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. KATHY HOCHUL, in her official capacity as Governor of the State of New York, JAMES V. McDONALD, in his official capacity as Commissioner of the New York State Department of Health, ANN MARIE SULLIVAN, in her official capacity as 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)

SEMI-ANNUAL REPORT

SUBMITTED BY

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INDEPENDENT REVIEWER*

* The members of the Independent Review team, Mindy Becker, Thomas Harmon, Stephen Hirschhorn and Kathleen O'Hara, contributed substantially to the research and preparation of this Report.

Contents

I. Introduction

The Independent Reviewer's Tenth Annual Report[1] recapped the history of this case which led to a Third Stipulation and Order of Settlement approved by the court on March 8, 2024. That order extended the court's jurisdiction and oversight until June 30, 2025 unless the court approves an earlier termination.[2] The extension also provides for the continued monitoring and oversight by the Independent Reviewer ("IR") not only of the transition process but also of continued support of the class members who have already been moved to community housing. In light of the relatively short duration until the anticipated termination of the court's oversight, the extension shortened the requirement for periodic reports from the IR from annually to semi-annually. This is the first semi-annual report submitted under the Third Stipulation.

The original Settlement Agreement gave a class of approximately 4,000 persons with Serious Mental Illness (SMI) residing in 23 Impacted Adult Homes[3] in New York City the choice to move into supported housing or other appropriate community housing with the services and supports they need.[4] This report covers the period from March 11, 2024 to September 30, 2024 and discusses the progress made in implementing the Settlement Agreement during this period.

The numerical and statistical information contained in this report was provided by the State in response to a request from the IR, and the assistance is gratefully acknowledged. Unless noted specifically, all of the data is current as of September 13, 2024.

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[1] Independent Reviewer's Tenth Annual Report, Doc. # 315, filed April 2, 2024, in 1:13-cv-04165-NGG-ST, hereinafter "Tenth Annual Report."

[2] Third Stipulation and Order of Settlement. Doc. # 304-1 filed December 19, 2023 in 1:13-cv-04165-NGG-ST. (hereinafter "Third Stipulation"); Memorandum Order, Doc. #416 filed on March 8, 2024 in 1:13-cv-04165-NGG-ST.

[3] An Impacted Adult Home is an adult home in New York City with a certified capacity of 120 or more in which 25 percent or more of the residents or 25 residents, whichever is less, have serious mental illness. Second Amended Stipulation and Order of Settlement, Doc. #160, filed May 18, 2017 in 1:13-cv-04166-NGG-ST.

[4] Stipulation and Order of Settlement was filed on July 23, 2013. *United States of America v. State of New York*, EDNY Doc. #5, 13-cv-04165.

II. Methods

Since March 2024, the IR and his associates engaged in a variety of activities to monitor the implementation of the Settlement Agreement, the March 2018 Supplemental Agreement,[5] as well as the March 2024 Third Stipulation and Order of Settlement, and to provide the State and Plaintiffs with information as early as possible to enable them to act as warranted to achieve successful implementation of their legal obligations.

During this reporting period, IR staff completed visits to the adult homes to interview a sample of class members in the transition process, and also met with a sample of transitioned class members in their homes to obtain their perspective on how the process of transition and post-transition has been going. (*See,* Appendix C) As described more fully in Section III. B below, the review of Decision Making Templates (DMT) continued in order to confirm the State's determination that the class members had made an informed decision not to transition. IR staff continued to participate in pre- and post-transition and Case Review Committee ("CRC") calls, including follow-up with the State and providers on outstanding issues identified during these calls. The IR staff also continued to take part in bi-weekly calls with OMH and the peer bridger agencies. The IR continued to attend the bi-monthly meetings convened by the State with the leadership of provider agencies to discuss progress in the implementation of the court orders and address emerging issues. The IR and staff attended regular meetings with the parties as well as periodic status conferences with the court.

As discussed more fully in Section IV below, during the period covered by this report, the State implemented the Special Focused Initiative (SFI) at four adult homes starting on July 15, 2024. The IR staff has conducted visits to several of the homes and maintained contact with the State's leads at each home to be apprised of the status of settlement providers' efforts to work together to assist class members interested in transitioning (the Yes group) to overcome barriers to transition with the help of the State's Escalation Team.

[5] Supplement to the Second Amended Stipulation and Order of Settlement, Doc. # 196-1, filed March 12, 2018 in 1:13-cv-04166-NG-ST. hereinafter "Supplemental Agreement."

III. Status of the case

A. Number of active class members

In each Annual Report, we track progress in implementing the court orders in this case and the work remaining to be done, in part by identifying the number of class members who are still "active" and part of the current workload of the State and its settlement providers. Fig. 1 displays the progressive reduction of the number of active cases since the Settlement Agreement was originally entered.[6]

As Figure 1 below displays, the number of class members residing in adult homes has dwindled to 1,328 class members, of whom 1,289 have made an informed decision to remain in the adult home after having been given the opportunity to transition to supported housing or another appropriate community setting with support services, as discussed in the next section. Another 79 are still actively involved in some stage of the transition process. Some have indicated their interest in moving from the adult home and are in the transition process; some have changed their minds after initially expressing interest in moving and for them and others who recently said "NO," the State is in the process of completing a DMT for submission to the IR; and for some DMTs have been submitted to the IR and are in the review process.

[6] The majority of the reduction has occurred due to deaths of class members, non-transitional discharges ("NTD") which occur outside the process of implementing the Settlement Agreement; and informed decisions by class members to remain in their adult homes. Diligent readers may note differences in the data presented herein with those presented in the State's Quarterly Reports, prior Annual Reports of the Independent Reviewer and the dashboard presented by the State at the October 18, 2024 Parties' Meeting. These differences are due in part to the differing dates of the various reports and a more accurate method of capturing the numbers of deceased members which impacts the number of cases reported in other categories (i.e., transitions, non-transitional discharges, non-SMI, etc.) Also, whereas Annual Report data reflects aggregate data on the number of moves, non-transitional discharges and non-SMI members, Quarterly Reports factor in deaths and thus reduce aggregate data.

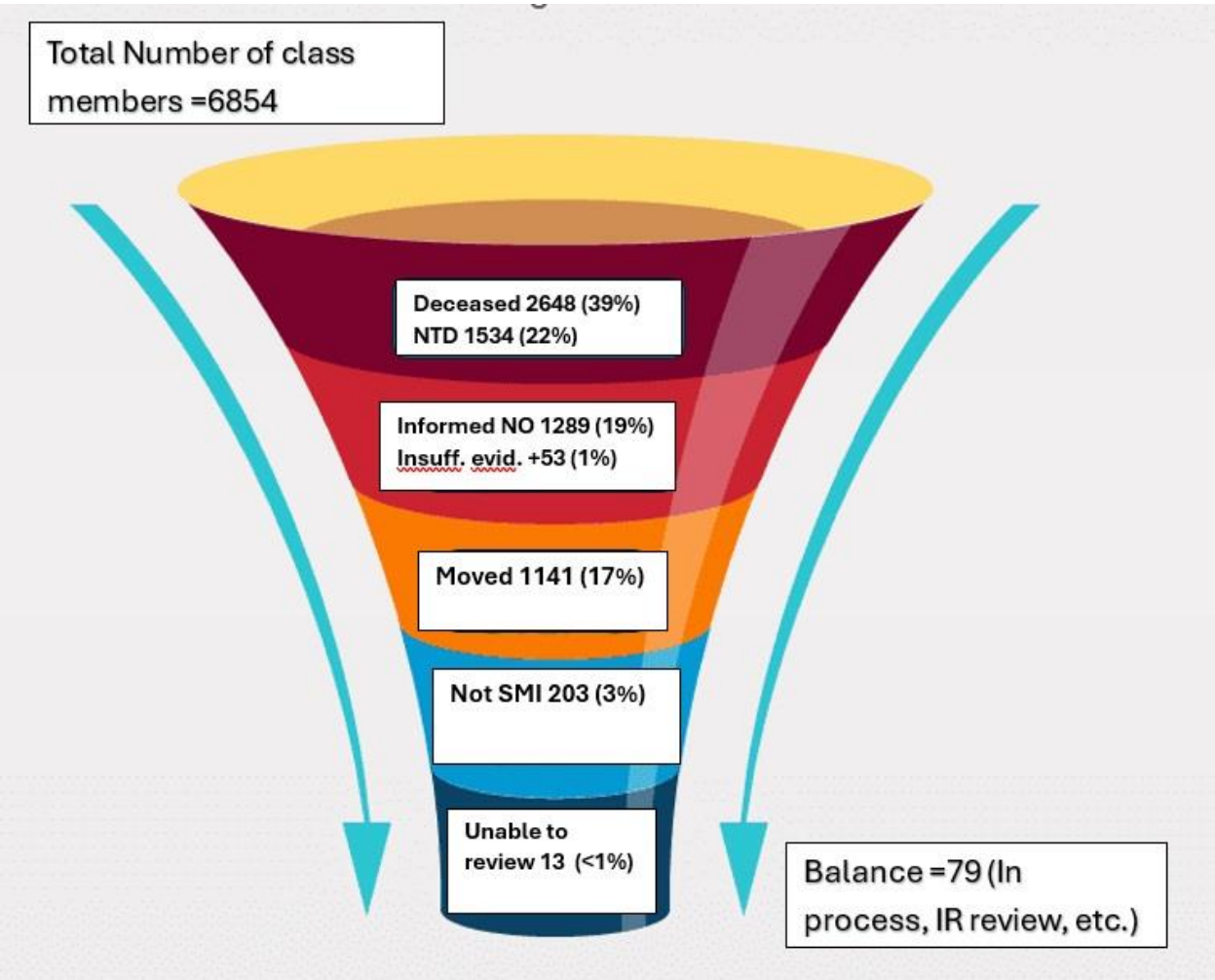

Fig. 1. Active class members

B. NO case reviews

The Supplemental Agreement entered into in 2018 made important changes to the Settlement Agreement and implementation process. First, it capped the class so that no persons with SMI who were admitted to the transitional adult homes after September 30, 2018 would be members of the class (Section G.1.). Such admissions were prohibited in any event,[7] so this provision was not envisioned as particularly impactful. (Section V below discusses screening and admissions) Second, it established a Decision Date by which class members had to declare their willingness to be assessed for transition to community housing or forfeit the opportunity to

[7] 14 NYCRR Part 580.6(c)(2); 14NYCRR Part 582.6(c)(2).

transition under the Settlement Agreement. (Section G. 2) The Decision Date for all class members expired on November 8, 2023.

To ensure that class members were making an informed decision to pass up their opportunity to transition from the Impacted Adult Homes, the IR created an Informed DMT to be utilized by the State and settlement providers to document their efforts to provide information required by the Settlement Agreement[8] to class members, and the class members' responses. Every case of a class member reported by the State as having declined the opportunity to transition from the adult home is reviewed by the IR team to ensure that they received the required information and made an informed decision. The process for reviewing these cases is described more fully in the Tenth Annual Report (Tenth Annual Report, Section IV. C.) The Third Stipulation between the parties which extends the case until June 30, 2025 provides that the IR's determination is conclusive, and if a class member has been determined to have made an informed decision by the time of the Decision Date, the State will have no further obligation to that person under the Settlement Agreement.[9]

As of September 20, 2024, the IR received DMTs and/or supporting documents that 1,355 class members had made an informed decision not to move. These were reviewed and discussed collectively by the IR's team. Of the 1,355 records received, seven class members died or were non-transitionally discharged (outside the Settlement Agreement process) after the DMTs were completed, and in six cases the documents were returned to the State as they could not be reviewed for technical reasons (*e.g.,* files were corrupted or were protected by security systems). Of the remaining 1,342 cases, the IR agreed that the member had made an informed decision not to transition in 1,289 cases (96%); in 53 cases (4%), the IR determined there was insufficient evidence that the class member had made an informed decision not to move.

[8] The Settlement Agreement required Housing Contractors to conduct in-reach to class members in the Impacted Adult Homes and to provide them with information about the benefits of supported housing, provide opportunities for them to speak to persons living in supported housing, to view photographs and/or virtual tours of sample apartments and to facilitate visits to supported housing apartments. Doc. # 160, filed May 18, 2017 in Case 1:13-cv-04166-NGG-ST.

[9] Third Stipulation and Order of Settlement. Doc. #304-1, filed 12/19/23 in 1:13-cv-04165-NGG-ST, ¶ C.1.

During the past six months, the IR shared the results of more than 280 "No Case" reviews with the Plaintiffs and Defendants. As noted in the Tenth Annual Report, the detailed review of individual class member's experiences identified settlement providers' practices that required improvement or changes. While not all of them ultimately affected the class members' decisions to remain in adult homes, and the overall approval rate from the IR's review of DMTs remains high, these reviews did identify the need for improvement in supporting those who were interested in moving, something that remains important in the waning days of the Settlement Agreement. For example, the IR found:

- Cases in which the DMTs provided scant information about efforts made to inform class members of their opportunity to transition, especially during the Full Court Press which was supposed to provide intensive and renewed efforts.

- In several cases, the settlement provider staff seemed unaware of the class members' prior in-reach and assessment history and solicited consents for assessments for several who already had active HRA approvals, which was noted on the face sheet of the DMTs. These attempts at unnecessary reassessments resulted in further unnecessary delays and communication challenges due to a housing contractor's (Comunilife) lack of capacity to perform timely assessments as a result of assessor leaves of absence and resignations. There also appeared to be an absence of State oversight of such reassessment attempts in light of DMT documentation of recent assessments and active HRA approvals.

- Cases in which some settlement providers questioned the results of assessments and HRA approvals and derailed the transitions they question. While it is possible that conditions change over time – including when settlement providers themselves are responsible for protracted delays – the State should carefully review the justification for such diversions.

- In a related vein, our review of several Park Inn cases that involved CMA NHCC and MLTC Riverspring revealed that these providers questioned class members' ability to live in community-based housing, despite prior clinical assessments and HRA approvals. These providers scheduled multiple IDT meetings during which they discussed members' perceived deficits in front of them, and subjected members to unnecessary and hard-to-meet requirements upon which transitions were contingent. At the same time, there is no clear evidence that these providers offered commensurate, person-centered support to help members meet their requirements and/or supported members in preparing for transition in ways they themselves felt important.

- Several cases highlighted the challenge of supporting class members who have complex diabetes treatment regimens but wanted to move out of the adult home. Some of these had

HRA approval for Level II housing[10] only due to the complex medical issues in managing diabetes. However, Level II programs reject such applications if class members cannot manage their own medication regimen and the programs could not access sufficient nursing support. The effect is that class members are left with no options to move from adult homes even if they continue to desire to do so.

- Cases in which there was insufficient evidence that the class member could comprehend the information being presented due to communication difficulties (*e.g.,* language barriers or speech and/or hearing impairments).

- There were cases in which it appeared that the class member seemed to be operating under delusions and there was insufficient evidence that the class member had sufficient cognitive ability to make an informed decision. We recommended in such cases to have the class member re-assessed specifically to address the cognitive issue and, if the reassessment confirms dementia or recommends that they remain in the adult home, the case be referred to the CRC for review and approval.

- In a few cases, DMTs referenced the involvement of a guardian but without discussion of the guardian's scope of decision-making authority or whether attempts were made to contact the guardian to discuss the settlement and the results of those contacts. There was also a case where a guardian remained unresponsive despite significant efforts made to establish contact. In this instance, we recommended that to prevent such a case from languishing in a state of limbo, the State and/or the plaintiffs contact the court that issued the guardianship order to report the guardian's non-responsiveness and to request a review of whether a change in the guardianship order is appropriate.

- We also reviewed a case where the class member wanted to move with a non-class member, but we did not find evidence that the process for accomplishing such a move and the related financial contribution by the non-class member was adequately explored and explained.

- Several of the cases reviewed indicated a prolonged failure by settlement providers to act promptly in response to class members' expressed interest in moving. There were long and unexplained delays that frustrated the class members, causing them to lose hope and eventually discouraging them from continuing with the process. In some cases, there were significant failures of settlement provider staff to assist class members with key tasks in the transition process. We continue to be concerned with the apparent lack of accountability of care coordinators for performing their critical duties. While these class members ultimately made an informed decision not to move, it is likely that these providers' failures to offer timely support played a part in their decisions.

[10] Level II Housing refers to other types of OMH housing, including Community Residence-Single Room Occupancy (CR/SRO); Congregate Treatment; and Apartment Treatment.

As a result of these reviews of DMTs, for class members who are still in the transition process, we strongly recommend that the State ensure that settlement providers' staff review the history of each of these class members to identify the length of their interest in moving, the obstacles they have encountered, and the failure of settlement provider staff to act quickly or at all when they expressed interest in moving. Out of such an individualized understanding of each person's experience, a truly person-centered plan can be developed and implemented. This is the last chance to do this for class members who have been waiting for years.

IV. Special Focused Initiative (SFI)

Using knowledge and best practices gleaned from prior engagement and FCP efforts, the State developed a plan to intensify its efforts to supplement the activities of Settlement providers through a hyper-focused, multidisciplinary team approach to transition the remaining class members in the "Yes" group who are interested in doing so and to document an informed decision for those who are not interested in transitioning. The goals of the SFI established by the State are: (1) to improve communication and enhance services being provided; (2) to identify transition barriers and outline a clear plan of action for each "Yes" case; (3) to ensure that each "Yes" class member makes an informed decision and completes the transition process, which includes moving into the community, if they desire to do so; and (4) to help each "Yes" class member reach completion.

The focused engagement efforts have a subset of State and settlement providers focus engagement efforts at four designated adult homes at a time. Wave 1, which began on 7/15/24 included Kings Adult Care Center (KACC), Mermaid Manor, Park Inn Home for Adults (HFA), and Sanford Manor. The expected timeline to complete Focused Engagement is predicted to be approximately eight weeks; however, depending on the adult home and the number of identified class members working on transition, this could be completed in a shorter or longer period. Each SFI will be considered completed once involved class members have either transitioned (or are scheduled to) or have made an informed decision to remain in the adult home.

These adult homes have been strategically chosen by the State, based on several factors including the number of in-process Yeses at the home. Focused engagement efforts include increased State staff presence at the home. According to the State, their staff (specifically, members

of the Escalation Team) are present at least two days per week and there will be an expected increase in settlement provider presence, allowing for same-day tours of housing and assessments. Further, some State staff have been trained in completing assessments and will be on hand to help complete assessments as the need arises. Lastly, they will seek to increase activities for the Yes group. Simultaneously other State staff will continue supporting "Yes" members at the other non-designated SFI homes. Of the six homes that will not have a formal SFI, four have at least one in-process Yes class member, and each of these homes were assigned a State staff person to engage with providers serving class members at that home to help facilitate the transition and decision-making process. The overarching goal of SFI is to ensure that each Yes class member makes an informed decision and completes the transition process, which includes moving into the community, if they desire to do so.

To discuss these efforts further, a virtual kickoff meeting was held prior to the start of the SFI at each of the Wave 1 homes which included a formal presentation about the SFI, one-pagers summarizing key information about SFI activities, and contact information at each of the four homes. Detailed below in Table 1 is the schedule of planned SFI engagement including the numbers of class members in the Yes group at all impacted homes at the start of the SFI and as of 9/12/24. Six of the homes which had two or less class members in the Yes group will not have a formal SFI. For the four of these six homes that will not have a SFI but have a class member in the Yes group, State staff were assigned to support them in activities similar to those in the SFI Wave 1 homes, beginning concurrent to Wave 1.

SFI wave number	Target start date	Adult home	# of class members at SFI start	# of class members on 9/12/24	Current Y group SFI wave # 1 (10/11/24)
1	7/15/24	Kings Adult Care Center (KACC)	10	9	10
1	7/15/24	Mermaid Home for Adults	5	4	4
1	7/15/24	Park Inn Home for Adults (HFA)	14	8	6
1	7/15/24	Sanford Home	3	4	4
2	9/30/24	Central Assisted Living (CAL)	9	6	
2	9/30/24	Queens Adult Care Center (QACC)	12	9	
2	9/30/24	Seaview Manor	7	6	
2	9/30/24	The Elliot Pearl House	7	7	
3	12/9/24	Garden of Eden (GOE)	5	4	
3	12/9/24	Lakeside Manor Home for Adults (HFA)	7	3	
3	12/9/24	New Haven Manor	7	5	
3	12/9/24	Surfside Manor	4	4	
4	2/10/25	Belle Harbor Manor	7	6	
4	2/10/25	Mariners Residence	3	3	
4	2/10/25	Parkview Home for Adults (HFA)	6	3	
No SFI		Brooklyn Adult Care Center (BACC)	2	1	
No SFI		Elm York Home for Adults (HFA)	1	1	
No SFI		Oceanview Manor Home for Adults (HFA)	2	2	
No SFI		The Veranda Assisted Living	0	0	
No SFI		The W Assisted Living at Riverdale	0	0	
No SFI		Wavecrest Home for Adults (HFA)	1	1	
			112	86	

Table 1. Planned SFI Schedule and Number of Class Members at all Impacted Adult Homes

Outcomes

- From the start of the SFI (7/15/24) through the 9/13/24 Weekly Report (i.e., approximately eight weeks after the start of SFI Wave 1) there have been seven transitions from six Impacted Adult Homes. Of these transitions, six have been to supported housing from BACC; Central Assisted; Lakeside; Park Inn; and QACC (2)

and one to Level II (Congregate Treatment) from Parkview HFA.[11] According to the Weekly Report, through 9/13/24 one of these transitions (LW) was from a home that was included in SFI Wave 1, Park Inn.[12]

- The State continues to work with some SFI Wave 1 involved class members as of 10/20/24 but according to Weekly Report 552 (through 10/11/24) no additional SFI-involved members have moved.

- Wave 1 Homes (Outcomes based on information provided through 10/11/24)
    a. Kings ACC- 10 class members in the Yes group at the start of the SFI:
        i. One class member (ML1) toured and accepted an apartment on 10/8/24, and another (KS) was accepted to the Bridge's East Harlem House Level II residence on 10/9/24, both with move dates pending.
        ii. Of four class members approved for Level II housing, two are pending reassessment (PS & NW) and two have medical issues that are impacting the transition process (LD & JJ).
        iii. One DMT (KK) was submitted and accepted by the IR; two others have DMTs in process (VB & MR); and one (ML2) is awaiting written confirmation of the Guardian's decision to not permit the class member to explore transition opportunities in Level II housing prior to completing the DMT.

    b. Mermaid Manor- Five class members in the Yes group at the start of the SFI:
        i. Toured and accepted an apartment, move date pending (LK).
        ii. Touring on hold for three class members; one awaiting receipt of his 2nd pension before he decides if he wants to transition (GI); and two others are currently in Rehab (PK & NL).
        iii. CRC approved class member to stay in adult home, and she agrees (JC).

    c. Park Inn Home – 14 Class Members in Yes group at start of SFI:
        i. One class member transitioned to SH four days prior to the start of SFI (SK).
        ii. One class member transitioned to supported housing (LW).
        iii. One accepted an apartment and needs a move date and to complete medication training and other transition tasks (AF).
        iv. One is waiting for housing that meets his preference (JG).
        v. Two are in reassessment (AW & MS [both went to CRC with recommendation to remain in the adult home, pending Plaintiffs questions/concerns]).

[11] Based on information from Weekly Report 548, through 9/13/24 the seven transitions occurred from: Central Assisted; Parkview; BACC; Park Inn (1); Lakeside; and QACC (2).

[12] Both Park Inn class members who are considered to have transitioned during SFI had move dates scheduled prior to the initiative's 7/15/24 start date. SK transitioned on 7/11/24, i.e., four days prior to the SFI start date, while LW transitioned on 8/7/24.

vi. Touring is on hold, as one class member wants to move "next year" (PH) and for another the DMT was returned by the IR on 8/13/24 with a recommendation that the class member's wishes be respected and his case be paused for six months to allow him more time to think through his past, disturbing experiences and the potential to transition again under more person-centered care (EI).
vii. Three have changed their minds and DMT is in process (LC, AD & BP).
viii. Three have had DMTs submitted and approved by the IR (AH, MO & PS).

d. Sanford Home – Three class members in the Yes group at the start of the SFI:
   i. Accepted in SUS Patchin House with move date of 10/21/24 (MA).
   ii. Accepted an apartment and had a move date for 11/6/24 but transition tasks remain incomplete, including medication training and he lost a recently acquired photo ID, impacting his ability to transition into Zara housing (BB), an supported apartment for which the management company requires a photo ID.
   iii. Vacillating in his decision to transition and was not enrolled in AH+- recently he said he wants to move, and a referral was shared for enrollment in HH CM (LR).

SFI Outcomes- Wave I	Kings ACC (10)	Mermaid Manor (5)	Park Inn (14)	Sanford Home (3)	Totals
Transitioned	0	0	2	0	2
Apt. or Residence Toured & Accepted (Pending Move Date & Completion of Transition Tasks)	1 1 Level II	1	1	1 Level II 1	4 SH 2 Level II
Awaiting Housing that Meets their preferences	0	0	1	0	1
Pending Reassessment	2 Level II	0	2	0	4
Medical issues impacting transition	2	0	0	0	2
Touring on Hold	0	1	2	0	3
Currently in Hosp/Rehab	0	2	0	0	2
DMT pending submission	3	0	3	0	6
DMT approved by IR	1	0	3	0	4
CRC Approved Stay in AH	0	1	0	0	1
Vacillating - Changes Mind	0	0	0	1 (currently saying Yes)	1

Table 2. SFI Outcomes for those in Yes Group at Start of SFI (Based on State's SFI Report Appendix F)

Observations in the Context of SFI Goals

Since the inception of the SFI at the four Wave 1 homes, IR staff have made several on-site visits and have maintained contact with the State Leads and other settlement provider staff to stay

apprised of the status of the initiative at each of the homes. Comparing our observations with the State's four framing goals for the initiative, we present some preliminary takeaways:

- **Goal 1: to improve communication and enhance services being provided**. It is encouraging to see some enhanced services being provided at SFI homes as well as across the settlement in general. These include:

    - A consistently increased on-site presence by State Escalation Leads and peer bridgers in SFI adult homes, as well as some observations of an increased presence by housing contractor staff and some AH+ and Pathway Home care managers. During our visits to SFI adult homes, housing contractor staff were not always on site during the days they had committed to, while care managers have not been asked by the State to commit to a consistent SFI on-site presence (beyond trying to be present for IDT and similar meetings). We are not able to gauge the degree to which care management services have been enhanced by the SFI because there is no specific commitment or measures they are being asked to fulfill.

    - An increased focus by the State staff on class members approved for Level II housing. During one visit to KACC, one of the State's Level II Leads was present and along with the home's Escalation Lead interviewed five of the seven class members approved for this level of care, along with the two peer bridgers, and housing contractor staff. An AH+ CM was present to discuss a class member currently touring SH apartments. During a visit to Park Inn the Escalation Lead reviewed Level II housing options and a potential virtual tour with a member while also offering to speak to her family members about her options to transition. The member was subsequently reported to have changed her mind about moving. Across the board, however, it is evident that the State has been actively engaged in facilitating Level II transitions at SFI and non-SFI homes.

At the same time, we are concerned to observe ongoing transition services and support gaps despite Goal1's language of enhanced services. These include:

- Transition tasks are still often delayed until a move date is selected. Specifically, as noted during visits, in calls with State Leads, and in the State's SFI report, medication training is still most often scheduled at the time of an acceptance of an apartment or Level II residence, rather when the class member expresses an interest in transition and agrees to be assessed. If all SFI-involved class members are in fact involved because they have been identified as "Yes" members, it is unclear why each of them has not already started medication training at the time SFI begins, as the State has continued to make statements (such as during the 10/14/24 Leadership Meeting) that medication training should begin at the time a member expresses interest in transitioning. This medication training lag has also been noted as problematic in the IR's interviews with class members (Appendix C) and during pre- and post-transition calls as well as Full Court Press (FCP) calls.

- Similarly, many of the class members in the SFI homes who have been approved for transition are still without photo IDs, which has been an ongoing problem cited in multiple Annual Reports and in the IR's interviews with class members (Appendix C), as well as on pre- and post-transition and FCP calls.

Finally, underpinning ambiguity about the full extent of enhanced services may be a greater ambiguity about the degree to which SFI has improved communication. While a consistently increased on-site State staff presence seems a key foundation for increased communication, it is not clear how, to what degree, and among which settlement service providers increased communication with the State, other service providers, and, importantly, directly with SFI-involved class members, occurs. It is most clear to us that State Escalation Leads in each involved home have made efforts to initiate increased communication among settlement service providers and other State staff; it is less clear to what degree different service providers may have increased communication with each other and SFI-involved class members. For example, through site visits and information requests to State staff we observed several instances in which State Escalation Leads scheduled meetings among providers, set up appointments for class members, and made themselves available for spontaneous conversation and support for given tasks. However, it is not clear to what degree service providers may have communicated with each other to accomplish tasks, to what degree they may have increased their direct communications with class members, etc. This is in contrast to the FCP, during which the State convened weekly all-provider calls. This structured convening of all involved providers made clearer the degree to which providers were communicating with the State and each other, both during the call itself and as they committed to working on certain tasks and then reported back on progress – including having communicated and/or collaborated with other providers -- the following week.

- **Goal 2: to identify transition barriers and outline a clear plan of action for each "Yes" case.**

The State has shared SFI trackers with the Office of the IR that document plans of action for each SFI-involved member, including identified transition barriers for each. Goal 2 as written thus seems to have been met, though to the degree it may be meant to contribute to both Goal 1 (improved communication and enhanced services) and Goal 3 (each "Yes" member making an informed decision) salient are the number of SFI-involved class members (n=19 of

32) who have neither transitioned nor made an informed decision not to transition. It may be worth reviewing and modifying the plans of action at this time to take into account new or still unresolved transition barriers. In some cases, instilling settlement service providers with more a person-centered approach to individual needs and preferences, as well as a greater sense of urgency in accomplishing transition tasks, may be warranted.

- **Goal 3: to ensure that each "Yes" class member makes an informed decision and completes the transition process, which includes moving into the community, if they desire to do so.**

Among a total of 32 class members identified for involvement in SFI Wave 1, one (approximately 3%) transitioned into the community as of 10/11/24; if we include the second member from Park Inn who transitioned just prior (7/11/24) to the start of SFI, approximately 6% of involved members have transitioned. Among these 32 class members, four have now had DMTs approved by the Office of the Independent Reviews, six are in the DMT approval queue, and one has been approved by the CRC to remain in the adult home. In other words, five SFI-involved members (approximately 16%) are now set to remain in their adult homes, and this count may increase shortly to 11 (or more) SFI-involved members (approximately 34%) set to remain in their adult homes. For the remaining 19 (approximately 60%) SFI-involved members, there is a need to ensure that as the SFI process continues Goals 1 and 2 are realized in such a way that they are able to reach an informed decision about transitioning. It is understandable that many of these members may feel ambivalent or overwhelmed about achieving transition. For example, we have observed members grow frustrated and/or ambivalent when faced with complicated Level II interview and touring processes, while other members balk at reassessments which can be arduous themselves and may lead to a change in the housing opportunities they understood themselves to have (i.e., a change from living in their own supported housing apartment to having to live in a congregate Level II setting). For other members who are already ambivalent, postponing housing tours despite the promise of the SFI to "allow same-day touring and assessments" and/or leaving transition preparation tasks (*e.g.,* medication training, obtaining IDs) unmet may lead them to decide more firmly not to transition.

- **Goal 4: to help each "Yes" class member reach completion.**

As depicted by the State's data (see Table 3), it is clear that SFI-involved class members are progressing toward a final settlement outcome, including transitioning into the community, making

the decision not to transition and going through the DMT process, and in instances in which State and settlement providers have decided their initial "Yes" interest and assessed eligibility may need to be modified, going through reassessment and/or the CRC review process.

Again salient are the SFI-involved members who continue to express interest in transitioning but face transition barriers not yet remedied by Goals 1 and 2. For these members, we reemphasize concern around transition tasks highlighted above; additionally for some of these members the continuation of these barriers is particularly vexing given that they have long histories of engagement with settlement service providers, including having already been identified as "Yes" members during their respective homes' FCPs.

V. Admissions & screening process

As discussed in the Eighth Annual Report, on July 9, 2021 the IR filed the Preadmission Screening Report with the court, reporting on a study of the State's preadmission screening process for SMI at Transitional Adult Homes ("TAH").[13] The report raised serious concerns about the ability of the process used by adult homes to screen prospective admissions for SMI.[14] In response, and as recommended in the report, the State mandated that all TAHs use a standardized mental health evaluation ("MHE") form developed in conjunction with the OMH for all new admissions. The State also committed to contracting with an independent agency to conduct the mental health screenings and did so in January 2022. A Dear Administrator Letter ("DAL") was distributed to all of the homes on March 14, 2022, and they were directed to start using the new screening process effective April 1, 2022. Since that time, both the preadmission screening and any mental health evaluations required as a result of a completed screen have been carried out by the State contractor.

Based on information provided by the State, between March 11, 2024 and September 13, 2024, under the current system there were 1,107 preadmission screens completed by the State contractor for admission to Impacted Adult Homes. Of these, 525 (47%) admissions were approved

[13] "Transitional Adult Home" means an adult home with a certified capacity of 80 or more beds and a Mental Health Census of 25 percent or more of the resident population. Transitional Adult Homes include NYC Impacted Adult Homes. "NYC Impacted Adult Home" means an adult home located in New York City with a certified capacity of 120 or more beds and a Mental Health Census of 25 percent or more of the resident population or 25 persons, whichever is less.

[14] Eighth Annual Report; pp. 11-12.

as not having SMI and 509 (46%) were found to meet SMI criteria and could not be admitted without an evaluation. The remaining 73 (7%) were closed for administrative reasons.[15] Of the 293 MHE that were completed during this period, 76 (26%) persons were found suitable for admission as their MH needs could be met in an Adult Care Facility (ACF) and 150 (51%) showed evidence of an SMI and could not be admitted unless they were returning to a TAH and had obtained a waiver. The remaining 67 (23%) were closed for administrative reasons. (See Table 3 below)

Determinations by Independent Evaluator	Preadmission Screens	Mental Health Evaluations
Can Admit (non-SMI)	525	76
Cannot Admit Without a MHE	509	
Cannot Admit–Evidence of SMI		150
Administrative Closure	73	67
Totals	**1107**	**293**

Table 3. Results of Preadmission Screens and Mental Health Evaluations conducted by Independent Evaluator March 2024 – September 2024

Currently six of the Impacted Adult Homes are no longer designated as transitional.[16] Non-transitional adult homes are not required to pre-screen for SMI or report on their monthly admissions. Of note, of the six non-transitional homes only Brooklyn Adult Care, Central Assisted and Wavecrest reported any of their admissions during this period, which included 61 individuals for whom no screen was needed, comprised of two returning class members, one post-class cap resident, and 58 Others.

As noted on the State's monthly reports to the court on admissions to the TAH, there were 312 admissions from March-August 2024. All 312 admissions were prescreened and 39 (13%) were flagged for potential SMI, including five returning class members. The State contractor's MHE confirmed that four (10%) of the 39 had SMI; one of the returning class members was found not to have SMI. The associated adult homes pursued and were granted a waiver for each of the four, and all five were admitted.

[15] Reasons provided for Administrative Closure included Incomplete referral; Application withdrawn; not enough Medicaid Information/Unable to determine; Discharged elsewhere; a recent MHE was used rather than performing a new one.

[16] The six adult homes are Brooklyn Adult Care Center, Central Assisted Living, Garden of Eden, Mariners, Oceanview Manor, and Wavecrest.

As mentioned in the Tenth Annual Report, when questioned how the State would know if individuals with SMI were being admitted to the Impacted Adult Homes, we were reminded that there is no regulation prohibiting non-TAHs (under 25% SMI) from admitting people with SMI. We subsequently learned that if a home deems itself under 20% MH census, they do not have to report at all. In light of the findings of the IR's Preadmission Screening Report cited above that raised serious concerns about the ability of the adult homes to effectively screen and accurately report prospective admissions for SMI, the IR recommended that "the State needs to implement a more assertive preadmission screening process for SMI, especially for the adult homes originally covered by this case, which does not rely entirely on self-reporting by the adult homes." The State's response reflected their intention to implement changes to the current regulations to address the issue.

In May 2024, amendments to sections 487.4 and 487.10 of Title 18 were proposed, and subsequently adopted in December 2024, which stated that *"if the facility has ever reported an individual as having Serious Mental Illness, such facility must continue to report that individual as having Serious Mental Illness until the department or its designee has conducted a mental health evaluation of that individual to confirm a change in status, and communicates written approval to the facility to discontinue reporting such individual as having Serious Mental Illness. Nothing in this paragraph shall require the department, or its designee, to conduct an independent mental health evaluation for an individual who resides in an adult home that is not defined as a transitional adult home as of January 1, 2022. For all facilities, a roster of all residents shall be submitted to the department on a quarterly basis in the manner prescribed by the department.*

While the new regulations will hopefully prevent homes from declaring themselves no longer a TAH without confirmation by the State of the change in status, it does not address one of the most egregious examples of the consequences of self-reporting. Specifically, the Garden of Eden HFA (GOE) first reported a drop-in the number of SMI residents in the First Quarter of 2022 from 158 to 18, a decrease of 89% in one Quarter. The parties were previously informed that enforcement actions were subsequently taken against the home and that they were again designated as a transitional home on June 27, 2023. However, GOE reported again on November 3, 2023 that their SMI census was under the 25% threshold making it a non-TAH, which it currently remains. As a non-TAH, it is not required to screen prospective admissions for SMI. A subsequent

investigation by DOH's Division of Adult Care Facilities and Surveillance was reportedly conducted, but the results are unavailable.

With the Third Stipulation scheduled to end on June 30, 2025, it is essential that the State strictly enforce the amended regulations regarding the admission of individuals with SMI to TAHs and the quarterly reporting requirements. Without that protection, it is possible that there would be no limit to the number of SMI residents in the homes and conditions may return to what they were before the Settlement Agreement.

VI. Interviews with class members

With the parties' agreement on a revised Settlement Agreement and its extension to June 30, 2025, the work remaining to be done and the cohort of members who are actively seeking to transition is a small subset of the total class (n=89 as of 9/9/24). The IR determined it would assist the State and settlement providers working with these members to review possible systemic issues that have arisen and are potentially ongoing for two groups: 1) class members who have been waiting to transition for extended periods of time, and 2) class members who were fairly recently transitioned, i.e., living in the community for approximately four months or more at the time of interview. We believed such a review would facilitate proactive attention to issues that have arisen and are likely to arise in the future. It would also help identify durable systems of support for members that may be needed once court oversight comes to an end.

We used a purposeful sample split between class members who:

1. were in process to transition (i.e., "Yes" members, or members who had affirmed they were interested in transitioning through the settlement), most of whom had participated in the FCP at their adult home and at the time of interview (n=13) and
2. had transitioned to the community (n=15) fairly recently (from four months to approximately two years prior to our interview).

Based on ongoing information from FCP and transition calls and provider input, we sampled a mix of members who were facing or had faced problems leading up to and following transition, as well members who had experienced more successful transition preparations and were anticipated to be doing well post-transition. We purposefully sampled members who were served by a diversity of settlement service providers and State staff. Interviews and member checks were

conducted from November 2023 through September 2024. For each member, at least one service provider (*e.g.*, peer bridgers, HC staff, AH+ care managers) was interviewed. In some cases, State staff (*e.g.*, Escalation Team members) were consulted about transition services and supports. For a few members a review of selected records, such as progress notes and medication lists was conducted but such reviews were not systematic. We emphasize that the focus of this project was interviews with class members; when we learned of contrasting perspectives or information from other sources, we incorporated them into our analysis, but the findings reported in Appendix C center on the member experience.

During our interviews we asked members if a given area of their transition preparations and/or post-transition lives posed problems for them. We categorized problems across three levels (significant problems, some problems, and no to low problems) using members' assessments, information from providers and records, and our own observations. These categorizations fed into seven key themes characterizing members' transition and post-transition experiences:

- apartment tours, matching based on needs, preferences (for Yes members waiting to transition) and Apartment and neighborhood problems at the time of interview (for post-transition members);
- person-centered care planning: IDs and related documents and person-centered care planning: financial and food security;
- medication training and ongoing support;
- isolation, loneliness in the community (for post-transition members);
- substance use, mental health, medical, mobility needs;
- help from mental health, medical providers (for post-transition members); and
- help from settlement service providers.

Detailed descriptions of each theme and case examples illustrating how specific class members have experienced situations relevant to each theme are in Appendix C. Here we reemphasize that we encourage the State to pursue the recommendations we have made to address problems members exhibited and described in relation to each theme.

VII. Recommendations

The recommendations which follow are drawn from the IR team's activities in monitoring the implementation of the court orders during this report period, including those described in Appendix C to this report. A draft of this report was provided to the parties. The State's comments and responses to the recommendations below are included as Appendix A to this report.

1. As this case nears the settlement deadline of June 30, 2025 and time becomes of the essence for class members who are still awaiting housing matching their needs and preferences, if the primary housing contractor seems to have difficulty locating such housing within a reasonable time, the State should circulate the housing referral to other housing contractors that may be able to locate such housing. Referrals may be especially helpful for members with more specific or individualized needs and preferences, such as accessibility needs.

2. During the FCP the State issued guidance to settlement service providers to commence medication training for class members assessed as needing it as soon as they indicated interest in transitioning. However, as described in this report, several providers continue with lengthy delays before they commence training. The State needs to implement more vigilant oversight of provider practices such as training that may delay transitions or jeopardize post-transition success. The State also needs to monitor more closely the type and frequency of medication training being offered to ensure that the expectation of a person-centered, "recovery oriented approach" is in fact being implemented.

3. A small number of class members are reluctant to take their prescribed medications which understandably complicates the challenge of providing them with medication self-management training. In these cases, settlement providers should be encouraged to explore the reasons for members' reluctance, to develop person-centered supports that may address this reluctance, and help members understand how their medication decisions may affect their prospect of transitioning to community-based housing.

4. For such pretransition concerns as those described above, the State's AHI Special Cases Committee (SCC) may be a useful resource; for concerns that are anticipated to continue or have continued post-transition (*e.g.,* post-transition medication training and support was accurately predicted to be needed for multiple post-transition members in this sample) timely referral the OMH Field Office's Committee on Complex Concerns (CCC) may be useful in ensuring the longer term wellbeing of members. We acknowledge that some of the most difficult member cases, including some represented in this sample, have already gone before one or both of these Committees, yet concerns remain. This suggests the need for continued, truly person-centered case conferencing, and openness to new or different services and

supports than those offered up to now in the settlement.

5. Several class members have been enrolled with ACT Teams but nevertheless have experienced significant, persistent service gaps both prior to and post-transition. In part, this is a result of some ACT Teams having a narrow view of their role as primarily addressing class members' mental health needs. As enrollment in ACT precludes the simultaneous provision of and billing for other care management services such as adult home+, this narrow conception of the role leaves members without critical supports in many domains where they need it and where, importantly, the ACT model itself would prescribe provision of services ranging from medication management to community integration. The State urgently needs to address ACT service gaps and encourage ACT Teams with low fidelity to the model to put plans in place to realize all service domains needed and desired by each enrolled class member.

6. In addition, we recognize that as is the case for all other service providers, ACT Teams likely have no prior exposure to the specifics of service provision as required by the Settlement Agreement. OMH reports that it has communicated with the leadership of agencies operating ACT Teams about the Settlement Agreement and class members' needs. Yet, while all other service providers are required to attend periodic trainings and meetings (*e.g.,* bimonthly all-staff provider meetings, FCP and SFI Kickoff Webexes, etc.), ACT Teams are conspicuously absent from these opportunities to learn about the Settlement and increase communication with other providers. We recommend the State work with OMH to ensure all ACT Teams involved in the Settlement attend the same trainings and meetings other providers attend.

7. In a related vein, during the last several months, as the number of class members actively engaged in the transition process has dwindled, and settlement provider staffing levels have diminished due to resignations and leaves, the roles and responsibilities of the remaining staff have blurred. For example, peer bridgers are increasingly being called upon to perform functions that are the responsibility of housing contractors or case managers. It is now more critical than ever to have clarity about the roles and responsibilities of settlement provider staff. The recently initiated SFI provides the opportunity for the State to clearly communicate expectations and accountability for each type of service provider.

8. In light of the many unsatisfactory conditions in class members' homes and the number experiencing adverse events that were identified in the course of our visits – some of which apparently not identified or addressed by settlement provider staff during their own periodic visits -- we recommend that the State develop and require the use of a checklist of critical items that must be observed and recorded during home visits. Such a checklist might include items on the amount, condition and storage of medications; the amount, condition, and adequacy of food; sanitation and hygiene of the home and member; the member's own questions and

concerns; etc.). As part of its Quality Assurance program, the State should regularly review such checklists to ensure that any identified problems have been corrected.

9. As isolation and loneliness seem to affect a significant number of class members who have transitioned to community living, there is a clear need for more attention to developing social connections and socialization options during the transition planning process. Such planning needs to be truly person-centered, taking into account the age, culture, other identities and interests of each class member. While a good starting point might be visits to Clubhouses, drop-in centers, and community resources like public libraries and places of worship which may be able to offer certain social support, a deeper and more personalized exploration of social interests should be part of the transition planning process. We also recommend the consistent offer of connections to former adult home residents living in the same buildings and/or neighborhoods as newly transitioning members.

10. What has emerged clearly from these interviews with class members in the community is the importance of their relationships with settlement provider staff as an important safeguard for them in the face of the multiple challenges they may face, due to factors as diverse as medical conditions, mental health and substance use concerns, money management, isolation, and questionable decision-making. This suggests the need for a thoughtful plan for long-term support past the termination of court supervision of the Settlement Agreement; such a plan would recognize the value of relationships with peer bridgers, housing contractor staff, home health aides, case managers, and natural supports that all may help buttress members' longer term health and safety in the community.

Appendix A. State Response to the Independent Reviewer's Semi-Annual Report

Since the beginning of the Settlement, the State has greatly valued the contributions of the Independent Reviewer (IR), who has helped the parties find their way through many difficult issues and whose judgment and fairness the State accepts without reservation. The State is heartened that the IR has approved 96% of the Decision-Making Templates (DMTs) the State has submitted, representing the informed decision of class members to remain in the adult home. In cases in which a DMT is not approved, the IR has requested additional supporting information for the DMT, rather than disagreeing with the conclusion that the individual has not expressed a preference to remaining in the adult home.

The Semiannual Report to be submitted to the court by November 1, 2024, finds various challenges in the Settlement's goal of giving class members wish to transition to supportive housing the opportunity to do so. The State takes some issue with the "Interviews" section of the document, which the State believes lacks sufficient context as it relates to the frustration of certain class members and the considerable efforts made on their behalf by State staff and Settlement Providers. Discerning the "truth" of a nuanced situation is difficult in the best of circumstances. A report based primarily on interviews with class members without the opportunity for Settlement Providers or State staff to confirm or contradict the class members' assessment of their situation is likely to be less reliable than a 360° review of the case.

Nevertheless, it would not be productive to litigate the descriptions of the highly fact-specific situation of each of the class members who were interviewed. Suffice it to say that if and when class members clearly indicate their desire to remain in the adult home or if the State concludes that it has exhausted all efforts to transition these class members, it will submit a DMT for such individuals that will provide extensive background about past transition efforts and obstacles to the class member's transition. As we noted in the last Status Conference, Appendix E of the Quarterly Report describes efforts for all in process "yes" class members on behalf of transitioning members.

In addition to the ongoing work of resolving individual class member problems, the State continues to refine its approach to the process of overcoming obstacles to transition for class members who wish to move to the community. For example, the Semiannual Report describes a new initiative, called the Special Focus Initiative (SFI), that is designed to ensure that we have as much focus as possible on the individual problems of transitioning class members. We don't generally view the issues we are addressing through the SFI as systemic, except to the extent that it is possible to have 100% confidence in the quality of execution at the point of delivery of care.

The State is as exasperated as the IR at some of the shortcomings described in the Interviews, such as canceling a tour because a housing contractor would not pay for an Uber ride (assuming, for sake of argument, that that occurred). The State delivers human and behavioral health services through not-for-profit providers. Even though the activities of the Settlement providers are managed – often micromanaged – by 26 dedicated State Settlement staff, errors of execution cannot completely be eliminated.

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The Semi-Annual Report outlines several challenges in the implementation of the Settlement for transitioning class members and offers recommendations for addressing these challenges. The State appreciates the recommendations from the IR. In most cases, the State is already engaged in the types of activities recommended, which are described below. That said, the IR recommendations are a useful reminder of the direction the State's efforts should take in meeting these challenges.

The following describes the challenges described by the Semi-Annual Report, the IR's recommendations, and the State's responsibility for innovations.

Housing Challenges

Challenge: Class members have specific housing needs related to accessibility, location, and other individual preferences. These needs are sometimes difficult to match with available housing, resulting in delays.

IR Recommendations: The report recommends enhanced collaboration among housing contractors, including that if a primary housing contractor faces difficulties in locating suitable housing within a reasonable time, the State circulate referrals to other housing contractors who may have access to appropriate housing options. The report recommends that the State's Escalation Team be actively involved in cases where members have waited an extended period or face complex housing barriers.

State Response: Settlement Staff already lead weekly apartment matching meetings with all Housing Contractors. During these meetings, all "In Process Yes" cases are reviewed, and referrals are shared with all providers with housing in member's desired area(s). OMH Staff share a monthly inventory list, which outlines all available apartments and provides apartment specifications, which includes apartment addresses and identifies accessible units.

The State will continue to push Housing Contractors to increase the acceptable rent levels to accommodate class members with mobility challenges. The State has recently held discussions with ICL specifically on this issue.

Delays in Pre-Transition Tasks (e.g., Medication Training, ID Acquisition)

Challenge: Class members may experience delays in essential pre-transition activities, like medication training and acquiring identification documents, which are crucial for a successful move. Medication training frequently does not begin as soon the class member has indicated a willingness to enter the transition process and may become a reason for delay in completing transition.

IR Recommendation: The State should ensure medication training begins promptly when a member expresses transition interest. It should also encourage a person-centered approach to medication training.

State Response: While State staff has issued guidance to settlement service providers to commence medication training for class member assessed as needing it as soon as they indicate interest in transitioning, for various reasons training is sometimes delayed. The reasons medication training is delayed include, but are not limited to: members declining training, members requesting to train only once they have accepted housing, members being medically compromised and unable to participate (e.g., hospitalized), members expressing ambivalence about moving, members being assigned transition tasks at incremental levels so as not to overwhelm them, staffing shortages at AHs, and logistical reasons (e.g., member is waiting for eyeglasses before completing training).

State staff and Settlement Providers make exhaustive efforts to promote medication adherence among class members. Appendix E and the State's responses to a group of class members with diabetes describes these efforts, which unfortunately are sometimes unavailing. Medication administration and adherence are reviewed in the transition planning process and are monitored post-transition during post-transition calls and settlement provider meetings. As needed, a registered nurse who is an OMH staff member has visited members in the adult homes and the community to provide medication education and training. Settlement providers, including Housing Contractor RNs and CHHAs have also provided medication education and training to members in the community struggling with medication management.

Support for Complex Medical and Mental Health Needs

Challenge: Class members with complex conditions, such as diabetes or cognitive impairments, face challenges when transitioning, as supported housing may lack adequate healthcare support.

IR Recommendation: Providers should ensure person-centered care by using specialized committees, like the OMH's Committee on Complex Concerns, to

support members with chronic conditions. Increased coordination between healthcare providers, housing contractors, and care coordinators is advised.

State Response: Complex cases are assigned to the Settlement's Special Cases Committee (SCC). Additionally, beginning in October, State Leadership staff reviewed each "In Process Yes" case in a series of SCC meetings to identify barriers and outline action steps. This process will continue at least quarterly. State staff have also begun reviewing "In Process Yes" cases at SFI homes monthly. Complex cases are also assigned to the Committee of Complex Concerns (CCC) after State and settlement providers have exhausted all reasonable efforts for transitioned members. The Post-Transition team meets bi-weekly and monthly to review all active incidents and discuss persisting concerns.

Lack of Accountability and Coordination Among Providers

Challenge: As the number of class members in transition decreases, provider staffing levels have also reduced, causing overlaps in roles and delayed response to members' needs.

IR Recommendation: The State should clearly outline the roles and responsibilities of each provider type to avoid role blurring. The Special Focused Initiative (SFI) offers an opportunity for the State to communicate expectations and accountability clearly to all involved staff.

State Response: The State recognizes this is a challenge and is taking various steps to address it. Leadership has and will continue to provide an overview of provider and state roles and responsibilities during SFI kick-off meetings, staff meetings, and provider specific calls, including weekly peer, housing, and care management calls.

Although the settlement has experienced lower employee turnover rates than the national turnover average in the behavioral health field of 40%, turnover is an ongoing challenge. Despite encouragement from the state regarding future state plans, settlement providers, understandably, have expressed employment insecurity with the upcoming completion of the Settlement. Leadership will continue to share future state plans to help alleviate these concerns.

In addition, State staff will continue to prioritize role discussions and emphasize job security during upcoming provider meetings. It should also be noted that roles are not static and even at this stage in the initiative, continue evolving. For example, in recent weeks responsibility for completion of DMT's have been

reassigned to housing and State staff, not peer staff. State staff has also taken on a more active role in adult homes and in the community, including visiting members in the community and escorting members on tours. Lastly, it should be noted that occasionally all staff are asked to assist in atypical tasks, such as housing contractors assisting in moving members to level II residences, outside of their agency, or peer staff escorting a member on a tour. In these cases, the tasks are assigned based on availability and client need (e.g., a last-minute level II, time-sensitive tour).

Social Isolation and Loneliness Post-Transition

Challenge: Many members experience isolation after transitioning to community housing, lacking sufficient socialization opportunities and community connections.

IR Recommendation: The State should develop a more person-centered approach to socialization planning during transition preparation. Connecting transitioning members with peers in similar situations and encouraging visits to community resources like Clubhouses or community centers, could alleviate loneliness.

State Response: Community integration is a core component of the transition planning process and is reviewed during 1:1 calls with AH+ CMs, Escalation calls, and pre- and post-transition calls. State staff have shared numerous resources to augment community integration, including contact and referral information for PROS programs, psychosocial clubhouses, and social day programs. State staff also encourage peer programs to promote community events to both “In Process” and transitioned class members to support community engagement and socialization opportunities with other members.

Despite encouragement, it is ultimately the class member’s choice to participate in formal programming (like PROS, psychosocial clubhouse, or a social day program). Many class members choose to wait until they leave the adult home to make the decision about how they want to spend their time. In practice, many class members choose to spend their time enjoying their new apartment (e.g., inviting friends and family over), or in their new community (e.g., walking around, visiting their friends and family, etc.). State staff will continue to reinforce that AH+ CM’s and Peer Bridgers must encourage class members to participate in activities/socialization outside of their homes that enriches their life in a way that fulfills their needs and desires. State staff will also participate in the upcoming

Baltic Street symposium, Unlocking the Power of Community, Addressing Loneliness to obtain resources and explore interventions.

Service Gaps from Assertive Community Treatment (ACT) Teams

Challenge: ACT Teams, while designed to provide comprehensive support, may have a narrow view of their role, focusing primarily on mental health and neglecting broader needs, such as medication management and social integration.

IR Recommendation: The State should encourage ACT Teams to adopt a holistic approach aligned with their original model and ensure they meet members' varied needs. ACT Teams should participate in settlement training sessions to align with other providers on class member support.

State Response: ACT Teams, which are comprised of clinical professionals, including prescribers and para-professional staff and have a maximum case ratio of 10:1, are generally considered the most effective and intensive form of community-based mental health services provided by OMH. To fold ACT teams into Settlement work, initiative Leadership created and circulated an ACT implementation and guidance one-pager in March 2024. Initiative Leadership staff also presented and provided an overview of settlement activities and ACT expectations during a monthly ACT leadership meeting in March 2024. The OMH Field Office has also identified a liaison at SPOA to prioritize all class member referrals for ACT placement and maintains regular contact with SPOA to ensure case prioritization for class members. Additionally, the OMH Field Office has identified a point of contact to address concerns with ACT teams. State staff maintains contact with the OMH Field Office, ACT point of contact. State staff also maintains at least bi-weekly contact with ACT teams assigned to members in the "In Process Yes" group to coordinate care and with ACT teams for transitioned Class Members with incident or cases of concern reports.

Although less than 10% of AHI Class Members, including confirmed No's, transitioned, and "In Process Yes" members, are enrolled in ACT teams, the State recognizes ongoing education and collaboration with ACT teams is beneficial. To enhance communication and collaboration with ACT teams, current practices will continue.

Additionally, Initiative Leadership staff will invite ACT representatives to all monthly Settlement Provider meetings. Initiative Leadership will coordinate with

ACT Leadership to schedule a presentation of ACT services to settlement providers and have them join in a discussion on how ACT teams can interface with this initiative. Lastly, Initiative Leadership will include ACT teams on the distribution list for initiative updates, such as emails advising providers of upcoming status conferences.

Gaps in Follow-Up and Accountability for Post-Transition Support

- **Challenge**: Post-transition, some members lack critical ongoing support, especially when service providers fail to conduct regular checks on living conditions or follow through with support needs, leading to lapses in care.
- **IR Recommendation**: The State should implement a checklist for providers to assess and address key needs during regular home visits. Quality assurance should include a review process to ensure these checks result in prompt problem resolution.

  State Response: Each Housing Contractor has an agency checklist of critical items that must be observed and recorded during home visits. In addition, starting in September 2024, Escalation Staff began participating in final apartment walk throughs for scheduled member transitions to identify potential apartment concerns and allow for time to resolve issues, prior to members moving into the apartments.

  State Post-Transition Staff review settlement provider notes as part of the incident review process for all reported incidents and make recommendations, as appropriate to settlement providers. Settlement providers are required to report incidents or cases of concern to the Post Settlement team to receive support from State staff to mitigate issues related to post transition services and needs.

  Settlement leadership has requested to review each Housing Contractor checklist to ensure they are in line with the State's expectations. Initiative Leadership will draft and share a home visit checklist for all providers to utilize, based on their scope of practice. For example, reviewing adequacy of food, may be on each provider's checklist, whereas reviewing that smoke detectors are in working order, might be on the Housing Contractor's checklist only.

Need for Long-Term Support Planning Beyond Court Supervision

Challenge: The end of court supervision risks leaving some members without adequate, long-term support systems.

IR Recommendation: The State should develop a comprehensive plan for long-term support that leverages relationships with peer bridgers, housing staff, and

community resources to provide stable, ongoing assistance for transitioned members.

State Response: The State agrees that a thoughtful long-term plan is needed and is in the process of developing an initial plan to be presented at the November Status Conference. Settlement leadership have been working with OMH and DOH leadership to outline a future state implementation plan, inclusive of a long-term state and provider supports for class members. The OMH Commissioner has pledged her commitment to the Class Members and has agreed to establish a plan to support class and post-cap class members.

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The State appreciates the considerable efforts made by the Independent Reviewer in identifying issues and recommending solutions. We look forward to discussing these matters in future parties' meetings and will be prepared to address these issues in the November Status Conference as well.

Appendix B Independent Reviewer's Comment on the State's Response

We appreciate the State's thoughtful response to the recommendations in this report and more generally, the efforts of the State and provider staff in implementing the court orders in this case. However, we stand by the factual accuracy of the events reported despite the suggestion that they might be subject to question. We note that much of the evidence to confirm these events is in the possession of the State or easily accessible (*e.g.* pre-transition and post-transition calls, and recorded Full Court Press calls led by State staff; provider emails and notes; incident reports; DMTs and Opt-Out forms submitted by the State to the Independent Reviewer, etc.). The Independent Reviewer team is open to further discussion of the specifics if the State deems it useful.

It is also worth observing that the types of issues and problems that were identified in this report are not new. The same issues have been reported upon in our previous annual reports and in the periodic memos that we have sent to the parties, including most recently in the cover memos transmitting the results of our reviews of the DMTs. (*e.g.,* delays in securing IDs, commencing medication training, scheduling apartment tours, gaps in case management, etc.)

The point is that despite the considerable efforts of the State to provide guidance and direction to providers, practice is not always consistent with expectations in such a decentralized system, as the State acknowledges ("errors of execution cannot be completely eliminated"). The more important point however is that the type of problems that we heard about in the course of these interviews, and which are very real, were not identified or corrected by the provider agencies' supervisors. Nor were they identified and corrected by the State's oversight of the providers. It is reasonable to conclude that other class members, not in our sample, may be experiencing similar problems without identification and correction. We believe it important that such deviations be identified and corrected both as to the specific instances and more broadly at the provider supervision and State oversight level.

Appendix C. Interviews with class members.

Contents

I. Introduction

With the parties' agreement on a revised and streamlined Settlement Agreement and its extension to June 30, 2025, it is clear that the work remaining to be done and the cohort of members who are actively seeking to transition is a small subset of the total class (n=89 as of 9/9/24). The IR determined that it would assist the State and settlement providers working with these members to review possible systemic issues that have arisen in the past and are potentially ongoing for two groups: 1) class members who have been waiting to transition for extended periods of time, and 2) class members who were living in the community for approximately four months or more at the time of interview[17] (i.e., fairly recently transitioned). We believed that such a review would facilitate proactive attention to issues that have arisen and are likely to arise in the future. It would also help identify the types of durable systems of support for members that may be needed once court oversight comes to an end.

II. Methods

A. Sample.

We used a purposeful sample split between class members who:

1) were in process to transition (i.e., "Yes" members, or members who had affirmed they were interested in transitioning through the settlement), most of whom had participated in the FCP at their adult home and at the time of interview had been waiting between six months and almost two and a half years from the start of their corresponding FCP (n=13) and 2) had transitioned to the community (n=15) including one who moved the year prior to their home's FCP, three during their homes' FCP 90 day periods, ten within approximately six months of their homes' FCP end dates, and one who moved approximately one year and nine months after their home's FCP end date[18]).

[17] By September 2024 three (JB, KS, RB) members in the In-Process "Yes" sample had moved to the community; they were not included in the post-transition count nor in measuring the length of time in the community at time of interview. They were, however, contacted post-transition to learn about their initial months in the community. Another member (DW) interviewed in the post-transition sample has been in process to return to the adult home; as of 8/27/24 Oceanview Manor had requested additional paperwork but the return seemed on track to go forward.

[18] Although by one measure the FCP initiative ended with the Park Inn Decision Date on November 5, 2023, we make frequent note of it because so many sampled members transitioned and/or were (re)engaged as "Yes" members during this process. Particularly for members still waiting to move, the FCP context is relevant as it was depicted as engaging them with a new, more intensive commitment from the State and settlement providers.

Our focus was on current "Yes" members, i.e., members who: 1) had expressed they wanted to and were/are still waiting to transition, as well as 2) members who had transitioned and thus had been "Yes" for at least some time prior to transition. However, our sample also included members who were categorized as "No" at the start of their respective adult home FCPs and, through the FCP process, had decided they did want to transition. In total nine members (n=3 in process, n=6 post-transition, or 33% of the total sample) were identified as having expressed previously that they were not interested in transitioning through the settlement, with their certainty ranging from "Soft" to "Hard."[19] Interestingly, without purposefully sampling for members with a "No" history this project includes four out of 15 transitioned participants (i.e., approximately 27% of the transitioned sample) who were "Hard No" at the start of their respective FCPs and who are now living successfully in supported housing (FA, GC, NLe, FY).[20] These "Hard No" members tended to be doing well in the community. For example, members GC and NLe regularly take public transportation to social activities including peer-run community events and day programs; keep up with appointments; and when they each faced adverse events in the community (*e.g.,* substance use, post-transition service gaps including a lack of life necessities such as food) they have communicated and been willing to work with settlement service providers to seek additional supports. These experiences provide support for the success of the State's FCP strategy in engaging and persuading some class members who had previously been disinterested in leaving the adult home to move to supported housing; further it supports the idea that even members who have spent years disinterested in and/or ambivalent about transition can live well in the community.

Based on ongoing information from FCP and transition calls and provider input, we sampled a mix of members who were facing or had faced problems leading up to and following transition, as well members who had experienced more successful transition preparations and were anticipated to be doing well post-transition. We sought to include members served by all eight housing contractors (HCs) and a cross-section of Health Homes (HHs) and Care Management Agencies (CMAs), including both Pathway Home teams (n=10 members enrolled) and four ACT Teams at the time of interview (n=4 members enrolled, and one additional ACT Team is

[19] Per the CCITR "No" definitions are: "the Soft No group is currently a yes, has transitioned in the past, was assessed and had a housing referral. The Hard No group has always said no to transition and assessment. The Medium No group has a history of being uncertain and/or declining assessment and never had a housing referral."

[20] Again, a fifth "Hard No" member (RB) included in the In-Process "Yes" sample had been a "Hard No" at the start of the Mariners FCP. He transitioned to a Level II facility on 5/1/24.

represented in the sample as one additional in-process "Yes" member was enrolled in ACT after our November 2023 interview). One member was enrolled in ArchCare PACE in lieu of a CMA. Both peer-run agencies and seven Managed Long Term Care Plans (MLTCs) were represented; at least three interviewed members had declined MLTC and CHHA services at the time of interviews. Additional participant characteristics are summarized below.

Table 1. In-process "Yes" Participant Characteristics (N=13)

Participant Characteristics	N (%)	Median
Age at time of interview		69.2
Female	2 (15%)	
Male	11 (85%)	
Adult home length of stay (LOS) in years as of *12/1/23*		10.4
Adult homes		
Belle Harbor Manor	1	
Mariners	2	
Mermaid	2	
Park Inn	3	
New Haven Manor	2	
Queens Adult Care Center	2	
Seaview Manor	1	
Status at start of respective FCP		
Yes	10	
No (Soft [n=2], Hard [n=1])	3	

Table 2. Post-transition Participant Characteristics (N=15)

Participant Characteristics	N (%)	Median
Age at time of interview		65.1
Female	9 (60%)	
Male	6 (40%)	
Adult home length of stay (LOS) in years *as of transition**		9.1
Adult homes		
Belle Harbor Manor	1	
Central Assisted Living	1	
Elliot Pearl House	1	
Elm York	1	
Garden of Eden	1	
Mariners	1	
New Haven Manor	2	
Park Inn	4	
Sanford Home	3	
The W	1	
Wavecrest	1	
Status at start of respective FCP		
Yes	8	
No (Soft [n=1], Medium [n=1], Hard [n=4])	6	
Moved prior to FCP	1	

*one member transitioned to supported housing from 2016 to 2021; this measure includes only his second LOS of 1.6 years.

Of note, in the process of contacting sampled members, we discovered 13 (eight in-process, five post-transition) members suffering adverse events or other difficult circumstances. These circumstances were impactful enough that 46% of our initially anticipated sample was considered unable to participate in interviews. They included:

- Two members who died, one while in the adult home (SS) and one post-transition (JL).
- Four members in skilled nursing or rehabilitation facilities. (RB, MD, SG, NaLe)
- Two members hospitalized, including one the day of interview. (BA and MC)
- One member returned to the adult home on 9/5/23, after one year in the community. He spent a few months in a Veterans Administration hospital, then did not want to return to his apartment. He disenrolled from care management on 10/31/23. (LS)
- One member who transitioned in May 2023 was reported to be decompensating and expressing interest in disenrolling himself from Pathway Home care management. (TE)
- One member who had been a "Yes" and whose lack of FCP support was described in the Ninth Annual Report disengaged with settlement service providers and became very emotional when we contacted her, then hung up on us. (EB)
- One member went missing from her adult home in early 2023 and was found in a crack house. As of 12/15/23 providers reported she was still using but also expressed interest in touring. She was not available on the day of the interview. In July 2024 her case was brought before the CRC with the recommendation to remain in the adult home. (JC).
- One member could not be located in the adult home the day of the interview. (SR)

In instances in which a member could not be interviewed, we attempted to locate another member with similar characteristics. For example, if Member A could not interview, we sampled Member B from the same adult home, who almost always also participated in the same FCP process and was served by the same HC and same peer-run agency. In some instances, we were able to replace one member with another served by the same HH/CMA and/or MLTC.

B. Interviews.

Interviews and member checks were conducted from November 2023 through September 2024. Class members were visited in their adult homes (if in-process) or apartments (if post-transition). One transitioned member did not want to meet in her apartment, so her housing case manager suggested conducting the interview at a nearby library; one transitioned member first spoke over the phone during a hospitalization, then engaged in an in-person interview once she returned to her apartment. We contacted most members at least once following their initial interviews to get additional information and progress updates from their perspectives. We

conducted second structured visits to three members whose circumstances had been concerning and/or had changed significantly (*e.g.,* moved from supported housing to Level II housing). We also conducted more informal second (or more) visits with several interviewed members during peer-led community activities (*e.g.,* during a monthly Ambassador activity and meal). Finally, we continue to maintain phone and text contact with several interviewed members.

For each member, at least one service provider (*e.g.*, peer bridgers, HC staff, AH+ care managers) was interviewed. In some cases, State staff (*e.g.*, Escalation Team members) were consulted about transition services and supports. For a few members, a review of selected records, such as progress notes, medication lists, etc. was conducted but such reviews were not systematic. We emphasize that the focus of this project was interviews with class members, and our analysis is similarly focused on what members themselves report about their experiences. When we learned of contrasting perspectives or information from other sources, we incorporated them into our analysis. However, the findings reported below center on the member experience, which may not always fully represent the points of view of settlement providers, the State, or other stakeholders.

C. Categorizing problems.

During our interviews we asked members if a given area of their transition preparations and/or post-transition lives posed problems for them. We categorized problems across three levels, using members' assessments, information from providers and records, and our own observations.

- We characterized members as having "significant problems" with a given area if they described or evidenced a problem that seriously impacted their lives, on a frequent basis, over a period of time and/or persisting through the time of interview. In other words, the degree, frequency, and duration of impact was significant. For example, a member who had been waiting some time for medication training and/or experiencing training that was not centered on their needs and preferences (*e.g.*, modified to fit their availability in the adult home, vision limitations, literacy level, etc.) and resulted in ongoing problems with self-administering their medication would be considered experiencing significant problems.

- We characterized members as having "some problems" if they described or evidenced a problem that impacted their lives over a period of time and/or persisted through the time of the interview but was managed enough to avoid severe adverse impacts on health or safety. For example, a member might be waiting anxiously some time for help obtaining IDs, but they had received loans from providers or had another means of cashing benefits checks.

- We characterized a member as having "no to low problems" if they stated they did not have problems and/or mentioned a minor or passing problem. For example, if a member had a short

wait for SNAP benefits to increase in full but they received food from settlement providers and/or home-delivered meals in the meantime, this would be considered no to low problem.

III. Themes

Below we report on key themes we found across interviews. In some instances, we indicate a theme was mostly to almost completely raised among one group of members (*e.g.*, isolation and loneliness among post-transition members) but often there was evidence of themes manifesting continuously, i.e., originating during the transition process and carrying into post-transition life (*e.g.*, delays or gaps in person centered care planning tasks that manifested prior to transition often led to ongoing challenges post-transition). In the interest of identifying potential systemic factors, we present below salient themes in terms of member- and provider-centered factors influencing the larger theme. We include examples of which members may have experienced these factors, and how. However, member experiences were rarely described or evidenced tidily; members did not experience one problem or success in isolation, nor in most cases was that problem or success cleanly attributable to one factor. A member who faced problems with IDs, for example, often also faced problems with financial and food security, may have faced mental health concerns, and may have questioned why a certain provider didn't help them. The same member, however, may have praised a different provider who offered additional support. Some of the below case studies illustrate the multifactorial nature of project themes manifesting in the day to day lives of members.

Finally, we emphasize that with a few exceptions, we have called attention to these findings previously[21] and are concerned that during this critical "winding down" of the settlement many of the same challenges that have plagued implementation from the start persist.

A. Apartment tours, matching based on member needs and preferences

[21] Prior examples of issues are included in Annual Reports, including several in the three most recent: Independent Reviewer's Eighth Annual Report, Doc. # 243, filed April 1, 2022, in 1:13-cv-04166-NG-ST, hereinafter "Eighth Annual Report;" Independent Reviewer's Ninth Annual Report, Doc. # 381, filed April 3, 2023, in 1:13-cv-04166-NG-ST, hereinafter "Ninth Annual Report;" and Independent Reviewer's Tenth Annual Report, Doc. # 243, filed April 1, 2024, in 1:13-cv-04166-NG-ST, hereinafter "Tenth Annual Report." Additional relevant documents include memos such as Independent Reviewer's memo filed February 4, 2022 entitled Memo on IDs and Transition Delays and Independent Reviewer's memo filed June 29, 2023 entitled Memo on Quarterly Report #35 Appendix E.

Table 3. In-process members: Apartment tours, matching based on needs, preferences (N=13)

Degree of problem	N (%)
No/low problems	0 (0%)
Some problems	10 (77%)
Significant problems	3 (23%)

Among 13 in-process members interviewed, all experienced problems in being shown apartments responsive to their needs and preferences. At the time of interview, ten members (JB, AF, AH, DB, RB, PK, RK, NL, ER, JS) were experiencing some problems and three (RA, MO, KS) experienced significant problems. During follow up contacts, as some members' waits for apartment tours and matching grew interminable, at least four (RA, DB, AF, MO) expressed immense frustration with the housing process, suggesting their overall experience was of significant problems. On the other hand, following their initial interviews other members (RB, NL) reported progress with touring and accepting apartments.

Some touring and matching delays seemed to be caused by members' personal circumstances or preferences. Two members (RB, DB) were waiting for Level II housing, though DB at times expressed disagreement with this housing determination. Upon follow up, RB was able to tour and accepted a placement at a Staten Island facility, transitioning there in May 2024. At least three members had expressed a desire to wait on touring and/or transitioning until a time better for them. For example, ER and AH spoke about waiting until after surgery and/or health needs were addressed to move; JS initially preferred to move in Spring 2024 though after accepting an apartment in May 2024 he asked to delay his move until after the Fall Jewish holidays. He also decided he wanted a different apartment, on a higher floor, which his HC is looking for.

Other members faced provider centered problems. For example, JB's CMA NHCC questioned if he was serious and capable of moving to supported housing after he changed his preferred borough from Queens to Brooklyn; after accepting a Brooklyn apartment, he was made to attend multiple IDTs NHCC convened before they would proceed with his transition. Another member (KS) was offered a Queens apartment which he understood he had accepted, then the apartment offer seemed to be rescinded, and he reported during our November 2023 interview that Comunilife staff and his NHCC AH+ care manager spoke with him about why that apartment was not a good fit for him. With help from his peer bridger, State staff were involved, and KS was able to transition to this apartment on 1/10/2024.

Finally, some touring and matching problems involved a confluence of both member and provider centered factors. For example:

- *DB, a "Yes" at the start of the New Haven Manor FCP, had expressed interest in moving since 2016, although she also expressed disagreement with, and a refusal to move to a Level II (CR-SRO) facility, for which she has been recommended. Her case is described differently among different providers and DB herself, making it difficult to know to what degree multiple challenging circumstances each contribute to housing tours and matching difficulties. Providers such as the Post Graduate ACT Team which had been serving her since February 2022 have expressed (such as during a 3/6/24 case conference) that DB is not capable of moving from New Haven and she in fact needs a higher level of care, citing concerns with her reluctance to take medications or engage in treatment, which they see as compounding her medical and mental health conditions and contributing to recent hospitalizations. At the same time, it was puzzling to observe during the 3/6/24 case conference that ACT Team members were unaware of what Level II housing was, and that DB in fact had not been assessed for supported housing but rather a Level II CR-SRO. State staff provided education to ACT team members about Level II, and they in turn expressed openness to DB touring such facilities. Other providers such as Community Access peers have offered examples of DB's independent living skills, such as her ability to manage her ADLs, schedule some of her own appointments, and articulate specifics about areas she would like to live in. DB herself cites similar examples as to why she thinks she can live on her own and does not want to go to a Level II facility.*

  Following the 3/6/24 case conference, State staff attempted to facilitate two Level II opportunities for DB in/around May 2024. She was offered and participated in a virtual interview with a CR-SRO in Queens, her preferred borough. DB made clear, however, that she did not want to live on the grounds of Creedmoor and once she became aware this was where the CR-SRO was located, she declined the facility. She was also offered a virtual interview with a Level II facility in Brooklyn but, as she preferred to live in Queens, this opportunity also did not advance. During a 8/13/24 update, State staff described trying to meet with DB to discuss exploring other boroughs for housing; she refused to open her door. To our knowledge, DB has not been presented with subsequent offers, leaving us to wonder if she would be more open to Level II housing if she was provided more person-centered options that matched her needs and preferences.

  As she remains at New Haven, multiple providers and IR staff have observed DB suffering periods of both depressed and heightened, sometimes aggressive, emotions. For example, at the time of our initial November 2023 interview, DB remained in bed with her eyes closed and her responses limited. She said someone (she could not recall who) had told her they would be offering her housing tours but never returned to take her on any. Her providers noted during this time that she also engaged minimally with them. Peers then noted that in Spring 2024, DB started engaging more and when we returned in June 2024, we observed that she was indeed engaged and talkative. At this time, she continued to manage at least some of her ADLs and was aware of and in communication with settlement service providers, as well as being

aware of transition tasks (e.g., pursuit of IDs) she would like to engage in. Unfortunately, on the day of visit, DB had witnessed another resident move out, leaving her yet more frustrated about her own lack of progress. She complained that the other resident, who had evident physical disabilities, was going to live in an independent setting and it wasn't fair that someone more physically independent like herself remained in an adult home. DB became so emotional that she refused to speak further and told us that whenever she had shared housing ideas, they were "stolen" from her, as she had watched other residents move out to areas she said she liked, while she herself remained "stuck."

It seems DB is indeed stuck in some sense: she does display behaviors (e.g., reluctance to take medications) and heightened emotions that could contribute to an assessment that she would benefit from a Level II setting. At the same time, however, she strongly desires to transition and is trying to demonstrate the skills she believes she has to do so. It may be valid to interpret her heightened emotions as evidence of the severity of her mental health conditions, yet there does not seem to be commensurate consideration for how a class member who attended all three FCP Kickoff events and has worked on transition tasks, including working on some on her own (e.g., going to the DMV to attempt to obtain IDs on her own), could understandably become disengaged, angry, or even aggressive in the face of a lack of progress for herself, especially while she watches other residents move out.

Another involved example is that of AH:

- *AH, a "Yes" member at time of our November 2023 interview, had a history of ambivalence. During the Park Inn FCP (starting in July 2023) he reaffirmed his interest in moving, but also stated he would like to wait to move until about July 2024. During our interview AH described medical concerns and a potential surgery as reasons to wait to move. He also said he discussed his reasons with providers and talked about options for touring sooner; he affirmed he was interested in touring, describing flexible preferences and "seeing what's out there." Despite AH's willingness to meet and communicate with providers, they and State staff raised his past ambivalence and lack of progress with transition tasks to question if he was truly committed to moving. They also questioned if he was actually willing to tour apartments. AH himself and Community Access peers saw his experience differently, having advocated for several months for tours, during which time HC Comunilife would make statements on FCP calls about available tours, yet did not follow through on any of them from 10/10/23 until 2/2/24.*[22]

[22] A more specific accounting of unfulfilled statements around tours for AH: on a 10/10/23 FCP call, Comunilife stated they were touring a one bedroom Far Rockaway apartment and could take AH along, then did not; on a 10/14/23 FCP call, Comunilife indicated they had a studio apartment in a Jackson Heights elevator building that AH could tour, yet no tour occurred; on a 11/28/23 FCP call, Comunilife reviewed potential one bedrooms in Jackson Heights, Far Rockaway, and Sunnyside, noting touring availability for four upcoming days yet AH was not toured; on a 12/12/23 FCP call, State staff reemphasized touring as a priority for AH but no Comunilife nor other staff could explain why tours had yet to occur; on a 12/19/23 FCP call, a peer noted AH had reiterated to her he wanted to tour and the Comunilife Program Director said although they had not offered him tours the previous week they would do so that week; by 1/16/24, AH had still not toured, his NHCC AH+ care manager reiterated his overall ambivalence and lack of progress toward transition tasks while his peer noted AH still stated he was willing to tour and would consider apartments in Queens or the Bronx. Comunilife noted they had one-bedroom apartments in Sunnyside and Elmhurst, yet again no tour resulted from this conversation; on a 1/23/24 FCP call, a tour was more firmly scheduled, though on this call and again on a 1/30/24 call AH's CMA NHCC questioned if he was touring "just to appease us." Finally, on

Over this period, State and provider staff brought up multiple member-centered factors they perceived indicated AH was not serious about moving. However, during these discussions it was never raised that Comunilife did not have its own touring transport means and had instead been relying on other providers such as Community Access to pay for Uber transport and accompany touring members. This provider-centered factor impacted AH for months yet neither he nor State staff were aware of it until 1/17/24 when the Office of the IR inquired about why touring seemed to be contingent on peer bridger availability. AH was finally taken to see a one bedroom apartment in Far Rockaway on 2/2/24, almost seven months after the start of the Park Inn FCP. He reported that the apartment was nice, but he continued to prefer to wait to transition until Summer 2024. AH also experienced troubling AH+ care management and medication training gaps, described on p.23 and p.33.

The State submitted and the IR approved in August 2024 a DMT for AH; it and supporting evidence suggested AH was informed about the settlement Decision Date but could not move past his ambivalence, making statements about not moving as recently as June 2024. The State's evidence, however, contained almost no consideration (save certain AWARDS notes) for how gaps in housing, care management, and MLTC service provision, persisting over years, may have compounded AH's ambivalence. Comparing State documentation with FCP observations and conversations with AH himself underscores an observation the IR made an April 22, 2024 memo to the Parties ("NO cases reviewed in April 2024"): while we do not have a systematic count of how many members arrive at a decision not to transition for similar reasons, there are several class members who seem to experience "a prolonged failure by settlement providers to act promptly in response to class members' expressed interest in moving," including "long and unexplained delays" and "In some cases, there were significant failures of settlement provider staff to assist class members with key tasks in the transition process." The handling of such key tasks for AH is described in more depth on p.23 and p.33.

Salient are the delayed tours and transitions experienced by five members waiting for accessible apartments and buildings (RA, PK, RK, NL, MO). These members have experienced especially long touring waits, delayed moves, and even move cancellations. For example:

- *MO, a "Yes" at the start of the October 2021 QACC FCP, says he wanted to move out since he arrived at QACC in 2011. He described his early encounters with the settlement as "I joined the ICL program but nothing ever happened, they never got in contact with me," leading him to move from QACC on his own for about a year in 2016. When he had to leave the basement housing he found on his own, MO returned to QACC and State trackers document him as interesting in transitioning beginning September 2017. It is unclear what services were afforded MO between then and the QACC FCP; he recalls no apartment tours despite his consistent interest in moving. Despite having multiple medical conditions including Type II diabetes, using a wheelchair, and seeing an array of medical and mental health providers, MO displays impressive self-knowledge and independence. He progressed far enough in the FCP*

2/2/24, Comunilife and NHCC staff accompanied AH on a tour of a one bedroom apartment in Far Rockaway. AH said the apartment was nice but he remained disinterested in moving until Summer 2024.

process to be scheduled to move to an Ozone Park apartment in July 2022, and on his June 2022 pretransition call his AH+ care manager emphasized his diligent preparations, which MO maintained: he has managed most of his own medical care; he was assessed as able to manage his own medications, including using a blood glucometer and sliding scale to administer his insulin;[23] and he oversees his finances and benefits. He even had SNAP while residing at QACC and during our November 2023 interview stated he hoped his AH+ care manager would reestablish contact with him because he needed help recertifying before his benefits expired at year's end.[24] He was particularly concerned about the loss of this benefit because it enabled him to purchase food consistent with the diabetic diet prescribed to him.

MO suffered a move delay and then cancellation in August 2022; he and HC ICL give differing accounts as to why he hadn't toured his apartment until immediately before his move, but when he did tour, they discovered the apartment and building were not fully accessible to him. The cancellation dismayed MO, and his dismay grew over the next year as, according to him, months passed without service provider contact. During our November 2023 interview, he praised the TSINY AH+ care manager he worked with leading up to the move, then noted that when she was promoted another care manager stayed in contact for at most four months, yet it had been many months since he had heard from TSINY. He also reported it had been months since ICL offered him apartment tours or contacted him. When asked about Baltic Street peer support, he said he didn't know when or if anyone from the agency had worked with him.

In December 2023 ICL offered MO another Queens apartment, then following his participation at the February 2024 Fairness Hearing ICL offered him two additional Queens apartments. While he could not accept the second apartment because the building was inaccessible to him, he accepted each of the next two, with preparations for the third advancing far enough for pretransition call on 7/29/24 for an August 2024 move. During this call both MO's own conscientious preparations and those of his new AH+ care manager and new peer bridger were evident. ICL described steps they had taken to ensure oversights with past apartments they had offered had been addressed in selecting this fourth apartment. Unfortunately, this move was also canceled, again due to oversights with the accessibility of the unit. Across these three apartments oversights included:

- *The second offered apartment building lacked a front entrance MO could enter in his wheelchair and the back service ramp gradient was so steep MO could not travel up it in his wheelchair; this apartment could not be accepted by MO once it became clear he could not enter the building. Debriefing about the experience of trying to maneuver the back*

[23] As of February 2024, MO reported he managed his diabetes well enough to transition off of injectable insulin, positioning him even better to handle his own medication in the community. Over the course of multiple potential transitions in 2024 there was at times a lack of clarity about MO's most current diabetes regimen but as of September 2024 it seems he continues to manage the condition without injectable insulin and his prior interest in a continuous blood glucose monitor has been noted but the device is not needed at this time.

[24] As of February 2024, MO reported that because none of his settlement service providers helped, he had lost his SNAP benefits and was worried about how and when he could reestablish them. Fortunately, by his 7/29/24 pretransition call MO's new TSINY AH+ CM reported that she had helped him recertify for SNAP as well as supporting him with other care management tasks.

service entrance, MO wondered why after years of delays providers could not show him a single building with a street-level, flat entry so he could enter his home with dignity.

- *The third accepted apartment, with a front entrance and elevator MO was pleased to navigate, had both a bathroom and kitchen that MO could not enter in his wheelchair. It is particularly disturbing that MO himself raised this with the Office of the Independent Reviewer on 6/7/24, yet prior to him sharing this information the transition was scheduled to go forward on 7/5/24, despite settlement service providers presumably having witnessed his inability to enter these rooms when they toured him.*

- *The fourth apartment also had a bathroom MO could not enter in his wheelchair, yet up through the 7/29/24 pretransition call this was not raised. MLTC Riverspring noted the lack of accessibility during a 7/30/24 assessment of the unit, and they and MO noted a walk in shower (in lieu of a bathtub/shower combo) would be preferrable for accessibility needs.*

In sum, having been a "Yes" at settlement in-reach since 2017 and having been a consistent "Yes" member since the 2021 QACC FCP, over the past two years MO had his hopes raised four times, only to be informed that each apartment he had been told was his would not be his, nor would he transition from the adult home. Looking back upon the efforts he had made to move MO said, "Sometimes I say it's been too many years, I'm gonna quit now, I'm gonna give up, I've been doing everything I'm supposed to, for what?" Still, he has persisted in his own preparations for transition and spoke with enthusiasm about meaningful goals for life in the community, such as exploring day programs, volunteering at a food pantry, and purchasing a Chrome book so he can learn more computing and Internet skills.

Another pretransition call for MO occurred on 9/27/24 for a 10/10/24 move to a Flushing apartment that he, settlement service providers, and State staff all toured to ensure accessibility. Of note, following the 7/30/24 cancellation of MO's most recent prior move, he was referred from HC ICL to TSINY. While it is encouraging to observe how quickly State staff and TSINY were able to locate, tour, and match MO with a fully accessible apartment, we emphasize that the Office of the Independent Reviewer had made a relevant recommendation via a 4/24/24 email to the Parties ("Serious consideration should be given to engaging other housing contractors in cases where the primary contractor seems to be having difficulty in making progress within a reasonable time. As the settlement clock continues to wind down, there should be a greater sense of urgency in getting the Yes group resettled.") We hope that for other members facing similar transition barriers (e.g., RA below) this recommendation might be pursued more quickly.

- *RA, another QACC resident, has struggled with similar barriers to transition. He began the QACC FCP as a "Soft No" who communicated he desired to move in 2022. During our November 2023 interview, he described many areas in which he feels prepared to transition. For example, he displayed a cardholder on the back of his cell phone where he keeps his NYS non-drivers ID, noting he knew it was expired and his sister would help him renew it; his Medicaid and Medicare cards; his EBT card; and an expired Access a Ride card, noting he did not use this service and might not renew it. He also described how his sister had his birth certificate for safekeeping, and she had helped him obtain a new Social Security card. RA is*

proficient with his cell phone, and described how he has and would continue to manage his ADLs if he could be provided with an accessible apartment. During our interview RA also brought out a pillbox he uses to manage his medications and listed the names and purposes of most of the approximately 10 pills in it. RA is active in scheduling and managing his own health care. He also enthusiastically described the life he hoped to live in the community; he spoke of his close relationship with his sister and her children and talked about watching movies with them and just hanging out. He loves to cook and would like to have his own kitchen to get back to cooking; he would also like a dog, having had dogs he loved in the past.

Given the efforts RA has made to prepare himself for transition, it is understandable he also expresses frustration with, and mistrust of the settlement after waiting so long for transition progress. Due to past injuries and medical concerns, RA uses a wheelchair and needs a fully accessible apartment, in a building that has a ramp and/or flat entry. He reported he wants to live alone and prefers a studio because it would involve less upkeep, but he is open to a one bedroom apartment. He also reported that while he would like to live as close to his sister as possible, he is open to touring multiple Queens neighborhoods. More specifically, his sister lives in Lefrak City in Corona, and he is open to touring in Corona, Jackson Heights, Rego Park, and any other area that would allow him to live in proximity to her. However, he describes his touring invitations to date as "They wanted to show me Far Rockaway, Brooklyn, nothing close." During our November 2023 interview RA could not recall the last time housing contractor ICL had been in touch with him but felt it had been a long time. He also did not know who his Northwell AH+ care manager was and said no one had helped with transition tasks for a long time; he again emphasized that only he and his sister were working on tasks like obtaining IDs. When asked if anyone from Baltic Street visited him, he asked "Who's Baltic Street," an unfortunate missed opportunity as RA is active with the Coalition of Institutionalized, Aged and Disabled (CIAD) and engaged with other forms of peer support.

Following RA's involvement in the February 2024 Fairness Hearing ICL did approach him, though his progress with transition preparations was slowed when his leg was amputated and he recovered in a rehab facility, returning to QACC on 5/30/24. ICL reported they showed RA photos of a Rego Park apartment while he was in rehab, but as this apartment was then accepted by MO, they had to inform RA it would no longer be available. On 6/10/24 the State reported that ICL would ask for a second apartment in this building for RA; it is unclear what progress occurred with this apartment. As of August 2024, the State reported that they were pursuing a promising lead for an apartment for RA, and as of September 2024 it was apparent that RA appreciated increased communications with a new peer bridger and State staff.

Finally, while this report elucidates several examples of disturbingly protracted waits for apartment tours and matching responsive to members' needs and preferences, we have also observed multiple examples of providers putting substantial time and energy toward finding apartments. For example:

- *In May 2024 SJMC Brooklyn matched JS with an apartment in his preferred neighborhood of Midwood, and when he then refined his preference to live in an apartment on the fourth*

(i.e., a slightly higher) floor without a fire escape due to feeling he could be at risk of break ins, SJMC began searching for another unit that would meet these preferences.

- *Similarly, SIBN has shown RK multiple apartments, including an apartment in a new building in Staten Island, near the water and matching other preferences like proximity to shopping. RK declined this apartment as he decided that he wanted to be situated on a floor high enough to have a view of the water. The specificity of this preference understandably entails more work for SIBN, but they continue to search with support from State staff who are also exploring Empire State Supportive Housing Initiative (ESSHI) apartments which might match his needs and preferences.*

- *While accessible apartments remain concerningly scarce across settlement stock, it is impressive to observe the accessible and attractive apartments some HCs have been able to find. MC, who ambulates primarily with a wheelchair, was proud to show off her large, recently renovated and accessible apartment in a "luxury" building near Kew Gardens Hills. During our June 2024 visit she and her aide proudly noted several features they liked about the apartment, including the open floor plan and large windows with sweeping views of the apartment complex's parks and gardens. We also appreciate that as MC's and MO's cases illustrate, TSINY has recently received referrals from other HCs and is able to match members quickly, to accessible, attractive units that meet their needs and preferences.*

Table 4. Post-transition members: Apartment and neighborhood problems at the time of interview (N=15)

Degree of problem *as recalled/reported at time of interview*	N (%)
No/low problems	6 (40%)
Some problems	5 (33%)
Significant problems	4 (27%)

Among 15 transitioned members, it was not clear how well each recalled problems encountered and their feelings around the touring and matching stage of the process, but at the time of interview five had and/or were experiencing some problems with their apartment and/or neighborhood (DC, VC, NLe, DW, FY, GC) and four had and/or were experiencing significant problems (SB, AS, GC, WH). For example, NLe recalled past concerns about his first building and neighborhood after falling into substance use there. He was moved to a new building and neighborhood by Pibly Brooklyn, which he felt positively about at the time of interview, noting "People, places, and things, people, places, and things" are the key to recovery, i.e., removing himself from the people, places, and things that led to his use has helped him maintain sobriety. SB and AS had experienced overall challenging transitions due to various member and provider centered factors, and their HCs noted hygiene (SB) and personal interactions (AS) had led others

in the buildings, including building management, to raise concerns about them. Both members also reported not feeling comfortable around others in their buildings, and to varying degrees they were not comfortable going out into their neighborhoods.

DC recalled frustration with the pace of his transition and, at the time of our November 2023 interview, reported both positive and challenging aspects of his apartment and building. He was proud to show off the apartment itself, a large one bedroom he had decorated with memorabilia such as model planes he enjoys creating and a comfortable recliner chair. He also pointed out the craftmanship that had gone into the well-preserved building doors, fixtures, and tilework. On the other hand, he said Comunilife had been slow to address the need for a ramp into the building, noting he and other members (*e.g.*, VC) had been told months before that it would be in place quickly to meet their accessibility needs. Further, DC had grown frustrated by the lack of building management response to tenants' repair requests and, having informed Comunilife, started organizing tenants' association meetings with an attorney he contacted from Communities Resist.

B. Person-centered care planning for transition and post-transition support

Table 5. All members: Person-centered care planning: IDs and related documents (N=26)

Degree of problem	N (%)
No/low problems	11 (42%)
Some problems	8 (31%)
Significant problems	7 (27%)

Table 6. All members: Person-centered care planning: Financial and food security (N=26)

Degree of problem	N (%)
No/low problems	10 (38%)
Some problems	7 (27%)
Significant problems	9 (35%)

Among 26 class members interviewed for this topic (two member interviews did not cover it), eight members reported that they had or were having some problems obtaining IDs and documents (RA, SB, JB, KS, NL, JS, FY, WH) and seven (SB, VC, AH, ER, AS, DW, GC) reported they had or were having significant problems obtaining IDs and documents. Financial and/or food insecurity, often underpinned by delays with IDs and related documents, was more difficult to measure consistently among in-process members, as they may not have had thought about these

aspects of their post-transition lives yet. However, interviews suggest seven members (FA, JB, RB, ED, AF, RK, AR) experienced some problems with financial and/or food security, while nine (SB, VC, AH, NLe, DW, AS, MO, GC, WH) experienced more significant problems. As reported above, in-process member MO expressed concern about losing SNAP benefits, reporting at the time of interview that his TSINY AH+ care manager had not visited him in months, and he needed help obtaining and submitting the renewal due in December 2023. MO did lose these benefits, endangering his ability to buy food consistent with the diabetic diet prescribed to him and causing him stress. Fortunately, by a 7/29/24 pretransition call his new AH+ care manager confirmed that she had helped him recertify. Another in-process member (RK) expressed concern that he was not able to cook or shop on his own and would need assistance; he also asked about Meals on Wheels and said no one had discussed this with him as an option.

Table 7. Post-transition members: Person-centered care planning: Financial and food security (N=15)

Degree of problem *as recalled/reported at time of interview*	**N (%)**
No/low problems	5 (33%)
Some problems	3 (20%)
Significant problems	6 (40%)

As financial and/or food insecurity is often more salient post-transition, we focused more discussion among 15 post-transition members. Three (FA, ED, RK) expressed some and six (SB, VC, AS, DW, WH, GC) expressed significant problems with financial and/or food security. Another member, NLe, reported having experienced significant problems in the past but felt he had a better handle on financial and food security since he had stopped using drugs. FA did not express problems with food security *per se*, but shared she was in the process of trying to get her SNAP increased from $183 per month. In conversation, multiple transitioned members did not have a clear sense of exactly all of the IDs they could expect to have, and some reported IDs had been lost or stolen since their move and they were waiting for help in obtaining new copies (SB, VC). These members and their providers also reported food insecurity linked to their missing IDs.

For the life of this settlement, the Office of the Independent Reviewer has raised the need for more timely, truly person-centered care planning to accomplish transition tasks such as obtaining IDs and documents and, related, establishing financial and food security (*see, e.g.,* Sixth-Ninth ARs, February 4, 2022 IDs and Transition Delays memo). At this stage, we recognize that multiple efforts have been made by State and settlement provider staff to streamline obtaining IDs

and documents, such as collaborating with other State and City agencies and involving State staff such as the Escalation Team. We further acknowledge that these transition preparations sometimes involve interacting with systems beyond the control of the settlement providers (*e.g.*, obtaining out-of-state and -country birth certificates; navigating HRA processes impacted by the Covid-19 pandemic and evolving still). However, given the State's commitment to transition all remaining "Yes" members, we believe it most productive to focus on how to overcome now known barriers to achieve better results during the terminal phase of implementation of the Settlement Agreement.

Project interviews suggest member-centered factors, such as age, health, mental health, substance use, and mobility limit some members in attending appointments needed to obtain IDs, documents, and benefits (SB, JB, AF, AH, AS, KS). For example, JB is an older adult with an unsteady gait; while he goes into the community with his peer bridger, he reports he is sometimes too tired to go to appointments his AH+ care manager sets, sometimes without consulting him first. Related to physical and mental health, long histories of institutionalization may leave some members fearful or apathetic about going into the community for appointments. In other cases (*e.g.*, NL), members have spent time hospitalized and/or in rehabilitation facilities, which has slowed the process of obtaining IDs and documents.

At the same time, interviews with members and settlement providers suggest strategies that may be effective in overcoming such barriers to attending appointments and completing tasks. For example, some members (*e.g.*, AF, JB) said they liked going into the community for an appointment *and* lunch out or a "fun" activity; this was more appealing than simply being told they had to attend an appointment. Other members expressed a preference for working on certain tasks with certain providers (*e.g.*, AH stated he would go to HRA if accompanied by a peer; AS would cash her benefits check if accompanied by her housing case manager and, later, a new aide with whom she had an especially good relationship).

Finally, some members described and evidenced a high level of independence and/or had help from outside support to obtain IDs and benefits with little settlement provider involvement (RA, SB, MC, DC, MO). For example, while DC was frustrated with what he perceived as a long wait to enroll in AH+ care management, he and his BAC care manager were able to prepare for his transition in just a few months, as he had kept track of his own IDs for years and other tasks moved faster because of this. RA has relied on his sister to help him pay for IDs; he states this is because his AH+ care manager does not visit him. Similarly, MO had a positive relationship with

a past AH+ care manager and they obtained some IDs together, but the care manager assigned to him at the time of his November 2023 interview had not visited him for some time, resulting in him trying to figure out tasks like SNAP recertification on his own and eventually losing both his SNAP benefits and his HRA approval. In 2024, increased State involvement and a new care manager supported MO in reestablishing HRA approval and SNAP benefits.

While class members might not have a clear sense of why providers had not helped them more or more quickly with IDs, through interviews and FCP and transition calls we have observed that the timelines the State created for transition tasks do not seem to be followed by settlement providers, particularly AH+ care managers. As implementation of the Settlement Agreement enters a final phase, there is a need for instilling both a greater sense of urgency in the completion of these transition tasks and instilling accountability for performance. Provider interviews also suggest some areas where more -- and more timely -- State support is warranted. Providers report that some adult homes still do not respond promptly for requests for Social Security Awards letters, residency letters, etc. and we have observed State staff (i.e., the Escalation Team) are not always prompt in assisting providers, resulting in bottlenecks in obtaining some IDs and benefits (SB, VC, AH, AS, GC). As of July 2024, the State is in the process of rolling out successive waves of its SFI, with the objective "to improve communication among State staff and Settlement providers in coordinating the management of resolving open issues" in order to "address transition issues among the remaining class members in the Yes Group." As we review information from the first four SFI adult homes, we are encouraged by preliminary evidence that increased State staff presence in the adult homes and facilitation of increased communication among providers may contribute to more timely and thorough completion of care management tasks. As SFI has limited scope, however, we encourage the State to intensify efforts for in-process "Yes" class members who would otherwise have to wait months for SFI to reach them. Particularly for members experiencing transition barriers and/or ambivalence, waiting for the benefit of this renewed effort may have deleterious impacts on their ultimate decision to transition.

Communication between providers and members, as well as among providers, also complicates timely attainment of IDs and other benefits. This sample includes members enjoying close communication with at least some providers to accomplish some transition tasks (DC, MC, ED, MO) as well as several members who evidenced a lack of clear and consistent communication from at least some providers (RA, SB, VC, MO, GC, WH). In some instances, it was concerning

to observe misinformation communicated to members and attempts to communicate misinformation to other providers serving these members. For example:

- *During the Park Inn FCP, AH's NHCC AH+ care manager and her supervisor told him that he had to save his PNA so that he could purchase his own birth certificate. Additionally, during multiple Fall 2023 FCP calls, NHCC labeled him "financially noncompliant" because he did not or could not save his money. In turn, both the State and Office of the Independent Reviewer clarified that members had a right to settlement services and supports regardless of their ability to contribute personal funds to transition tasks; State staff then had to provide education to the care manager and supervisor during multiple, additional FCP calls so they understood they could apply for a free idNYC as a starting point for obtaining other IDs (as NHCC declined to pay for AH's birth certificate themselves). After multiple reminders about the idNYC, the care manager then began to report AH was simply "noncompliant" because he would not attend appointments to obtain it. While this would suggest a member-centered barrier to transition preparations, there seemed to be no consideration for how the preceding months of misinformation AH experienced may have influenced his perceived noncompliance around related appointments (i.e., having been told for months he had to save his PNA to purchase a birth certificate in order to advance toward transition, he may have felt uncertain about whether or not he was also going to be required to save for and/or bring his own money to an idNYC appointment).*

  Compounding misinformation concerns, as AH decided not to transition, the State provided a July 2024 Opt Out form and companion DMT for him. These documents indicate that during the four month AH+ extended enrollment period that AH agreed to, his care manager did not make progress toward obtaining his IDs, with a note that there were no idNYC appointments available for February or March 2024. Given that the Opt Out form also notes the extended enrollment period ran from 10/4/23 to 2/5/24, i.e., it ended five days into the months she could not obtain appointments, the information presented to and about this member is even more unclear . AH's DMT also documents that as recently as April 2024, the care manager was still contacting peers and asking them to take AH to ID appointments, as she said she had been told previously that this was a task for peers. This misinformation had persisted after multiple FCP calls in 2023-2024 during which it was explained that obtaining IDs was a care management task, though peers could provide support with transportation and accompaniment in emergency circumstances. The DMT documents that peer staff reiterated this to the care manager on 4/12/24 and also informed her that a specific peer she thought may have been available to accompany Park Inn members, such as AH, on appointments had left Community Access in November 2023.

From interviews, FCP, and transition preparation calls we have also noticed inconsistent communication among providers resulting in missed opportunities to include members in appointment setting and reminders and to ensure members could be accompanied to appointments. For example, JB's NHCC AH+ care manager complained he was not willing to attend appointments she set, yet as discussed on 12/28/23 Park Inn FCP call it was not until the morning

of (*i.e.,* a couple hours prior to) a PROS intake appointment that she herself scheduled did she communicate that she would not accompany him. Although this caused stress for State, peer staff, and JB himself, they worked together quickly to ensure he could get to his appointment.

AF's situation presents an example of how the absence of person-centered care planning persisting over an extended period of time may contribute to both member ambivalence and potential member disengagement from transition preparation. Among several concerning aspects of his situation is that once certain providers perceived him as unable to comprehend or engage with transition tasks, his lack of progress was framed in terms of his perceived deficits, with little consideration for the service provision which had contributed to his uncertainty.

- *When Seaview FCP calls began in April 2023, AF's Community Access peer spoke of her year-long engagement with him. She noted he consistently attended activities she organized, he was an artist with training in painting, and he had even led (non-alcoholic) Sip n' Paint activities at Seaview. She also explained that although he spoke both Spanish and English, his cultural orientation was Latin American, including sometimes presenting as reticent, quick to agree with others, and sometimes opening up more in Spanish. She emphasized his love of painting, decorating, and dining out. As AF had only recently expressed interest in transitioning, other providers such as his latest Northwell AH+ care manager and HCs (both FOO and ICL) were just beginning to get to know him. These providers did not seem to integrate AF's peer's suggestions into their interactions with him, instead noting he was "inconsistent" and "might have dementia" because he expressed interest in living in both Far Rockaway and Brooklyn and did not seem to understand all the care management tasks he was told to participate in. They described him as "just saying yes" whenever they approached him, and his AH+ care manager was quick to note when he missed appointments (e.g., an Access a Ride interview) yet no provider other than the peer seemed to raise what motivations AF might have to move and, therefore, what might help him follow through on transition tasks.*

  Despite challenges between AF and some providers, by a 6/6/23 FCP call he had toured and accepted an ICL apartment in Brooklyn. His AH+ care manager was surprised to learn this, as she had not been informed of the tour nor his acceptance, and it was noted that many care management tasks (a Social Security Awards letter, an Access a Ride appointment, setting up medication training, obtaining providers in the community, etc.) had yet to be done. Then, on a 6/20/23 FCP call State staff, themselves expressing shock, announced that when they attempted to submit a 30-day move notice to Seaview, they learned that an IDT had been convened by the AH+ care manager and ICL program director, with AF the only other person present. Neither the State nor the peer who had known AF the longest and could speak to him in Spanish, using culturally congruent conversation norms, were made aware of the IDT.

  The outcome of the IDT was that AF no longer desired to move, though the two providers present could not articulate what AF's needs or concerns about moving were. Instead, AF's AH+ care manager complained "he couldn't answer any of the questions [on the Transition Planning Tool, i.e., regarding transition tasks], he doesn't even understand, he doesn't have

the ability to take care of himself," and seemingly as an example of the latter, "he's in a diaper." The AH+ care manager did not explain why AF had so many transition tasks outstanding; the focus was on the member's perceived deficits, not how to center planning on his needs and interests, nor if or how she was working within TPT and Dashboard timelines.

State staff asked AF's providers to hold an additional IDT with his peer present to explore his interest in moving further, but over the remainder of 2023 AF expressed uncertainty about moving. After the second IDT, he disclosed to his peer that he was worried about laundry and keeping up around his own home; he also liked seeing friends and staff at Seaview and worried about living far from them. At the time, he expressed interest in moving, particularly if it might be possible to live near the adult home and still see his friends.

When we interviewed AF in November 2023, we also observed what providers had noted: he was soft-spoken, reticent, and eager to please to the point of going beyond what he himself may have desired to do (e.g., staying into his dinner hour so as not to seem rude in ending our interview). However, his reticent endorsement of moving became more enthusiastic when framed not as a "yes" or "no" question, but rather as a person-centered question of what he would like to do if he was to move. AF became animated talking about painting, including listing favorite subjects to paint; reiterating he would like to take more art classes if he moved; and sharing how he could decorate his new room with certain favorite paintings. He also shared his love of martial arts, recounting how he used to practice and asking to join a gym so he could start practicing again. When framed in terms of what he wanted to do, AF also spoke about what he had done to prepare, such as how he felt about learning to take his own medications, and what he was still worried about such as managing his own laundry.

From late 2023 into 2024 AF has continued to exhibit some ambivalence about transition preparations. However, he has remained engaged with Community Access peers and HC FOO. For example, the FOO in-reach specialist has worked to show AF Far Rockaway housing that might meet preferences such as living near friends and staff at Seaview. AF has also participated in several community-based activities with peers and Ambassadors. Although AF was without care management for a prolonged period, he was enrolled with CMA FOO on 8/27/24 and it is encouraging to observe that after past negative experiences with care managers and CMAs a more supportive relationship seems to be forming between AF and his new AH+ care manager.

Finally, we spoke to multiple post-transition members and providers who reported problems with obtaining IDs and other documents once in the community; in turn these members also reported concerns about their financial and/or food security (SB, GC, VC, AS, WH, DW, FY). In 2023, the State explicitly focused on sticking to move dates once they were set, resulting in many members moving without all IDs and/or financial and food security completely in place. While it may be reasonable to go forward with a move and plan to complete some tasks post-transition, the State and settlement providers again seem to lack a sense of urgency in implementing such plans,

resulting in members enduring challenges such as obtaining and cashing checks and relying on food drops from HCs and peers. Among this interview sample, the need for multiple months of food support from HCs and peers is common (*e.g.,* JB, ED, NLe, KS, GC) and there are examples of the need for even longer term food support for over six to nine months (VC, AS) and even over one year post-transition (SB, WH).

Related, some members lost IDs after transition and experienced protracted waits with little care management assistance to secure replacements. For example, at the time of her interview DW said she had lost multiple IDs, including her non-drivers ID. It is unclear when she informed which providers about these missing IDs, but while waiting for help she herself tried to call the NYS DMV and could not make progress because she ended up on hold with them "forever." In other cases, waits for lost IDs and/or lost benefits cards, and/or related benefits concerns were complicated by struggles members themselves may be having with money management and management of food and meals. For example:

- *At the time of her December 2023 interview, SB reported her EBT card had been lost or stolen sometime (she could not recall when) after her February 2023 transition. She also suffered complications with her Social Security Disability Insurance (SSDI) benefits, which continued to be sent to Wavecrest throughout 2023 despite State and provider involvement; additionally, despite discussion around the potential to receive Supplemental Security Income (SSI) to supplement her fairly low SSDI benefits, specific actions or progress around this were not clear at the time of interview.*[25] *This confluence of ID and benefits problems left SB describing her first 10 months community as "not how I thought it would be" and very stressful as she did not have her own money to make her own purchases when she wanted. During our interview she also displayed a United Health Care "OTC" card that she kept in her wallet, as well as related paperwork for it. This card, preloaded with a cash value, can be used for over-the-counter (OTC) health products, food, and utilities. SB found the card helpful for purchases in the past, but it had expired and as of December 2023 her requests for help renewing it had not been answered by providers. To ensure post-transition food security both HC Pibly Bronx and Community Access peers brought her groceries regularly, then when Community Access concluded post-transition services Pibly shouldered the full responsibility of grocery deliveries two to three times per week, a considerable support they continue as of September 2024.*

  Though SB remained without an EBT or active OTC card into 2024, these benefits cards were then reestablished for her. However, as of September 2024 she continues to struggle with food

[25] We flag here that SB's benefits situation is especially complex and we have not been able to pursue and verify all information shared with us during the course of this project. We would like to continue to follow up on: 1) the amount of SSDI SB is currently receiving, as there was the suggestion in January 2024 that the Social Security Administration might reduce her benefits; 2) progress on pursuing SSI for SB, as her SSDI alone raised financial concerns for her and her providers; 3) any additional steps to improve food security for SB.

security. Providers such as her Postgraduate ACT Team track her EBT balance online, and a pattern of rapid spending is clear. Though providers have spoken to SB about her rapid spending on and consumption of food, it seems she has not been able to moderate her habits. Her cigarette consumption, which she seems reluctant to discuss, likely influences her lack of overall financial and food-specific security. The result is that even with SNAP benefits and a new EBT card, additional monies from her OTC card, and a weekly cash allowance Pibly (her representative payee) provides, SB remains at risk of running out of food. In addition, options for cooking and/or reheating food are limited; after SB was found multiple times to have left the stove ignited the apartment is now without gas as a safety measure. She does have a microwave that she and her aide use to prepare and reheat food. As of September 2024, State staff and settlement service providers continue to convene periodic calls to discuss her situation, and in line with a recommendation we present below, her situation has also been brought to the OMH Committee on Complex Concerns (CCC). Still, her financial and food insecurity, as well as multiple other concerns (see p.44), persist.

SB's situation underscores that even when settlement service providers and the State do attempt to address post-transition problems, some particularly complex problems will persist. As service provision shifts from serving in-process "Yes" members to long term services for transitioned members, SB's situation may serve as an instructive case study to assess and learn from approaches to keeping the most vulnerable members safe and well. SB's case also underscores that as the settlement approaches its end date, certain providers *(e.g.,* HCs, MLTCs and CHHAs, peer bridgers in a to be determined post-settlement role) will assume greater workloads to attempt to keep members safe, well, and stably housed. Consideration of how these providers may in turn be better supported is needed.

C. Medication training and ongoing support

Table 8. In-process members: Medication training and ongoing support (N=12)

Degree of problem	N (%)
Already self-managed, assessed as able to self-manage medication	2 (16.6%)
No medication training to date (including one member with a history of refusing to take medication)	8 (66.6%)
Some problem	2 (16.6%)

Table 9. Post-transition members: Medication training and ongoing support (N=14)

Degree of problem *as recalled/reported at time of interview*	N (%)
No/low problems	7 (50%)
Some problems	3 (21%)
Significant problems (including two members with a history of refusing to take their medications)	4 (29%)

Among 26 class members interviewed about medication (two member interviews did not cover it), over half of in-process members (n=9 of 13) (DB, RK, PK, JS, RB, NL, AH, AF) reported (and/or providers confirmed) that they had not had training at the time of interview. All of these members had been "Yes" members for at least the length of their FCP and the State had been issuing guidance for over a year to start medication training at the time of "Yes." Thus, regardless of how members categorized their experience, based on past history, it is reasonable to foresee that many of them will experience significant challenges. Some of these members seemed surprised and worried that they would be expected to self-manage medications. For example, RK shared that he takes about 10 pills, and no one had yet discussed medication self-management with him, though as a Mariners resident he had been involved in the FCP in Fall 2021. Of the remaining in-process "Yes" members, two (JB, KS) expressed some problems, such as some confusion with complex medication names they were working on during training, while two others (RA, MO) said that they already self-managed and/or had been approved to self-manage their medications. A final in-process member is involved in a more complex situation:

- *At the time of our November 2023 interview, DB reportedly had been refusing to take her prescribed medications for at least one year, understandably complicating medication training by her Post Graduate ACT Team. During a 3/6/24 case conference, team members described her refusal to take psychotropic medications, including a monthly injection, as rendering her in an "actively psychotic" state and contributing to her recent hospitalization. They also noted because she refused to take medications for medical concerns, conditions such as her Type II diabetes could be worsening. The team had tried to pursue Assertive Outpatient Treatment (AOT) for DB, but as she was taking medications while hospitalized, she was determined not to meet the criteria for it. Team members reported they did visit her twice per week and educated her about her medications, yet they also noted DB "shuts down" when they tried to discuss medications. Further, they noted she had told them she did not take her medications because it was against her religion. The ACT Team did not discuss particulars of DB's religious beliefs and/or how medication education might be tailored to address these beliefs.*

  Following the 3/6/24 case conference, a Community Access peer bridger and State staff person approached DB about her medications. DB was open to discussing why she did not want to take them, and among multiple concerns she shared that she was under the impression that a particular cardiovascular medication would stop her heart so she could not take it, while another oral medication was simply so large that she was afraid of choking when she tried to swallow it. To address these concerns, the peer accompanied DB to the medication room and advocated for the large pill to be cut in half; DB was then willing to try it and found it much easier to swallow. The peer also provided DB with education around her other medications, including providing enough information about the previously concerning cardiovascular

medication that she was willing to try taking it as well. By a 5/20/24 update, DB was reported to be taking her medications and acting like a "different person." She was increasingly engaged, was willing to go out into the community, had made an Access a Ride request and gone to the DMV on her own to apply for her non-drivers ID. The peer described it as: "She is doing absolutely fantastic, she seems different, more alive, she smiles!" When we visited DB in June 2024, this increased level of engagement and independence was apparent (though as described on p.11 we also noted DB's mood was negatively impacted by witnessing another New Haven resident move out, compounding her frustration about her own lack of transition progress).

Unfortunately, DB's peer left her position in late June 2024. During multiple August 2024 updates, State and other provider staff reported that DB was upset about the peer's departure and her disposition changed; by 8/27/24, her ACT Team reported she has stopped taking at least some of her medications and was not open to restarting "due to delusions and paranoia." During a 8/29/24 case conference, it was reasserted that the peer's departure had a huge impact on her decline, and she had refused her antipsychotic injection for the past two months. The ACT social worker stated she tried to explain to DB that the plan to transition was still the same and the team was there to assist her as the peer was, but DB was closed off to them.

At this time, a comprehensive review of the many efforts providers have stated they have made to educate and train DB on her medications may be warranted, including an assessment of which strategies (such as those initiated by DB's peer) have worked best. We also underscore that because multiple providers have noted DB seems most engaged when discussing a potential transition, a more specific connection between medications and transitioning into the community might help convince her to reengage with them.

Among 14 post-transition members, two[26] (SB, AS) have a history of refusing to take medications since prior to transition. Here again, there is a foreseeable risk that these members will experience significant medications problems. However, these members were also able to articulate past problems (*e.g.*, side effects, the trauma of forced medication) and their providers perceived their baselines off medications as causing significant problems at this time. Among remaining post-transition members, two (VC, WH) expressed recent, significant problems with being able to (VC) or being able and willing (WH) to take medications, while three post-transition members (NLe, LL, GC) evidenced and/or expressed some problems. The remaining seven post-transition members did not express problems with their medications.

[26] As of February 2024, one member who characterized himself as having some challenges with his medications during our November 2023 interview may have entered into a pattern of erratic use of his medications. This member has not expressed this potential situation to us directly and if he does so during future check-ins, we will indicate it.

In the IR's Eight and Ninth Annual Reports we described medication assessment and training redesign efforts the State has made, including implementing a standardized assessment tool and expanding the role housing contractor Nurse Assessors play in assessment and training support. We have also noted examples of Nurse Assessors overcoming barriers to training when CHHA staff contracted by ALPs and MLTCs have not offered timely, person-centered training for certain members (*e.g.,* The IR's June 21, 2021 Memo #216 In-person Visits by Care Managers). Further, in the Ninth Annual Report, we described what the State called a "more recovery-oriented approach" to training that shifts the focus from a high level of pretransition preparedness to ongoing training and support during and following transition. Finally, in reporting on FCP progress, we have noted that as of the FCP, the State has asked providers to start medication training as soon as a member is identified as a "Yes" instead of delaying training for weeks, months, or even years into the transition process. It is all the more concerning, then, to encounter several members who continue to experience long delays, as well as training that seems to emphasize perceived deficits instead of building upon person-centered strengths. Members' perceptions of the lack of and/or problems with training was confirmed by providers during this interview project as well as during FCP and transition calls. For example, during this project (i.e., well after the State issued guidance about starting medication training at "Yes"):

- *Mermaid Manor member PK's Maimonides AH+ care manager supervisor stated they usually do not start medication training until one month prior to move (in reference to the Mermaid Manor ALP nurse who would be asked to conduct the training).*

- *Belle Harbor member JS's Pathway Home WellLife care manager stated they would start medication training once a move date had been set.*

- *Park Inn member JB's NHCC AH+ care manager supervisor stated "we want to know if he's serious about" the apartment he accepted before they put in a medication training request. This statement was made after NHCC already convened multiple IDTs, Community Access peers advocated on behalf of JB's desire to move, and housing contractor Pibly Brooklyn confirmed JB had accepted an apartment.*

Of note, the above examples and others from this sample include both ALP-enrolled and MLTC-enrolled members. It is especially puzzling that MLTCs would delay or limit medication training as members they serve presumably remain in their care post-transition. VC – who himself identified problems in this area -- illustrates the compounding risks of delayed training and a lack of post-transition support from MLTC ArchCare and other providers.

- *Former Elliot Pearl resident VC suffered a series of move delays and a cancellation in 2022, followed by additional move delays in 2023. While multiple reasons were given for the delays and cancellation, medication training needs were raised by his FOO AH+ care manager and MLTC ArchCare staff in 2022 and 2023. However, his providers had delayed setting up medication training. First, providers questioned VC's ability to read and had to be reminded that literacy/numeracy limitations did not preclude the right to prompt medication training. Providers also expressed concerns about VC's eyesight (including a potential glaucoma diagnosis and the need for new corrective lenses), stated they would schedule medication training after his ophthalmology appointments and treatments, yet did not schedule these appointments for months. Finally, in Spring 2023, ArchCare staff vacillated between setting up medication training with their own CHHA contractors and setting it up with other CHHA contractors working at Elliot Pearl. Over the course of months, other service providers such as VC's AH+ care manager and State staff were aware of this vacillation on transition calls, yet it persisted, and no progress was made on medication training. After the Office of the Independent Reviewer and State staff pressed for clarity on VC's training and other outstanding transition preparation, he was finally able to receive increased support and, despite vision limitations, demonstrated he was able to manage his own medications.*

  VC transitioned to the community in May 2023 and when visited in November 2023, he was proud to show off his clean apartment and describe how he managed many of his own ADLs. He also took the initiative to raise concerns about his medications, saying he was worried that his neighbors might call the police because he was finding himself speaking too loudly, even yelling in the middle of the night. He felt his yelling was caused by stress, anxiety, and insomnia, which in turn was caused by needing more or different medication. He also reported he sometimes took extra doses of one psychotropic medication to try to get a better night's sleep. VC thought he should talk to his PCP about his medication concerns, adding "I'll call him myself," but he also struggled to use his cell phone (it had been set to Airplane Mode at the time of our interview, which he did not realize nor know how to correct).

  VC also showed us his blister packs, which were in a state of severe disarray, with the front and back cardboard appearing water-damaged and peeling, leaving pills missing or trapped between blisters. Some blisters had multiple pills in place, some had none, and there seemed no order to which pills VC may have taken, when. He also stated that he thought someone may have entered his apartment and stolen his medications. When asked if anyone was helping him with the blister packs or reminding him to take his medication VC said no, despite affirming he had a home health aide and Comunilife case manager visiting him regularly, as well as a Community Access peer checking in. Though he recalled the FOO AH+ care manager who had worked with him through his transition, he was not able to name his current care manager and said he didn't think such a provider had visited for "a long time." He was familiar with the name ArchCare but could not recall when he had last spoken to providers from this agency. Given the concerns and myriad delays these providers themselves raised around medication self-management, it was dismaying to hear that VC had no sense of post-transition medication support from them. Even if VC misremembered support that had occurred, the state of his blister packs suggests that providers such as FOO and ArchCare (through its contracted aide agency) either had not visited him in person or had not reviewed his medications in person for some time. Because of the potential danger of overmedication and/or sudden cessation of

medication, the Office of the Independent Reviewer contacted the State following this visit (11/9/23) and staff stated VC would be transitioned to Pathway Home WellLife for increased care management support. It took approximately six months to move VC to a higher level of care management and it is unclear if or how medication oversight and support was provided in the interim, however as of May 2024 VC was enrolled with Pathway Home.

Such cases suggest that the most salient observation and corresponding recommendation we can make is also the simplest: providers are not following the State's guidance to commence medication training for most members at the time they become "Yes" nor at another, early point in their transition process such as at the start of their homes' FCP or even, now, at the start of their homes' SFI. In many cases, the training when provided is infrequent; for example in an Opt Out form for AH dated 2/2/2024, it was noted that in April 2023, AH's MLTC Riverspring Nurse Care Manager (NCM) considered him "not a good candidate to move into the community because he wouldn't be able to take care of himself and he also wouldn't be able to adhere to medication regimen." At the same time, Riverspring staff also cited as evidence of attempting to train him "Class Member meets with Park Inn CHHA nurse 1x/month for medication education/management." When in May 2023 AH's AH+ care manager attempted to go directly to the CHHA nurse to ask for medication training for AH, the "CHHA Nurse… reported she would confer with MLTC NCM," i.e., the CHHA nurse would confer with the same provider who had stated AH was not a good candidate to move into the community in part because he wouldn't adhere to his medication regimen, training for which, at that time, was only occurring once per month as "education/management".

Beyond the cases described here, we are aware the State is present on many FCP and transition calls that include additional examples of the failure to initiate timely, frequent medication training as encouraged by the State. Presumably, the one-on-one care manager supervision calls conducted by the State, and possibly SFI "improved communications" also provide evidence of such lapses. State staff, including both the Escalation and Post-transition Teams, should take a more involved role in overseeing the prompt start to training for all remaining "Yes" members, as well conducting checks on ongoing medication training and support for members who have transitioned since the 2021 medication management redesign.

Additionally, while this sample did not include members struggling with diabetes treatment regimens,[27] we are aware of other members experiencing significant barriers to transition and/or post-transition struggles due to blood glucose monitoring and/or insulin injections. We have encouraged the State to consider providing additional guidance and oversight – extending well into post-transition life – for such members.

Turning to member-centered factors, we again recognize a few interviewed members (DB, SB and AS) declined to take some or all prescribed medications prior to and continuing into transition while other interviewed members have evidenced spotty agreement with, and willingness to take prescribed medications (*e.g.,* WH, NLe). Understandably, these choices complicate provider efforts to pursue training, including ongoing post-transition training and support. Further, we recognize there is no "silver bullet" strategy to convince members who decline to take medications to try and/or regularly take them. As the Housing First model[28] would suggest, however, there are members who may demonstrate more openness to medications when presented if it is linked to a major life opportunity such as moving to one's own apartment.

Indeed, over the course of this project, the three interviewed members most staunchly against medications (DB, SB and AS) were all willing to discuss why they did not want to take them. DB's concerns are depicted on p.29; SB and AS both stated medications "haven't worked" in the past and made them feel poorly; AS alluded emotionally to experiences of being hospitalized and medicated against her will, while SB spoke about one medication (Haldol) which had helped her during a past inpatient stay, though she declined to try it again. Respecting that providers have tried to motivate members like these, we encourage the State to provide additional support to them, including making space and time to discuss the reasons behind each member's hesitancy around medication, and emphasizing person-centered hopes and goals in the community to encourage members to try to train for and take their medications.

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[27] We note MO is an example of how beneficial person-centered medication training and support can be. He has Type II diabetes and several other medical conditions but during the QACC FCP he diligently trained to use a glucometer and sliding scale and was found capable of measuring his own blood sugar and managing his own insulin injections; this was confirmed during an October 2022 pretransition call (though this move was then canceled due to apartment accessibility concerns). While it is unfortunate that he has suffered multiple move cancellations, during his wait he has managed his diabetes so well he stepped down to oral medication only in 2024.

[28] Rezansoff et al., "Housing first improves adherence to antipsychotic medication among formerly homeless adults with schizophrenia: Results of a randomized controlled trial."

We also note that the three sampled members who declined to take their medications are enrolled with ACT Teams. As these teams seem to focus their work on behavioral health tasks, it could be beneficial for all providers to learn from any promising practices ACT offers around medication education and management. As such practices have not yet worked for these three members, there may also be a need to discuss options beyond care management models for class members with the most significant medication-related challenges (*e.g.,* the most appropriate level of housing as pursued for AS, time-unlimited peer support as pursued for DB, etc.).

D. Post-transition isolation, loneliness

Table 10. Post-transition members: Isolation, loneliness in the community (N=15)

Degree of problem *as recalled/reported at time of interview*	N (%)
No/low problems	6 (40%)
Some problems	6 (40%)
Significant problems	3 (23%)

Among 15 transitioned class members interviewed, six (FA, SB, VC, NL, MLM, WH) reported that they had or were having some problems with isolation and/or loneliness and three considered this to be a significant problem they faced (LL, AS, FY). Some members who raised feelings of loneliness or isolation provided examples of specific barriers to socializing. For example, two members (FA, FY) said they could not go to holiday parties their respective HCs (SJMC BK and TSINY) held due to lack of transportation to get there. FA, who travels by public transportation, said she was not comfortable taking it after dark. Similarly, MLM reported although she wanted to try attending PROS, she had been told she would have to take public transportation to get there and was concerned about that during the wintertime. As of March 2024, a member (JB) initially interviewed while in process had moved to supported housing and had also encountered barriers to socializing. While he often expressed interest in attending Community Access activities, he and peers noted his home health aides, including multiple aides with limited English proficiency, seemed sometimes unable to understand and sometimes unwilling to support him in scheduling Ubers (paid for by Community Access) and/or accompanying him in Ubers to outings. The peers continued to try to communicate with JB's aides so that they could understand the importance of social opportunities for him.

Other members who raised feelings of loneliness or isolation did not have a sense of what types of activities or people they might like to engage with, understandably complicating what providers could offer them. For example:

- *AS complained at length about loneliness, but she also expressed she did not trust most people, nor did she desire to leave her apartment. As reported by some of her providers and observed during our November 2023 and follow up June 2024 interviews, AS frequently experiences heightened emotions and yells at others. These factors left her struggling with both isolation and a desire – but no clearly identified options in supported housing – for socializing. In turn, her providers experienced an outsized responsibility to spend time with her, as she had positive relationships with Community Access staff, her TSINY housing case manager, and her NHCC ACT therapist. In fact, when asked in November 2023 if she was happy living in the community, AS reported she was, but she was very lonely and desired more frequent provider visits. Following our initial interview in November 2023 AS was moved to a CR-SRO due to concerns with her health, mental health, and conflicts that had arisen in supported housing. As of June 2024, AS complained about the CR-SRO's location on the grounds of Creedmoor Psychiatric Center, which left her feeling fearful and even more isolated than before. At the same time, she spoke about how pleased she was with her new home health aide and evidenced frequent, close communication with her. With the encouragement of CR-SRO staff and the support of her aide AS begrudgingly began taking public transportation on occasional shopping trips and to her first primary care physician (PCP) visit in years. She also complained about the CR-SRO staff and other residents, yet evidenced frequent conversations and interactions with them, including sitting on the front steps of the building and chatting seemingly contentedly with other residents. AS's case presents an opportunity to explore potential strategies for navigating member's stated preferences, some of which may be contradictory (e.g., a strong desire to make social connections versus a strong desire to self-isolate in supported housing), alongside health, mental health and safety considerations which also may contradict some member needs and preferences.*

Other members made efforts to socialize but could be supported more in finding person-centered options. For example:

- *NLe has been attending a day program about four days a week but as a relatively young man (almost 46 years old at the time of interview) he said it would be nice to meet people close to his age instead of the older adults who tended to go to program. When asked, he stated he was not aware of Clubhouses or other program models that attract a more diverse membership, and said he would like to learn more. In the meantime, when asked about challenges in the community he admits "I feel lonely a lot." Given he is in recovery from substance use, meaningful social opportunities seem a key missed opportunity.*

- *Prior to transition, LL expressed his desire to have an apartment mate and had been told by housing contractor FOO that a potential apartment mate would join him after his 12/7/22 move. According to LL he did not have the chance to meet with a potential apartment mate until September 2023, though he liked the individual he met then and looked forward to having him move in. This individual's move was delayed, however, and*

he never joined LL in the apartment. LL continued to express to all his providers, and IR staff during his November 2023 interview, that he was waiting for an apartment mate to move in, and he didn't like living alone. LL also said that while he liked living in the apartment more than the adult home it was burdensome to have to do everything (e.g., pay bills, take his medications, etc.) on his own. He explained that while he was able to do these things, it was hard and didn't like living by himself. By 1/24/24 LL told his peer bridger that he had enough and wanted to move back to New Haven Manor. When asked whether it would make a difference if he got a housemate, he said no, he was done living alone. He had also been diagnosed with cancer and this may have impacted his decision. Another update on 2/12/24 indicated that LL had been hospitalized and was in poor health. He stated he did not want to return to his apartment and instead he was discharged from supported housing to a nursing home at this time. It is unclear whether having an apartment mate would have made a difference to his supported housing tenure. In the least, it is unfortunate that his providers could not do more to find an apartment mate for him after assuring him it would be possible.

Overall, such cases underscore the need for care planning to be truly person-centered (i.e., match ages, other identities, and/or interests of members), start as early as possible, and to continue post-transition as new needs and interests might arise. In addition to taking a more person-centered approach in facilitating social opportunities, State and settlement provider staff could consider other, simple steps to expand such opportunities. One step would be to systematically offer and, when desired, facilitate introductions among members living in the same buildings and/or neighborhoods. We have noted anecdotal examples of such introductions in the past, such as HC ICL connecting member AT to another Spanish-speaking member in her building (see Ninth Annual Report). In addition, in June 2024 we became aware of TSINY and Community Access connecting two class members who had recently moved into the same Queens apartment building. A third member who was interviewed for this project (MC), had returned to the building after a hospital stay and providers informed her that if in the future she was interested, they would connect her as well. However, we more often observe such connections happening spontaneously, when members encounter each other, leading us to wonder about potential missed opportunities for connections. One example of a spontaneous connection arose during these interviews:

- *VC mentioned he had a friend living down the hall and asked to introduce us; it turned out friend DC was a class member who had transitioned to the building a few months after VC. Providers did not introduce the two men, but they encountered each other in the building and developed a mutually supportive relationship. Both were Veterans and enjoyed sharing stories about their experiences in the Air Force (DC) and Army (VC). As depicted above, VC was struggling with his medications and increasing stress and anxiety at the time of interview. While he appeared agitated at the start of our visit, once in the company of DC*

he became more at ease, laughing and joking with his friend. For his part, DC was pleased to have a friend who admired his Captain rank and explained that when VC became agitated "I just tell him 'Enough! Calm down or come back later.'" DC, a highly independent class member, was well versed in both his own service options (e.g., he had switched MLTC plans himself after realizing Riverspring had not pursued services he felt he was eligible for) and those VC had and could have (e.g., he advocated for VC to get help to connect with the Veterans Administration, which VC had expressed interest in but was unable to pursue on his own). DC had also gotten to know "half a dozen" other tenants and organized a tenants' association; he invited VC to get to know their neighbors too. For his part, VC knew DC had mobility concerns and had taken a fall after moving into his apartment; he said he kept an eye on his friend to make sure he didn't fall again.

Finally, during most of our interviews it was encouraging to observe members had positive relationships with at least some service providers. It was also evident that multiple providers went beyond their job roles to engage in informal, friendly activities and support. For example:

- *MC faced hospitalization for medical concerns just weeks after her October 2023 transition. During treatment and rehabilitation, she reported that she felt great support from her Community Access peer bridger, TSINY housing case manager, and TSINY AH+ care manager. She noted that having been engaged with the settlement and an array of providers since 2015, "no one's ever treated me better" than her housing case manager, who visits her regularly and is always available over the phone.*

- *The same TSINY housing case manager was also praised by AS, who had refused to leave her building with anyone but him, including relying on him to drive her to cash her checks and help her navigate shopping trips. Calls to check in with this provider were a highlight of AS's days.*

- *Soon after moving DC, an otherwise highly independent member, fell in his apartment. He describes how fortunate he felt to have his BAC AH+ care manager scheduled to see him that day. The care manager found him after the fall, called emergency services, and was extremely caring, checking in frequently afterwards to ensure he felt okay.*

- *After GC's exceptionally difficult transition to the community -- involving an HC FOO apartment that was in a state of disrepair necessitating a temporary stay in another unit, as well as several CMA FOO care management supports not in place for months after his transition -- a new FOO AH+ care manager was assigned to him. Both GC and other service providers agree that once his new care manager stepped in communication with him and other providers increased, and even as service gaps lingered, it was evident that she was making progress on several tasks, including helping GC obtain a working cell phone, SNAP, and SSI benefits after he suffered months without them. We appreciate that individual service providers may "inherit" already delayed transition tasks, and that the effects of these delays compound over time. GC's new care manager offers a positive example of undertaking the provision of services at a particularly difficult juncture and working at a quicker pace, with more communication, to address member challenges she "inherited" from other providers.*

GC also reported that during his difficult first months in the community he enjoyed frequent visits from Community Access peers, attended community events with them, and felt he could count on them showing up when they said they would. During our interview he also said, however, that they didn't always keep their word. Through further discussion, it became apparent that because peers were visiting GC most frequently, they had become the "face" of the settlement, and were often the ones to tell him that there was not progress on service gaps that were the purview of other providers. From GC's perspective, because the peers were with him but could not directly remedy the gaps he suffered, it felt like they were not fulfilling the promises of the settlement that he heard during the FCP. For their part, GC's peers spoke of the emotional toll of being stuck between members' evident need for help and underlying service gaps outside of their ability to address directly. Despite this toll the peers offer a positive example of bridging service gaps and providing a great deal of support during a particularly difficult time in GC's transition.

- *FY reported a positive relationship with her Pathway Home Post Graduate AH+ care manager, who speaks Russian. Although FY speaks English well, Russian is her primary and more comfortable language and being able to communicate with her care manager this way helps her. Her providers also helped her get Russian-speaking home health aides with whom she has a good rapport, and who cook her Russian cuisine.*

- *Beyond FY multiple other members reported and evidenced highly positive aide relationships. MC called her aide "fantastic" and during our visit we observed their comfortable back and forth about decorating the apartment, shopping trips, reminding each other about where they placed certain items, etc. During our June 2024 follow up visit with AS it was also evident her current aide was a critical companion. CR-SRO staff noted it was the aide who helped AS set up her tablet to watch daily news videos, one of her most enjoyable past times. Both staff and AS noted the aide's presence was a key reason she would try to take public transportation, try to go out into the community, and even try attending a PCP appointment for the first time in years. AS emphasized as difficult as the appointment was for her, her aide was there and spoke up on her behalf, protecting her from procedures like bloodwork she did not want done. Finally, as described on p.45 the kind of work aides may undertake for members like SB (i.e., with complex medical and mental health concerns such as incontinence) is both especially grueling and yet absolutely pivotal to their ability to remain in community housing.*

Understandably, most service providers have limits to the amount of time and nature of social support they can offer members. Peer bridgers, though also operating with limits, have more flexibility in the amount of time and types of engagement they undertake with members. One result appears to be supportive, meaningful relationships that serve as true "bridges" between the adult home and the sometimes lonely initial transition to the community. For example:

- *NLe was a "Hard No" at the start of the Garden of Eden FCP and admittedly intimidated by the home's administrator to the point that he questioned if he could make it in the community. He credits his Baltic Street peer with helping him gain the confidence and initiative to try to*

transition: "He just kept coming back around, coming around, talking to me, helping me understand what it would be like." Further, as a relatively young man, NLe enjoyed the opportunity to just talk to another young man like himself.

- *FY was also a "Hard No" at the start of the Mermaid Manor FCP, and she too credits her Baltic Street peer with supporting her in considering the possibility of transitioning. He "encouraged me for five years to go out and tour apartments," and he supported her with her preference to live in Brighton Beach and take the big step to accept the apartment she was shown there. From FY's description of her transition, it is evident her peer helped her feel motivated to try to move and stay engaged in the process.*

- *DC reported that his Community Access peer had helped him advocate for himself during the Belle Harbor FCP, ensuring he was enrolled with an AH+ care manager after a seemingly interminable wait. He also enjoys going on Community Access outings, such as the Summer 2023 Mets game. After DC transitioned, he relished his peer's visits, setting up chess games they could play and earmarking New Yorker articles he wanted to discuss.*

- *More reticent members AF and JB both reported they enjoyed speaking with their Community Access peers, and we observed that with the peers they became more talkative, joked around, and were interested in community outings, despite other providers reporting they were unwilling to leave the adult home or complete certain tasks. We also observed the peers' consideration for their Latino backgrounds and how to offer culturally congruent services, which had not been raised by any other provider while we were present. Specifically, one peer working with AF and one peer working with JB separately noted that while each man could speak English fairly well, some of their reticence and passivity in conversation was not necessarily because of a lack of comprehension nor a sign of cognitive limitations, as other providers had stated. Instead, the peers had considered that for cultural reasons the men might expect to engage in more ongoing relationship-building and traditional, slower paced conversations than the rapid-fire, task-oriented meetings they were sometimes asked to engage in. Peers also noted that when confronted with what they perceived as rushed and/or aggressive providers, AF and JB defaulted to saying little and simply agreeing with providers in order to avoid conflict and conclude the conversations; the peers reiterated cultural norms might guide this behavior, which was in contrast to other providers who raised such interactions as evidence of cognitive decline.*

- *LL, who reported suffering from loneliness as he waited over a year for an apartment mate, appreciated the companionship his Community Access peer offered him. He enjoyed the personalized gestures she offered, like receiving gifts of fresh fruit from her.*

Another benefit the peer-run agencies offer and continue to expand upon is community-based groups and activities. The social exclusion inherent in living in institutionalized settings like adult homes leaves many class members with little sense of what social connections and activities they might want to pursue; it is difficult for them to know what social options they have – much less

what they might enjoy -- after years of social exclusion. However, in the course of this project we observed some ambivalent in-process members explore and gain a better sense of what they might like to do in the community through peer activities, which in turn seemed to reinforce their interest in transitioning. For example, the Community Access peer, aware of AF's interest in art, did not just invite him to her Sip n' Paint group, but asked him to co-facilitate, both reaffirming his love for painting as well as fostering in him a sense of self-efficacy around helping others, which he could carry into community life. Another Community Access peer encouraged member JB to go out to Rockaway Boardwalk with her and pick up recyclables, explaining it was both a neighborly activity and one that he could try to earn some extra spending money once he moved. As a smoker, JB admitted he has sometimes struggled with budgeting his money and seemed to appreciate learning about activities he could try out when he moved.

We have also observed class members enjoying interacting with others during activities such as Community Access's Rockaways bowling group as well as baseball games and Baltic Street's Culinary Event. Some members sampled for this project referred back to enjoying these larger scale events, and for members in the community recurring meet ups such as the bowling group seemed especially important opportunities for consistent socialization.

Overall, we reemphasize that the peer bridger program is a bright spot in Settlement implementation, and many members report they would like to continue to spend time with peers. While the renegotiated Settlement Agreement provides for 90 to 120 days of post-transition peer support, we encourage the funding and staffing of peer services to extend further post-transition, and past the Settlement end date. We also encourage the State and providers to expand efforts to expose members to other peer-led and identity-driven social options such as Clubhouses, the Baltic Street Resource and Wellness Center, Senior Planet centers, and faith- and culturally-based groups.

E. Emerging member considerations: Increased needs around substance use, medical and mental health needs

Among 28 class members interviewed, five reported and/or evidenced some medical, mental health, and/or substance use problems (JB, DC, ED, AH, NLe, WH) and seven members considered this to be a significant problem they faced (RA, MC, VC, MO, ER, AS, FY). In addition, providers serving 21 members expressed concerns over medical and behavioral health (i.e., mental health, and/or substance use) problems (RA, DB, SB, MC, VC, ED, AF, AH, NLe, LL, MO, FY, ER, AS, KS, DW, NL, RK, PK, GC, WH).

Tables 11. All members: Substance use, mental health, medical, mobility needs (N=28)

Degree of problem *as recalled/reported by members*[29]	N (%)
No/low problems	14 (50%)
Some problems	6 (21%)

For example, both ER and his providers spoke about a hernia condition causing him great pain and impeding his engagement in transition activities. At the same time, at the time of interview ER was reported not to attend appointments to prepare for hernia surgery, further delaying his health and transition readiness. FY suffered a fall shortly after she transitioned which led to surgery and a long period spent in the hospital and a rehabilitation facility. Upon her return to supported housing, she now faces mobility limitations which make it difficult for her to leave her apartment, limiting her life in the community.

In addition, we spoke with some members who did not acknowledge, downplayed, and/or selectively disclosed some problems; for example, DB, SB, and AS have Type II diabetes diagnoses but do not believe the diagnosis and/or do not believe they need to take medication for it. At the same time, some providers may overestimate how challenging or risky some conditions and/or behaviors may be; for example, one member disclosed that they self-medicate with marijuana and when they admitted this to certain service providers it was labeled "substance abuse" that could jeopardize their success in the community. After this experience, the member no longer discloses and sometimes denies that they use marijuana to help with medical conditions; their PCP and a specialist physician know this, and they otherwise prefer not to discuss it.

There are also members struggling significantly in the community who more forcefully deny and/or refuse to talk about medical and/or behavioral health challenges. For example:

- *Prior to transition, State and provider staff were aware SB had complex medical conditions and a history of refusing to take most to all of her prescribed medications, compounding medical and mental health concerns. Staff demonstrated initiative (e.g., SB was enrolled with the Post Graduate ACT team prior to transition) and cross-agency communication (e.g., holding multiple check in calls in addition to regularly scheduled, State-run transition calls) to provide services and supports that could match her needs. Still, in December 2023, SB herself described her approximately 10 months in the community as: "It hasn't really come together yet, I'm still waiting for things to come together." As depicted on p.26 settlement*

[29] It was unclear how to weigh member versus provider perspectives here, as members might focus on certain needs and providers on others. However, we note that if provider perspectives had been systematically incorporated a higher number of interviewed members (at least 21, or 75%) could be considered experiencing some to significant problems.

provider factors have complicated SB's life in the community, but her own medical and mental health needs, and her reluctance to discuss or address them, also contribute to her challenges.

While SB takes few to none of her prescribed medications, she will engage in some discussion of her reasons, which may suggest more conversations and a willingness to try alternate medication could occur at some point. However, SB's providers report she is not open to discussing her medical or mental health conditions, including the incontinence that seems to define her life in the community. When we visited SB in her apartment, the impact of the incontinence was striking; her apartment smelled strongly of urine and excrement, an odor apparent upon entry in the front hallway of the building (SB's apartment is near the front entrance). While her apartment was tidy and her home health aide was actively cleaning it, she (the aide) admitted she could not effectively address the odor and described her continuous efforts to place, then replace incontinence pads on SB's bed and loveseat. Despite these efforts and fresh pads laid down for our visit, the loveseat was damp when we sat on it. SB herself was semi-dressed, in bed, and providers reported this was consistent with how she usually spent her days; she is able to remove and replace her own Depends but perhaps because of the frequency of use she does not regularly dress fully, nor leave the apartment beyond occasional trips to purchase food and cigarettes down the street. While SB may have an aunt living in Queens, it is unclear if she has contact with her or any other family members; she seems to live in isolation apart from service provider interactions and has declined opportunities to visit day programs or participate in other social activities.

Home health aide services were inconsistent in 2023 – SB herself asked one aide not to return to the apartment because she did not clean well, while other aides stopped showing up – and when she has been without aides SB has not been able to properly dispose of her soiled Depends, either leaving them piled up in the apartment or placing them in a building trash container where the smell became severe enough to prompt building management to complain to HC Pibly Bronx. During 2024 SB and her service providers have remarked on the remarkable consistency of the home health aide we met in December 2023, who has remained working five days per week in SB's apartment despite the extraordinarily difficult conditions. As another service provider noted, every morning after SB has passed the night alone, with no one to attend to her incontinence needs,"it looks like no one was ever there, she [the aide] has to start all over again," cleaning up soiled Depends, urine, and feces. While the efforts of this aide cannot be praised enough, it is understandable that she has raised thoughts of moving on. It is in turn difficult to imagine how SB could remain in livable conditions in her apartment, given the challenge of finding another aide willing to commit consistently to the same work. SB was also described by multiple providers as "a chain smoker," though she describes her smoking in more moderate terms. Either way, the odor of cigarette smoke was highly evident during our visit, furthering what seems to be a close-to-unbearable atmosphere for service providers, other building residents, and SB herself.

SB's difficult year and a half in the community, including approximately nine hospitalizations between February 2023 and September 2024 (a majority for medical reasons, though some for mental health reasons), exemplifies three emergent concerns. First, both in-process and recently transitioned members appear to have more complex, higher service needs

than earlier cohorts of transitions. In cases like SB's, higher service needs are compounded by post-transition service gaps (described on p.26), underscoring how vital person-centered pre-transition preparations are for these members. Second, some of these members' complex needs are compounded by the degree to which they are willing to discuss them and engage with potential supports. This in turn compounds the complexity of providers' work. Third, it is not always clear if and/or how the State has responded to both member and provider concerns; increased, consistent communication from the State that includes tangible steps to address specific member needs and/or provider concerns are needed. At the same time, we also appreciate that over the course of the past year the State seems to have increased the use of both the AHI-specific Special Cases Committee (SCC) for pretransition concerns as well as the OMH Field Office CCC for concerns with transitioned members. These Committees seem a useful resource for the most challenging member situations, but they too have limits; it is our understanding SB's situation has been presented at the CCC and yet conditions have not improved for her. Further thinking around what kind of planning and additional or new service provision might be explored to support the most vulnerable class members as the Settlement winds down.

Finally, we note other member interviews present a sense of what has worked in terms of increased, individualized supports. For example, NLe met a woman in his building who became a romantic interest and encouraged him to start using crack cocaine with her. Fortunately, NLe's providers knew him well enough to notice a change and spoke openly with NLe about his substance use. NLe himself was open to their recommendations and support. While we have observed no guaranteed successful responses to member substance use, cases like NLe's suggest the critical role of AH+ care managers and other service providers taking the time to build rapport and trust with members, and being consistent presences in members' lives. These foundations of strong client-provider relationships, which NLe reports having, may increase members' trust and openness to providers when uncomfortable and contentious issues arise.

F. Emerging provider considerations: Connections to outside providers, shifting provider roles and responsibilities, and the increasing role of Assertive Community Treatment (ACT) Teams

Table 12. Post-transition members: Help from mental health, medical providers (N=12)[30]

Degree of problem	N (%)
No/low problems	0 (0%)
Some problems	10 (67%)
Refuse to engage with medical providers[31]	2 (18%)

Among 28 class members interviewed, thirteen reported they were having some problems with at least one mental health and/or medical provider. However, some in-process members did not discuss medical and mental health providers; other in-process members did not distinguish or evidence a clear difference among care provided within the adult home, versus care from outside providers, versus connections to new providers in preparation for their moves. Because in some of these cases we were not able to clarify which providers these members may have referred to, we have not included a table of these incomplete counts. Instead, we focus on the 12 post-transition members who spoke to this theme, among whom ten reported some problems (FA, JB, DC, MC, VC, LL, MLM, DW, FY. GC, WH). Upon discussion, it was apparent problems were not always with providers or their care *per se*. Sometimes logistics and access to their providers were of greatest concern, such as setting up appointments, transportation to providers, and tasks members needed help with to expand services. In other words, many post-transition members need help with tasks that would seem to be the purview of AH+ care managers, so that they can in turn enjoy more consistent, comprehensive services from medical and mental health providers.

For example, members expressed concerns over canceled transportation to appointments, the desire to pursue different transportation options (*e.g.*, to apply for Access a Ride), and/or the desire to find providers closer to their apartments (FA, LL, FY). Other members (GC, VC, WH, DW) evidenced problems with using and/or paying for their phones which in turn impeded their

[30] This table reflects that three post-transition members did not speak to this theme and the degree of problems they might have reported is not represented.

[31] Both members also refuse to engage with mental health providers in general, though they accepted visits from ACT Team mental health providers. As of June 2024, one of these members, AS, had received person-centered motivation from staff at the CR-SRO she had moved to, as well as from a home health aide who had built a strong rapport with her, leading to her attending a PCP appointment for the first time in years.

ability to set up appointments and/or transportation. On the other hand, at least one member (MC) benefited from settlement service providers working collaboratively with medical providers during her first weeks in the community, when her health declined and she was diagnosed with multiple conditions adult home providers had never mentioned. In this case, settlement providers quickly coordinated care vital to her health and wellbeing in the community.

Finally, three members (DB, SB, AS) refused to see medical providers and received mental health services only through ACT, a significant problem particularly given their medical diagnoses (*e.g.*, Type II diabetes, incontinence). However, AS, who transitioned from supported housing to a TSINY CR-SRO in November 2023, received person-centered motivation from on-site staff (*e.g.,* they discussed attending community-based providers' appointments as showing off her independent living skills, which in turn could help her transition back to a lower level of housing as she desired) and in June 2024 she attended a primary care physician (PCP) appointment, the first in many years. AS described this visit as extremely difficult, but because her home health aide went with her and advocated for what AS told her was important (*e.g.,* due to past trauma, AS was adamant she could not have blood drawn), she was able to achieve this care goal.

Table 13. All members: Help from settlement service providers (N=28)

Degree of problem *as recalled/reported at time of interview*	**N (%)**
No/low challenges	12 (43%)
Some challenges	9 (32%)
Significant challenges	7 (25%)

Turning to settlement service providers, nine out of all (n=28) interviewed members reported that had or were having some problems with at least one provider.[32] Seven members reported a significant problem with a settlement provider. For example, multiple members did not know who their current AH+ care managers were or questioned if they had one; some of these members were able to speak about prior care managers with whom they had more contact and wondered why their current care manager did not provide similar contact.

[32] Unlike other themes, here we have not included all class member initials because some members indicated concerns with "telling on" specific providers and the potential for providers to then be made aware of or glean who reported problems with them. In subsequent paragraphs, we provide initials for situations that are well enough known that it was not the involved member themselves who first indicated the problem, relieving this concern, as well as situations in which the member indicated they were comfortable with their initials being used.

Other in-process members expressed frustration with HC staff not taking them on tours or offering apartments matching their needs and preferences (RA, DB, AH, MO). Some post-transition members expressed frustration with specific supports their HCs and CMAs had committed to but not provided. Examples ranged from fairly minor and easily addressed problems, such as missing shower bars or accessibility features such as a promised ramp, to severe and protracted problems such as HC FOO attempting to cancel GC's move the morning it was to occur (3/12/24), having not informed Central Assisted Living, the State, Community Access, nor GC himself beforehand. The stress this situation caused GC was compounded when he arrived at the apartment to find it filthy and in disrepair, precipitating an interim move to a temporary apartment until FOO could address the preparations they had committed to by his original day of move. As GC himself exclaimed "This wasn't what they promised me it would be like!" A few members also raised more specific concerns with MLTCs (*e.g.*, a nurse care manager not making DC aware of the full range of benefits he could receive, prompting him to switch plans on his own) and home health aides (*e.g.*, multiple members raised issues of inconsistent coverage, such as aides not arriving on the weekend and aides who did not clean or complete tasks in the way they desired).

We did not ask settlement providers a precisely analogous question about relationships with members, nor did we systematically interview all providers serving all sampled members. However, conversations across providers yielded several instances in which a given provider described difficult interactions with members and/or expressed a gap in knowledge about them. In addition, some providers described difficult interactions with, and/or a lack of clarity about the role and work of other providers serving the same member. Taken as a whole, these comments suggest two subthemes. First, many of the concerns members expressed about settlement providers, such as the need for more consistent, person-centered communication, are not new. Second, new types of providers, specifically ACT Teams, are increasingly involved in settlement service provision in lieu of AH+ or Pathway Home care management. Over the course of this project, approximately 42 ACT Teams have served as many as 98 members; as of 8/19/24, 88 members, including five interviewees are being served by four Teams[33]. It is unclear, however, what the State's overall vision is for ACT Team involvement in the settlement. It is also unclear how ACT Teams have been trained on and understand their roles within the settlement, a unique

[33] As of January 2024 one additional member (KS) who was an in-process "yes" at the time of interview transitioned to the community and was transferred from NHCC AH+ care management to the VNSNY Queens ACT Team.

setting for ACT. Finally, it is unclear what -- if any -- training and support other service providers or class members have received to understand how ACT Teams fit into overall settlement service provision.

One result of this ambiguous rollout is that multiple types of service providers, such as HC and peer-run agency staff, working with multiple ACT Teams, reported they did not understand well what the role of the ACT Team was, only that it did not seem analogous to the role and repertoire of care management that AH+ and Pathway Home covered. For instance, multiple providers reported being told by multiple ACT Teams that they provided mental health services only. These other service providers were left uncertain about who should be handling care management tasks they had been trained to understand AH+ care managers handled. In multiple cases we observed, including cases from these interviews, providers such as HCs and peer bridgers were left to take on tasks they had understood to be AH+ or, if they did not take them on, observing them remain undone and members struggling. As indicated above, examples of such tasks included HCs and peers helping members apply for and secure benefits, ensuring food security, and supporting members with medication education and training. More specifically, ACT-enrolled members such as SB, AS, and WH lacked and/or lost some of their IDs and faced post-transition food insecurity. HCs Pibly Bronx and TSINY and Community Access were engaged in regular, ongoing food shopping for these members; while AS was in supported housing it was her TSINY case manager who routinely helped her cash her benefits check, transported her to the grocery store, and helped her shop.

Interviewed members with ACT Teams did not have many complaints about them and spoke well of individual staff. However, members could not articulate what the team was supposed to do for them. For example, AS said a staff person visited her regularly and she liked her "Because she always agrees with me," but when asked what else the staff person or other team members did for her, she could not name anything beyond the visits, which she would like more frequently. SB said that a staff person from her ACT Team visited her, affirmed that they had spoken to her about taking her medications, and also said that the ACT team had not helped her with her lost EBT card or expired OCT card at the time of our November 2023 interview (her ACT Team was then involved in addressing these benefits gaps in 2024).

Our observations and interviews suggest that despite the State's efforts at settlement-specific training for involved ACT Teams, additional training and ongoing monitoring is needed.

Further, at least some of the ACT Teams involved in the settlement would benefit from discussion and/or training around ACT as an evidenced based practice (EBP). The success of ACT as an EBP rests on decades of research in which ACT Teams *with high fidelity to the model* lead to significantly improved client outcomes as compared to other care management models. Model fidelity involves adherence to core components which include assertive outreach by a multidisciplinary team; rapid, continuous, and long-term care; and a "*holistic approach to person-centered services that encompass what is necessary to an individual's successful transition to community living*"[34] (italics are our own). While behavioral health services are certainly a part of an ACT Team's repertoire, medication management, physical health management, financial support, support around ADLs, appointments, social integration, etc. may all be included in person-centered services, per the model. ACT has also been described as "a model of care providing treatment and rehabilitation *in addition to* performing case management functions,"[35] i.e., case management is at the core of the ACT model (italics are our own). We are thus concerned that observational and interview examples of care management tasks such as obtaining IDs, ensuring financial and food security, etc. go unaddressed by Settlement-involved ACT Teams. If the inclusion of ACT is meant to better support higher needs members, this apparent drift from model fidelity raises the question of the appropriateness of ACT.

Second and related, other types of providers are navigating shifting roles and responsibilities simultaneous to a natural reduction of staffing as the settlement winds down. As illustrated above, multiple staff across multiple HCs and peer-run agencies have assumed some care management responsibilities when ACT Teams have not done so, yet many of these agencies are also experiencing staff resignations, leaves of absence, and intentional hiring pauses.

It is also of note that many members still in-process to transition, as well as many recently transitioned members, evidence complex needs. At this point in the settlement the class is also elderly, suggesting even those successfully living independently in the community may have reached or soon will have higher service needs. We are at a contradictory point of the winding

[34] Bond and Drake, "The critical ingredients of assertive community treatment"; Bond, Drake, Mueser, and Latimer, "Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients"; Monroe-DeVita, Morse, and Bond, "Program fidelity and beyond: multiple strategies and criteria for ensuring quality of assertive community treatment."

[35] Bond, Drake, Mueser, and Latimer, "Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients", 145.

down of the settlement, with staffing being reduced, but potentially higher member needs. This necessitates a thoughtful reassessment of the roles and responsibilities of provider agencies and staff that remain, including HHs/CMAs, ACT Teams, MLTCs, HCs, and the peer-run agencies.

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