by the parties.

Reviewer staff had participated, due to the issues they presented. Three were selected because they were discharged from supported housing after their transition.[11]

The sample included nine women and 19 men. The youngest was a 31 year old man and the oldest a 76 year old man. There were three class members in their 30s, one class member in her 40s, 12 in their 50s, five in their sixties and seven in their 70s. While 10 had lived in an adult home for five years or less, seven had been there for 10 years or more, and two had been there for more than 20 years. 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.

In conducting this review, we obtained and reviewed case notes from Housing Contractor case managers, and Health Home and MLTCP care coordinators and nurses. 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.

In the end, two of the class members in the sample did not leave the adult home although transition plans had been developed for them and they came very close to their moving date. They are part of a larger cohort of class members who withdrew their consent to moving somewhere along the line in the transition process.

With a few exceptions, we met with the class members in their homes to hear their perspectives on their transition, their new living arrangements, and the adequacy of services and matters that might be improved. Two home visits could not be scheduled due to infestation with bedbugs. Five other class members were no longer in their supported apartments. As available, we interviewed their case managers, care coordinators, AH+CMs, and Home Health Aides, PCWs or RNs who provided them with direct support. In some cases, we also spoke to

> The Independent Reviewer team conducted an in-depth review of a non-random sample of 28 class members who had expressed an interest in transitioning from adult homes to supported housing, and who had left or had been scheduled to leave the adult home between March 25, 2016 and July 19, 2016.

[11] In the body of this report, the randomly selected class members are identified by a single asterisk (*) placed next to their initials; the second group by a double asterisk (**); and the third by a triple asterisk (***). The same designation is made in the key provided separately to the parties identifying the class members whose cases are described in this report by initials.

supervisory staff of the Housing Contractors, MLTCPs and Health Homes, and mental health programs they attended.

One can reasonably expect that the experiences of the sample class members described below have been shared with other residents in the adult homes they left, and perhaps more widely. These communications can have a significant impact upon the current residents of adult homes who are considering a move of their own.

In reading this report, the reader should keep in mind that many class members who leave an adult home maintain some level of connection to the people they left behind, especially as they often do not have other social networks at the time of transition. Successful transitions where the class members are safe, happy in their new surroundings and enjoying greater freedoms, choices and new experiences can be a positive motivating force for those who are uncertain about the decision they have to make. But this is a two-edged sword. The challenges, frustrations and adverse experiences of the movers –delays in getting their money, SNAP benefits, or linkage to medical and mental health care, bad experiences with housemates, etc. --can also dissuade the stayers from taking the same step. It is an unfortunate truism that bad news tends to travel faster and wider than good news. Case managers, care coordinators and others supporting the class members would do well to keep in mind that their efforts are likely to have an impact well beyond the individuals they work with directly.

A. Housing choice

In general, the description in the Second Annual Report (pp. 15 *et seq*.) of the class members' apartments, the neighborhoods in which they were located, their access to resources in the community and the process of apartment selection remains largely the same. However, more of the Housing Contractors are now providing access to a choice of studio and one bedroom apartments than previously, although they remain in short supply.

While there are attempts to honor choice, the housing stock and availability, particularly in Brooklyn and Queens, continue to 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. Data presented in the Independent Reviewer's Second Annual report indicated that two of the Housing Contractors had not offered this choice. (Annual Report p. 85, Table 5.) Specifically, Federation of Organizations, which serves four adult homes, did not offer its 23 class members who transitioned studio or one-bedroom apartments; and all of the 25 class members transitioned by Jewish Board II, from the two adult homes they serve, moved to multiple bedroom units.

As of March 10, 2017, Federation of Organizations has transitioned nine class members to a studio or one bedroom apartment, while Jewish Board II has transitioned four class members to live in similar units. There appears to be a greater availability of studio and one bedroom apartments to class members who choose to live in the Bronx or Staten Island. The highest percentage of studio or one-bedroom apartments is currently provided by Pibly, which serves the two adult homes in the Bronx. They have placed 56 of their 73 class members, or 77%, in studio or one bedroom apartments. St. Joseph's Medical Center, which serves one of the three Staten Island adult homes, has transitioned 20 of their 41 class members, or 49%, to single occupancy units. Presently 154 of the 471 class members, or 33% who have transitioned to supported housing, have moved to a studio or one bedroom apartment (See Table 2). This compares favorably to 58 of the 237 class members, or 24.5%, who transitioned to single supported housing units as of March 11, 2016. It is a positive sign that Housing Contractors appear to be making greater efforts to provide the opportunity to more class members, who choose to do so, to live alone. If in fact there is a greater availability of studio and one bedroom apartments in the Bronx with Pibly, and in Staten Island with St. Joseph's, other Housing Contractors with class members insisting on living alone, might want to discuss with them their interest in living in one of these boroughs if it would mean a more timely transition to the community. If interested, the individual could be referred to that Housing Contractor.

> Virtually all of the class members we interviewed expressed satisfaction with having moved out of the adult home. Although, as described below, several experienced bumps along the way in their transition to the community or soon thereafter, the problems they encountered were usually resolved eventually through the efforts of case managers and care coordinators

Another element of choice is the desire of some class members to live in a borough other than that served by the Housing Contractor assigned to their adult home. 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 471 transitions to supported housing, as of March 10, 2017, 16 class members have been placed in supported housing with contractors able to offer housing in other boroughs. Seven of the eight housing contactors have been successful in securing housing for these class members in Queens (5); Bronx (6); Brooklyn (4); and Staten Island (1) As previously reported by the Housing Contractors, the specific preferences of the class members, especially the locations, have posed significant 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 members' specific request, 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 and in some cases their HRA approval expires.

Supported Housing Contractor	Studio/One Bedroom	Two Bedrooms	Three Bedrooms
ComuniLife	9 (6)[12]	22 (11)	2 (2)
Federation of Organizations	9 (0)	13 (6)	23 (17)
Institute for Community Living, Inc.	6 (3)	54 (44)	0 (0)
Jewish Board of Family & Children's Services I	24 (15)	50 (37)	0 (0)
Jewish Board of Family & Children's Services II	4 (0)	48 (24)	1(1)
Pibly Residential Programs	56 (11)	14 (4)	3 (0)
St. Joseph's Medical Center	20 (9)	21 (13)	0 (0)
Staten Island Behavioral Network, Inc.	10 (3)	30 (7)	0 (3)
Transitional Services for NY, Inc.	18 (11)	28 (10)	6 (3)
TOTAL 471 (237)	**156** (58)	**280** (156)	**35** (23)

Table 2. Class Members Transitioned to Supported Housing Units as of March 10, 2017

In 19 of the cases that had their referrals withdrawn after they were approved by HRA and referred to the Housing Contractor between March 11, 2016 and March 10, 2017, the reason given was the preference of the class member to live in a borough other than the one served by the agency that had received the housing referral package. In nine of these cases the class member was subsequently referred to a Housing Contractor serving the borough of their choice, and three of those class members have since transitioned. In another two cases, the class members changed their minds after the referral was withdrawn and transitioned in the borough of their adult home, served by their original Housing Contractor. However, there was no indication that in the other eight cases, that a subsequent referral to a contractor serving the borough of their choice had been made yet.

Yet another aspect of choice arises when a class member moves from the initial apartment to which he or she was transitioned. Such a move may occur either because the lease has expired and the landlord refuses to renew it, or because a situation with a housemate has become so

[12] ( ) = Class members Transitioned to supported housing as of March 11, 2016 (Independent Reviewer's Second Annual Report; p.85)

dysfunctional that a move is necessary. When a secondary move is contemplated it is sometimes the case that a class member who has had an unsatisfactory experience with a housemate expresses a desire for a one bedroom or studio apartment. There have been instances where a Housing Contractor attempts to hold the class member to adhere to the initial choice to accept a two-bedroom apartment. It would be a better practice to respect the principle of choice in housing when a secondary move is being considered, especially since it is likely that such a choice is a more informed one than the initial choice expressed when the person was living in an adult home.

Virtually all of the class members we interviewed expressed satisfaction with having moved out of the adult home. Although, as described below, several experienced bumps along the way in their transition to the community or soon thereafter, the problems they encountered were usually resolved eventually through the efforts of case managers and care coordinators. In most of the cases, case managers and care coordinators made regular and frequent contact with class members to monitor their services and intervene to provide assistance when it was needed. Although there were a few exceptions, from a review of the documentation, there seemed to be a good level of communication between Housing Contractors, Health Homes and MLTCs, and as needed with providers of medical and mental health services as reflected in the progress notes we reviewed.

B. Planned moves that did not happen

Two of the class members in the sample who had indicated an interest in transitioning to supported housing changed their minds somewhere along the process and, at the time this report was being drafted, they remained in an adult home. These cases illustrate the various influences upon decision-making of class members, as well as the ambivalence some of them express during the sometimes lengthy period between their initial expression of interest, and the various stages of reviews and approvals required to get to the point of transition.

> *RB** is a 58-year-old man who has lived in the adult home since August 2013. Before that he lived in an unnamed supervised facility for 15 years and with his grandmother. He has never lived alone. RB expressed an interest in supported housing at in-reach on October 21, 2015. He made it all the way through the process up to a pre-transition call on April 11, 2016, the assignment of an adult home plus care manager and a scheduled move date of May 4, 2016. However, the private psychiatrist treating him at the adult home and his father were opposed to the move and he backed out. His family was withholding ID information and objecting to the adult home nurse instructing him in self-administering his insulin injections. When visited by a member of the Independent Reviewer team on October 28, 2016, he once again expressed an interest in moving to a one-bedroom apartment, complaining of the noise and the number of people in the adult home. He said he had told a "lady" (whose name/agency he could not recall) of his interest within the past two weeks or so. Housing contractor records indicate that RB expressed his renewed interest in moving on October 10 and by*

October 28th a meeting was held with the family. Following the meeting, RB informed the in-reach worker that he did not want to move and upset his family. He said living in the adult home was the best choice for him. His application for supported housing was withdrawn on November 4th.

- *IH**, a 72-year-old woman, said Yes to transition during in-reach on July 16, 2015. She was approved by HRA for transition, had a housing interview, selected an apartment, and gave her 30 day notice on February 26, 2016. However, at the time of her March 14, 2016 pre-transition call, a number of key arrangements had not yet been put in place. Although her adult home plus care manager diligently attempted to engage and support IH in securing services and benefits she would need for a safe transition, IH was not cooperative in the completion of the tasks/steps needed to get services like SNAP, an appointment for mental health services, an ID, change in SSI and representative payee status, and CHHA. Due to her failure to complete these necessary tasks and her resistance to the repeated efforts of her care coordinator to assist her, she was eventually terminated from both her health home and MLTC and remains in the adult home. For several months, she has been refusing to meet with her care coordinator or the social worker from the MLTC. She also refused to speak with a member of the Independent Reviewer team who attempted to understand her concerns.*

These two class members were part of a larger cohort of class members who changed their minds after having received HRA approval, as reported by the State, since March 11, 2016. For eleven such class members who had received HRA approval for housing and had their applications withdrawn, no reason was offered. For another fifteen, some of the reasons given included: they preferred to live in the adult home; were no longer interested or not ready; were moving out of state with a significant other or family; or were waiting for their significant other to return from rehab.

- *MV, a 53 year-old man, has lived at the adult home for 3 ½ years, moving there from another home after Hurricane Sandy, where he had been since 2008. When a post transition call of June 2, 2016 was cancelled for MV and his girlfriend MM, staff of the Independent Reviewer's team followed up with OMH to learn that they both cancelled their moves the day prior to the move out date. The reason given was that he had been vacillating about the move and then on May 11, 2016 in meeting with his care manager and Housing Contractor he decided not to move, and MM said that she would not move without him. The documented reason for withdrawing the referral was that they did not feel ready to move and wanted to work on personal and relationship issues.*

  On July 8, 2016 MV agreed to meet with a representative of the Independent Reviewer, who asked if he could tell him what made him change his mind about moving. He said "I wanted it to be done right." When asked if he still though about moving out, MV said that "maybe in six months to a year I will reconsider it…there are things I have to work out….." MV and MM subsequently moved to an apartment together on November 29, 2016, a little more than six months after they had changed their minds.

- *During a pre-transition call for MK. on April 11, 2016 it was announced that his planned roommate, BW, had changed his mind, and was not moving. The call proceeded and everything was in place for MK to move on April 25, 2016, and they would seek a new roommate to live with him. The following day it was reported to the Housing Contractor that each had informed their therapist at NYPCC that they had changed their mind about moving to supported housing. Neither class member reportedly gave specific reasons to their care coordinator for the change in their decision. On April 15, 2016, the Housing Contractor's Peer Specialist met with MK. She reported that all he said to her was that he did not want to move. When in reach staff spoke with him again during May 2016, he was still not interested and his referral was withdrawn during September 2016. Although housing staff were unable to get in touch and speak with BW, as most often he is out of the adult home, during October 2016 he again said he was ready to move, as long as it was close to transportation so he could visit family, and he is now in the Assessment process.*

  On September 13, 2016 staff of the Independent Reviewer's team visited the adult home and tried to meet with both class members, but were only able to interview MK. When asked why he had changed his mind about moving to supported housing, he said "I had wanted to move- but I changed my mind… I want to stay here. I've been here 20 years (actually 23) ...I told my family after I changed my mind and they were OK with that." He said "nobody influenced me" and ended by saying "I may change my mind in the future."

As reported by the State, since March 13, 2016, nine class members declined to proceed with seeking housing after they were approved by HRA for housing. Two of the cases are included below:

- *RP is a 49 year-old woman who has lived at the adult home for nine years. She had said Yes to in-reach in January 2016, but subsequently refused assessment in March. She later changed her mind and said Yes to in-reach and was assessed by TSI in July. She then reported to housing staff that although she did not want to move at that time, she agreed to have the assessment package submitted to HRA just in case she changed her mind. Although recommended for Apartment Treatment, which the assessor reported was her choice, she was approved by HRA for community care (supported housing) and level II in October 2016. The approval is good for one year. She hasn't changed her mind since.*

- *MA is a 53 year-old woman who has been at the adult home for 13 years. She was originally on the Fast Track, as someone who was identified as interested in supported housing at the outset of this initiative. However, she said No in July 2014 but then said Yes in August 2014. However, she declined assessment. She continued to say No during regular in-reach visits until, July 2016 when she presented as Uncertain/Considering it, and agreed to be assessed. After assessment, the care coordinator decided to submit the HRA application just in case she changed her mind. She was approved for supported housing on September 27, 2016. To date she has not*

changed her mind, and as of October 12, 2016, when she received in-reach again, she was not interested in moving.

C. Transitions that worked well

As noted earlier, virtually all class members reported being happy to be out of the adult home and in their own apartment.

- *ML*, a 56 year-old man, who had been in an adult home for six years, reported that it is "wonderful" to be living where he is. "I can cook what I want…The stores are nearby….It is a very nice and clean neighborhood…I feel safe…I can do what I want." He indicated that the transition did take "some time" but that it was worth the wait. He is satisfied with all the services he receives.*
  This was one of the few apartments visited over the past two years where there were personalizing touches. There were knick-knacks on the kitchen shelves; pictures hung on the walls; and even a model airplane suspended on one wall in the living room area. Also in the living room was a large fish tank with fish in it swimming around. ML indicated that the fish are something he really enjoys, it is something to look forward to every day: coming home to feed them.
  ML reported that he is satisfied with his health and MH providers. He reported that he loves the NYPCC program in Springfield Gardens which he attends 4 days a week/full time. He has attended it for eight years and a key feature of the program he really enjoys is doing volunteer work through the program, which he has been doing for the past eight years. This volunteer work involves sorting and stocking clothing, serving refreshments at the program, etc. The program also offers groups in current events, reading/writing (which he particularly enjoys), and recreational activities which he attends. Records also indicate he is involved in budgeting and cooking classes at the NYPCC.

During interviews with class members, recurring themes that were voiced included an appreciation of the privacy of their new housing; freedom from crowds, noise and smoking; feeling safe in their neighborhoods; being able to maintain their own schedules and choice of foods; and having more spending money. Several mentioned their appreciation of their home health aides and the assistance they received with cooking, cleaning and other chores.

- *GP*, a 73-year-old woman who had been in an adult home for 18 years, moved to supported housing with her friend, CL. She said she never wanted to live alone, has medical issues and wanted someone to talk to. She and CL are reportedly very close, and said it is "like having my sister with me" and she described doing many things together, including making appointments to see their providers of service.*
  They both maintain a clean attractively decorated apartment, and have advocated for changes in furniture and a paint job to accommodate their wishes to improve their

Another class member, CP**, stated "this is the safest I've felt in years." She said that she would tell other adult home residents who are thinking of moving to "take a chance and give yourself a chance." Also, "make sure you click with your roommate; look for someone you are compatible with."

living situation. She is independent in all of her ADLs, and was assessed by an MLTC and determined not to require their support services. She and CL take turns cooking and order food on line from Pea Pod. They also spend a lot of their time together.
She said that "it was great to have a place of my own" and "coming and going as I want"..."do my own cooking," as she described making a pot roast. She said for her "it is coming back home" and "was just like riding a bike...something you don't forget how to do, no matter how long." GP spoke of liking to use a computer, and explained that in the adult home she had her own laptop. However, her roommate has just gotten a new computer for both of them to use with her grant money.
She has never been married and has no children but has close family ties and frequently spends time with her nieces and nephews. In speaking of the support that she gets to live in supported housing, she mentioned her family, specifically her sister and her nieces, who were "ecstatic about my move." She said she missed some of her friends from the adult home, but continues to visit with them. She also mentioned her care coordinator, who she said "is great." She said that she comes to see her, and helps her with anything she needs. She says she took her to apply for Access-A-Ride. She said she likes having a laundry room downstairs in her building, so she doesn't have to go out to do it.

- *JSP* , a 31 year-old man, who spent 10 years in an adult home, moved to supported housing with a roommate who was his friend. He said that having his own apartment is fantastic. One can do what one wants, like eat when you want and eat what you want, rather than what is being served. "I can go to stores to buy what I want." "I can associate with the people I want to." He spoke of it as being an escape from the "rules" of the adult home where there were certain times to wake up, certain times to go to bed, etc. He said you'd get in trouble if you didn't follow those rules.*
Paradoxically, while he disliked the rules of the adult home, he said he and his housemate have come up with rules for their place and have divided responsibilities: who will clean and which rooms; who will cook (and when) and who will clean the dishes; who will pick up the day's mail; who will take out the garbage; when will laundry be done; etc. Not easy work, he said, but needed in order to keep living independently.

- *RM*, 67 years old, has made a very successful transition to the community despite initial anxiety and mention of wanting to return to the adult home, medical problems and persistent psychiatric symptoms. He has received well-coordinated services from both his housing case manager and his AH+CM. Although he continues to hear*

voices, sometimes directing him to hurt himself, he says "I do not listen to them" and has learned to manage his symptoms. He realizes the value of his psychotropic medications in helping him to do this. His treatment was complicated by having a colostomy procedure during September 2016, which he managed well. If not for his housing case manager showing up when he told her not to visit because he "did not feel well," and then getting him to the hospital, he would not have received timely care. He is adjusting well and has received nursing and HHA assistance since his procedure. He has made friends with his neighbors (non-class members) and has had BBQ and other social activities with them, but says he would like to be more social and attend more of St. Joseph's events.

He has no interest in therapy or a day program (PROS is not offered on SI), but keeps all of his mental health and medical appointments. He proudly refers to "his team" and it appeared that they all work closely together. It is also of note that each housing case manager's notes for both clients (RM and JSM*) were most often comprehensive and closely linked to a detailed support plan with realistic goals and objectives. In both cases, case managers visited three or more times a month, more frequently than the minimum requirement of a monthly visit.*

RM said that when he first moved the adjustment was difficult. While he did not like the adult home, the staff there took care of his cooking, cleaning and medication, which he now had to do for himself. After the first 4-6 weeks he said "I want to go back to Harbor Terrace." However, his team said that they could give him whatever help he needed to assist him in learning to do the all these things for himself, like the cooking, shopping, laundry, cleaning the house, and taking his medication. RM said he was very happy with the move.

- *CA*, a 46 year-old woman who had been in an adult home for five years, needed the intensive support from her AH+CM and her treatment team at New Horizons to maintain her in supported housing. When she spoke of not wanting to take medications anymore or to attend her day program, the care coordinator arranged for her to be seen by a nurse practitioner, who changed her medication to a long acting injectable. This resulted in a marked improvement in her involvement in her treatment. Her person centered care plan also targeted significant areas that she had struggled with, such as understanding her mental health diagnosis; treatment and medication compliance; and managing her independent living skills, including shopping, cooking, budgeting and managing her money.*

- *AG*, a 58-year-old man who had spent 26 years in an adult home, transitioned to supported housing and appears to be doing very well. He keeps his apartment very clean and neat. He was well-groomed and neatly dressed. He can independently use public transportation, which he uses to get to his PROS program in Harlem. He attends five days a week and fully participates in his groups and programs. He is working towards his goal of getting a job and he is getting the assistance he needs to achieve this. He stated that he needed proof that he graduated high school, so his case*

manager helped him get a referral letter from his high school. He mentioned that he is looking to get a license to do security work, but he needs to take classes for it and he has to wait for a new semester to start. He earned a grant which will pay for his certification (a 16-hour class) to get a security license.

- *QY*, a 35-year-old man, liked moving out very much. For him it meant Freedom! He is independent and can do what he wants now that he is on his own, like making Asian food for meals. He said many people don't want to leave the adult home because they "do everything for you there." However, he didn't like it there. There was a lot of violence and people yelling and screaming. When asked how he spends his free time, he indicated that he attends the American Adult Day Care Center five days a week. This is located in his old neighborhood of Flushing which has a large Asian population. He reported that he enjoys it: he gets a free meal, he can play ping-pong and pool and he also has access to computers. He also returns to that neighborhood, via public transportation, to visit his mother and to use the Public Library which he says is one of the largest in Queens.*

D. Class members who experienced difficulty but remained in supported housing

Some class members encountered various problems after their transition to the community. Nevertheless, with the assistance of Housing Contractor case managers, AH+CMs, and others, the problems they encountered were addressed, permitting them to continue living in supported housing. However, in some cases, there was a lack of diligence by the Housing Contractor case managers or the AH+CMs, who failed to carry out their responsibilities in a timely manner, as described below. (E.g., CMc* below, and RD* in the following section)

Ten of the 28 of the class members in the sample experienced significant difficulties during the transition or after they had moved to their supported apartment.

Some of the problems the class members in the sample experienced were compatibility with housemates whom they had not known previously. The Independent Review Team has observed that when class members move into an apartment with another person with whom they have a solid pre-existing relationship that contributes to the likelihood of success in the community due to the additional source of support they have. (E.g. *GP**, *JSP**, above) Five of the class members in our sample moved with a person they had selected with whom they had a strong relationship, and which they cited as one of the positive aspects of having moved from the adult home. It is also the case that a poor housemate match can add conflict, stress and anxiety at a time when the class member is dealing with a significant change in life circumstances, and can undermine the chance of success of the transition. Unfortunately, nine of the class members cited problems with their housemates. While some of these were relatively minor disputes which could be resolved, others affected the viability of the arrangement.

Perhaps the most common problem, experienced by 17 of the 28 class members in the sample, was qualifying for and receiving SNAP benefits, an issue that was discussed extensively in the Second Annual Report (pp. 28-31), and does not seem to have improved. It should be kept in mind that class members live on limited budgets, with little margin to deal with unexpected expenses or loss of benefits. 45

Among the issues that have arisen are securing appropriate photo identification, and proving income and expenses to justify the level of benefits. In some cases, the problem of delay can be traced to difficulty with getting the Housing Contractor agency to provide documentation of the lease and utility expenses which is necessary to qualify for more than the minimum SNAP benefit of $16 a month. In others, the problem seemed to be the availability of the class members when they were contacted to confirm information provided to the SNAP office. In a few cases, there was inconsistent or delayed follow-up by care managers who were to assist the class member obtain the benefits. However, despite this problem, no class member was without food due to a lack of SNAP benefits.

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Thirteen of the 28 class members in the sample experienced financial problems either due to delays in receiving their SSI payments following their change of address from the adult home, or due to the difficulty in budgeting and managing their money. While none of these problems jeopardized their housing, and Health Homes and Housing Contractors were quick to step in and assist in overcoming potential problems, this is an area that requires proactive attention in the planning process for transitions.

Eight of the class members in the sample experienced occasional problems with running out of their medications, not taking them as prescribed or issues with pharmacies/insurance coverage, but most of these were resolved reasonably promptly. Eight also had problems with keeping their appointments for mental health services. Most of these were remedied with the efforts of their care managers. Similarly, a few had problems with keeping medical appointments, sometimes due to issues with transportation to the appointments.

- *BM**, a 74-year-old woman, had lived in an adult home for 11 years before moving to supported housing. She was generally happy in her apartment before a housemate, whom she had never met, moved in. From the time her apartment mate moved in around August 2016, all notes indicated constant issues between BM and her apartment mate. When she*

still had an HHA, the HHA complained that she couldn't keep up with the mess that the apartment mate made (she refused her own HHA). The Housing Contractor case manager noted the problem and indicated that they were looking for another apartment for the house mate. But as of the date of a visit in mid-December, she was still there. Most notes by her therapist and her care coordinator are focused around her displeasure with her housemate who has caused her stress and anxiety. BM complained of her housemate being messy and dirty, making noise and using her belongings, including food and personal items. She had to clean up after her and cook for her. BM also told her therapist and care coordinator that she uses her household and personal items, eats her food and doesn't chip in for them. There was also a mention that she hadn't paid her portion of the utility bill. She stays up late and plays loud music. An August 24, 2016 care coordinator note indicated that the HHA and care coordinator had informed the Housing Contractor of these complaints on several occasions. There were very scant notes by the Housing Contractor case manager, not even meeting the minimum once a month requirement. However, because her care coordinator and her therapist were on top things, she has been able to manage the conflict.

- *Another case illustrating issues with housemates is that of AA*, a 62-year-old man who had lived in an adult home for two years. Significant problems in area of housemates and housing have resulted in three apartments since transition, and then a return to the 2nd apartment a few days after the move to the 3rd, when according to his case manager, he saw a mouse.*

  Although he got along with his first roommate initially, and really loved the apartment, it soon developed into a conflictual relationship. On May 11, less than a month after they moved in together, it is reported that AA threatened his roommate with a 7inch knife and prevented him from using the stove. On June 20, AA reportedly struck him with a cane, which he said was in self-defense. During that conflict, the police were reportedly called twice and his roommate was taken to the psychiatric emergency room and released. Following this altercation AA moved to another apartment on the same day.

- *BC**, a 51 year-old man, who moved out of the adult home where he had lived for 10 years, with his 67 year-old friend and roommate, had done fairly well, in large part due to the support of his roommate. However, the transition has had several challenges, including a recent psychiatric hospitalization due to non-compliance issues with his medication. In addition, he and his housemate have "chosen" to eat all of their meals out, do not shop, and had no food in the house at the time of the visit to their apartment. Neither of them have SNAP.BC was apparently denied SNAP soon after transition due to the lack of a utility bill, despite an SSI income of $773/month, and the application was apparently not pursued.*

  There were some problems noted with him managing his medication, which was addressed initially by visits from the SIBN agency nurse until she left the agency. He sometimes has run out of his psychotropic medications, which most likely contributed to him being put on injectable Haldol in September. Of note, he refused the injection in December. Despite his issues with medication compliance, BC always told both his housing case manager and his

AH+ CM that he had sufficient medication and was taking it as prescribed. There were no contacts with his mental health provider to verify his reports. Also, as of December, BC was changed to regular case coordination, after the six month review found he no longer required the weekly visits of the AH+CM.

BC was hospitalized in January 2017, after reportedly running out of his Haldol, and then losing his rent check and his SS Benefits Debit Card. This caused him to go into an outburst during which he broke he broke most of the glassware in the apartment, and cut himself with shards of broken glass. His housemate called 911 and BC was taken for an evaluation which resulted in his admission to RUMC Medical to treat the cuts, and then to the Psychiatric Unit; he was discharged on 1/10/17. HH notes reveal that the Social Worker at RUMC relayed that EMS said that in addition to cutting himself, BC had attempted suicide by overdosing on Advil. In addition, he reportedly had seizures while in the Emergency Room.

Notes following his hospitalization reflect that his case manager and care coordinator have (finally) spoken to him and his housemate about shopping and preparing some of their own meals, rather than eating all of their meals out, which they reportedly agreed would save them money. In addition, BC was restored to AH+CM and the care coordinator said he applied for SNAP for BC on January 12, 2017 and that BC would be receiving a call.

- *CMc*, a 54-year-old man who had lived at the adult home for five years, transitioned to supported housing on April 22, 2016. He experienced significant problems with his finances and access to mental health services for the first six months after transition.*
  As of June, CMc was not receiving SSI funds. On occasions in June, CMc looked disheveled/dirty, in need of a shower/shave, and new clothes. He informed the AH+CM *that he had no body wash or shampoo as he had no funds. The* AH+CM *took him shopping for needed items and gave him cash. ICL, the Housing Contractor, informed the care coordinator that the SSI funds should come in July. Wrap around funds continued to be used for needed items. A July 14th care coordinator note indicates the funds were received.*

  CMc never successfully followed through on appointments with mental health providers (to renew medications). Upon transition on April 22, 2016, he was to attend an NYPCC mental health program. He was seen on April 25, 2016 to begin the intake/screening process, but failed to keep most other appointments. He was sent a number of outreach letters advising him to call the clinic. NYPCC called the care coordinator on June 15, 2016 to advise him they were closing the case and left a message. A June 16, 2016 note indicates the care coordinator never called back. Also, he was deemed incapable of self-administering medications and there were problems with securing/maintaining CHHA services. In the interim, according to a September 20, 2016 note by the care coordinator Supervisor, he stopped taking his medications. In a December 23, 2016 conference call, when the Independent Reviewer team member asked the Health Home and case management agency "didn't anyone notice that he was out of medications or none had been renewed," the Supervisor indicated that ***he never ran out, as he was not taking***

***them**! She also indicated that the agency had concerns about CM's* AH+CM *in this case as well as others, and so they replaced him in September.*

Overall, the fact that the plans for mental health, medication monitoring and aide services fell apart and remained unresolved for so long reflects a lack of coordinated efforts by all of the team members.

- *RA* is a 59-year-old man who was born and raised in Puerto Rico. Spanish is his primary language. RA lived at an adult home for 13 years with his wife. RA has not had an easy transition. However, he remains in supported housing with a lot of support from his MLTC care coordinator, HHA, AH+CM, and case manager.*

  At the beginning of his transition there were serious problems with RA's compliance with taking care of his diabetic needs. He needed assistance and on numerous occasions he would not be home at the scheduled time to receive his insulin shot, despite all parties involved discussing with him the importance of this. The services were also arranged around his schedule to come before he went to his program or out for the day, and in the evening when he got home from his program. Compounding the issue was that he would eat excessively (a whole chocolate cake, a gallon of milk), and on five occasions he started vomiting and feeling bad due to increased blood glucose levels, requiring him to go to the hospital. A July 13, 2016 note indicated that Elderserve and the AH+CM were so concerned about him being able to be stable in the apartment, there was a discussion about looking into a 24- hour supervised setting.

  RA also often did not have a lot of food in the house because he would eat whatever was there quickly. Throughout most of the notes provided RA's blood glucose level ran high even when he was compliant with taking his insulin, due to his eating habits. Later notes indicated that he was more compliant in assuring he was home when he needed to take his medication. It was mentioned that he still needed verbal prompting to be able to take his insulin and check his blood glucose levels. Follow up information provided his by case manager indicated that his blood glucose levels have been more under control and that he is more compliant with making sure he is available during the times he is assisted with taking his insulin injections and other medications.

  RA was scheduled to attend a PROS program twice a week. Early in the transition he did not always attend regularly, and/or did not always participate. However, by July 2016, there were notes that he was regularly going to the program and attending groups (mostly Spanish speaking groups). He also attends a senior day care program three days a week.

  Based on notes, it appears as though all the entities were communicating and ensuring proper follow up and care. There was a meeting with the housing contractor, MLTC, and AH+CM to discuss the issues of RA's non-compliance with treatment and how they could continue to support him.

E. Class members who left supported housing for another level of care

In addition to the two class members in our sample who did not leave the adult home, six others were discharged to supported housing, but later moved to a different level of care. [13]

- *TL*, a 76-year-old man who had spent 32 years in the adult home, moved to a supported apartment on June 23, 2016. On July 28, 2016, he suffered a fall in the bathroom of his apartment and injured his forehead. He was taken to Jamaica Hospital. After a short stay in rehab, he was discharged back to his apartment. While there, he informed his care coordinator that he no longer wanted to live in the community, and that he is a sick man. He said he wanted to go to a nursing home as he could not cook or take care of himself. He asked to see a doctor, as he was not feeling well, shaking a lot and drooling. He was taken to Queens General Hospital and admitted. He was later transferred to the Highland Care Center, a nursing home. He told his care coordinator on September 1, 2016, while he was at the Highland Care Center, that he did not wish to live in the community. He had thought he could handle it there on his own, but he cannot. He had called the adult home asking to go back, and they were willing to accept him. On the State's Week 149 report, he is shown as having returned to the adult home after transition.*

- *LB***, a 62-year-old man who had been in an adult home for a year and a half, moved to a supported apartment on February 16, 2016. At the time of the pre-transition call, LB was noted to be independent and able to do for himself with no concerns about the move. While in the adult home, he received mental health treatment from the on-site contractor providing that service. He was reportedly not receiving any psychotropic medications and there appeared to be nothing in his history predictive of the subsequent events (while also noting that he was consistently found to be a poor historian and there were many missing details in his mental health history). Because he was receiving mental health treatment at the adult home with a private contractor, the mental health records were never reviewed and a psychiatric evaluation was never obtained from his treatment providers.[14]*

  On the day following his move, when his care coordinator accompanied him to Social Security, she noticed that LB was confused and disoriented and wearing the same clothing he had on the day of the move. She discussed this with him and he said "So, I did move," and said he was "tired." Despite this she did not arrange to accompany him to the mental health intake appointment he had the following day at 8:45 am., deciding instead to send a taxi for him. However, he did not go downstairs when the taxi called, and he failed the appointment. Later that day the care coordinator, housing case manager and agency nurse visited him at his apartment. The nurse did a MS assessment and found him to be confused and disoriented, not knowing the correct date or where he lived, or when he last ate. He still thought he was living at the adult home.

[13] Two of them, TL* and RD*, returned to an adult home while this review was in process.

[14] The difficulties of obtaining records from the psychiatric service providers at this adult home have previously been called to the attention of the Department of Health.

He was taken to Staten Island University Hospital but not admitted and they were to send him home in an ambulette (which is not reflected in PSYCKES for that date). The next morning LB was found wandering in the streets, after spending the night in Brooklyn, by a couple of good Samaritans who contacted the care coordinator. One of them drove him back to his apartment, where his care coordinator and housing case manager were waiting. He was still wearing the same clothing as the day of his move, which he had soiled, and he appeared even more disoriented and confused than the previous day. He was taken to Richmond University Medical Center (RUMC) Comprehensive Psychiatric Emergency Program (CPEP) where he was admitted on February 19, and discharged on February 22, to ICL's Stepping Stone Residence for respite. Upon discharge, he was noted to have neuro-cognitive deficits and was a risk to self or others, and needing a supervised program where he would not administer his own medications. He was eventually admitted to the ICL Stepping Stone Treatment Residence which is a community residence program with 24/7 staffing, providing long-term transitional housing and on-site services to 150 adults on five floors of 30 residents each. When visited at the residence and asked how he felt to be out of the adult home LB said, "I see no difference…I still don't cook for myself; and although I had a refrigerator and a hot plate in my room in the adult home, I do not have either of those here." He did say he liked it better in the community residence than in the adult home, and felt he had more freedom.

Most notably, despite his rapid decompensation, and CPEP admission, LB was not connected with a mental health treatment provider by Stepping Stone or his AH+CM *until June 2016.While the Residence notes stress that he needs to improve his ADL, it is unclear what actual training he is receiving. Review of the residence record and talking to his case manager reveals that LB is not currently making sufficient progress towards independent living. He remains there.*

- *EE*, a 34-year-old woman who had spent four years in an adult home, moved to supported housing on May 25, 2016. Prior to EE's May 25, 2016 move it was planned that she would attend a Catholic Charities PROS program, that she and her* AH+CM *would visit SSA to change her SSI level/status (she was to be her own rep payee) and that CHHA services would be arranged by the care coordinator. She had been deemed capable of self-administering medications and SNAP had been applied for in April.*

  What followed in the weeks and months after her move was a pattern of her refusing repeatedly to keep appointments that were necessary to arrange services and supports for her. She did not attend her PROS program and would not accompany the AH+CM *to SSA to change her SSI status/level. The* AH+CM *would intervene with PROS to arrange new start dates which EE didn't keep and began looking for other mental health programs. She also arranged follow up dates to take EE to SSA, which EE agreed to, but when the time came to go EE backed down. EE did accompany the* AH+CM *to a hospital to receive a monthly Haldol injection on 6/3. But she did not attend a 6/30 appointment with her primary care physician.*

More troubling, the Housing Contractor and care coordinator heard that neighbors and others were complaining about her behavior of begging for food or money, flagging down cars and soliciting sex. She reportedly had minors/neighborhood children in her apartment and was giving them alcohol in exchange for drugs. Although she was counseled about her inappropriate behaviors and safety issues, they continued. Her apartment was frequently described as being cluttered/dirty with garbage strewn about. Shortly after a hospitalization in July 2016 precipitated by an alleged break-in to her apartment, and her admission that she had stopped taking her medications and was abusing illegal drugs, her treatment team concluded that she needed a higher level of care because she could not make "cognitive decisions on what is right or wrong." But there was no clarity about who would initiate an application to HRA for a higher level of care.

Following her discharge from the hospital, her pattern of noncompliance with recommendations of her care providers continued. In August 2016, a referral was made to Adult Protective Services regarding behaviors that endangered herself as well as the minors who were using her apartment. However, APS like her case managers and a Mobile Crisis Team, was unable to meet with her despite multiple attempts. EE had taken to spending nights in various hospital emergency rooms and shelters, and avoiding a return to her apartment, as she owed too much money to people who lived around the area. She would use borrowed cell phones to call her case managers and agreed to meet them in public places rather than her apartment.

In September 2016, the Housing Contractor agreed to move her to a different apartment, while counseling her against her resumption of the behaviors that made her first apartment uninhabitable. Despite her agreement, within the first week, her new apartment was described as being a mess, with urine and cigarette ashes on furniture, and clothing on floors throughout. She was also found engaging in sex outside the building, and the landlord was asking for her to be evicted. In a meeting with the Housing Contractor on September 13, 2016, she was given the choice of returning to her old apartment and she said she would rather live in a shelter. Despite being informed of the consequences of her choice, she voluntarily discharged herself and was taken by the Housing Contractor staff to the Woman's Drop-in shelter in Brooklyn.

In this case, her Housing Contractor case manager, and the AH+CM *made frequent visits and contacts with EE (far more than what was expected), maintained contact with each other and offered her much needed assistance (escorts to appointments, etc.). But she posed significant challenges (refusing assistance) and when the issue of an alternative level of care was raised in July, it is not clear why it was not acted on, or if all the parties agreed on who would act on it and when. In the end, she became homeless.*

- *JSC*** is a 70-year-old woman who had lived in an adult home for eight years. Her case appears to be a good example of "whatever could go wrong, did go wrong." Despite the consistent involvement of her care coordinator with New Horizons and her housing case manager at TSI, many of the planned services were not delivered in a timely manner or were not delivered at all, including obtaining ID; SNAP benefits; Money; HHA and CHHAA services; mental health services; Day Program services; and transportation.*

Also, complicating her transition was that she was to move in with DG, a good friend of hers from the adult home, which was viewed as a positive in increasing the likelihood of her making a successful transition to the community. However, at the time of her move on March 25, 2015, DG was hospitalized, where he remained until May 12, 2015. In effect, JSC lived alone for most of her first two months in the apartment, which was extremely difficult for her, especially without support services in place, given her inability to manage many of her ADLs independently (e.g., she did not shower for several days until she asked for help from her Housing Contractor to turn on the shower; unable to turn on the stove and trouble with the phone, etc.). Although not always documented in the record, in speaking with housing and care management staff, they attributed many of the delays and problems facilitating the delivery of support services to JSC's refusal to accept them, or to keep appointments.

On June 25, 2015, three months after her transition, when the Housing Contractor case manager visited she was not wearing pants, and was emitting a strong body odor. When asked to get dressed she refused and became agitated. This resulted in the NYPD coming and taking her for psychiatric evaluation. She was subsequently admitted to Northshore LIJ Hospital, and later transferred to Highland Care Center Rehabilitation Center on July 1, 2015 for kidney problems; then to Kingsbrook Jewish Medical Center (KJMC) for psychiatric reasons on July 7, 2015, during which she was taken to court and was ordered to be treated over her objection to take medications and receive food. During August an NG tube was inserted to force nutrition. She was transferred back to Highland Care on September 10, 2015 and was discharged back to her apartment on October 1, 2015.

Following her discharge, she was assigned an AH+CM who arranged for HHA services for her, which started on October 7. Efforts were also made to get her ID and to refer her to a mental health provider, which were not successful. On December 7, 2015, her roommate reported to her care coordinator that she was taken to Northshore LIJ as she was "acting different than usual." She was admitted on December 9th, with Abilify added to her regimen. Although scheduled for discharge on January 19, 2016, it was canceled and she was again taken to court for treatment over objection. On February 9, 2016 application was made for long term treatment at Creedmoor PC and she was transferred on March 18, 2016. She was discharged from TSI's Supported Housing program on March 25, 2016.

When a member of the Independent Reviewer team met with JSC at Creedmoor PC during December 2016, she presented as a very thin and psychiatrically challenged individual, with poor personal hygiene and ADL. It was very difficult for her to answer questions, but she stayed focused on help to her get out of Creedmoor and move to her "own place." She summarized the difficulties she had in supported housing saying, "I would have been alright if they would have left me alone."

It should be stated that this was a very challenging and labor intensive case for both the Housing Contractor and the care coordination entities and included ongoing, consistent contact and attempts to address problem areas by those involved. Her housing case

manager saw her at least weekly when she was not hospitalized, far more than the once a month required visit. Although she did not receive AH+CM *until October 2015, she was visited regularly by her care coordinator or a peer, far more than the monthly visits required prior to the Adult Home Plus program being implemented. There were also a lot of collateral contacts between all involved entities.*

- *HR***, a 74-year-old man who had lived in an adult home for six years, moved back to the adult home within four days of transitioning. The notes from the Housing Contractor case manager indicated that during a home visit on July 22, 2016 (three days after the move) HR expressed concerns regarding missing his former roommate that he has known for 15 years. The original plan had been for his adult home roommate to move as well, but he changed his mind and did not move. Later that same day, the Nurse Care Manager witnessed HR at Parkview while she was there meeting with another class member. HR was meeting with the administrator and asking to return to the adult home. He told her that he does not feel good living in the community. He feels lonely and "doesn't feel he can cope with managing himself." The Elderserve note stated that "move lasted 4 days. He moved back in with his roommate. He stated he feels safe with peers and staff whom he feels comfortable with in the ACF."*

- *RD*, a 64-year-old man who had lived in an adult home for four years, moved to supported housing with a roommate he had met once prior to moving in. Shortly after he moved from the adult home, he was admitted to a NYC hospital on April 27, 2016 and discharged on May 6, 2016 with acute renal failure, anemia with blood loss, atherosclerosis of the coronary artery, chronic kidney disease stage 3, renal failure syndrome, GERD and Gout. He was transferred to Promenade Nursing Home for rehabilitation apparently due to poor ambulation because of gout. He was discharged from Promenade Nursing Home on May 16, 2016 and returned to his supported apartment. Notes indicated that his care coordinator assisted him with making follow up appointments with various doctors. There was a therapist note on July 18, 2016 indicating that RD had expressed a desire to move back to the adult home because there were too many stressors at the apartment. He cited that the ceiling in the bathroom caved in, that he still had no landline (only a cell phone which he doesn't like using), no television, no dentist or speech therapy appointments and his housemate had bedbugs which brought them into his room. He cited the bathroom ceiling as the last straw, and by his July 25, 2016 therapy appointment, he told his therapist he moved back to the adult home and that he feels safer there.*

  But, once at the adult home, he started having issues with his roommate and wanted to go back to the apartment. His therapist arranged a meeting with the Housing Contractor supervisor who reassured him he could return. He returned to the apartment on or about July 30, 2016. Therapy notes after that indicated that he was happy to be back at the apartment; however, he still had no landline or dentist appointment.

  When visited by the Independent Reviewer team, he seemed to be doing relatively well. He enjoys living in his apartment, spends time with his mother and aunt, and is able to cook,

shop and uses public transportation independently. He also is attending a social club, which he sought out on his own. He receives care coordination through Village Care and care management and mental health services through the Jewish Board. He sees a psychiatrist monthly and a therapist weekly. The last few notes from his Village Care care coordinator and therapist indicated that he is doing much better and has adjusted to living in his apartment.

However, there are a couple of lingering issues, including bed bugs and his inability to keep his bedroom clean and neat. The visit could not take place in his apartment due to bedbugs. A previous attempt to exterminate them was unsuccessful because his bedroom was "unlivable, dirty and unprepared for the exterminator." It should be noted that the Housing Contractor case manager notes were very sparse. Unlike the housing records of other class members reviewed, this case manager did not meet the once a month face to face requirement.

Subsequently, Independent Reviewer staff learned that RD had moved out of his supported apartment and into an adult home on January 23, 2017, despite efforts by his AH+CM and case manager to offer him whatever supports he needed. His rationale for moving was that he did not feel he could take care of himself anymore and felt he needed to be in a more supervised setting.

V. 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 requires that residents who decline an offer to move to supported hosing be offered the opportunity of additional in-reach periodically but on no less than an annual basis. (*Id.* ¶ I. (2)) The Settlement Agreement 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 the past year the numbers of class members receiving in-reach at the 22 impacted adult homes has increased significantly.

A. In-reach data

	Class Members IR'd	% of Total IR'd	Total IR Sessions	% of Total IR Sessions
Total Class members in-reached	4,404	100%	9,901	100%
Class members with 1 IR session	1,723	39.1%	1,723	17.4%
Class members with 2 IR sessions	1,026	23.3%	2,052	20.7%
Class members with 3 IR Sessions	878	19.9%	2,634	26.6%
Class members with 4 IR sessions	515	11.7%	2,060	20.8%
Class members with 5 IR sessions	181	4.1%	905	9.1%
Class members with 6 IR sessions	53	1.2%	318	3.2%
Class members with 7 IR sessions	19	0.4%	133	1.3%
Class members with 8 IR sessions	6	0.1%	48	0.5%
Class members with 9 IR sessions	2	0.05%	18	0.2%
Class members with 10 IR sessions	1	0.02%	10	0.1%

Table 3. Distribution of 4,404 Class Members having in-reach, by number of in-reach sessions and percent of totals

As of March 10, 2017, in-reach had been offered to 4,404 of the 3,906 class members,[15] and 2,263, or 51% of individuals in-reached had said Yes. (See Fig. 3) Although the current rate of individuals saying Yes to in-reach (51%) is lower than that of the first year (60%), it is slightly higher than the rate of 46.8% reported in the Independent Reviewer's Second Annual Report.

During the past year the numbers of class members receiving in-reach at the 22 impacted adult homes has increased significantly. (See Fig. 2) By March 10, 2017, most if not all of the class members had received in-reach at least once, most more than once. The 4,404 members in-reached had received a total of 9,901 in-reach contacts; 61% had received in-reach at least twice and 38% had received three or more in-reach contacts. Nevertheless, the rate of class members

[15] Due to admissions and discharges, the 3,906 is a snapshot in time and there are actually more class members in adult homes during the course of a year. See Table 1.

expressing interest in transitioning remains at 51%. (See Fig 4.)

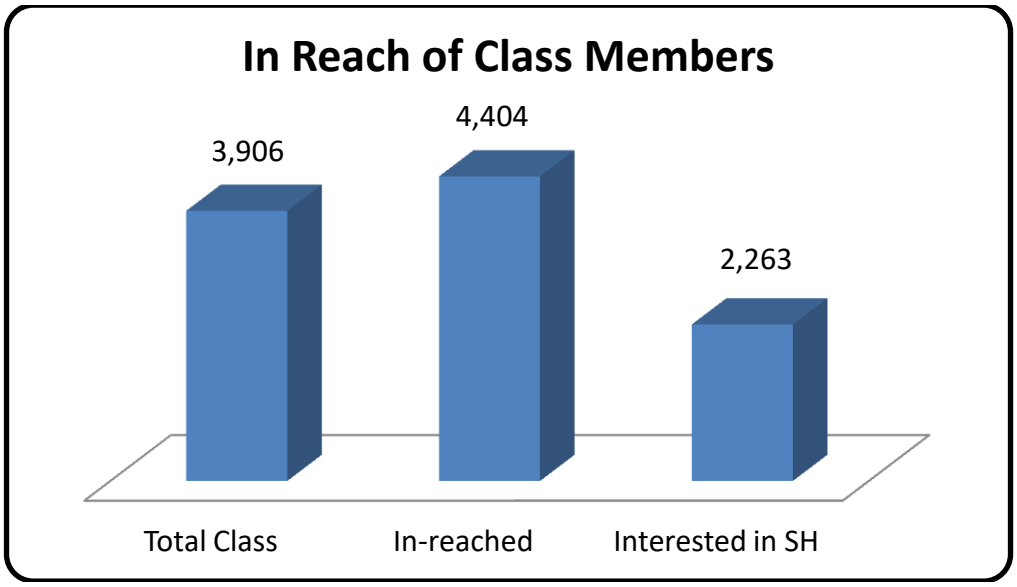

Figure 4. Class members expressing initial interest in supported housing

As reflected in our Second Annual Report (pp. 39-50), there appear to be a number of factors contributing to the low rate of interest in transitioning at the point of in-reach.

- First, the list of people placed on the "Fast Track" early on in the process (i.e., people expressing interest in moving even before or during the course of the Settlement Agreement) has essentially been exhausted; they have received in-reach.

- According to in-reach staff, many people who have lived in adult homes for many years report being "comfortable" there and fear the unknown of "supported housing." Some residents also report confusion about what the transition will entail which fuels uncertainty about moving.

- Reportedly, some residents have been influenced by what they hear from adult home staff or other residents about individuals who have transitioned and have experienced problems, such as delays in SNAP or other benefits or needed services, or have returned to adult homes.

- Discouragement or other influence, subtle or otherwise, by adult home administrators or staff, was also cited by Housing Contractors who reported their access to individuals has been limited or has been confined to settings that are not conducive to private, uninterrupted conversations about transitioning. (It should be noted that 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."

- Instances of discouragement by family/guardians, as well as by therapists, were also 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.

In response to a request from the Court, during the past year the Independent Reviewer conducted a more focused review of issues relating to in-reach. Among other things this included observations of all Housing Contractors' in-reach activities at 15 of the 22 homes, an attempt to examine in-reach staffing data related to vacancies and functions, and a review of actions taken on 18 complaints of discouragement filed with DOH.

The Independent Reviewer's report was filed with the Court on September 27, 2016. However, due to the report's inclusion of potentially personal identifying information of class members and other sensitive matters, it was filed under seal. A redacted summary of the report's major findings and recommendations is presented in Appendix B. A summary of its major findings is presented in Section IV. C.

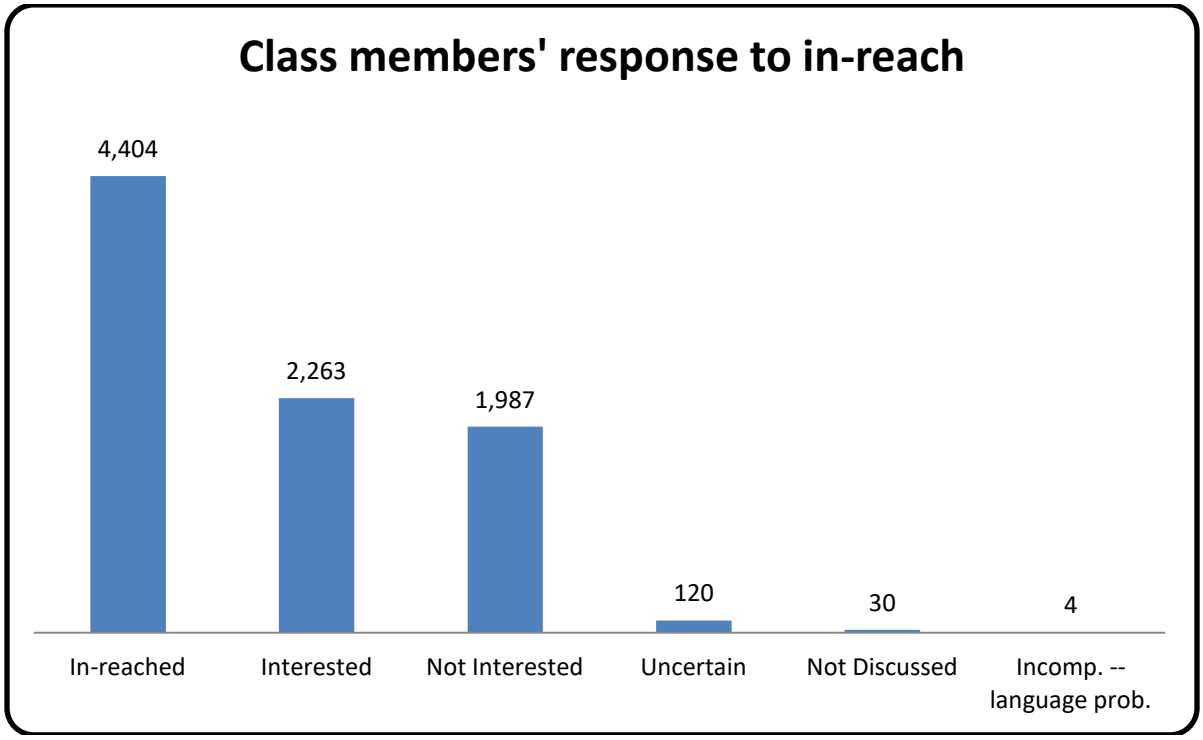

Figure 5. Class members' response to In-Reach as of March 10, 2017

B. Performance by Housing Contractors

Housing Contractor	Class per 3/22/17 CTL	Total IR Contacts	Members IR'd	% of Class IR'd	Yes	% Yes
Phase I (4/1/14)						
JBFCS I	461	1,619	630	137% why	339	53.81%
Phase II (7/1/14)						
CommuniLife	589	1,431	664	113%	317	47.74%
JBFCS II	362	875	447	123%	213	47.65%
FOO	463	1,359	588	127%	318	54.08%
ICL	440	1,065	548	125%	294	53.65%
TSI	401	1,106	481	120%	210	43.66%
Phase III (4/27/15)						
Pibly	282	835	399	141%	239	59.90%
SIBN	283	843	344	122%	195	56.69%
St. Joseph's	239	768	303	127%	138	45.54%

Table 4. Variable Performance of Housing Contractors as of March 10, 2017

The Independent Reviewer's Second Annual Report discussed the uneven performance of Housing Contractors. At that time, weekly reports issued by the State presented data on individuals who had at least one in-reach contact; the data did not indicate the total number of in-reach contacts a class member had over time. However, using the percentage of individuals a Housing Contractor had in-reached in its assigned homes, one could make rough comparisons. As reported in the Second Annual Report, for example, ICL which had in-reached 77% of the class members in its assigned homes lagged behind the other four Housing Contractors which, with ICL, started in-reach activities on July 1, 2014 as part of Phase II. Their in-reach rates ranged from 88% to 99%.

The State's data reports now reflect the total number of in-reach contacts class members have had over time which allows for better comparisons of Housing Contractors' performance. As indicated in Table 5, that performance varies.

As of March 10, 2017, JBFCS I has had the most in-reach contacts with 1,619 in-reach sessions, which is understandable as it started in-reach several months before other Housing Contractors. However, of the five Housing Contractors which commenced in-reach activities in

Phase II, two (ComuniLife and FOO) outpaced the others. ComuniLife, for example, had 1,431 in-reach contacts and FOO made 1,359 in-reach contacts, while ICL made 1,065.

Variability among Housing Contractors was also noted in the response to their in-reach efforts. As of March 10, 2017, 51% of class members said Yes to transitioning upon in-reach. Five Housing contractors – JBFCS I, FOO, ICL, Pibly and SIBN – had positive (i.e., Yes) response rates greater than 51% on average for the homes for which they are responsible, but three – ComuniLife, JBFCS II and St. Joseph's had overall positive response rates of below 51%.

The variability is even more pronounced on an adult home level as indicated in Table 5. Some Housing Contractors with overall positive response rates of 51% or better have had positive response rates of below 51% at some of their homes. JBFCS I, for example, had a 61% positive response rate at Oceanview Manor, but only 47% of class members at Mermaid Manor said Yes upon in-reach. FOO had a 65% positive response rate at New Haven Manor but a 44% rate at Central Assisted Living.

On the other hand, Housing Contractors with overall positive response rates below 51% had better than 51% rates at some of their homes. ComuniLife, for example, with an overall Yes rate of 48% had a 57% positive response rate at Belle Harbor, but a 43% rate at New Gloria's Manor. Neither St. Joseph's nor TSI had positive response rates greater than 51% at homes they were responsible for.

It is unclear the extent to which either the Housing Contractors' in-reach approaches/styles or adult home factors influence the variable rates to in-reach.

Housing Contractor	Adult Home	Class per 3.22.17CTL	Total IR Contacts	In-reached as of 3/10/17	Said Yes	Yes %	Transitions
CommuniLife	Belle Harbor	112	262	137	78	57%	8
CommuniLife	New Gloria Manor	126	330	141	60	43%	5
CommuniLife	Park Inn Home	170	398	183	88	48%	12
CommuniLife	Surfside Manor	181	441	203	91	45%	8
FOO	Central Assisted Living	147	401	186	81	44%	5
FOO	New Haven Manor	108	303	143	93	65%	18
FOO	Seaview Manor	111	333	131	68	52%	11
FOO	Wavecrest HFA	97	322	128	76	59%	14
ICL	Brooklyn ACC	160	499	222	135	61%	33
ICL	Queens ACC	280	566	326	159	49%	27
JBFCS I	Mermaid Manor	170	499	212	100	47%	18
JBFCS I	Oceanview Manor	118	471	182	111	61%	27
JBFCS I	Surf Manor	173	649	236	128	54%	34
JBFCS II	Garden of Eden	176	432	206	68	33%	26
JBFCS II	Kings ACC	186	443	241	145	60%	29
Pibly	Parkview HFA	124	411	142	72	51%	14
Pibly	Riverdale Manor HFA	158	424	257	167	65%	62
SIBN	Lakeside	176	549	214	113	53%	28
SIBN	Mariner's Residence	107	294	130	82	63%	11
St. Joseph's	Harbor Terrace	239	768	303	138	46%	44
TSI	Elm York Assisted Living	213	546	261	107	41%	27
TSI	Sanford Home	188	560	220	103	47%	25

Table 5. In-reach & Transitions by Housing Contractor as of March 10, 2017

C. A review of in-reach related matters in 2016

As previously mentioned, in response to a request from the Court, during 2016 the Independent Reviewer conducted a more focused review of issues relating to in-reach. Due to confidentiality of class members' personal information, the Independent Reviewer's September 2016 report to the Court was filed under seal. A redacted summary of the report's major findings and recommendations is presented in Appendix B. Generally, however, among other things the

review revealed:

- Less than conducive conditions provided by adult homes for in-reach staff to meet with residents and discuss transition opportunities, as well as adult homes limiting in-reach staff's access to class members;
- Inability on the part of in-reach staff to provide meaningful information to class members concerning reasonable questions they have about transition;
- Language obstacles which impeded effective in-reach;
- Problems with in-reach staffing and the effective use of peers; and
- Ongoing problems of subtle and blatant discouragement of class members by adult home staff.

VI. Assessments

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)

Problems persist in the assessment process. There remain significant and growing delays in completing assessments. There are noteworthy changes in the outcomes/recommendations of the assessment process which warrant further scrutiny and explanation.

The purpose of a comprehensive assessment is 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))

As discussed in the Independent Review's first two annual reports, the assessment phase of the transition process has been plagued by problems resulting in delays of individuals desiring to move from their adult homes to actually transitioning out. Over time, the State has taken a number

of steps to address this issue, including augmenting the types of required psychiatric records that could be included/considered in the assessment process, expanding the types (and thus the number) of licensed clinicians who could conduct components of the assessment process and, most recently on July 1, 2016, vesting assessment responsibilities, which previously had been spread across a multitude of Health Homes and MLTCPs, in one entity: Transitional Services of New York, Inc. (TSI). Also in 2016, the State instituted a practice of offering the opportunity for assessment to class members who said No or were Uncertain about transitioning so that they would have an understanding of the housing and service options available to them if they decided to transition.

While Independent Reviewer staff's observations of TSI assessments have been positive overall, based on data reported in the State's Weekly Report 156 ending March 10, 2017, there appears to be room for improvement which may prove necessary to meet the Settlement Agreement goal of achieving 2,500 assessments by July 23, 2017.

A. Continuing delays in the assessment process

As indicated in Table 6 (below), the number of class members willing to move who are in the assessment phase of transition has grown from 449 in July 2015 to 811 as of March 10, 2017.[16] The median number of days in the assessment phase from the point of saying Yes at in-reach to the point of completion of assessment (as indicated by the distribution of a final Adult Home Resident Assessment Report – AHRAR) has grown from 79 to 269. Nearly 59% percent of the people in the assessment phase as of March 10, 2017 have been there for more than six months compared to 32.7% in July 2015.

[16] Notes about cases in assessment process: On July 1, 2015 and March 11, 2016, this number was calculated by taking the number of people who said Yes at in-reach and were referred for assessment but who did not have a final AHRAR distributed and who had not died or were not discharged outside the transition process. By December 30, 2016, certain changes had been made to the State's weekly reports. The column indicating date of referral for assessment was eliminated, replaced by a column for date of referral to TSI, which did not include all referrals for assessment. TSI was also conducting assessments of people who did not express an interest in moving but were willing to be assessed. However, the revised weekly data reports did indicate whether the individual was in the assessment phase (eliminating those who had died or were discharged in some other fashion). The number of cases in the assessment process on March 10, 2017 was calculated by taking the number of people who said Yes at in-reach and were listed as being in the assessment phase in Weekly Report 156 ending March 10, 2017. It does not include the 59 individuals who said No or were Undecided about moving at in-reach and were referred to TSI for assessment after July 1, 2016. Nor does it include 92 cases which, according to the Weekly Report, were in the assessment phase but also had final AHRARs distributed, indicating that assessments had been completed. It is unclear what the status of these individuals was as of March 10, 2017, so they were excluded from the analysis.

	7/1/2015	3/11/2016	3/10/2017
Cases in Assessment Process	449	683	811
Range of Days in Assessment from In-reach	0-470	0-695	1-969
Median # of Days in Assessment	79	87	269
% of Cases in Assessment more than Six months	32.70%	27.70%	58.5%

Table 6. Delays in Completing Assessments

It is not clear the extent to which the transition of assessment responsibilities to TSI contributed to the increasing delays in the assessment process. On and following July 1, 2016, when TSI assumed responsibility for assessments, it inherited a sizable assessment backlog of 771 class members who had said Yes at in-reach prior to July 1, 2016, some having said Yes at in-reach as early as 2014. There was also an understandable lull in completing assessments (as indicated by a finalized AHRAR) following July 1, 2016 as TSI began and started to ramp up its operations. (Figure 6.)

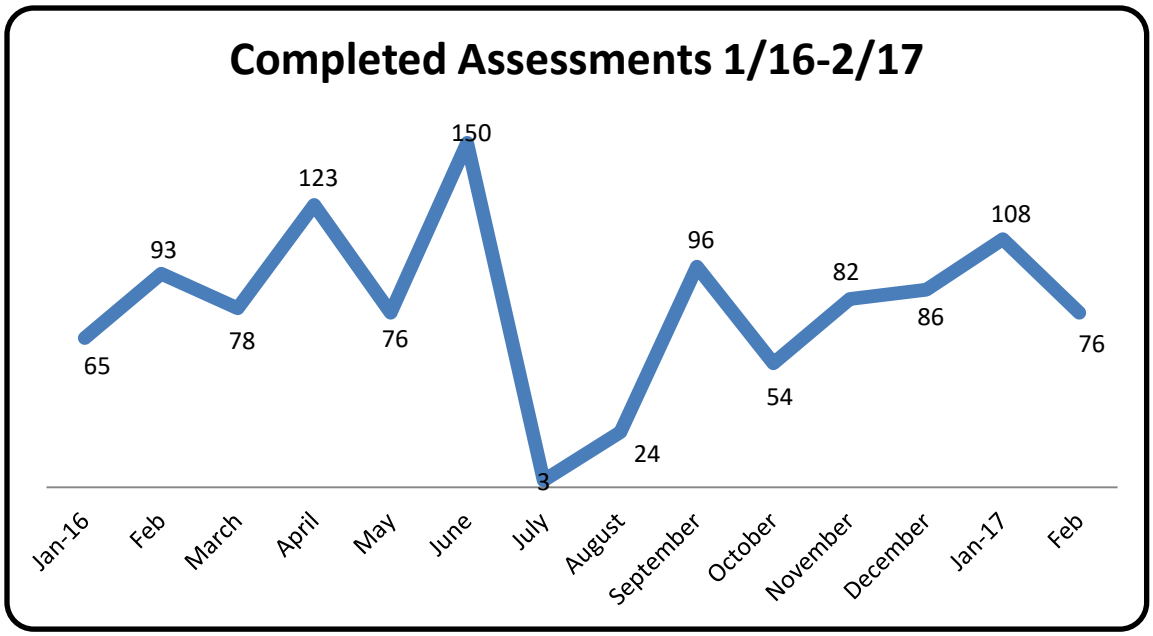

Figure 6. Rate of Completed Assessments by Month: January 2106 – February 2017

The contract with TSI creates a two-pronged approach to the work of completing assessments. For new referrals for assessments, the expectation is that the assessment will be completed within 45 days of the referral. At the same time, the assessors will work on clearing up the accumulated backlog within six months of commencement of work under the contract. With a limited number of assessors and a deadline for completing new referrals, the effect has been that class members in the backlog witness newer referrals progressing through the assessment process,

while they continue with their prolonged wait for the same service. Many report feeling disheartened by the continued delays.

B. Changes in assessment recommendations/outcomes

As of March 10, 2017, 1,667 class members had final AHRARs which listed housing and service recommendations/outcomes.

It should be noted that cumulative data as of March 10, 2017 provided by the State, indicate that 1,891 class members have had at least one assessment. However, for a variety of reasons (e.g., a change in clinical situation, such as a hospitalization; delays in, hesitation, or a change in mind about moving coupled with expired HRA approvals for transition; etc.), a number of these individuals require re-assessment, and recommendations/outcomes about their initial assessments are not presented in the State's weekly data reports. The 1,667 figure referenced above represents those individuals who have been assessed and have not been referred back for further assessment. The recommendations/outcomes of their final AHRARs are the basis for this discussion.

As illustrated in Table 7, there have been some noteworthy changes in the outcomes or recommendations of assessments over the years – changes which warrant scrutiny and explanation. Some of these changes appear to be particularly acute since TSI commenced operations in July 2016.

- The recommendation that an individual remain in an adult home constitutes 1.5% of all recommendations overall. However, in 2016 it constituted 2.8% of recommendations. It should be noted that following TSI's assumption of assessment responsibilities, the percentage of recommendations to remain in an adult home dropped to 1.3%.

- At the same time, however, recommendations for Level II OMH Housing (Apartment Treatment, Congregate Treatment and CR-SRO) have grown from 0.5% in 2014, to 4.4% in 2015, to 8.8% in 2016, and to 11.2% in 2017. They constituted 13.6% of the recommendations made during the first eight months of TSI's operations (July 1, 2016 through February 28, 2017). It should be noted that the Settlement Agreement does not specifically require the State to create additional capacity in these types of housing options to accommodate class members, and a relatively small number of those who have been recommended for Level II have actually been placed in such housing. Of the 102 individuals who as of March 10, 2017 had been approved by HRA for OMH Level II Housing, 18 (18%) have transitioned to such. Three (3%) died and six (6%) were discharged from the adult home in a manner outside the transition process.

- Recommendations for supported housing as a percentage of all recommendations have steadily decreased from a high of 72.2% in 2014 to 44.4% in 2017. Since TSI has assumed assessment responsibility, recommendations for supported housing constituted only 37.5% of the assessment outcomes. Given the strong presumption in the Settlement Agreement about the qualification of class members for supported housing, and the potential to provide a wide variety of Medicaid funded support services to the class, this is a matter of significant concern.

	2014-2016 #	2014-2016 %	2014#	2014%	2015#	2015%	2016#	2016%	2017#	2017%
AHRAR Recs/Outcomes	1667	100%	187	100%	479	100%	794	100%	207	100%
Adult Home	25	1.5%			2	0.4%	22	2.8%	1	0.5%
Apartment Treatment	13	0.8%					12	1.5%	1	0.5%
Congregate Treatment	25	1.5%	1	0.5%	9	1.9%	7	0.9%	8	3.9%
CR-SRO	77	4.6%			12	2.5%	51	6.4%	14	6.8%
Declined Assessment	398	23.9%	34	18.2%	74	15.4%	226	28.5%	64	30.9%
Declined Transition	64	3.8%	7	3.7%	23	4.8%	34	4.3%		
Discharged prior to Assessment	7	0.4%	4	2.1%	1	0.2%	2	0.3%		
Housing other than SH[17]	2	0.1%			1	0.2%	1	0.1%		
No SMI	127	7.6%	6	3.2%	23	4.8%	80	10.1%	18	8.7%
OASAS	12	0.7%					8	1.0%	4	1.9%
OPWDD	2	0.1%					1	0.1%	1	0.5%
Senior Housing	5	0.3%					1	0.1%	4	1.9%
Supported Housing	909	54.5%	135	72.2%	334	69.7%	348	43.8%	92	44.4%
Undecided	1	0.1%					1	0.1%		

Table 7. Number and Percentage Distribution of Final AHRAR Recommendations/Outcomes by Years

- The percentage of cases in which it is determined that the individual does not have a SMI has increased from 3.2% in 2014 to 8.7% in 2017; 12.9% of assessments finalized after TSI's takeover of the assessment process indicated the individual was not SMI.

- There has also been an increase in final AHRAR's with the outcome of "declined assessment" from 18.2% in 2014 to 30.9% in 2017. Since TSI assumed operations, 31.3% of final AHRARs were "declined assessment." It does not appear that this is due to TSI attempting to assess individuals who said No or were Uncertain about moving at in-reach, a process which began in 2016. Of the 172 cases after July 1, 2016 where the individual "declined assessment," the majority, 130 (76%), had expressed interest in moving at in-reach; only 42 (24%) had said No or were Uncertain about moving at the time of in-reach.

[17] Notes in the Week 156 report indicate that one of these individuals wanted to live in something "other than supported housing." In the second case, the recommendation was "Fountain House" an agency which offers a variety of OMH and other housing options.

	11/1/15 - 2/28/17#	11/1/15 - 2/28/17%	Pre TSI 11/1/15-6/30/16#	Pre TSI 11/1/15-6/30/16%	Post TSI 7/1/16-2/28/17#	Post TSI 7/1/16-2/28/17%
AHRAR Recs/Outcomes	1,120	100%	600	100%	520	100%
Adult Home	23	2.1%	16	2.7%	7	1.3%
Apartment Treatment	13	1.2%	4	0.7%	9	1.7%
Congregate Treatment	16	1.4%	5	0.8%	11	2.1%
CR-SRO	67	6.0%	16	2.7%	51	9.8%
Declined Assessment	311	27.8%	148	24.7%	163	31.3%
Declined Transition	41	3.7%	41	6.8%		
Discharged prior to Assessment	2	0.2%	2	0.3%		
Housing other than SH[18]	1	0.1%	1	0.2%		
No SMI	104	9.3%	37	6.2%	67	12.9%
OASAS	12	1.1%	1	0.2%	11	2.1%
OPWDD	2	0.2%			2	0.4%
Senior Housing	4	0.4%			4	0.8%
Supported Housing	523	46.7%	328	54.7%	195	37.5%
Undecided	1	0.1%	1	0.2%		

Table 8. Number and Percentage Distribution of Final AHRAR Recommendations/Outcomes in the Eight Months Pre and Post TSI

In weekly data reports submitted by the State, people who have declined assessments have been reported as having completed assessments. There has not been much discussion about this practice, especially as they were relatively few in number in the early stages of implementation, and there seemed to be plenty of time to get to the 2,500 assessments required by year four. Now, as these declined assessments account for nearly one-quarter of all assessments, and 31.3% of the completed assessments since TSI took over, a more critical analysis is needed about how to account for them. One of the purposes of the clinical assessment was to identify whether the class member met one of the disqualifying conditions laid out in the Settlement Agreement. (§F (5)) If the assessment cannot be performed, that purpose is not being achieved and the "completed" assessment has no substantive content at all. At the same time, however, if the person does not participate in the assessment process, it would not be possible for the assessment to determine "the

[18] Notes in the Week 156 report indicate that one of these individuals wanted to live in something "other than supported housing." In the second case, the recommendation was "Fountain House" an agency which offers a variety of OMH and other housing options.

housing and service needs and preferences of the NYC Adult Home Resident for purposes of transitioning from the NYC Impacted Adult Home." (§F (2)) As of March 10, 2107, of the 1,667 individuals with completed AHRARs, the outcome/recommendation for 398 (23.9%) was declined assessment.

C. TSI assessment observations

Independent Reviewer staff had the opportunity to observe 10 assessments conducted by the three full-time and two part-time TSI assessors. (As of November 28, 2016 according to DOH, TSI had four full-time assessors, two part-time assessors and two per-diem assessors.) – although in slightly different fashions: some went through the tool question-by-question, A-to-Z, while others asked very open ended questions which opened the door for conversations about issues covered by the tool and then returned to certain items with specific follow-up questions; and in a number of cases, the assessor was also joined by the individual's HH/MLTCP care coordinator/manager – someone with whom the individual was familiar - which aided in the assessment process.

> Overall, Independent Reviewer staff were impressed with what they observed: the assessors were courteous and kind toward the individuals they met with; they spent anywhere from one to two or more hours with the individual, allowing the individual to ask questions or take a break if they so desired; it appeared they covered all the items in the Community Mental Health Assessment tool

During the assessment observations, some issues arose which have been shared with TSI. Assessors reported difficulty in obtaining information from the mental health contractor for Mariners and Lakeside adult homes on Staten Island, which are owned by the same operators. This issue has previously been called to the attention of DOH.

Some assessors worked part-time, in the evenings or on weekends. While this is very convenient for the individual being assessed given his/her schedule, it often precludes care coordinator/managers who work a more typical 9-5 day from participating in the assessment. TSI and the assessors, however, reported that in such situations they usually confer with the care coordinator/manager prior to or after the assessment. At a Housing Contractors' Supervisors meeting on January 9, 2017, TSI announced that they had revised their assessor staffing pattern, eliminating part-time assessors in favor of full-time assessors. At that time, it was reported they had four full time assessors, one per-diem and were in the process of hiring an additional full time assessor.

Although all assessors indicated that the training they received prior to beginning their work was very good, a couple expressed the need for additional, refresher or more "hands-on…in-

the-field" training. As one person put it, "Once one finishes the training, you think you know it, understand it, but then you start actually doing the assessments and all these other questions come up which one didn't anticipate." The assessors, however, did indicate that TSI supervisory staff have an open door policy and they are free to consult with them on any problems or issues. Supervisory staff also reported accompanying people in the field to observe and offer assistance in the assessment process.

If, as reported by the State in cumulative data, 1,891 class members have had at least one assessment as of March 10, 2017 an additional 609 individuals need to be assessed in order to meet the benchmark of 2,500 assessments by July 23, 2017, approximately four and a half months from March 10, 2017. This equates to about 135 assessments per month. In the previous four and a half months (October 24, 2016- March 10, 2017), TSI completed 396 assessments, about 88 per month on average. Undoubtedly, TSI will have to continue to monitor and revise if necessary its staffing patterns and pay close attention to the training needs of assessors if more are hired. This does not address the other requirement of the Settlement Agreement that as of July 23, 2017, all class members assessed and found appropriate under a person-centered care plan developed pursuant to ¶ G, be transitioned from NYC Impacted Adult Homes.

D. Persons recommended for Level II housing

As noted earlier, the percentage of assessments resulting in recommendations for Level II OMH Housing (Apartment Treatment, Congregate Treatment and CR-SRO) has been growing, particularly since July 2016 when TSI assumed responsibility for the assessment function. To better understand the reasons for such recommendations, in November the Independent Reviewer's team requested records for a sample of 10 of the 27 assessments completed between July 1, 2016 and November 28, 2016 which resulted in Level II OMH housing recommendations. The records requested and reviewed included the final AHRARs, the CMHAs, comprehensive psychiatric evaluations or psychosocial histories and notes from Level II calls, which are calls made before AHRARs with such recommendations are finalized. The calls involve OMH and DOH representatives, the assessor and staff from the housing and HH/MLTCP agencies.

The Settlement Agreement (¶F.5) requires that the assessment process begin with the presumption that residents can live in supported housing and that a resident will be considered appropriate for supported housing, if desired by the resident, unless the assessment discloses that the resident:

- Has significant dementia;
- Would be a danger to self or others in supported housing even if receiving the services currently available and provided under the New York State Medicaid program;
- Needs skilled nursing care that cannot be provided outside of a nursing home or hospital; or

- 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, unless another public (e.g., Medicare) or private (e.g., Meals on Wheels) program will pay for or provide the needed service, the individual is eligible for the program, and the program is available to the individual.

If upon assessment an individual is found ineligible for supported housing, the assessor indicates which of the four exclusionary criteria apply by checking a box on the AHRAR; the assessor also provides a narrative explanation of the evidence supporting ineligibility for supported housing.

In two of the 10 cases recommended for Level II OMH housing examined by the Independent Reviewer, the reason why that recommendation was made was not because they met one of the four exclusionary criteria, but rather because the individuals requested to live in OMH Level II housing.[19] The case of GR is an example.

- *GR is a 61-year-old man diagnosed with Schizophrenia, paranoid type. He had lived in the adult home for about a year and prior to that for six months in a State Psychiatric Center. The AHRAR and the CMHA indicated that GR requested to live in an Apartment Treatment program and that during the assessment he was provided with education about the wrap around services available to him in supported housing so that he could make an informed decision. However, he indicated that he believed he would be more comfortable residing with roommates, being visited by staff more often and work on independent living skills before moving into supported housing. Specifically, he cited his need for assistance with cooking – he was not confident he could cook for himself - and cleaning. He also requested assistance with money management and medications. He had never lived on his own. According to the AHRAR, prior to living in the adult home, preceded by a six month stay in a psychiatric hospital, he lived with his family his whole life and they took care of him.*[20]

It would appear that the needs identified by GR could have been met in supported housing. And while respecting his preference for Level II housing, one could well question if his choice might have been different had he received additional education by in-reach workers and peers about supported housing and the services available such as home health aides, PCWs, etc...

[19] As discussed above, when a recommendation for something other than supported housing is made based on the exclusionary criteria, the AHRAR requires the assessor to identify the exclusionary criteria met. However, if the reason behind the recommendation is the person's preference for something other than supported housing (and not ineligibility based on the exclusionary criteria), such must also be noted and explained on the AHRAR.

[20] When GR's case was reviewed by HRA, it approved him for both Level II and supported housing, thus opening the door to options beyond the assessor's recommendation. In fact, the broader options created by the HRA approval resulted in his moving to supported housing, notwithstanding the assessment recommendation for a Level II placement.

Dangerousness is the most frequently cited criteria in determining a person's ineligibility for supported housing. . . . However, in our review of the eight sample cases, it was not always clear if the dangerousness criterion was met.

A closer look at the State's weekly data indicates that in 18 of the 96 cases recommended for Level II OMH housing as of December 30, 2016 (19%), exclusionary criteria were not cited as the reason; the person was *not found ineligible* for supported housing. It appears the recommendations were based on the individuals' preference, like in the case of GR.

In the eight other cases examined by the Independent Reviewer, the recommendation for Level II OMH housing was based on exclusionary criteria making the person ineligible for supported housing. In all eight cases, the dangerousness criteria was cited, i.e., the person would be a danger to self or others in supported housing even if receiving the services currently available provided under the New York State Medicaid program.

Dangerousness is the most frequently cited criteria in determining a person's ineligibility for supported housing. As of December 30, 2016, of the 96 cases recommended for Level II OMH housing, exclusionary criteria were cited in 87. In 67 cases (77%), the dangerousness criteria was cited; in 11 cases (13%), the need for a type and/or frequency and duration of service to live in supported housing that is not available under the Medicaid program was cited as the reason. In no cases were the criteria pertaining to dementia or the need for skilled nursing care cited. Dangerousness was cited as the reason in all 36 cases found to be ineligible for supported housing since TSI commenced operations in July 2016.

However, in our review of the eight sample cases, it was not always clear if the dangerousness criterion was met. None of the individuals was homicidal or suicidal at the time of the assessment.[21] Additionally, in most cases, the CMHAs completed by the assessor noted no recent (within the past year) episodes of harm to self or others. Several case examples are illustrative.

[21] In a response to a draft of this report, the State writes:

> This is an overstatement of the criteria. . . . We have found situations and behaviors which are dangerous to self and others (e.g. fire setting). Homicidal and suicidal situations require a call to 911 and evaluation for hospitalization there are also instances in which class member is unable to advocate for themselves which can lead to harm to that class member.

The point of these case examples is to highlight the challenge of specifying the basis for a determination of dangerousness. Using an inability to advocate for oneself as a standard for dangerousness would be an extraordinarily broad interpretation of this criterion, especially since it can be addressed by the provision of adequate supports in supported housing.

- *DB is a 52-year old woman diagnosed with Paranoid Schizophrenia and for the past eight years has resided in shelters and an adult home. According to the AHRAR, DB is actively psychotic at baseline and has very limited to no insight into her mental illness. She is delusional and paranoid: she feels like she is being persecuted by the government and has been wrongly diagnosed as having schizophrenia. She reported she feels staff are trying to kill her by giving her medications - especially insulin (she believes it is poison). DB stated she feels she does not need to take medications; she has a history of non-adherence and has been on Assisted Outpatient Treatment in the past, but is now adherent with medications, as they are supervised by adult home staff.*

  According to the AHRAR, DB has had unprovoked incidents regarding staff and other residents, most recently in July 2016 when she threw her walker at an aide. This event was also noted in her CMHA which added that police had to be called and she was examined at a local hospital and released. The CMHA, one of the few of the eight to note any recent events of harm to self or others, also noted that she screams and yells at adult home nursing staff on nearly a daily basis when they attempt to administer her insulin.

  The AHRAR concludes that given her history of non-adherence with medication and need for ongoing supervision for medication adherence, DB would benefit from placement in a CR/SRO. Such placement is also recommended as she has no informal supports, is unable to appropriately advocate for herself, and needs to learn basic living skills and psychoeducation.

Some individuals were actively psychotic at the time of assessment or had not lived independently for many years and consequently needed a high level of staff assistance on a daily basis. But does this constitute dangerousness, or does it constitute the need for services which may or may not be available through supported housing? The AHRARs and supporting documents did not directly address the question.

- *TB is a 72-year-old man diagnosed with Schizophrenia who has lived in adult homes since 1993.*

  According to the AHRAR: "Class member presents as actively psychotic at baseline. Class member presents with disorganized thought process which interferes with his concentration, organization, and overall ability to manage his illness and take his medications. Class member relies on the support of the adult home staff to remain adherent. He also requires reminders for mealtime. He has been residing in adult homes for over 20 years. Class member would benefit from an environment where his medications are supervised, where he receives ongoing psychoeducation about his mental illness and symptoms to improve insight, and ongoing aide service to assist with ADLs. He is unable to advocate for himself and requires trained MH staff to assist in training on

appropriate behaviors, socialization skills, and basic living skills to transition to more independent living."

According to TB's CMHA, there have been no recent events of harm to self or others; the CMHA does note an arrest for Robbery in 1963.

- *SM is a 48-year-old man diagnosed with Schizophrenia. He lived in an adult home for approximately ten years.*

  According to the AHRAR: *"Class member is recommended for Apartment Treatment Program. Class member has resided at Lakeside Manor for ten years and reported living with his mother for seven. Class member has not lived independently for almost twenty years. Resident has a long history of substance use and one suicide attempt. Class member reported consuming alcohol and smoking marijuana in the last thirty days. Class member is diagnosed with the following medical conditions: NIDDM, HTN, obesity, BPH, AFIB, GERD, constipation, joint pain, history of foot cellulitis, COPD and anxiety. Class member does not have any social supports and minimal time spent living independently.*

  According to the CMHA completed on SM, there have been no recent events of harm to self or others. The one suicide attempt referenced above occurred approximately 20 years ago. The CMHA also notes that he is independent or requires minimal assistance in most functional areas.

  Notes from a September 1, 2016 Level II call for SM indicate that an OMH representative stated that it was "a stretch to say that he was a danger to self or others" based on available information. However, a DOH representative on the call stated that "during care planning meetings if team believes he is progressing and appropriate for supported housing they can request a reassessment at that time." The AHRAR recommending Apartment Treatment placement was finalized within several days.

- *HT is a 66-year-old man diagnosed with Schizophrenia. He has resided in his current adult home for about 10 years and before that in another adult home for 10 years. During his assessment he was noted to be appropriately dressed and groomed, oriented in all four spheres and forthcoming and compliant. His CMHA indicates no episodes of harm to self or others and that he is independent or requires minimal assistance in ADLs.*

  The AHRAR, however, states: *"Class member is recommended for a community residence due to his lack of independent living skills. Resident has been domiciled at* (the adult home) *since July 13, 2006 and reported living in another adult home for approximately ten years. Class member also reported a history of homelessness since the age of 21. Class member reported a long history of substance use beginning in his early 20's and stated he is actively using. Class member reported the use of crack cocaine, marijuana and consuming alcohol. HT stated he consumes alcohol on a weekly basis. He enjoys drinking a beer while riding the Staten Island Ferry. Class member stated the last time he smoked crack was approximately four months ago. Class member stated he does not know what causes his*

usage and denied being under any stress. Class member stated his longest period of abstinence is his current four months."

As noted previously, the Settlement Agreement does not specifically provide for the creation of Level II OMH beds, which are already at a premium, for class members and relatively few class members recommended for Level II have been transitioned to the community. Of the 102 class members approved by HRA for Level II-Only as of March 10, 2017, 18 have transitioned directly to Level II housing, 10 since March 11, 2016. As such, care must be taken to ensure that this is the most appropriate recommendation to make at the time of assessment.

For cases where such a recommendation is being considered based on the individuals' preference rather than one of the exclusionary criteria, efforts should be redoubled to ensure that the individual receives all the necessary information about supported housing and available supports therein so as to make an informed decision.[22]

For those cases where recommendations for Level II OMH housing are being made because the individual is assessed to be ineligible for supported housing, closer scrutiny needs to be paid by assessors and those involved in Level II calls concerning the exclusionary criteria upon which the determination is being made.

For those cases where recommendations for Level II OMH housing are being made because the individual is assessed to be ineligible for supported housing, closer scrutiny needs to be paid by assessors and those involved in Level II calls concerning the exclusionary criteria upon which the determination is being made. Is there evidence to support the dangerousness criteria and if so, what is it? Or, as opposed to dangerousness, does the evidence suggest the need for many or intense supports and services? If so, which of these cannot be provided in supported housing, thus warranting a recommendation for Level II OMH housing? What assurance is there that such services will be provided in the Level II program? And, recognizing that Level II housing is temporary and time-limited, what is the plan to prepare the class member for supported housing? These questions should be directly addressed in final AHRARs.

[22] In its response to a draft of this report, the State commented:

> The State takes its guidance from the *Olmstead* case and Title II of the Americans with Disabilities Act which state that there is no requirement that community-based treatment be imposed on patients who do not desire it: "Nothing in this part shall be construed to require an individual with a disability to accept an accommodation . . . which such individual chooses not to accept." (Citation omitted)

The Independent Reviewer did not suggest or recommend imposition of a decision upon a class member; rather the provision of sufficient information, including the availability of Level II placements to accommodate an expressed preference, to make an informed choice.

E. HRA review of housing recommendations

Of the 900 applications approved by HRA as of March 10, 2017, 798 (89%) were approved for Community Care (supported housing) and Level II and 102 (11%) for Level II-Only, or other than supported housing. To date, 18 class members have been transitioned directly to Level II housing, 10 since March 11, 2016.

As reported in the Independent Reviewer's Second Annual Report, as of March 11, 2016, HRA had differed with the Assessor's opinion in five of the 57 cases (9%) approved for Level II, when supported housing had been recommended. (Second Annual Report, p. 67) This marked a decrease from 21%, as noted in the Independent Reviewer's First Annual Report. (First Annual Report p.42) The number and percentage of cases in which HRA differed with the recommendation of supported housing has decreased even further during the current reporting period.

In two of the 72 cases (3%) that HRA approved for Level II from March 11, 2016 to March 10, 2017, 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/CMHA, led to a determination that the resident would not be safe in supported housing. The following examples of reasons provided by HRA in these two instances which countered the Assessor's recommendation are illustrative.

- Reason in the case of WA: *Client has at least 10 psychiatric hospitalizations in the last 3 years. 27 ER visits for mental health reasons in five years. History of fire setting. UAS states client requires supervision.*

- Reason in the case of JST: *Two psychiatric hospitalizations within the last three years. Psychiatric evaluation was from recent hospital admission, which was prompted by client punching roommate in the face. Client believes that she is 22 weeks pregnant with multiple visits despite no medical evidence to support statement. Delusional about cancer diagnosis.*

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, as was the case in each of the above examples.

In three examples provided by HRA where the Assessor has recommended Level II placement, all between October and December 2016, HRA determined that the individual was qualified for Community Care and Level II, as indicated below:

- Reason in the case of RP, which was discussed in Section IV B, above: *Clinical information didn't support the exclusion of community care. History of 20*

hospitalizations and none within last eight years. Maintained on medications. (AHRAR noted: "Client is apprehensive about living on her own. Client indicated that they would like to be in a structured environment.")

- Reason in the case of HP: *Client may prefer and be more successful with more support, but there are no reasons provided to indicate she would be dangerous to herself/others if placed in supportive mental health housing with supports that do not include on-site care. Able to maintain appointments and fair control with current medications.* (AHRAR noted: "Per client's request, level II 24 hr. residence is recommended. Client reports being unable to cook and manage medication. Will not move unless in a level II facility."

- Reason in the case of GR: *There is no documentation of any behavioral issues to preclude considering Community Care housing. Client currently engaged in treatment. Per Psychiatric evaluation client appears confused regarding housing and request appears to be similar to that of an adult home.* (AHRAR noted: "Client requested level II. Client has never lived on their own, and resided with family that assisted with cooking, etc. Client would like apartment treatment and then consider moving to more independent setting, and would like more staff contact.)[23]

It was clear in each of these cases from the comments in the AHRARs, that although there was no indication that the individual met the criteria for exclusion from supported housing, the recommendation was made because of the class member's preference. HRA noted "clients who are approved for Community Care and Level II housing can be referred to Level II only housing programs at the discretion of the provider. In each of these cases Community Care was granted due to no clinical indication for a Level II only determination."

F. Persons determined not to have a Serious Mental Illness

As noted in the foregoing, there has been an increase in the percentage of cases in which assessments of class member resulted in the determination that they do not have a serious mental illness. The determination of whether or not an individual has a serious mental illness is a clinical judgment which, when made by a qualified professional, is entitled to a level of deference. However, to better understand how such determinations are being made in these cases, the Independent Reviewer and team engaged in conversations with DOH and TSI. We also reviewed the final AHRARs and supporting documents (e.g., Community Mental Health Assessments – CMHAs, PSYKES Clinical Summaries, etc.) used by assessors in making their determinations in 10 of the 30 assessments conducted by TSI between July 1, 2016 and November 18, 2016 that resulted in the determination of non-SMI.

The Settlement Agreement (¶ C. 5) defines a person with serious mental illness as an

[23] GR moved to supported housing.

"individual who meets criteria established by the Commissioner of Mental Health, which shall be persons who have a designated diagnosis of mental illness under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (but not a primary diagnosis of alcohol or drug disorders, organic brain syndromes, developmental disabilities or social conditions) and whose severity and duration of mental illness results in substantial functional disability."

Further, it indicates that an individual is presumed to have a substantial functional disability as a result of mental illness if the individual received treatment from a mental health services provider operated, licensed or funded by OMH within the 24 months preceding the date on which this Agreement was "so ordered" by the Court, unless the assessing entity determines, based on information which the assessing entity shall document, that the individual's mental illness has not resulted in a substantial functional disability.[24]

In determining members of the class, the State casts a wide net. On a quarterly basis, adult homes submit a roster of residents to DOH. On it they must indicate whether or not the individual has a serious mental illness. Additionally, the State runs the roster of residents against Medicaid billing data to determine if any individual, regardless of what the adult home indicated on the roster, had Medicaid claims for behavioral health services. If the individual was either 1) identified by the adult home as having SMI or 2) had a Medicaid claim for even one behavioral health service, the individual is considered a class member and placed on the Community Transition List (CTL) for in-reach, assessment, etc. The CTL identifies the source(s) of the SMI related information: the adult home roster, Medicaid claims data or both.[25]

According to TSI staff, assessors avail themselves of all relevant information to arrive at the determination as to whether or not an individual is SMI. In addition to meeting and interviewing the individual, assessors review PSYCKES data; interview adult home and/or care management staff; and secure and review adult home records (e.g. medication records, transfer sheets or medical evaluations which list diagnoses, etc.) as well as records from current mental health providers.

They also complete a Community Mental Health Assessment (CMHA) which, among other things, probes an individual's functional abilities and limitations. As reported by TSI, a sustained (12 month) disruption in any one of the array of living/self-care skills would amount to a

[24] The Settlement Agreement also indicates that a substantial functional disability can be presumed in certain cases based on information concerning the individual's SSI/SSDI status shared between the Social Security Administration and the State, pursuant to an agreement to share data, unless the assessing entity determines, based on information which the assessing entity shall document, that the individual's mental illness has not resulted in a substantial functional disability.

[25] The CTL indicated that in nine of the 10 cases reviewed by the Independent Reviewer it was Medicaid claims data, not information provided by the adult home, which resulted in the individual being placed on the CTL. In one case, both the adult home and Medicaid claim indicated the person received behavioral health services.

substantial functional disability. If this were the result of a DSM-V diagnosis not excluded by the Settlement Agreement, the individual would be considered SMI.

TSI staff, however, indicated that there are occasions when a CMHA may not be completed, such as when an individual claims they have never been treated for mental illness and the claim is supported by staff, other records, etc.

If TSI determines that an individual is not SMI, it records the determination and provides a narrative explanation for the determination on an AHRAR which is submitted to DOH for review. Documents secured and reviewed by TSI in formulating the determination are not submitted to DOH.[26]

Review of 10 Sample Cases

In a majority of the cases reviewed, the assessor's AHRAR determination of non-SMI appeared to be well considered and supported by documents TSI secured. For example, in four cases the primary problem/diagnosis was substance abuse-related which is excluded from the definition of SMI. In other cases, individuals had behavioral health diagnoses, such as major depression, but such was not the cause of substantial functional disability. For example:

- *RH became depressed following a stroke in 2000 which left him confined to a wheelchair. Prior to the stroke he was employed and lived independently. Currently, he requires assistance in daily living but this is due to the stroke, post-stroke right hemiparesis and resulting mobility and self-care difficulties.*

- *JT's record of psychiatric treatment began upon admission to the adult home. Billing data indicated he was treated for major depression and has been prescribed an anti-depressant in the past. Currently he is not on any psychoactive medications. The completed CMHA indicated no substantial functional disability.*

In two cases, however, it was not clear whether or not the individual is SMI based on the documents reviewed.

- *The AHRAR for JA indicates that he denied having a psychiatric diagnosis or ever being prescribed psychotropic medications. It notes that he had a brain aneurysm, was diagnosed with Presenile Dementia in 2011, has memory difficulties and has gotten lost in the*

[26] According to DOH, supporting documents are not required for non-SMI cases as such cases are not submitted for HRA review/approval. The purpose of reviewing supporting documents in other cases is to ensure that the entire package which will go to HRA is comprehensive and cohesive. If a case is not going to HRA, the AHRAR is reviewed to check for completeness and comprehensiveness. The reviewer will also check that the documentation on the AHRAR reflects a thorough assessment and may reach out to TSI with any questions and may request more information if necessary.

community. It concludes: "Based on (JA's) diagnosis of brain aneurysm (Subarachnoid hemorrhage) approx. thirty years ago, his self-reports of not have a SMI and his Dementia diagnosis, as well as assessment supporting symptoms of these disorders, he does not meet the criteria as a class member. He does not have a substantial functional disability as a result of serious mental illness."
However, supporting documents in the case indicate that JA attends an OMH certified continuing day treatment program almost daily; has an Axis I diagnosis of Depression due to another medical condition and Bipolar disorder; and that he is prescribed Lithium and Seroquel. The CMHA completed in this case indicates he requires assistance and/or supervision in several areas of daily living, e.g., shopping, transportation, medications, etc.

In this case, it is not clear if the Dementia and the brain aneurysm of years ago are considered an Organic Brain Syndrome (excluded as an SMI by the Settlement Agreement) or what weight was given to his diagnoses of Depression and Bipolar disorder, medications for such and regular attendance at a day program. Nor is it clear whether the limitations in functional abilities documented on the CMHA rise to the level of substantial.[27]

- *The AHRAR for TBA reports his diagnoses of Unspecified Depressive Disorder and Antisocial Personality Disorder (in 2014) and Adjustment Disorder (in 2015). It reports he is not currently enrolled in mental health services and is not on psychotropic medications. The assessor recorded*: "During encounter resident appeared alert, cooperative, and oriented x3. He denied any history of psychiatric hospitalization or perceptual disturbances and did not appear to be in acute distress during encounter. He has been residing in the adult home following medical treatment. He does not present with any symptoms that would impair his day to day functioning. Resident does not have a substantial functional disability as a result of a serious mental illness. He does not meet the criteria as a class member."

[27] In its response to a draft of this report, the State asserts:

> there are several instances in the Draft Report in which the assessors' judgments are challenged despite their training and the data gathered and reviewed in order to make such a judgment. Again, the *Olmstead* decision supports the "reasonable assessments" of professionals in the determination of whether an individual meets the eligibility requirements.

As this report makes clear, the Independent Reviewer recognizes the deference owed to the considered clinical judgment of a qualified professional. These case histories are presented for two reasons: 1) to illustrate the need for greater clarification about what constitutes a serious mental illness under the Settlement Agreement, particularly when there is both a mental health diagnosis and a non-mental health diagnosis which may affect functional limitations; and 2) to support the need for review of the underlying documents in cases where the individual was determined not to have a serious mental illness within the meaning of the Settlement Agreement to evaluate the reasonableness of the conclusion.

However, adult home records secured by TSI indicate he carries diagnoses of Depression NOS and Dementia, and is being treated with Celexa. Although the assessor reported that the resident did not present with any symptoms that would impair his day-to-day functioning, many of the sections pertaining to daily living skills in the CMHA completed in this case were left blank, as were many of the other CMHA sections.

These cases suggest the need for more clarity about the diagnosis of dementia: is it an Organic Brain Syndrome, and how should it be considered in the presence of other psychiatric diagnoses, such as Depression? Clarity as to what constitutes a substantial functional disability also seems to be warranted, as does better guidance for assessors about when to complete a CMHA, and in its entirety, as a tool for documenting individuals' functional abilities and disabilities. Finally, given the gravity of the determination that an individual is not a class member, DOH should consider whether assessors should submit supporting documents for review at the time they submit AHRARs for non-SMI cases.

These cases suggest the need for more clarity about the diagnosis of dementia: is it an Organic Brain Syndrome, and how should it be considered in the presence of other psychiatric diagnoses, such as Depression? Clarity as to what constitutes a substantial functional disability also seems to be warranted, as does better guidance for assessors about when to complete a CMHA, and in its entirety

VII. HRA Review and Unable to Complete Cases

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, 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.

The need for case reviews and discussions with DOH had been greatly reduced due to the vastly improved consistency, quantity and quality of the information being provided in the assessments.

As discussed in the Assessment section, above, effective July 1, 2016, DOH contracted with TSI-NY to be the sole assessment entity in the adult home initiative. In place of the UAS-NY nursing assessment, TSI-NY assessors would use the Community Mental Health Assessment (CMHA), which was found to be more applicable to the adult home class members being assessed. In anticipation of the change, HRA Administrative and Supervisory staff met with TSI-NY representatives on the use of the CMHA. The instrument was reviewed with particular attention to those areas that would require the assessors to provide comments and further details on hospitalizations, harm to self or others, alcohol & substance abuse, etc. In speaking with the Assistant Deputy Commissioner and the Director of Supportive Housing for HRA in January 2017, they were very positive about the changes and said that the new assessment process was running very smoothly. They said the need for case reviews and discussions with DOH had been greatly reduced due to the vastly improved consistency, quantity and quality of the information being provided in the assessments. They did caution that although the new assessment process started July 1, 2016, it took several months for the impact of the new process to be felt, as many of the old assessments were still coming in.

Once a complete assessment package has been approved by DOH, the Health Home's Care Coordinating agency submits an application to HRA for approval, whereas previously this was done by the assessing entity. An application package to HRA currently includes an abbreviated HRA application, the finalized AHRAR, the CMHA and a comprehensive psychiatric evaluation or a psychosocial history assessment (psychosocial) in lieu of a comprehensive psychiatric evaluation, which was initiated in the summer of 2015. Applications are approved for Community Care (i.e., supported housing) and Level II, or Level II housing only. Level II Housing refers to other types of OMH Housing, including Community Residence-Single Room Occupancy (CR/SRO); Congregate Treatment; and Apartment Treatment.

In view of the delays that had been experienced in transitioning many of the class members, OMH approached HRA about increasing the duration of the HRA approval from six months, which is standard for the HRA application, to one year, in order to allow additional time for the transition process to be completed. According to a DOH FAQ, effective February 24, 2016, all new HRA approvals in the Impacted Adult Home Initiative are for a one year period, and all HRA approvals in effect at that time were extended to one year. The increase in the approval period was granted because HRA was informed that as a result of close monitoring of the class member's clinical status, they could be assured that an individual at high risk would not be

transitioned to independent living. While extensions are generally not granted, HRA representatives stated that if there is a move date or a placement in mind, exceptions can be made.

The median length of time from submission to HRA to approval is 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 previously reported, in August 2014, DOH expanded its quality assurance reviews of AHRARs (and supporting documents) from 10% to 100% prior to submission by assessing entities to HRA, which has continued and affected the improved results

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 10, 2016, 955 applications had been submitted to HRA of which 900 (94%) were approved and 55 (6%) were classified as UTC, a slight decrease from the 7% noted in the Independent Reviewer's Second Annual Report (p. 65). Thirteen of these 55 will forever remain on the UTC list because the class members have died (4) or are non-transitional discharges (9) of people who left the adult home to live on their own or with family, went to an inpatient psychiatric or rehabilitation facility, or other disposition. Removing these class members from the count reduces the UTC cases to 42 or 4%.[28]

In addition, updated information we received from DOH during March 2017 indicated that six of the class members designated UTC, had refused to be reassessed or otherwise indicated that they were no longer interested in transitioning at this time (including one Guardian on a class member's behalf). For these six, it was a median of 86 days, or roughly three months, from the date their HRA application was submitted and found UTC to the date they declined transition or refused re-assessment. This is in addition to the many months that they had been waiting since they said yes to in-reach. it is unclear what role, if any, the delay in the application process played in their eventual decision.

This left 36 cases of class members who were still interested in transitioning but were UTC as of March 10, 2017. The median number of days that the 36 cases had been UTC was 198 days.

Below is a summary of the reason for the HRA determination of UTC (and a definition of terms), the number of cases and the median length of time cases have been in each category as of March 10, 2017.

[28] Of the non-transitional discharges, two had subsequently been approved by HRA for Level II placements with agencies not involved in this initiative.

Determination Reason	Applications	Median # of Days
Missing/Incomplete Supporting Docs.	9	60
Requested Additional Information	11	83
Assessment Discrepancy	3	358
Axis I Unsubstantiated	8	321
Timeline of Assessments	5	91
Totals	36	198

Table 9. Reasons for UTC status

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, or CMHA, for some assessments completed after July 1, 2016.

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.

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

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.

During March 2017 DOH provided the Independent Reviewer with the current status of those cases that were UTC as March 10, 2017. Of the 36 cases under review:

- 19 Awaiting TSI assessment;
- 17 HRA applications to be re-submitted due to needing additional information or to resolve discrepancies and other concerns.

Of the 19 class members who are waiting for TSI assessment, as of March 10, 2017, they have been UTC for a Median of 343 days. This includes 17 who were UTC prior to the TSI Assessment process started on July 1st. The other 17 class members have HRA applications that are currently being prepared to be resubmitted after they address HRA's concerns. The median length of time they have been UTC is 44 days as of March 10, 2017; in most instances the applications were missing information related to psychiatric history. This data is reflective of the long wait to be assessed for those that have been in the backlog, as discussed in the Assessment section, Given the much shorter length of time that cases that do not currently require reassessment

are UTC, it is possible that once the backlog is addressed, the length of time that it takes to address these issues will be reduced.

HRA often requested additional information related to their psychiatric history, which was not provided. Some have been waiting more than a year since their application was submitted.

- *LO - HRA application was submitted on October 30, 2015. It was found to be UTC on November 4, 2015 as the Axis I Diagnosis was unsubstantiated, apparently due to an incomplete CPE. HRA was requesting more details on prior psychiatric history, including suicidal/homicidal ideation or intent. No further submissions to HRA occurred since that date.*

- *SR – HRA application was submitted on November 18, 2015 and was UTC due to Missing/Incomplete Supporting documentation. In several contacts, HRA, requested missing pages and information from the CPE; and then found the UAS to be incomplete. This case was removed from the UTC list as the class member is back in the assessment queue.*

- *ALH- This class member said yes to in-reach during November 2014. She was assessed during December and her HRA application was submitted on April 27, 2015. It was found UTC due to an assessment discrepancy, as more information was needed on the supervised level of housing from the psychiatrist. This information was never provided and the class member refused transition on August 28, 2015, four months after the HRA application was submitted.*

- *EG – This class member said yes to in-reach during June 2015 and was assessed during July. Her HRA application was submitted in August 2015, and she was recommended for Level II. Her application was UTC for Missing/Incomplete Supporting Documentation for 507 days. HRA stated: "Please review AHRAR Community Housing recommendation and resubmit." EG was reassessed by TSI on December 12, 2016 with a recommendation for Supported Housing and the AHRAR was distributed on January 6, 2017. The HRA finally approved her transition in February.*

HRA provides monthly half-day training to those completing the HRA application, including those new to the Adult Home Plus initiative. During the training the Director of Supportive Housing for HRA speaks specifically about the Impacted Adult Home applications and provides context to the process, which differs from the information provided to other referral sources. Since the Independent Reviewer's Second Annual Report issued in March 2016, through December 2016, HRA has conducted eight training sessions for 78 staff. The data suggests that after the agency completing the application submits it to HRA and receives the determination of UTC, along with the rationale, there are still significant delays in addressing these concerns. The need still exists for the State to redouble its quality assurance review efforts to remedy cases that

have lingered in the UTC category for unacceptable periods of time, especially when re-assessments are required, and to limit the number of cases referred to HRA with missing, inconsistent, outdated or otherwise flawed application packages.

VIII. Person-Centered Care Planning Process

The person-centered planning process and the expectations of Housing Contractor, MLTC and Health Home staff have been described in detail in the Second Annual Report (pp. 86-88) and do not require repetition.

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 or were scheduled to transition, visiting with them in their homes; reviewing care plans, support plans and progress notes; and interviewing staff. The Independent Review team also participated in 75 transition calls and 56 post-transition calls and 15 "Level II" calls; and met with all Housing Contractors and at least scores of 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 prior annual reports. (First Annual Report, pp. 47-53; Second Annual Report, pp. 70-73)

1. Delays in the delivery of services

As discussed earlier, a majority 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. Seventeen experienced problems with the timeliness and adequacy of SNAP benefits, sometime for several months after their transitions. Thirteen had problems with the finances, in obtaining their SSI funds, dealing with changes in representative payee status and in managing their money. Fourteen experienced problems with timely provision of HHA, CHHA or PCW service.

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 most of the individuals we followed, it wasn't always the case.

- *GP*, a 73-year-old class member who was discussed above in Section IV C, was generally well supported by her Housing Contractor case manager and health home care coordinator. But neither of them ever made contact with her mental health provider. Their records indicate that she was generally compliant with her medical and psychiatric treatment as they were unaware that she had canceled five of her nine appointments with her therapist.*

The Independent Reviewer's team also 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. In-reach workers who are in adult homes weekly if not more frequently are often beset by individuals who've said Yes to moving and are now inquiring about their status in the process. However, as opposed to a year ago when Housing Contractor staff reported difficulty in contacting HH/MLTCP care managers to even schedule a care planning meeting, they voiced less of a problem in that regard now. In fact, often when class members approach them with questions, they are able to link the individual with their care coordinator or call the care coordinator directly about the individual's status, which we observed happening during our in-reach visits. In part this may be the result of the growth of the Adult Home Plus Care Management (AH+CM) initiative, which increased the number of care managers and significantly reduced their caseloads. Whereas in the past care coordinators had caseloads of 75 or more class members, under AH+ the care coordinator to class member ratio is 1:12. And AH+ CMs are expected to maintain weekly contact with class members. Undoubtedly this helps facilitate communication among the key parties. However, only 867 of the 2,263 class members who have said Yes at in-reach have AH+CM care managers and reportedly there is a high turn-over rate among AH+CMs. There has also been difficulty recruiting AH+CMs on Staten Island leading to the reassignment of some class members to different care management agencies.

3. Need for more robust care planning and training in person centered planning

As reported in the Independent Reviewer's prior annual reports, HH/MLTCPs have a variety of templates for developing care plans. 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. Robust care planning that enables individuals to envision a satisfying and fulfilling life in the community and that offers the prospect of fulfilling life goals and ambitions is also an important part of maintaining the motivation for change from the status quo.

As a result of discussions last year 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 in 2016 for AH+ care managers on recovery and person-centered care. Five sessions were offered for front line care managers and supervisors. Topics included among other things: developing recovery-based relationships, person-centered care and recovery language, cultural competency, successful engagement practices, wellness recovery action planning, trauma informed care, and employment and economic self-sufficiency. A sixth session was offered just for supervisors dealing with supervisory issues.

At least 20 care management agencies participated in the first five sessions and attendance at each ranged from 55 to 82 care managers/supervisors. Twenty-four supervisors from 15 agencies attended the sixth session.

Independent Reviewer staff attended most of the sessions, and were impressed by the quality of the presentations. Unfortunately, not all care managers were required to attend and it appears the training will not be offered again, although slides and materials presented at the sessions are available on the DOH website. The ongoing turnover in care coordinators also reduced the impact of the training provided, and despite this considerable effort by the State and its contractor, the Independent Reviewer staff continue to encounter skimpy and superficial plans all too often. During our site visits and conversations with class members, several told members of the Independent Reviewer team of their desire to work, pursue education, volunteer or work on a hobby. Almost invariably, they had not told their case managers or care coordinators of these interests, although they see them much more frequently. This suggests to us that the PCP process is not probing sufficiently to elicit information about such interests.

Several cases are illustrative.

- *The care plan developed by RM* 's Health Home care management agency identified only one goal relating to his maintenance of health which was to be accomplished by his keeping appointments with health providers, which was to be monitored by his care coordinator, and by his care coordinator assisting him with scheduling transportation for medical appointments.*

- *JSP* informed Independent Reviewer staff at the time of his interview, five months after his transition, that he would like to be engaged in volunteer work "to give back to the community." However, neither his care plan developed by his Health Home nor the support plan developed by his Housing Contractor addressed the issue.*

- *TD's Health Home care plan addressed less than a handful of issues: maintaining her health, keeping mental health appointments, maintaining housing by paying her rent and securing necessary transition-related documents (e.g., birth certificate and IDs).*

- *When ML* was interviewed six months after his transition, he informed Independent Reviewer staff that he would like to learn to read and write better. His Housing Contractor worker who was present during the interview was unaware of this, and the care plan developed by his Health Home care manager addressed only health and housing needs.*

- *AA*'s Health Home care plan addressed his clinical and ADL needs, but it did not address his socialization needs. He reported to Independent Reviewer staff that he felt lonely. In his tenure in supported housing he had roommates who wanted to keep to themselves, he reported, and did not want to do anything. He indicated that he would like to watch sports with others.*

It should be noted that while the care plans developed for these individuals did not address issues such as socialization, educational and employment/volunteer needs and interests, in two cases care management notes indicated that some of these needs and interests were being addressed to some degree. In JSP*'s case, notes indicate that the topic of doing volunteer work had been discussed with him on occasions and that he reported he is "not ready yet." In AA's case, progress notes indicated that staff have suggested that he become involved in a clubhouse program to address his socialization needs, but he declined. That such occurred seemed to be due more to happenstance as it wasn't part of the person-center care plan designed for the individual.

Although they too are to be person-centered, support plans developed by Housing Contracts within 30 days of the class member moving into supported housing also tend not to address the total person. For example, in JSP's case, discussed above, the goals of his support plan are essentially that he pay his rent on time, keep his apartment clean and keep his scheduled mental health appointments. Support plans developed for TD** and ML* were also rather anemic. In TD's case, the one goal of her support plan was to improve her health by keeping all appointments, with housing staff monitoring to ensure health related needs are being addressed and providing services to alleviate any fears or anxieties should they arise, which could cause her health to fail. In ML's case, the single goal of the support plan pertained to helping him deal with stress and learning coping skills for such.

There also appeared to be variability among support plans developed by Housing Contractors. In contrast to the support plans cited above, there is RM*'s. The support plan developed by his Housing Contractor appeared to be even more comprehensive than the care plan developed by his Health Home, which had only one goal pertaining to health maintenance. RM's support plan included items such as assisting him in learning how to use the U.S Mail and addressing envelopes; banking and the use of ATMs; preparing grocery shopping lists and going shopping; refilling medications seven days before they ran out; engaging in community

recreational events, with staff providing him listings of free events on a regular basis and also helping him choose and budget for events that are not free, such as movies.

In JSM*'s case, between the care plan developed by his Health Home and the Housing Contractor's support plan, an array of needs and interests were identified beyond basic health and safety matters. Among other things, the plans addressed his becoming familiar with businesses in his new community which he could use; budgeting, not just to pay rent and utilities, but to have sufficient funds for leisure time pursuits; engaging in peer support groups and community activities; exploring tobacco cessation options; and obtaining his driver's license so he can drive, which he used to do in the past.

Addressing the totality of the individual should not be left to chance. It is also suggested that this uniform template, completed jointly by both the HH/MLTCP and the Housing Contractor, could serve as the care plan and support plan that currently each is required to maintain separately. As important as, and even more important than having a template is the scrutiny of the adequacy of care planning in addressing these essential dimensions of life during the pre-transition and post-transition calls that are convened by DOH & OMH staff.

> As in prior annual reports, the Independent Reviewer again repeats his call for a uniform care planning template which addresses the major life domains of an individual, both critical life and safety matters and, equally as important, matters that make one's life whole, such as vocational, educational, spiritual, social and community/civic interests and needs.

IX. Need for Formal Quality Assurance Mechanisms

The Independent Reviewer's Second Annual Report discussed the fact that individuals who transitioned from adult homes sometimes experience crises which jeopardize their continued stay in supported housing. As we noted there, 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 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. For this reason, the Independent Reviewer has repeatedly recommended that such occurrences be seized and capitalized on as learning opportunities about how to support individuals with intensive needs.

Our most recent review of sample cases, exemplified by the following three, reinforces our continued belief in the need for clearly articulated Quality Assurance Review expectations and mechanisms. The three cases were previously discussed in more detail in Section IV. E (*Class members who left supported housing for another level of care.)*

- *LB was the individual discussed at pp.29-30 who decompensated within 24-48 hours upon transition, was examined and released from an emergency room, then found wandering around and in need of assistance by passersby the next day, subsequently psychiatrically hospitalized and then transferred to Level II housing.*
  This incident was reported to DOH by the Health Home which, with its downstream care management agency, conducted a review resulting in a plan of correction. The review did not probe nor speculate about the sudden and severe onset of mental status changes within 24-48 hours following transition. However, it did identify issues of concern including the fact that care management agency staff, although available 24/7, did not follow up to ensure LB 's safe return to his residence the evening of his first ER visit and only learned about his need for assistance through the intervention of a passerby who found him wandering the next morning. It also identified concerns about whether or not LB was properly cleared/approved to self-administer his own medications and whether or not he needed services from a Certified Health Home Agency (CHHA). Although not directly related to this incident, the review also raised concerns about AH+ care managers carrying mixed caseloads (which included non-class members) and the manner in which care management services were transferred from one agency to another when LB was moved into a CR/SRO in a different borough.

Quality Assurance reviews, however, were not conducted in the following two cases.

- *EE was the woman discussed at pp. 30-31who upon transition resisted attempts by her care coordinator and others to engage her in needed services and soon became involved in inappropriate and dangerous behaviors, was hospitalized where a recommendation for a higher level of care was made, which no one acted upon, was released from the hospital, continued engaging in inappropriate and dangerous behaviors and subsequently became homeless.*

- *JSC, discussed at pp. 31-32, was the 70-year-old woman whose services planned at the time of transition never came to fruition. She spent most of her tenure in supported housing hospitalized in psychiatric and rehabilitation facilities until she was discharged from supported housing about one year after she was transitioned to it from her adult home.*

It is generally understood that Quality Assurance reviews are intended to identify the root or underlying causes of an untoward event for the two-fold purpose of remedying such in the instant case and preventing them in the future. They also present teaching moments, opportunities from which other agencies or the system as a whole can learn in order to better provide supports and services.

It is not clear why an incident report was filed and a review conducted in LB's case and not the others. And while in LB's case the review identified areas in need of corrective action, it did not probe the more fundamental reason of why his transition ended so unsuccessfully, so quickly. In the other cases, where no Quality Assurance reviews were conducted, neither the agencies directly involved nor the system as a whole, benefited from understanding and addressing issues such as: how best to support an individual who is resisting attempts at engagement in mental health services or other needed services (e.g., securing ID, aide services, etc.); how best to address significantly inappropriate behaviors which jeopardize residency in one's supported apartment; how to facilitate transition to a higher level of care when such a need is being expressed; or how to revise care plans in light of changing support need and ensure that all parties are on board and the supports are delivered.

X. Conclusion

First, it is noteworthy that virtually the entire class has had the opportunity to receive in-reach at least once and to be made aware of the opportunity they have to transition out of an adult home to supported housing or another community residential alternative. Many have had this information provided to them more than once.

Second, although the pace of assessments has been a continual obstacle to the implementation of the Settlement Agreement, 1,891 class members have been assessed at least once for their eligibility for supported housing and the majority has been found eligible. When completed application packages recommending supported housing have been submitted to HRA for approval, 99.6% are approved for supported housing. Most importantly, 491 class members have been transitioned to the community and this review of a sample of the movers has determined that the vast majority have been happy that they made the move.

As could be expected with a group of people dealing with serious mental illness as well as an assortment of medical diagnoses, a subset of the class members moving to the community have experienced periods of turbulence but except for a small handful, with the support of the case managers, care coordinators and AH+CMs and other providers of service, they have maintained their tenure in the community.

It is apparent as the implementation of the Settlement Agreement has not proceeded as originally anticipated and that the pace of transitions of class members who are interested in moving to supported housing or other community residential alternative has been slower than envisioned. In each of the annual reports and periodic progress memos to the parties, the Independent Reviewer has offered recommendations to address the obstacles that have been encountered. While the State had disagreed with or not adopted several of these recommendations, it has eventually adopted others (e.g., smaller caseloads for care coordinators through the Adult

Home Plus program, and more recently, relying on a single contractor to perform assessments), but the time lag in doing so has been too great to overcome the cumulative effects of the initial slow progress.

As this report is being drafted, the parties have agreed to review provisions of the Settlement Agreement to consider revisions that might be warranted to streamline the implementation process as well as to facilitate the achievement of the goals of the agreement.

XI. Recommendations

A. In-reach

It is clear that this initiative is now in a different phase than the first rounds of in-reach when there were a significant number of fast-track and motivated residents anxious to leave the adult home when offered the opportunity during a brief in-reach session. In-reach staff are now interacting with residents who have declined the opportunity to transition to supported housing, many more than once, or who said Yes at one time but dropped out somewhere along the lengthy process of assessment, HRA application, housing interviews and visits to prospective apartments which were described in the Second Annual Report. Significant subsets are difficult to engage in a conversation about moving and, even when engaged, express considerable ambivalence. Presently, 51% of individual in-reached have said Yes to moving.

- There is a need to rethink the current approach to in-reach whereby a professional in-reach worker and a peer visit homes, most with more than 125 residents, once or twice a week for several hours. Such may have worked earlier, but it is not the best way to engage the class members now living in the homes, to help them envision a life outside the home and the opportunities it presents, or to assure them that someone will be present to assist them on their transition journey and its many steps should they decide to embark on it.

  The current in-reach model should be augmented by the creation of a Peer Ambassador program whereby a full-time equivalent peer – someone in recovery from mental illness who has walked the walk to community living – is present at each home. The peers would be tasked with three functions:

  - Engaging individuals in discussions and providing information about the Settlement Agreement and the services and opportunities available through supported housing and, most importantly, addressing questions and fears they may have about transitioning;
  - Identifying individuals who are interested in transitioning; and
  - For individuals who are interested, serving as a “hand-holder” and a conduit of information through the transition process until they move out.

- There continues to be uneven performance among Housing Contractors with regard to the number of in-reach sessions they are conducting. OMH should continue to monitor Housing Contractors' staffing levels and performance.

- Likewise, DOH should continue to monitor adult homes' compliance with its June 6, 2014 directive to Adult Home Administrators (DAL) 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."

As was stated in the Independent Reviewer's report to the Court on in-reach, it is also recommended:

- The current practice of requiring training in Motivational Interviewing largely through the use of online videos does not seem to be effective. At the least, this training ought to be supplemented by requiring in-field modeling of these skills by supervisors who have been trained in MI, and requiring observations and assessment of competence of the trainees.

- Continuing the use of a variety of in-reach strategies other than interviews in the adult home. Given the changing nature of the in-reach function, it is increasingly important that the in-reach staff become a familiar presence with adult home residents and have opportunities to develop relationships with them that permit meaningful communication about potentially life-changing decisions. The State should also consider additional in-reach strategies, such as: 1) involving AH+CMs with in-reach conversations for people who have changed their minds after having been assigned a care manager; and 2) involving clinical staff at mental health clinics and PROS programs in the in-reach effort to motivate adult home residents in exploring the possibility of transition to community living.

- Use of a Quality of Life survey instrument in interviews to enable adult home residents to focus more concretely on different dimensions of life and satisfaction with their current circumstance. (This would also create the possibility of doing subsequent surveys with the same instrument post-transition to determine whether and how quality of life has improved.)

- Language Issues/LEP Services- Based on observations of two Housing Contractors utilizing Language Line Services, it is apparent that it is not realistic that an interpreter who knows nothing about the Settlement Agreement and supported housing will be able to effectively communicate this to a class member over the phone. It is recommended that each Housing Contractor examine how language services are being presented and seek an alternative to phone translation, particularly while calling from the adult home. (In response to report citing the St. Joseph situation with LEP, OMH required a corrective action plan. A new Cantonese speaking Supervisor was hired in Housing and assists with translation as needed.)

- We recommend that OMH/DOH, as a supplement to the FAQs that are periodically updated, create some case scenarios, drawn from experience, to make the responses to

common questions (about supported housing, budgeting, money management, roommates, sharing housing with family members, etc.) more concrete and understandable, and disseminate them to the case managers and the AH+CMs.

- Housing Contractors have made progress in their ability to offer a choice of studio and one bedroom apartments, although such are not available in all boroughs due to market conditions. Housing Contractors in Brooklyn and Queens should consider offering class members who have a strong preference for studio or one bedroom apartments referrals to Housing Contractors in the Bronx or Staten Island where such apartments are more readily available. We note that in seven of the 15 cases where class members' referrals were withdrawn because they preferred to live in another borough, it was not indicated that a referral had been made to a Housing Contractor in the borough of their choice. This should be done in all instances in a timely manner.

- The state should encourage Housing Contractors to periodically convene a housing fair to promote their services and offerings to class members, using pictures and videos of their apartments, and opportunities to speak to willing residents of their housing units.

B. Assessment

- The sizable and growing backlog of individuals in the assessment phase of transition must be addressed. It is recommended that additional assessors be hired to address this issue until the backlog has been eliminated and the assessors are able to keep up with the timely completion of new assessments.

- To assist in determining whether or not an individual has SMI and his status as a class member, the Independent Reviewer recommends that further guidance be offered concerning about the diagnosis of dementia, is it an Organic Brain Syndrome – which is excluded from the definition of SMI, and how should it be addressed in the presence of other psychiatric diagnoses. Clarity as to what constitutes a substantial functional disability is also warranted as is better guidance for assessors as to when to complete a CMHA *in its entirety* as a tool for documenting an individual's functional abilities and limitations. Further, it is recommended that when AHRARs indicating a person is not SMI, and thus not a class member, are submitted to DOH for review, supporting documents (e.g., CMHAs) also be submitted for consideration during the DOH review.

- If a person is determined not to have Serious Mental Illness, the individual should be informed of his right to seek a review of this determination, and provided with information about the availability of legal assistance in the review process.

- In view of the fact that the Settlement Agreement does not provide for the creation of additional Level II OMH housing opportunities for class members, greater attention must be paid by assessors, Housing Contractors, HH/MLTCPs and State representatives to cases in which recommendations for such housing are being considered. The Independent Reviewer recommends that:

- In cases where such a recommendation is contemplated based on the individual's preference, additional information and education about supported housing and the services and opportunities this housing option offers so the individual can make an informed decision.

- For those cases where recommendations for Level II OMH housing are being made because the individual is assessed to be ineligible for supported housing, closer scrutiny be paid to the exclusionary criteria upon which the determination is being made. Is there evidence to support the dangerousness criteria and if so, what is it? Or, as opposed to dangerousness, does the evidence suggest the need for many or intense supports and services? (*E.g.*, ACT or Home and Community Based Services, etc.) If so, which of these cannot be provided in supported housing, thus warranting a recommendation for Level II OMH housing? What assurance is there that such services will be provided in the Level II program? And, recognizing that Level II housing is temporary and time-limited, what is the plan to prepare the class member for supported housing? These questions should be directly addressed in final AHRARs.

C. Person-Centered Planning

- As in prior annual reports, the Independent Reviewer again repeats his call for a uniform care planning template which addresses the major life domains of an individual - both critical life and safety matters and, equally as important, matters that make one's life whole, such as vocational, educational, spiritual, social and community/civic interests and needs – be developed and used by HH/MLTCPs. Ensuring that the totality of the individual's needs are addressed should be by design, and not left to chance as is often the case. It is also suggested that this uniform template be completed jointly by both the HH/MLTCP and the Housing Contractor and could serve as the care plan and support plan that currently each is required to maintain separately. *As important and even more important as having a template is the scrutiny of the adequacy of care planning in addressing these essential dimensions of life during the pre-transition and post-transition calls that are convened by DOH & OMH staff.*

D. Quality Assurance

As indicated in this and the Independent Reviewer's previous annual report, individuals who transition from adult homes sometimes experience crises within the first several months which jeopardize their continued stay in supported housing. Such unanticipated events present opportunities to learn how to better support the individual in the instant case, and all individuals who are in the transition process, if they are seized and reviewed to identify and remedy the underlying or root causes of the crisis. It does not appear that such Quality Assurance reviews are routinely conducted. The Independent Reviewer recommends that the State establish criteria (e.g., delayed or interrupted delivery

of services called for in care plans, hospitalizations, returns to the adult home, discharges from supported housing, etc.) which would trigger and guide a Quality Assurance review involving the agencies supporting the individual to determine and rectify issues which may have contributed to the untoward event. Where it appears that issues identified in a specific case could surface in other cases involving other support agencies, they should be alerted to such and ways to prevent or safeguard against them. A Quality Assurance mechanism, as suggested by the Independent Reviewer, need not be indefinite; it is intended to be a time-limited vehicle (six to nine months) to ensure oversight of the person's successful transition to the community and to better understand and remedy issues that may compromise such.

Appendix A

Acronym or Abbreviation	Meaning
ADL	Activity of Daily Living
AH+ CM	Adult Home Plus Care Manager
AHRAR	Adult Home Resident Assessment Report
APS	Adult Protective Services
CBC	Coordinated Behavioral Care
CC	Care Coordinator
CDTP	Continuing Day Treatment Program
CHHA	Certified Home Health Aide
CIAD	Coalition of Institutionalized Aged and Disabled
CM	Care Manager
CMHA	Community Mental Health Assessment
CPEP	Comprehensive Psychiatric Emergency Program
CR-SRO	Community Residence - Single Room Occupancy
CTL	Community Transition List
DAL	Dear Administrator Letter
DOH	New York State Department of Health
DSM-V	Diagnostic and Statistical Manual of Mental Disorders - 5th Edition
FEGS	Federation Employment & Guidance Services
FOO	Federation of Organizations
FTL	Fast Track List
GERD	Gastroesophageal Reflux Disease
HC	Housing Contractor
HCS	Health Commerce System
HH	Health Home
HHA	Home Health Aide
HHC	Health & Hospitals Corporation
HRA	Human Resources Administration
ICL	Institute for Community Living
JBFCS	Jewish Board of Family and Children's Services
LHCSA	Licensed Home Care Service Agency
MFY	Mobilization for Youth
MH	Mental Health
MHANYS	Mental Health Association in New York State
MHC	Mental Health Clinic

MI	Motivational Interviewing
MLTCP	Managed Long Term Care Plan
NYAPRS	New York Association of Psychiatric and Rehabilitation Services
NYPCC	New York Psychotherapy and Counseling Center
OMH	New York State Office of Mental Health
PCS	Personal Care Services
PCW	Personal Care Worker
PERS	Personal Emergency Response System
PROS	Personalized Recovery Oriented Services
PSYCKES	Psychiatric Services and Clinical Knowledge Enhancement System
QA	Quality Assurance
RUMC	Richmond University Medical Center
SA	Settlement Agreement
SCAA	Schuyler Center for Analysis and Advocacy
SIBN	Staten Island Behavioral Network
SMI	Serious Mental Illness
SNAP	Supplemental Nutrition Assistance Program (Food Stamps)
SSA	Social Security Administration
SSI	Supplemental Security Income
TSI	Transitional Services for New York, Inc.
UAS-NY	Uniform Assessment System for New York
UTC	Unable to Complete

Appendix B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA, Plaintiff, v. STATE OF NEW YORK, Defendants	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)

SPECIAL REPORT ON IN-REACH AND HOUSING CONTRACTOR STAFFING
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.

I. Introduction

At the status conference on February 19, 2016, in response to the Plaintiffs expressed concern about the declining rates of positive responses to the in-reach efforts of Housing Contractors, the Court requested that the Independent Reviewer report back to the Court after consulting with the Defendants. (Tr. pp. 41-42) Later, the Court also asked the Independent Reviewer to report on staffing levels at Housing Contractors to perform the functions assigned to them. (Tr. p. 55)

In response to these concerns, the Independent Reviewer and his staff have met on several occasions with representatives of the Office of Mental Health and the Department of Health to discuss these issues. The Independent Reviewer's Second Annual Report provided an initial response to the Court's request. (Dkt. No. 63, filed 4/1/16, pp. 39-52)

Much of the information needed for a more thorough examination of these issues, however, was not readily available in time for the annual report. The Independent Reviewer requested and received from the Office of Mental Health case specific information maintained in its CAIRS database regarding the in-reach activity of the Housing Contractors. We also sought and received the assistance of OMH in obtaining staffing data from the Housing Contractors. In addition, the Independent Reviewer team conducted a new round of observations of in-reach sessions by Housing Contractor staff in an attempt to determine whether the manner of conducting in-reach might have an effect on the responses received.

II. In-Reach Observations

The Independent Reviewer team conducted site visits and observations at 15 adult homes served by the eight Housing Contractors during the period from April to July 2016 as displayed in the Table below.

HOUSING CONTRACTOR	ADULT HOME	ACTIVITY	IN-REACH DATE
COMMUNILIFE	New Gloria	Observed In-reach	5/26/16
	Belle Harbor	Observed In-reach	8/17/16
	Park Inn	Observed In-reach-Open House/Model Apartment	4/18/16
FED OF ORG (FOO)	Wavecrest	Observed In-reach	6/8/16
	Central Assisted Living	Observed In-reach	6/9/16
ICL	Brooklyn Adult Care Center	Observed In-reach	6/16/16
	Queens Adult Care Center	Observed In-reach	6/28/16
JBFCS	Surf	Observed In-reach	6/15/16
	Garden Of Eden	Observed In-reach	6/28/16
PIBLY	Parkview	Observed In-reach	5/25/16
SIBN	Lakeside	Housing Group W/SIBN And CIAD	7/7/16
	Mariners	Model Apartment/Open House	7/19/16
ST. JOSEPH'S MEDICAL CENTER	Harbor Terrace	Observed In-reach	7/8/16
TSI NY	Sanford	Observed In-reach	6/7/16
	Elm York	Observed In-reach	6/8/16

A. The physical environment

The physical environment in which in-reach is conducted varied considerably among the adult homes visited. Although the DAL issued by the DOH requires adult homes to provide a suitable and private space[29] this is not always the case. Frequently, in-reach is performed in dining rooms when they are not in use. (BACC, Cent. Asst. Living, New Gloria, Park Inn, Surfside) Although adult home staff may go in and out of these areas, in some cases a section has been partitioned to provide a modicum of privacy. Another common location is a multi-purpose recreation room (Kings ACC, Wavecrest, Elm York, Oceanview) or an office (QACC, Mermaid, Sanford). At Lakeside, most of the in-reach sessions are conducted in class members' rooms. At Belle Harbor, ComuniLife conducts in-reach in a laundry room. SIBN also conducts sessions at its model apartment, which provides a private space for the conversation, away from the adult home, while

[29] 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."

also allowing the class members to envision what their supported housing might look like and to continue to ask questions throughout the transition process. While some of these locations were less than ideal, the in-reach teams were able to perform their functions adequately. In a few cases, the space was a serious impediment to conducting in-reach conversations. (Garden of Eden, Oceanview, Elm York, Surf)

- At Elm York, in-reach was being conducted in the recreation room which is located at the back end of the adult home, off a large day room and with glass windows that look out on the street on one side and into the dining room on the other. The room is about 40 feet by 15, with a long conference table and chairs at one end, and a TV with four rows of chairs at the other. The TV was blaring although no one was watching. A group of Spanish-speaking nurses was sitting in the TV chairs, apparently being recruited by a provider. Other small groups of people were seated at the conference table, some staff, some family visits. The room was noisy, with the multiple sources of stimuli. At about 10:45, the in-reach staff was asked to leave the recreation room as there was a staff meeting planned. They moved to the equally noisy day room where about 50 residents were watching two TVs. A line of residents snaked into the day room from the adjacent nursing station which was doing a pill call. The PA blared in the background. It was difficult to engage any residents in conversation for the duration of the observation.

- At Surf Manor, the in-reach team worked for three hours at an unstaffed counter at the entrance, meeting with class members on the list and not on the list, and where one of them conducted a phone conversation using a Language Line with a French speaking class member, originally from Haiti. Most of these interactions occurred within feet of the entrance to the adult home, which had a lot of traffic, while other class members gathered in the lobby, and some arguments and other loud resident interactions occurred. The setting was chaotic and not conducive to in-reach and even farther removed from a place where one would want to practice motivational interviewing or engagement of any kind. The atmosphere and history of engagement at Surf Manor has reportedly not been smooth, and space has always been an issue. Although the dining room was used during visits made in the past, the in-reach staff reported that it is generally not made available to them (although, at the insistence of the Assistant Administrator, it was used for one class member who was yelling in the lobby). (Subsequent to this observation in June 2016, and reporting of the Independent Reviewer team's concerns to a Supervisor, they meet with residents in the dining room).

B. Access to class members

In-reach staff report that some adult homes have been very cooperative and helpful in facilitating their visits and contacts with residents for in-reach and other conversations. (Kings ACC, Oceanview, Surfside, Harbor Terrace) Some allow in-reach staff to make direct contact with residents rather than having to go through the adult home staff to have them paged (Harbor Terrace, Lakeside, Wavecrest, Belle Harbor) and permit access to residents' rooms. (BACC, Belle Harbor, Park Inn, Lakeside, Sanford, Harbor Terrace) But these are exceptions, as most of the

others are much more restrictive and do not permit access to residents' rooms. (Queens ACC, Garden of Eden, Surf, Mermaid, Oceanview, Surfside, New Gloria, Mariners, Elm York) Worse, some of these homes place strict limitations on the presence of in-reach staff, requiring them to vacate the premises by 5 p.m. (Garden of Eden) or leave the in-reach space by 3 p.m. (New Gloria) Aside from limiting the time in-reach staff spend at the adult home, staff also use dilatory tactics to further limit the opportunity that the in-reach staff have to speak to residents.

- Garden of Eden (GOE) has reportedly always been a difficult adult home to conduct in-reach because the management has reportedly been less than helpful and staff discouraging to class members. The list of residents to be interviewed is given to the receptionist who sits behind a plexi-glass window who makes an announcement, when she "gets around to it," which is often garbled, and most people reportedly do not respond to it. In-reach staff are not allowed to go to the rooms, nor can they call the resident's rooms, unless they know their cell phone numbers. The in-reach worker said it was a struggle to find many of the residents at GOE, which has resulted in them developing alternative strategies, detailed below. The in-reach worker described a recent interaction where he approached two residents who were standing with staff. They both vehemently rejected the idea of supported housing and told him to "leave me alone." However, a few minutes later, one resident came back to the in-reach room and said he wanted to move, and signed the consents, saying he could not say this in front of staff.

- ComuniLife staff described New Gloria's as the least cooperative of their four homes. They provide a list with names of residents to be seen and the staff calls them down. However, one front desk staff in particular will offer an opinion on who will say Yes or No, and will often skip over the names of those who they believe should not be seen. In one instance the staff person mentioned that the resident had signed a letter (not presented) saying the in-reach staff is causing him anxiety. In-reach staff say they have to be vigilant and insist that they call the residents on the list.

  Another resident, HS, who said Yes to in-reach in November 2015, informed ComuniLife that a staff person told her that "if it does not work out for you in supported housing you will be placed in a homeless shelter," which concerned her. To date, she is still interested in moving and is currently waiting to be assessed by TSI-NY.

C. Efficiency/effectiveness of in-reach

From the recent round of observational visits, it is clear that this initiative is in a different phase than the first rounds of in-reach when there were a significant number of fast-track and motivated residents anxious to leave the adult home when offered the opportunity during a brief in-reach session. In-reach staff are now interacting with residents who have declined the opportunity to transition to supported housing, many more than once, or who said Yes at one time but dropped out somewhere along the lengthy process of assessment, HRA application,

housing interviews and visits to prospective apartments which were described in the Second Annual Report. Significant subsets are difficult to engage in a conversation about moving and, even when engaged, express considerable ambivalence as illustrated by the following example.

- SS is a 73 year-old woman who has been at Surf Manor 38 years. According to the CCITR she was originally Fast Track and was seen as follows: 3/17/14 uncertain; 8/20/14, yes; 7/1/15, no; 7/22/2015, no; 2/17/16, no. She reportedly declined assessment as per AHRAR of 3/4/15 and per final AHRAR of 5/4/16. When asked by the in-reach worker if she had thought about moving to Supported Housing, SS said she had been here over 30 years and it "would be hard to uproot myself." She said, "if I lived outside the home I would have one roommate; but here I have a lot of friends." When asked about declining the assessment in the past, SS said that the assessor told her "it would not be easy for me" that "I would have bills to pay" and she felt that "she discouraged me." She said the nurse told her she thought, "I have too many health issues," and told her to "stay with your nurse here;" and SS told her "she was willing to wait." SS said that she thought she could do it despite her problems, and that she was tough physically, but not emotionally. After about five minutes, in-reach worker asked if she wanted in-reach today, to which she replied: "not today, I have too many things on my mind." The weekly report had her as saying No to in-reach on that date, 6/15/16. However, the following week's report reflected additional in-reach on 6/22/16, and a change to Yes.

Many of these residents are older, have lived in an adult home for decades, making them more resistant to change even as they are well aware of the shortcomings of their current residence.

- G.S., a 63 year-old man, has been at BACC for 28 years. The in-reach worker approached him after she had made a presentation about the Settlement Agreement, and asked him what he thought. He said he wanted to stay in the adult home. At the same time he complained that he wanted "the conditions to change" but he didn't want to move, and was noted as No.

Dealing with this changed environment requires a fuller set of skills to engage these residents, and develop relationships with them that enable meaningful discussions about a potentially life-changing decision. Unlike the first round of in-reach where a brief conversation often resulted in a decision to transition, it is likely that it will require many conversations and much more information and support to assist class members in making an informed decision. However, at the same time that the demand for such skills has increased, Housing Contractors have faced a high level of turnover in the in-reach staff positions. With on-going recruitment for case managers for supported housing, and by health homes, MLTCs and other providers, trained and experienced in-reach staff have access to many other professional opportunities and are taking advantage of them. In turn, this results in recruiting new staff who lack the experience of their predecessors, and who require training before they are assigned to what has become a more challenging and difficult job. They also seem to need more in-field modeling of engagement skills and supervision while using them. In this environment, as we have reported previously, it is unusual to see motivational interviewing being used, although in fairness to the staff, they are often not given the opportunity

to engage in an extended conversation where motivational interviewing is possible.

Nonetheless, we have witnessed some of the experienced in-reach workers develop effective strategies to build relationships with adult home residents by becoming a familiar and regular presence in the homes, engaging them in open ended conversations and giving them the time and space to determine when and if they want to engage in discussion of the opportunity to transition to supported housing.

- We observed in-reach sessions with class members who had said "no" to transitioning previously: SJ who said "no" in 11/15; SW who said "no" in April and early May 2016; and SC who said "no" in 2015 and again in early May 2016. During the 5/25/16 sessions, all three gentlemen again stated they were not interested in transitioning. In the cases of SJ and SW, men in their 60's and 70s, both of whom had lived in Parkview for over 30 years, the in-reach worker had the opportunity to engage them in conversation.
  Both appeared to be higher functioning than many of the other residents and seemed to have carved out a life outside the AH, and its day room and programs.
  The in-reach worker (whom both knew from prior visits) used motivational interviewing to engage them, even after they said they weren't interested. When each man entered the in-reach space, they greeted her warmly but then quickly said, "I'm not interested in moving." She would say "that's OK…may I ask you a question?" With their OK, she asked an opening question (with some follow ups), "before you lived here, did you ever live on your own and what was it like?" Both gentlemen opened up about this. This was followed up with open ended questions about how they came to live at Parkview, why they like it, what other things they would like to do…and the possibility of pursuing such outside Parkview.
  SJ talked about having a job and being successful in the past..."but that was years ago when I was young." He went on to explain that now he can relax. Life is convenient. Meals are served, he's two blocks from the subway station and he can go into Manhattan whenever he likes…which he does frequently he said. The in-reach worker attempted to open the topic to the fact that one could still have these same opportunities living outside Parkview. But he said he was not interested, and when she offered him a brochure on the initiative and the Adult Home Guide book on the matter, he refused to take them.

  The second gentleman, SW, started off the conversation by saying something along the lines of: I know you want to talk to me about moving, but I've already told you, I don't want to move. She asked the same open question about his prior life and he recounted that he always lived with his family until they decided he needed to live with others which prompted his placement here. In talking about things he would like to do, in response to the in-reach worker's question, he indicated that he would like to learn Spanish. She indicated that enrollment in Spanish classes could be arranged as part of a bundle of transition services, but he still said he didn't want to leave the place with all its hotel services. As he left the room, he took the literature about the transition (which he had never taken before) and said to the in-reach

worker "I suppose you'll want to see me and talk again in a couple of months. That will be a pleasure."

Following these in-reach sessions, the in-reach worker indicated that this was the longest either man had stayed and talked...and it was the first time the second man had accepted the literature to read. She indicated that her goal is to keep engaging people, again and again, and over time the amount of time they are willing to spend to explore the possibilities of transition will increase from one minute, to five minutes, to ten minutes until they are motivated and equipped with enough information to say yes, if they so choose.

D. Identifying and focusing on class members who are uncertain

The Independent Reviewer team has noted the infrequent documentation of Uncertain/Considering it as opposed to Yes or No at in-reach. Many of the in-reach workers see their goal to move class members from a "No" to an "uncertain/considering it" and then putting more energy into converting those to a Yes. However, it does not appear that in-reach workers are fully capturing those that are uncertain/considering it, based on the low numbers in the latest weekly report. Some of the in-reach workers believed that they were not to use this “uncertain” category in their report. Although OMH clarified this issue at a Housing Contractor meeting, at the original three pilot JB homes there is still a total of three in this category on the last Weekly Report. At Elm York and Oceanview there are none. However, as noted on the table below, there are only 78 in all 22 homes, or an average of four Uncertain/considering at all adult homes.

As described above, at this stage of the process it often takes many conversations with a class member to develop a relationship with the hope of piquing their interest in supported housing. It is a step forward for someone who says No and walks away, to then say No and accept a pamphlet or the Guide on Supported Housing, in the hope that next time they may be Uncertain and considering it. It seems like a reasonable approach to focus more energy on moving the Uncertain group to Yes, and we have observed some of the more experienced workers starting a session by making reference to their previous conversation with the resident and picking up from there to discuss their current state of mind. For this strategy to be fully successful it will be important to correctly identify the class members who should be in the Uncertain category.

Uncertain at In Reach as of Week 128 (thru 8/26/16)

HC/AH	Uncertain	Total by HC
ComuniLife		14
Belle Harbor	4	
New Gloria	5	
Park Inn	1	
Surfside	4	
FOO		25
Central Assisted	8	
New Haven Manor	4	
Seaview	5	
Wavecrest	8	
ICL		3
BACC	1	
QACC	2	
JBFCS		12
Oceanview	0	
Mermaid Manor	2	
Surf	1	
Garden of Eden	5	
Kings	4	
Pibly		3
Parkview	1	
Riverdale	2	
SI-BN		15
Lakeside	9	
Mariner's	6	
St. Joseph's		5
Harbor Terrace	5	
TSI-NY		1
Elm York	0	
Sanford	1	
TOTAL		**78**

E. Providing clearer answers to residents' questions

Related to the previous issue, it is the Independent Reviewer team's sense that a significant number of people who are uncertain or ambivalent about moving to supported housing after having expressed an interest are in this state because they have had difficulty getting a clear answer to their questions about the implications of moving. Responses are often vague and uncertain to questions on issues such as: How much money will I have? Who is my roommate going to be? Can

I share the apartment with my sister (who is not a class member)? Will I get a home health aide to help with cooking and cleaning? Will I be able to enroll in a computer class?
The inability to get a clear answer feeds into the uncertainties caused by the long delays in the process and creates unnecessary doubt.

We understand that precise answers can depend on individual circumstances but there is nevertheless room for better handling of these reasonable questions. With almost 400 people having moved, there is now a body of experience about how these issues have been dealt with and different case scenarios could be created about what a budget would look like for someone on SSI/SSDI, or with a pension of $x. Examples could be given about class members who have moved in with a relative or non-class member, and how that has worked out financially. This is where turnover adds to the problem --the in-reach workers class members are now dealing with probably weren't around when these issue were last dealt with by their agencies and probably do not know what was done or what is possible.

We recommend that OMH/DOH, as a supplement to the FAQs that are periodically updated, create some case scenarios, drawn from experience, to make the responses to common questions like these more concrete and understandable, and disseminate them to the case managers and the Adult Home Plus care coordinators. CIAD has prepared excellent materials it uses in budget presentations to housing groups at adult homes, which are an example of the type of information that ought to be readily available to Housing Contractor in-reach workers and Adult Home Plus care coordinators.

F. Use of peers.

As with other aspects of in-reach work, there was a lot of variability in the use of peers. As discussed in the section on staffing below, some Housing Contractor had vacancies in the peer positions. The best of the peers brought energy, passion and a spirit of helpfulness to their jobs and were able to engage with adult home residents through their shared experiences in the mental health system. Some lived in supported housing and could directly address the challenges and fears, as well as the joys of living independently, and with a variety of supports available. Others did not share their backgrounds, or identify themselves as peers, and appeared to bring very little to the table, going through the actions to try to “sign up” residents for supported housing.

In-reach teams also took different approaches to their work. Some worked as teams, with the peer and the professional in-reach worker meeting jointly with residents, while others essentially performed the same function separately. The duration of the in-reach interactions were highly variable. Some lasted less than five minutes as the class members were not interested in having the conversation, while more substantive conversations went on for 20-30 minutes.

G. Use of pamphlet/script.

As these in-reach sessions were often the second or third conversation with a resident about supported housing, there was more inconsistency in whether in-reach staff used the OMH pamphlet or a script to ensure all elements of the Settlement Agreement were covered.

Conversations were often more organic and sometimes very brief, if the residents were disinterested. It was also evident during the observations that several class members do not retain information that has been given to them, do not remember previous in-reach sessions, even those that occurred relatively recently, and don't recall having declined an assessment. The more skillful in-reach workers made a point of beginning a conversation by referring to their last interaction with the class member, and picking up the thread from there.

Some of the Housing Contractors (Pibly, SIBN, ICL, St. Joseph's) made a practice of assembling a folder of materials including the OMH pamphlet, the Resident's Guide, and a business card with contact information to hand out to the residents they met. Others, like FOO, JBFCS and ComuniLife also distributed the materials. Pibly created a short video about its supported housing program and explaining the steps in the transition process. Many of the staff used the Adult Home Resident Guide and its chart displaying an overview of the transition process as an aid in their conversations.

H. Use of multiple strategies/Robust in-reach.

There has been an overall increase in the numbers of Housing Contractors using different strategies to reach residents. Housing Contractors have held open houses at their model apartments, hosted pizza parties, invited former adult home residents who had transitioned to come and speak to those considering a similar move, held a meeting on the sidewalk outside an adult home, and hosted groups at their model apartments to assist class members prepare for transitioning to supported housing.

- We observed the first Open House breakfast that was conducted by ICL at Brooklyn ACC. A table was attractively set up with bagels and Dunkin Donut minis along with coffee and juice. Another table was filled with in-reach materials including individual folders that are given to class members that contain the Adult Home pamphlet and the Guide. There were also picture books of furnished apartments that ICL has provided to class members. The in-reach worker had made an initial presentation about the Settlement Agreement to start the event, and used the User Guide to walk class members through the process when meeting individually with them. In all, ten class members attended, including, E.O. and E.C., who are living in supported housing, and came to present on their experiences since moving out of BACC. Six class members who had most recently said No attended. In addition, in attendance were one man who has been approved by HRA and referred for housing, but is waiting for his girlfriend, also present, who said Yes 5/5/16 and is waiting to be assessed.
  E.O. and then E.C. spoke. E.O. moved 3/3/16 into a two-bedroom apartment with a man he knew from Brooklyn ACC. He stressed how happy he was in supported housing and how important it was to get a good roommate, if you are to live with someone. He spoke of all of the help and supports available. He also mentioned the $5,000 enhancement that will allow him to get other things that he needs, which he is now waiting to receive. E.C. who moved 11/23/15, spoke briefly how she had presented in court in favor of the settlement and how ICL helped her to get the

apartment, and fully furnished it. She said it is "great." She said ICL will help and guide you and mentioned that she got along with her roommate

- At Garden of Eden, the in-reach staff have attempted to deal with the limitations on access imposed by the adult home by arriving at 7:30 a.m. while residents are getting their medications and before they leave for program, and meeting with interested residents in the lobby area.

- ComuniLife held a "Sandwich Truck" meeting on the sidewalk outside Belle Harbor to meet with residents and present on the Settlement Agreement.

I. Outreach To Families/Guardians.

As noted in the Second Annual Report (pp. 87-88), families can play an important role in the decision of a class member to move to supported housing, even when they do not have formal decision-making authority. Nevertheless, it is not common to see proactive outreach to involved family members to inform and educate them about the opportunities offered by the Settlement Agreement. Typically, in-reach staff say that they would involve families if the class members wanted this and consented.

- At Parkview, while on-site, the in-reach worker from Pibly was approached by a class member who had said Yes previously but backed out during the assessment phase. He stopped by to see the in-reach worker. He indicated that both his uncle and psychiatrist (who is off-site) believe he shouldn't move. The in-reach worker asked, and the class member gave permission to speak with these individuals on his behalf to explain the process, supports in the community, etc. and to also relay this information to his care manager (the Care Manager is changing). Her plan was to contact the care manager and develop a strategy for educating the uncle and psychiatrist. She also wanted to make sure that the class member had an ally with him (either her or the care manager) during the assessment so that he would not be alone with a stranger and felt empowered to express *his* desire.

- Similarly, family contact was demonstrated in the case of MP who said yes to moving previously, but stopped by to see the FOO in-reach worker. His biggest concern was that his mother doesn't want him to move. He explained that his mother who is not his legal guardian but lives nearby, visits and calls. She wants him to "follow the rules/regulations" of the adult home so that he can be in "good condition" and move home with her. "What if I fail and can't come back (to the Adult Home)? he asked." The in-reach worker asked an open ended question along the lines of what are the rules/regulations you need to follow or things that would indicate you're in good condition? MP explained being compliant with medications, taking showers, taking care of himself, etc. She went on to explain that becoming independent in these activities can also be done while one lives in supported housing and she asked if she could talk with his mother. He said, "it won't work…my mother is afraid I'll fail." The in-reach worker was affirming, explaining that parents are like that, they care, and they don't want their children to fail. She

then again asked if she could talk with his mother or all three of them talk together. It would give her (mom) the chance to explain her concerns which they could discuss and the worker could explain the program and other things. MP consented, but indicated he didn't have his mother's telephone number. He agreed to give mom her number the next time mom calls and the worker gave him her card.

J. Time spent on non-in-reach functions

It is also becoming clear that the job of the in-reach worker has been changing to encompass a wider set of duties. While the initial focus was simply on explaining the Settlement Agreement and the choices available to class members, now as most have already received at least one in-reach, and many of those who said Yes have been waiting for several months for other steps in the process to occur, the regular presence of the in-reach worker at the adult home is serving a different function –one of keeping them connected to the process, answering their questions, keeping them motivated and countering the discouragement they feel from the endless waiting and from the efforts of others to discourage them. (Second Annual Report, pp. 44-47)[30] During our observations we noticed that the in-reach workers were spending a substantial amount of their time at the adult home answering questions of class members who were already in the process, and relaying messages from the supported housing staff to class members.

- AM sought out the FOO in-reach worker out with questions. He had been in-reached three times before, declining transition on 8/16/15 and 4/6/16, but saying yes on 5/25/16 – the week before. He had obviously read the Adult Home Guide as he had underlined sections of it, and some of these seemed to have prompted questions about programming, supports and finances. He explained that he had once before lived independently and it didn't work out. The in-reach worker demonstrated some motivational interviewing techniques in response to his statement, beginning first with the open ended question of "what happened?" He explained that he found some of the tasks/aspects of keeping up an apartment (cleaning, laundry, etc.) difficult. He was also bored by his day program at the time; it focused on "did you take a shower or how to take a shower" and he wanted to learn things that would be "enriching" (his word) like computer skills. He described that he once attended a TSI program that taught such things and that he was interested in that or vocational training. He also said that he heard rumors of people failing in supported housing and having to return to the adult home and that administration says things like "why do you want to move, you have everything here, but if you want to, go ahead." After expressing these concerns, AM added that he was reluctant to move until he saw a woman who was obviously "mental" move out and do well (in that she hasn't returned).
  The in-reach worker, in response, demonstrated reflective listening and also affirmation. She said something along the lines of "you will face some challenges

[30] A class member who illustrates these dynamics dynamic is SS discussed earlier in this report.

upon moving, I'm not saying you won't, but…" She then went on to explain the in-apartment supports that would be available and the range and types of day-time programs including PROS and vocational services. She explained that during the assessment step, he should mention his concerns and desires to the assessor so that they are worked into the care plan.

AM's financial question dealt with whether he'd have money to buy some new clothes. The answer to which was yes and the in-reach worker re-explained the rent/payment system and what he'd have available for himself. What was interesting, though, was AM's reason. He wanted to go to church on Sundays, which he could not do at present, as he would miss lunch which is served at the adult home before he could return. He wanted nicer clothes to go to church. In addition to the financial issue, this led to a conversation about the ability to set one's own schedule (meals, etc.) when living in supported housing. AM left the session still wanting to move to supported housing and some of his fears allayed.

K. Language issues.

The state has made substantial efforts to attempt to accommodate the different languages that are used by class members. The OMH pamphlet explaining the provisions of the Settlement Agreement have been translated into nine languages and distributed to all of the Housing Contractors. There remain languages and circumstances where in-reach workers have to rely upon language translation services to communicate with class members, with unsatisfactory results. For example:

- There appears to be a fairly large Asian population at Harbor Terrace, that comprises the majority of those who have not yet been seen for in- reach. According to the CCITR of 7/8/16 there are 279 class members on the current CCITR and 61 of those have not yet been seen for in-reach. Of those 61, 45 or 74% had Asian surnames. Of those 28 were listed as speaking primarily Chinese and three Korean. The fact that two of the class members on the list for the day of the observation were said to be Vietnamese and did not speak English, raises the question of the accuracy of the primary languages listed on the CCITR.
  TN was the only one of the six who did not come down when paged, and who was in his room when we knocked on the door. This 63 year-old man of Vietnamese extraction has been at Harbor Terrace for five years. He does not speak English and appeared to not understand English. The in-reach worker called the language line that they use and asked for a Vietnamese interpreter. TN stood in his room, fully dressed, while his roommate slept in the next bed with the covers over his head. The in-reach worker used his cell phone on speaker mode. The interaction was substantially as follows:

  In-reach worker to Interpreter: *I want to talk to him about the Adult Home Plus Initiative. It is an initiative to see if people are interested in transitioning from living in the community to living in their own apartment, and I am with a gentleman*

right now to see if he is interested in doing so. And many services can be provided for him.

Interpreter: *When you say living in the community, but moving to his own apartment……*

In-reach worker: *He is living in an Adult Home right now but try to see if he wants to live in his own apartment.*

Interpreter: OK (he then speaks to TN in Vietnamese for less than a minute)

Interpreter: *No, No, I don't want to move*.

In-reach worker: *Can you ask him why he does not want to move or why he wants to stay here?*

Interpreter: (speaks with TN and TN responded.) *He said he does not want to move out.*

In-reach worker: *Can you tell him he can get help through case management services, (and we would) provide the services he needs throughout the process; he can continue to see his doctor, continue to see his mental health provider, to get the services he needs throughout the process; his counselor; he will get case management services four times a month, so he can get the skills he needs to transition to the community, and all the services that he is getting in the Adult Home he can get in the community as well*.

Interpreter: translated for 45 seconds… (brief response) *"I don't want to go."*

In-reach worker: *Is there anything positive that he might like about having his own place?*

Interpreter: (translated- reply) *"He doesn't want to go."*

In-reach worker: *Tell him if he has any questions he can come see me, my name is Richard.*

Interpreter: *He says No*.

Based on this observation, the ability to present the options available in the Settlement Agreement to some of the Asian population in this home is severely compromised. Working with a translator is a skill that needs to be learned. Sentences need to be short, so that the communication that is attempted is what is being heard and understood. The in-reach worker's sentences were so long and would be confusing to someone who really had no idea what he was talking about.

- Another Housing Contractor, JBFCS uses the services of Transperfect Remote Interpretive Services for all other languages, which was observed being used, with questionable effect.

While at Surf Manor the in-reach worker approached AV, an 82 year-old Haitian male who has lived at Surf for three years, in the lobby at the counter near to the entrance of the Adult Home. He said he speaks primarily French. Although the Adult Home Pamphlet is printed in both French and Creole, the in-reach worker did not offer him a copy in his native language. When she realized that he was French, she elected to use the language line that JBFCS has access to. She called the service from the lobby, which was very noisy and chaotic, as the dining room was being used for dinner. When she got the interpreter on the line using her cell phone on speaker mode, the following conversation transpired:

In-reach worker: *Can you ask him if he is interested in moving out of the Adult Home to the community because I am providing supported housing to him."*

Interpreter: *He said he used to work and was not responding to the question*.

In-reach worker: *Can you ask him if he is interested in moving out to an apartment that we would provide to him. We would provide him with everything…so he has everything….*

Interpreter: *He's talking about the job he has*.

In-reach worker: *Ask him if that means he is not interested in moving out of the Adult home.*

Interpreter: *Is he mentally challenged?…he is speaking very fast*.

In-reach worker: *I cannot discuss that with you as it is confidential….Is he saying he is not interested?*

Interpreter: *He says the same things over and over…I am not sure that he understands the questions in French*.

The in-reach worker thanked the interpreter for his time and ended the call after a few minutes. This interaction was entered on the Weekly Report as "Not interested in moving at this time." It was particularly disconcerting that the LEP service was used with a Haitian class member, on a cell phone in a crowded noisy lobby, where the interpreter did not think the class member understood what was being discussed, and he was not offered a pamphlet on the initiative in his native language. During a follow-up call with the in-reach worker's Supervisor, it was suggested that when it is difficult to do it on the phone, as in this case, they hire an interpreter to speak with individuals face to face. Doing it via the phone in the lobby, given what is required at this stage of in-reach, would be very difficult to engage the class member in the process.

III. Staffing data

We attempted to see if there was any correlation between the performance of Housing Contractors and their level of staffing of the in-reach function, an issue which was discussed in the Second Annual Report (pp. 47-50). Although that report provided a snapshot of the vacancies existing on March 11, 2016, we attempted to obtain a more comprehensive set of data about the duration of vacancies and their possible impact on the performance of the Housing Contractors. We requested that the OMH obtain information from the Housing Contractors as of the date of the first in-reach by each agency, to adjust for the different start times and contract status, and to measure by when each started work in the field. Specifically, we requested information based on the authorized budget approved by OMH for the in-reach clinical and peer staff:

1. the number and percent of work days authorized positions were not filled;

2. the utilization of authorized and unauthorized leave by in-reach staff;

3. the percent of time that persons in filled positions spent on non in-reach functions.

Unfortunately, this effort did not produce any useful information, although the inquiry and the questioning from OMH may have prompted the Housing Contractors to fill vacancies, as they reported a substantial decline in vacancies from March to June 2016. There are several reasons why this effort was unproductive.

V. Some agencies did not fully answer the questions. One agency (ComuniLife) seemed to evade most of them altogether even after we brought the matter to OMH's attention in late June.

VI. Agencies answered the questions differently, perhaps due to their interpretation of the question. For example, some agencies reported specific days/percentages of vacancies while others slipped by with a comment such as "a brief period" or difficult/challenging to calculate. Likewise, one gave a specific breakdown of leave usage (personal, vacation days, etc.) while others said simply what staff are entitled to or that nobody took any authorized or unauthorized leave.

VII. Although some data were provided on the use of in-reach staff for non-in-reach functions, it was not particularly illuminating as it again appears that agencies may have interpreted the question differently. Two of the responding eight agencies gave clear cut examples of in-reach staff doing housing staff duties. But a third agency, while providing time percentages, cited examples of staff engaged in supervision and going to mandated meetings/training that could be part of their in-reach responsibilities although not technically in-reach. A fourth agency gave us a percentage figure but only for one worker this past fall/winter. And a fifth agency reported that 100% of in-reach worker time has been spent on in-reach, but only since May 2016.

It is evident that until recently the State was not closely monitoring how the Housing Contractors were staffing their functions, although the OMH regularly exhorted them to fill the authorized positions. The State has not tried to understand the reasons for the variable performance or the role that staffing might play.

IV. Recommendations

The Independent Reviewer recommends:

a. The current practice of requiring training in Motivational Interviewing largely through the use of online videos does not seem to be effective. At the least, this training ought to be supplemented by requiring in-field modeling of these skills by supervisors who have been trained in MI, and requiring observations and assessment of competence of the trainees.

b. Continuing the use of a variety of in-reach strategies other than interviews in the adult home. Given the changing nature of the in-reach function, it is increasingly important that the in-reach staff become a familiar presence with adult home residents and have opportunities to develop relationships with them that permit meaningful communication about potentially life-changing decisions. The State should also consider additional in-reach strategies, such as:

    1) Involving Adult Home Plus care managers with in-reach conversations for people who have changed their minds after having been assigned a care manager.

    2) Involving clinical staff at mental health clinics and PROS programs in the in-reach effort to motivate adult home residents in exploring the possibility of transition to community living.

    3) Implementing a Peer Ambassador program, perhaps under the auspices of CIAD, as a supplement to current in-reach efforts. Peer Ambassadors, preferably former adult home residents who live in supported housing, would undergo peer advocacy training and be assigned to specific adult homes, to speak to residents about the Settlement Agreement and serve as "case finders" who would refer interested residents to the housing contractor for formal in-reach and consent.

c. Use of a Quality of Life survey instrument in interviews to enable adult home residents to focus more concretely on different dimensions of life and satisfaction with their current circumstance. (This would also create the possibility of doing subsequent surveys with the same instrument post-transition to determine whether and how quality of life has improved.)

d. Language Issues/LEP Services- Based on the observations of two HCs utilizing Language Line Services, described above, it is apparent that it is not realistic that an interpreter who knows nothing about the Settlement Agreement and supported housing will be able to effectively communicate this to a class member over the phone. It is recommended that each Housing Contractor examine how language services are being presented and seek an alternative to phone translation, particularly while calling from the adult home. It is recommended that St. Joseph examine their need for Chinese, Korean and Vietnamese translation services and seek an effective means to communicate with the Asian class members still waiting to be in reached.

e. We recommend that OMH/DOH, as a supplement to the FAQs that are periodically updated, create some case scenarios, drawn from experience, to make the responses to common questions posed by class members (about supported housing, budgeting, medication management, roommates, sharing housing with family members, etc.) more concrete and understandable, and disseminate them to the case managers and the Adult Home Plus care coordinators.

Appendix A.

Synopsis of Individual Agency's Responses to Each Question

Question 1: Since the start of In-Reach work, # and % of workdays authorized in-reach positions were not filled?

ComuniLife Did not answer this question. Upon receipt of this response in June (one of the few we received directly from the agency) we wrote to OMH on 6/23/16 saying, "…they do not provide the data OMH requested concerning vacancies and the leave utilization. Other documents suggest some gaps in their staffing patterns." It appears that OMH did not address these observations with ComuniLife when its response was first received in June and we raised concerns. As a point of reference, this agency, per OMH started in-reach work in July 2014.

FOO Did not directly or fully answer this question. It reported that it had a staff member completing in-reach since inception (7/14) via professional staff (ST who left and was replaced by MA); it didn't address any gap in service during this transition. It also did not report that a full time peer in-reach specialist position was vacant (or for how long); this was reported in an OMH snapshot of HC staffing patterns sent to us in about 3/16. As a point of reference, this agency, per OMH started in-reach work in July 2014.

JB Agency reported specific data on its two units: Coney Island (CI) the original JB since March 2014 when JB began in-reach and the former FEGS (Duryea) since JB took over operations in June 2015. It also reported data on professional and peer in-reach staff. CI had a vacant professional item for 30 days (5.24%) and a part-time vacant peer item for 70 days (20.1%). Duryea had a vacant professional item for 19 days (18.2%) and a vacant part-time peer item for 46 days (44.2%).

ICL Reported that the professional in-reach worker item has never been vacant. Its peer in-reach position was vacant for a "short period" in spring 2016; no specific data given. It also noted that the professional in-reach worker went on maternity leave, but while out her item was filed by another social worker. As a point of reference, this agency, per OMH started in-reach work in July 2014.

ICL-SIBN Reported its in-reach team is 1 FTE clinician, 1 FTE peer item equivalent (consisting of three positions) and a 0.60 RN. One 0.25 peer position has never been filled. No #/% of days given. Agency began in-reach work probably in May 2015 when St. Joe's and Pibly did.

St. Joe's reported that the professional in-reach staff item was vacant for 9 days and that the position was 71% filled. (Not clear how 9 vacant days would equate to 29% vacancy rate.) They reported no vacant days (100% fill) for in-reach peer staff. Per OMH agency began in-reach work in May 2015.

TSI Did not distinguish between peer and professional in-reach positions. They reported in-reach positions were vacant for 93 days: a vacancy rate of 9.7% for the period 7/1/14-5/31/16. Per OMH, began in-reach in July 2014.

Question 2: Utilization of authorized and unauthorized leave by in-reach staff.

ComuniLife Did not answer this question. Upon receipt of this response in June (one of the few we received directly from the agency) we wrote to OMH on 6/23/16 saying, "…they do not provide the data OMH requested concerning vacancies and the leave utilization. Other documents suggest some gaps in their staffing patterns." It appears that OMH did not address these observations with ComuniLife when its response was first received in June and we raised concerns.

FOO Did not completely answer this question. They reported that the only extended leave they had was for a peer worker from 1/14/15 – 7/31/15 when she left the agency. (Per the OMH 3/16 snapshot, this position was vacant at the time.) FOO did not report any authorized time off (vacations etc.) for any staff.

JB Reported unauthorized leave at 0% and that staff are entitled to three weeks of authorized leave annually. Did not provide usage data.

ICL Reported in-reach social worker went on maternity leave 2/16-3/16 when she left agency, but during that time her role was covered by another social worker.

ICL-SIBN No unauthorized leave has been used. One 0.25 FTE peer has been on medical leave since 4/1/16.

St. Joe's Reported 0 use of authorized and unauthorized leave.

TSI Reported that in-reach staff used 49% of accrued leave between 7/14 and 5/16: a total of 40 vacation days and 21 personal days.

Question 3: % of time that persons in filled positions spent on non-in-reach functions.

ComuniLife 15%. Per ComuniLife this includes showing clients apartments, completing intake assessments; this # will decrease once the program is fully staffed by 7/5/16. Per OMH 3/16 staffing snapshot, agency was short two of three authorized housing staff.

FOO 8%. Per FOO, these functions include supervision and attending agency mandated trainings/meetings.

JB 10%. Per JB these activities are kept to a minimum to help transition (e.g., visiting apartments, crisis intervention.) Per OMH 3/16 staffing snapshot, JB's CI & Duryea were short two of 5.5 housing staff.

ICL Agency claims this is challenging to calculate; has varied with census, transition challenges posed by individuals and the number of housing staff. They report that this past fall and winter it is estimated that **40%** of an in-reach peer's time was devoted to housing support and not IR. Per OMH 3/16 staffing snapshot, agency was short one of four housing staff.

ICL-SIBN 0%

St. Joe's	0%
TSI	0%