Appendix A

A Review of A Sample of Class Members Living in Supported Housing

SUBMITTED BY

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I. Introduction

As described in the Semi-Annual report, the Independent Reviewer team undertook this review of a sample of class members to understand how less intensive monitoring and oversight processes work. We selected a sample of 30 class members out of the group of 705 who had transitioned to the community no more recently than 1/1/2023 (*i.e.,* two or more years ago) and, if they had been initially enrolled in more intensive Adult Home Plus care management with its 1:12 caseload ratio, had likely been "stepped down" to mainstream health home care management and/or disenrolled from health homes entirely. In this report, we present the results of that review.

II. Methods

A. Sample.

We used a stratified random sample based on a pool of transitioned class members who met the following criteria at the time of interview:

1) Had moved into supported housing between the start of the settlement implementation in 2014 and no more recently than 01/01/2023;

2) Were still active members of the class (*i.e.,* had not died, transitioned to live permanently in a setting outside of the settlement);

3) Had not stepped up their housing level (*i.e.,* transitioned to Level II housing or returned to an adult home); and

4) Either were not in a specialized care facility (*e.g.,* hospital, skilled nursing facility [SNF]) or seemed to be able and desire to transition back into supported housing in the future. More specifically, initially sampled members found to be in such facilities (n=7) were assessed with input from their providers to gain a sense of their overall ability to be interviewed and potential to return to supported housing. This resulted in one out of the seven initially sampled members (RT) remaining in the sample.

As the final sample criteria indicates, in the process of contacting initially sampled members, we discovered 13 members had suffered or were suffering adverse events or other difficult circumstances impactful enough that 43% of our initial sample was considered unable to participate in interviews. They included:

- Four members who had died. (LD, PM, RR, MW)

- Six members in skilled nursing or rehabilitation facilities who had no clear discharge date and/or were unlikely to be discharged (or already discharged) due to mental and/or physical health conditions. (VB, BF, PF, CH, WM, JR)

- One member discharged to a Level II facility. (PR)

- Two members who were hard to reach due to member-specific circumstances (involved in a previous IR review and recently experiencing increased behavioral health concerns, involved in eviction proceedings and unable or unwilling to be in contact[1](NL, MM))

In instances in which a member could not be interviewed, we referred to a larger random sample we had drawn in anticipation of some sampled members not being able to interview. For each originally sampled member who could not interview, we located the member whose transition date was closest to the unavailable member and used them as a replacement. For example, if Member A could not interview and had a transition date of 01/01/15 we replaced them with Member B who moved on 01/20/15 and had the closest move date to Member A. In some cases, replacement members were served by some of the same providers, though in other cases they were served by different providers. Of note, in some cases a replacement member was also found to be unable to interview and we had to move onto a third or even fourth transitioned member to identify one in a stable enough situation to interview.

We consider the extensive unavailability of initially sampled members a finding in and of itself, and it should frame all other findings described here. This study explores the experiences of a sample of the class who transitioned to supported housing and, with the help of settlement service providers, outside providers, and/or natural supports, have found ways to manage challenges and maintain at least a baseline level of health and stability despite them. While it identifies the strengths and vulnerabilities in the support systems ***this study is not generalizable to represent the full transitioned class***, as it does not include the experiences of class members who likely have had the most significant challenges post-transition,[2] given that the challenges that

[1] More specifically, MM is in the process of being evicted from her apartment by the housing contractor and involved with court hearings. IR staff efforts to contact her directly went unanswered.

[2] We acknowledge that some transitioned members were excluded from our sample for reasons that could have been unrelated to how they were faring in settlement supported housing. A key such reason was members who moved out

impeded interviewing them also had obvious, often significant and long-lasting impacts on their lives (*e.g.*, long term or permanent residency in a SNF).

While we did not sample based on providers, our final sample included members served by most settlement service providers. More specifically, the sample represented members served by nine housing contractors (HCs), four Health Homes (HHs)[3] and several Care Management Agencies (CMAs), and two Programs for All-inclusive Care for the Elderly (PACE) programs.[4] Two ACT Teams were represented in this sample.[5] Both peer-run agencies and nine Managed Long Term Care Plans (MLTCs) were represented. Although we did not have access to records to allow a systematic view of Medicare enrollment, at least three members were enrolled in a Medicare Advantage plan at the time of interview. Two members received standard settlement HC case management but were ineligible for Medicaid-funded services due to their income (VC, SL) and VC also received other services typically provided through the settlement from the Veterans Administration.

Of note, eight members were not enrolled in any level of HH care management at the time of interview and one additional member (AP) was disenrolled from mainstream HH care management on 2/28/25 (approximately two weeks after our interview, though he did not seem aware of his impending disenrollment upon interview). Fourteen members were not enrolled in MLTC care management, though we learned that three of these members received similar services

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of settlement housing to live with family or in other, non-congregate settings; in such cases, members may have been struggling in supported housing and/or may have simply desired to live with their family, a companion, etc.

[3] We did not systematically check for Health and Recovery Plan (HARP) enrollment among this sample and only late in our research did we become aware that at least one member (HO) is enrolled in HARP. As the HARP HCBS and CORE programs offer enrollees an array of services that may enhance community-based living and community engagement, there may be value in exploring the potential "fit" among member needs and preferences, the limitations of other care management programs (such as time limitations on AH+ and HH+) to meet these needs and preferences, and HARP program offerings.

[4] One member (DL) was enrolled in PACE at time of his 6/18/18 move, then disenrolled on 3/1/23 to enroll in a MLTC and mainstream HH. In June 2024, he was assessed as meeting statewide criteria for HH+ and was transferred to this program, in which he was still enrolled as of 3/10/25. A second member (VB) was enrolled in ArchCare PACE at the time of her 6/1/17 move and remains enrolled as of 3/31/25.

[5] One member (GD) was in process to enroll with an ACT Team at time of interview and, per State report, was officially enrolled subsequent to the IR interview, on 2/25/25.

(*e.g.*, home health aides or HHAs[6]) through HealthFirst Medicare Advantage; if a systematic review of Medicare records was undertaken, there may be evidence more sampled members also receive such services. Of the overall sample of 30, four members were not enrolled in either HH or MLTC care management.

Members and, sometimes, providers and records offered the following reasons for lack of care management services:

- For HH care management: disenrolled or stepped down without person-centered education/explanation. In such instances, we could see HH/CMA agency records documented contacts with the members, and there may have also been documentation of assessments and information given to the member that disenrollment or service step downs would occur. The members themselves, however, did not have a clear sense of changes to their service level or how it would impact them. As we have found in past reviews, some members were also unclear on their care management services in general, staff members names and/or how to contact them, etc. (*e.g.*, AP, NL)

- For HH care management: disenrolled or stepped down despite their expressed desire to continue care management, or a higher level of care management. (*e.g.*, DV, AS)

- For MLTC care management: we did not observe clear instances of members enrolling and then being disenrolled from MLTCs; we did observe members who had not enrolled in MLTCs and did not seem aware they could pursue enrollment, nor how they might pursue it. (*e.g.*, RA)

- For both HH and MLTC care management: individual choice, *i.e.*, the member had been educated on options to transition to a lower level of HH care management (*e.g.*, from AH+ to mainstream) and chose to disenroll instead, and/or the member had been made aware of MLTCs and declined to enroll. (*e.g.*, HO)

- It remains unclear how members with PACE or Medicare Advantage and receiving home-based services might have enrolled and or disenrolled with these plans (*e.g.*, if they arrived at this decision after education/explanation, and if Medicare Advantage precluded or replaced PACE and/or MLTC plans) (*e.g.*, VB, ECH, NL, DL, CV).

- Two members were not eligible for HH or MLTC care management because their income was too high to be eligible for Medicaid-funded services (*e.g.*, VC, SL).

Full participant characteristics are summarized below.

[6] We did not systematically check for the specific categorization of all home attendants serving this sample; we refer to them collectively as home health aides for simplicity but it is possible some are considered personal care workers, etc.

Table 1. Participant Characteristics (N=30)

Participant Characteristics	N (%)	Median
Age at time of interview		67.5
Female	12 (40%)	
Male	18 (60%)	
Adult home length of stay (LOS) at time of transition		5.0
Supported housing LOS as of 1/1/2025		7.0
Adult homes (transitioned from)		
Belle Harbor Manor	2 (7%)	
Brooklyn Adult Care Center	1 (3%)	
Brooklyn Terrace	2 (7%)	
Central Assisted Living	2 (7%)	
Elliot Pearl House	1 (3%)	
Elm York	1 (3%)	
Kings Adult Care Center	2 (7%)	
Lakeside	2 (7%)	
Mariners	1 (3%)	
New Haven Manor	2 (7%)	
Oceanview Manor	1 (3%)	
Parkview	2 (7%)	
Queens Adult Care Center	1 (3%)	
Sanford Home	1 (3%)	
Surfside	1 (3%)	
The Veranda	2 (7%)	
The W Assisted Living	5 (17%)	
Wavecrest Manor	1 (3%)	
Enrolled in care management at time of interview[7]	22 (73%)	
AH+	0 (0%)	
HH+	1 (3%)	
Mainstream HH	17 (57%)	
PACE	1 (3%)	
MLTC	16 (53%)	
ACT Team	2 (7%)	
No care management	4 (13%)	
Engaged with other settlement service providers		
Housing contractor case management	30 (100%)	
MLTC	16 (53%)	
Medicare Advantage (known)	4 (13%)	
Peer bridgers (*ever* engaged in person)	14 (47%)	

[7] Some care management categories are exclusive: members enrolled in one level of HH care management are enrolled in no other level of HH care management; one member enrolled in PACE is enrolled in no other care management. Other care management categories are not mutually exclusive, specifically several members have both some level of HH care management and MLTC care management. It was beyond the scope of this review and the State's own tracking to systematically verify how many members of the sample are enrolled in Medicare, but at least three sampled members are enrolled in a HealthFirst Medicare Advantage plan that provides home-based services of the type MLTC plans would offer.

B. Records review.

For sampled members we requested service records from their: HC; HH and/or ACT Team or PACE for those currently enrolled; MLTC for those currently enrolled; Medicare Advantage plan for three members for whom we became aware were currently enrolled; and peer-run agency for those ever enrolled. More specifically we asked each agency for the following types of records for the past two years (*i.e.*, January 2023 through February 2025):[8]

- any assessments completed;
- any new care (treatment) plans;
- all progress notes (note we requested only progress notes from the peer-run agencies as we were aware they do not complete assessments or care plans).

We reviewed records both prior and subsequent to interviewing class members, noting common patterns within and among different provider documentation. We used some information from records to prepare for and prompt certain interview questions, and we also reviewed records post-member interviews to compare and contrast member perceptions with provider documentation. Depending on individual member situations, we also followed up with the member themselves, providers, and/or State staff to understand better why there might be contrasting or conflicting perceptions on certain aspects of a member's post-transition life.

C. Interviews.

Interviews and member checks were conducted in February and March 2025. Class members were visited in their apartments; in one instance, after a short visit to the apartment, the interview was conducted at a nearby coffee shop due to the extremely dirty and cluttered apartment condition. In several instances, we provided members with our contact information and either received and/or initiated a member check with them following our initial interview. For example, a few members with concerns about outstanding apartment repairs called to ask for help; other members called with questions or concerns related to care management tasks; and a few members sent text messages to say hello.

[8] Of note, some providers sent records covering a longer span of time than requested, *e.g.*, from the time of transition into the community through present. These notes provided helpful additional context for members' overall trajectories in the community and the procurement of comprehensive provider notes may be worth considering for ongoing monitoring of the class.

Although not systematic for all 30 members, following interviews we also engaged in follow up communications with settlement service providers and State staff. This included HCs, HH/CMAs, peer-run agencies, and MLTCs. This follow up communication allowed us to clarify information that may not have been clear or current from members themselves or their records, and also allowed us to communicate what we considered time-sensitive concerns to providers.

D. Categorizing problems.

During our interviews we asked members about how their lives in the community were going overall, including asking about what they liked about living in the community as well as what was hard or problematic for them. We categorized problems across three levels, using members' own perceptions, information from providers and records, and our own observations.

- We characterized members as having "significant problems" 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, if a member and/or provider had reported problems with an apartment and/or building and had a lengthy wait for repairs, hoarding or vermin remediation, etc. and these conditions resulted in ongoing health or safety concerns, this 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 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 and/or replacing IDs, but they had received loans from providers or had other 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 and/or a SNAP recertification deadline was missed but they received food from settlement providers and/or home-delivered meals in the meantime, this would be considered no to low problem.

III. Findings

Below we report on key thematic findings across interviews. 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. As many interviewed members have been living in supported housing for some time, with less intensive and frequent service provider involvement (*e.g.*, many

have been stepped down to less intensive forms of care management), we have tried to highlight instances in which more frequent communication and/or earlier identification/response to problems may have helped both members and providers manage them more easily.

Finally, we emphasize that with few exceptions, we have called attention to similar findings previously[9] and encourage the Parties and providers to consider how the post-settlement year and the Post-Settlement Wellness Monitoring Program offer a critical opportunity to create more proactive and systematic processes for monitoring problems before they reach the point of formal incidents or crises. We also underscore that many potential factors, salient among them the aging of the class, suggest that problems similar to those we report will likely persist and intensify in nature, making the need for proactive monitoring all the greater.

A. Housing and neighborhood experiences

1. Apartment and buildings

Table 2. Apartment and building experiences (N=30)

Degree of problem	N (%)
No/low problems	8 (27 %)
Some problems	12 (40 %)
Significant problems	10 (33 %)

Among 30 class members interviewed for this topic, 12 members reported that they had or were having some problems with their apartment and/or apartment building and 10 reported they had or were having significant problems with their apartment and/or apartment building. Of note, of all the life domains we asked members about, apartments and buildings elicited the most reports of problems, and more members (10) considered their apartments and buildings to cause significant problems than any other domain. Common problems reported and observed by IR staff included:

[9] 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.

- Broken and/or malfunctioning building features, such as building intercoms and elevators that go out periodically, sometimes for extended periods (AP, AM); broken front building doors or locks that allow strangers to enter buildings (VC, GW); broken apartment entry doors (NL, GW) that allow strangers to enter apartments; and broken mailboxes and/or protracted periods without mailbox keys (NL, GW). Some buildings also had broken and/or malfunctioning features needed for accessibility, ranging from fairly minor (NL's back stairstep handrail was broken) to significant (ECH's building's chair lift was broken, and the HC case manager reported the landlord did not have plans to repair it, rendering her homebound when her HHA was not present to help her navigate stairs).

- Broken and/or malfunctioning apartment features, such as stoves with some to all burners not working (VC, SB, BR, SG, DW); ovens not working; interior doors missing and/or damaged (GD); holes in or damaged ceilings and walls (SB, MB); exposed wires where a smoke detector presumably had been (VC); leaking and/or un-flushable toilets; leaking bathroom and/or kitchen faucets (AS, VC); slow and/or backed up drains; unreliable to no hot water (VC); and damaged and dirty furnishings.

- Vermin, mold, and unsanitary conditions in many apartments, including bedbugs and cockroaches despite periodic remediation (WB, GW); peeling paint and black mold on (primarily bathroom) ceilings and walls (AS); peeling laminate countertops (VC) and peeling or damaged stove enamel (DM); and, in several apartments, hoarding and/or filthy conditions, sometimes despite the member having a HHA (AM).

- Heating in members' apartments varied widely. Several apartments we entered were noticeably chilly, some so much so that we left our coats on inside (SB, DM, GW, NL). In some instances, an issue with the boiler or radiator had been identified and repairs were scheduled; in other instances, we learned that building management adhered to periodic heating practices, *e.g.*, turning on heating in the evenings only, even during brutally cold February temperatures. Other members complained that the heat was not sufficient, causing them to require space heater and extra blankets (MB, SF) and one member's heat had stopped working on the evening prior to the IR visit (VB). Follow up indicated that it was addressed quickly. At the other extreme, broken air conditioning, which was not repaired for months, led to excessively warm apartments (RT).

Comparing member reports and our own experiences in these apartments and buildings to provider records and communication, it is clear there are myriad factors contributing to these housing problems. Some are more member-centered; for example, some members have a history of damaging their own apartments (GD) and some seem to engage in behavior meeting the clinical criteria for hoarding (*see,* WB, AM below), making it challenging for either them or their service providers to keep the surroundings clean and in good repair. Members may invite guests into their apartments who damage and/or steal items (RT), other members may have a history of selling

apartment items like televisions (SB), and one member was the victim of an extensive burglary while he was hospitalized (GW).

At the same time, one of the most salient findings from this review was the contrast between what members and provider records reported versus provider actions. More specifically, we were surprised to learn how often providers were aware of apartment and building problems, yet allowed them to persist, sometimes for months. For example, many members reported that they had told their providers about malfunctioning appliances, problems with heating or air conditioning, mold in the bathroom, etc. Provider records suggest these problems were also evident when they entered affected apartments and buildings; many records, particularly HC records, made note of such problems. In some cases, provider records and follow up conversations indicated that providers had made at least some attempt to contact building supers and/or management companies to address problems but, perplexingly, if these entities were not responsive, providers did not necessarily follow up. That providers could be aware of and document such problems, yet stood by over prolonged periods of time, often as the problems worsened, suggest the greatest concern is not with any given problem in the apartment or building itself, but rather with unresponsive service provision that is not in line with the Settlement Agreement. Class members' experiences illustrate the compounding of housing problems by inadequate service provision:

- AP is 55 years old and moved into Pibly Bronx housing on October 2019. The intercom at the entryway of his building sporadically does not work, making it difficult for providers to enter; this problem is compounded by an elevator that is frequently out of service, sometimes for as long as a month and a half. As AP lives on the fifth floor, it is difficult for providers to reach his apartment for visits. On a few occasions, they have asked AP to meet them downstairs when the elevator was not working, meaning it was the class member, not the provider, who took on the burden of climbing up and down five flights of stairs. Records indicate his Pibly case managers have been creative in using WhatsApp to conduct virtual site visits, and because AP has good smartphone skills they have also conducted virtual apartment inspections this way. However, the unreliable elevator is an unnecessary obstacle and AP is experiencing unsatisfactory solutions to a recurring problem that has not been resolved. Within his apartment, AP was also without a functioning stove for two months as he waited for it to be repaired, and he experienced lengthy delays in fixing electrical problems which resulted in flickering or non-functioning lights.

- SB is 59 years old and moved in November 2020. He has lived in the same two-bedroom apartment since his move, mostly alone although with a housemate from January 2023 to March 2024. According to HC SJMC Brooklyn, his housemate spent much of his supported housing tenure hospitalized and eventually moved out because he posed a threat to SB. While

living at Brooklyn Terrace, SB had been stabbed by a roommate and suffered a long hospitalization; given his past trauma, moving a potentially violent class member in with him seems a particularly misguided match.

SB lives in a very small two-bedroom apartment with one-bedroom missing a door, which his former housemate reportedly removed. SJMC reported the door had been replaced and removed again at some point. While the furnishings and window blinds in the main room seemed in good repair, there was a garbage can in the kitchen area that was filled to the brim, with no garbage bag insert. Records indicate that SB had a longstanding problem with learning how to use his stove, which was eventually addressed, though he now prefers to keep the breaker turned off (as it was during the time of interview). In his bedroom, SB was proud to show off some of his clothing, but he had accumulated such an amount that there were clothes all over the floor, in two large suitcases, and bursting from the bureau and closet. SB's mattress was in horrible disrepair; patches not covered by a sheet showed totally shredded material and it was clear it needed to be replaced. Bathroom sink and tub faucets worked, but the bathtub was filthy. SB said he had no money to get cleaning supplies but as soon as he did, he would get them and clean the tub. There was also no toilet paper in the dispenser and SB said he did not have any in the house. There was also an opening in the bathroom ceiling. SB did not have a television, though SJMC reported they had provided him with multiple televisions and suspect he sells them.

SB's apartment was also extremely cold and none of the radiators were producing heat during our visit. SB said that they all worked, and that the heat is off during the day but comes on at night; records indicate SJMC had reported this problem to the landlord in November 2024. In further conversation, SJMC also reported the issue of periodic heating has been ongoing with many of their landlords, who explain it in terms of a decreased need for heat while tenants are out working during the day. Given that the majority of the class does not work, it is concerning that any HC and/or the State would not advocate further in the face of such an explanation.

The conditions SB is experiencing are unacceptable, particularly when observed in light of his enrollment with SJMC case management, CBC mainstream HH care management, and MLTC ArchCare; he is enrolled in all three major types of settlement service providers, all three of which presumably observe his apartment conditions and yet allow them to persist. Of particular note, SB also receives over 30 hours/week of HHA services through a subcontracted Licensed Home Care Services Agency (LHCSA). It seems SB has a complicated relationship with his HHA; he does not ask her to do household chores and she seems to choose and/or is unable to do them, as it appears she spends very limited time in the apartment. SB said his HHA delivers food to him and leaves; he is okay with this as "she has other people to see and enough to do" and grows upset when his other providers ask him about the HHA. SB's SJMC case manager confirmed that on the day of interview she observed the HHA drop off food, yet at the time our interview, SB had no food in his refrigerator or freezer, just an array of spices, Adobo and oil in the cupboards.

Following the IR visit and communication, SJMC committed to buying SB a new mattress and spoke to his Catholic Charities care manager about stepping up services from mainstream to

HH+ care management. In March 2025, his current care manager reported that she was working on updated psychiatric and psychosocial assessments to proceed with the step up and effective May 1, 2025 SB has been receiving HH+ services. Finally, it is notable that despite SB's current circumstances, he reported that he does not want to move from his apartment, which SJMC has offered many times.

- VC is 61 years old and moved to HC Risewell supported housing in February 2016. She retired from the Air Force with a pension, SSDI, and savings in excess of $200,000. Due to her income, she is ineligible for Medicaid-funded services, so she has no HH/CMA; Risewell case management is thus her primary source of settlement services and supports. VC has had a terrible journey in supported housing. In addition to the most recent two-year period, we received progress notes from 2016. These notes describe her initial move to a shared apartment in which she experienced numerous problems that eventually prompted a move to her current apartment. Problems included: a hole in the ceiling above the shower which was leaking, mold, and a foul odor in the water coming out of the sink in the kitchen. These conditions went uncorrected for over two months, while she was being informed that her rent would be increasing due to her income level. She also complained of a lack of privacy as her roommate would go through her things and steal her money. At the time, her VA benefits were being managed by Federation Financial Management services (now Risewell). She was eventually moved on 9/2/16, and liked her new apartment although the gas was not turned on for three weeks after the move. In the meantime, she was offered the opportunity to go to a model apartment to have hot water to shower, but was provided no transportation to get there.

  VC's current apartment (visited for this review) also has significant problems. Her Risewell case manager was making regular visits, and as measured solely by the frequency of contact, she was diligent in attempting to meet with the class member multiple times a month. Yet, the class member was living in squalid conditions, with no hot water, a leaking toilet, no key to the front door, a broken stove, no food in the refrigerator, the lamination on the kitchen counter was peeling off, and there was an exposed wire in the ceiling where a smoke detector should have been.

  Subsequent to the report of our visit, the State informed us that the locks on VC's door were changed and she was given a key; hot water and a working stove were in place; the leaks were repaired; a phone was purchased; and the lamination on the counter was fixed. VC was offered enrollment in non-Medicaid care management but declined.

- ECH is 72 years old and moved into her first Risewell apartment in June 2017. She described her housemate in this apartment as constantly smoking and using drugs, leading her to move to her current apartment, in a two family rowhouse, in Far Rockaway. ECH likes aspects of this apartment, but there are about seven steps from inside the front door up to her unit and, since she moved in, her mobility has decreased and she currently relies on a rollator to ambulate. She no longer feels safe leaving her apartment and navigating the stairs without assistance. There is a chair lift but it has been inoperable since she moved into the apartment, and, according to her Risewell case manager, the landlord does not plan to fix the lift.

This lack of an accessible means in and out of her apartment affects ECH greatly. She has an HHA present for six hours on weekdays and five hours on Saturdays and when her HHA is present, she can support her in navigating the stairs to/from her apartment. However, when her HHA is not present, ECH does not leave her apartment because she cannot safely navigate the stairs on her own. ECH likes to go out and makes efforts to be engaged with the world beyond her apartment; she mentioned she enjoys visiting a friend who lives in Brooklyn, going out in her neighborhood with her HHA, and occasionally using Access-a-Ride to go to Macy's and Walmart.

Her case manager reported during the interview that she had shown her a video of a newly renovated Risewell apartment with a flat entry and was arranging a tour for the first week of April 2025. Upon follow up, however, the Risewell Program Director stated the apartment was still being renovated and would not be available to tour until the end of April. The Program Director acknowledged ECH's current need for a flat entry apartment, but also stated that she visits her friend on the weekends, suggesting she is able to navigate the stairs outside her apartment unassisted during these times. Still, there is a concern for her safety to evacuate in an emergency.

- WB is 60 years old and has been living in his Pibly Bronx apartment since he transitioned in February 2018. He likes his apartment and his neighborhood and is often out, including visiting nearby restaurants. Despite positive aspects to his housing and community integration, WB has a serious hoarding problem. His apartment was severely cluttered, with a variety of items covering most surfaces. There was a path from the front door through the kitchen to the living room, bedroom and bathroom, but no place to left to sit. As he declined to have visitors in his bedroom, it is unclear where or how he sleeps. The apartment was also in need of cleaning and Pibly records indicated there had been a cockroach infestation. His smoke detector was beeping and needed a new battery, which he said had been going on for a while but had not been reported to his Pibly case manager. The refrigerator was well stocked but reeked of rotten food; WB did not seem to think this was a problem. Due to hoarded items, there was no room on kitchen counters to prepare or cook food. WB said uses his microwave for frozen meals and also likes to go out to eat at a deli and have pizza.

  Pibly records indicate his case manager attempts to visits him twice a month but he often does not answer his phone or door despite multiple case manager attempts. According to more recent progress notes, he is sometimes unavailable for about a month at a time. When his case manager does visit, notes indicate that they try to work with him on hoarding, trying to get him to clean out some of the items he brings in from the street. There are notes indicating that he is offered professional cleaning assistance at various intervals. He is sometimes cooperative and helps clean out items; other times he is not home when the cleaning is scheduled. WB's case manager indicated that he collects more items quickly after each cleaning, consistent with symptoms of hoarding. Progress notes indicate that his JBFCS care manager communicates with his day program workers and his therapist, but only one note on 5/18/23 specifically mentioning hoarding, and WB's therapist indicated that they didn't know about it.
  At the time of interview, WB was enrolled CBC mainstream HH care management in addition to Pibly case management. According to a 2/5/25 care management note, his care manager inquired about his eligibility for HHA services and was told by the State that he was already

approved. It is unclear when or why his HHA services were stopped as he had HHA services when he transitioned in 2018. HH records indicate that following the IR interview on 2/20/25, MLTC assessments were scheduled and he was approved for 16 hours/week of HHA services.

- AM is 65 years and has been living in Pibly supported housing since November 2016. She was moved from her first apartment due to safety concerns (*e.g.*, with shootings) in the neighborhood and building. She is happy with her current one-bedroom apartment and neighborhood. However, AM's apartment is cluttered to a level indicating hoarding. She says the items she collects are for her son and family in Jamaica, though her HHA and Pibly case manager confirmed that she has been hoarding for a long time. Her bed, which she says she sleeps in, was completely covered with things when we visited; AM says she moves them over to sleep. Despite severe clutter, there was room to sit at the kitchen table and the apartment appeared very clean. Pibly records indicate that staff try to encourage her to declutter her apartment, but she insists that she is shipping many of the things to her son in Jamaica, while at the same time stating she does not have the money to ship them. Pibly records also indicate that her HHA, who is also her friend, was witnessed helping her declutter. AM was disenrolled from AH+ care management on 8/31/2018 and per State records is currently not enrolled in any HH care management. She is enrolled in HealthFirst MLTC services but it is unclear if and how they may have attempted to address the state of her apartment beyond HHA support.

- MB is 65 years old and has lived in a one-bedroom Pibly Bronx apartment since January 2019. At the time of interview, there were some areas MB's apartment that were not clean, particularly the kitchen and bathroom floors and walls throughout the apartment. There was also little food in his refrigerator and cupboards. MB did not seem concerned with the state of his apartment, noting his daughter, who is his HHA through the Consumer Directed Personal Assistance Program (CDPAP), helps him with cleaning, grocery shopping, and cooking. Given the state of the apartment, it was surprising to learn that his daughter/HHA has a work schedule of eight hours per day, Monday through Friday. Although the IR visit occurred during this work schedule, MB's daughter was not present. In reviewing records, it appears that Pibly noted once in the past two years that MB's daughter was helping him, while a 10/2/24 Pibly note indicted that certain parts of the apartment needed cleaning. At this time, MB's wife was very ill and Pibly offered him cleaning services but he declined, stating that his daughter was scheduled to come the next day to clean and shop. MB is enrolled in CBC mainstream HH care management but records document an apartment visit on 9/24/24 that does not speak to the state of the apartment, with no documented visits since then. When IR staff mentioned to Pibly staff that the apartment was not clean in certain areas despite the hours of HHA services MB has, they noted that MB had not expressed any problems, and it is difficult for an HC to attempt to address potential problems when a family member is the HHA.

  During an interview, MB also complained that his apartment was cold, although at that time it felt warm to IR staff, raising the possibility that MB might have a condition that made him more sensitive to cold. As it is, however, MB sleeps on a bed in the living room instead of in the bedroom because the bedroom window leaks air. Pibly seems to have addressed the leak but not repainted the window. MB and Pibly staff also raised that ultimately the building management needs to hire a contractor to fix the problem, which would involve the brick façade on the outside of the building. At the time of interview, the apartment walls were also

dirty and in need of repainting; Pibly staff said that they had reached out to the building super and a Pibly contractor is planning to look into painting as well. MB reported in general he waits a long time for building maintenance to make repairs.

Despite the many apartment and building problems members, provider records, and IR observations indicated, it was uplifting to see other examples of members' positive experiences, such as:

- JA was 67 years old at the time of interview and moved into Comunilife housing in July 2019. He has lived in the same one-bedroom apartment on the ground floor of a two-family home in Far Rockaway since transition. He said he loved the apartment, which was extremely clean and neat. When asked about any problems he has had, he reported there had been a leak in the bathroom ceiling with only a patch covering it for a long time before it was fixed in Summer 2024. His Comunilife case manager noted that there was a slow drain in the shower that was addressed in November 2024, though JA did not recall this. He also had problems with roaches coming from behind the stove, though an exterminator had addressed them; overall the problems he had encountered had been fairly minor and addressed. JA has an HHA who visits three days per week who cleans, does laundry, and goes with him to shop, while also making him prepared meals that she brings from home. JA says he does not cook because he doesn't know how to turn on the stove on and said "it's too dangerous for me." At the time of the visit, there was food and prepared meals in the refrigerator.

- SJ was 65 years old at the time of interview and had been living in SJMC supported housing since April 2016. After living for over eight years in a shared apartment, she finally moved into her own apartment, as she desired, in October 2024. Her new apartment is in a recently constructed elevator building near the Verrazano Bridge; she lives on the third floor and there are beautiful views of the water from some parts of the building. SJ really likes her new apartment, which she says is quiet and without the loud music she had to hear in her last apartment. She loves having her own space and feels very comfortable having her family over in it. All areas of the apartment including the living room, kitchen, dining area and bathroom were very clean and neatly appointed. She had sufficient cleaning supplies as well as clothing in her bedroom bureaus and closet. SJ also had a bulletin board that contained her current rent amount and a calendar of activities from SJMC for the month. She also had a bill chart that listed the account number and phone numbers to pay her utility and cable bills. SJ's sister is her HHA through the CDPAP program and helps her three hours per day, two days per week. Her sister provides significant support, helping with cleaning, grocery and clothes shopping, laundry, and reminding and accompanying her to appointments. SJ's sister also provides her with companionship. Although SJMC had encouraged SJ to enroll in care management services, SJ felt that what they would do would conflict with what her sister was already doing for her and has declined for now.

- HO was 68 years old at the time of interview and had been living in ICL supported housing since November 2015. Following a harrowing housemate experience in a previous East New York apartment (see p.19), he moved to a one-bedroom apartment in Ridgewood in April 2023. HO's apartment is very clean and decorated with lush houseplants and personal touches like

Puerto Rican flags. Impressively, HO maintains his home completely on his own; although he understands he could be assessed for MLTC and HHA services, for the time being he is content to clean and cook for himself. He describes himself as an "early person" and likes to get up, bathe, make himself coffee and feed and sit with his plants, calling his massive Money Plant "my lady." He has a television in his bedroom with cable service and like to watch programs in the evening; he also likes to listen to music and cook. HO manages his own money and reports no problems paying his bills, though sometimes he has to make decisions like not traveling to a nephew's house to watch the Superbowl because car fare to destinations far from bus routes is too expensive.

HO's building is in a bustling, gentrifying neighborhood with many shops and restaurants. While his East New York apartment and neighborhood were "very hard" and felt unsafe, he feels secure and happy in his current apartment and neighborhood. He enjoys walking around and going shopping; he exchanges greetings with some of the people he sees regularly on the street, and many of the store cashiers know him. He occasionally attends Mass at a nearby Catholic Church, going more often when the weather is warm. He has a daughter and three sisters who live in East New York and nieces and nephews across the city. HO sees his family regularly and one sister has visited him in his current apartment, though he usually goes to see them. Although his building is some distance from the subway, there are bus stops close by and HO navigates bus routes well. His Half-fare card recently expired and he says he knows he needs to renew it; because he was disenrolled from CBC mainstream HH care management on 7/31/2024, he handles such tasks on his own and sometimes asks his ICL case manager – whom he describes as "wonderful" -- for help. He also receives prepaid Metrocards to see his therapist biweekly, and he is able to walk to his PCP's office just three blocks away.

2. Neighborhood experiences

Table 3. Neighborhood experiences (N=30)

Degree of problem	N (%)
No/low problems	20 (67 %)
Some problems	8 (27 %)
Significant problems	2 (6 %)

Among 30 class members interviewed for this topic, eight members reported that they had or were having some problems related to their neighborhood environment and two reported they had or were having significant problems with their neighborhood. The most common problem reported was safety and security concerns. Members reported witnessing shootings and other violent crimes, car vandalism, and worrying about and experiencing burglaries (EM, CV, GW).

Another neighborhood concern members reported was transportation, including access to transportation within the neighborhood as well as transportation time and logistics to travel to other parts of the city. For example, RA lives in a Queens Village apartment complex that three HCs

(Comunilife, ICL, TSINY) rent from. The apartments are spacious and the immediate neighborhood includes a variety of shops and restaurants. There is an LIRR stop and local bus stops nearby. However, the apartment is so far removed in Eastern Queens that traveling to other areas of the five boroughs is very involved in terms of logistics, time, and, depending on the means of transportation (*e.g.*, if the LIRR or car services are used), cost. The neighborhood may be a very good fit for members who are content to spend most of their time in the immediate area, but for those with connections to other parts of the city, it can be a particularly challenging location. The isolation of this neighborhood as well as his desire to try living on his own, around other Italian Americans, has led to RA to ask to move; HC ICL is planning to offer him a tour of a Bensonhurst apartment, which is a neighborhood he formerly lived in.

3. Housemate experiences

Table 4. Housemate experiences (N=9)

Degree of problem	N (%)
No/low problems	5 (56 %)
Some problems	2 (22 %)
Significant problems	2 (22 %)

This sample of 30 members included nine members who reported having or having had housemates. Among these nine members, two members reported that they had or were having some problems with their housemate(s) and two reported they had or were having significant problems with their housemate(s). Problems ranged from fairly minor concerns, such as a lack of privacy, figuring out how to "handle" housemate's habits, split up household chores, and communicate with each other (RA, VC, DV, CH), to the risk of and actual theft and violence between housemates (SB, VC, HO). HO's experience was unfortunately extreme.

- HO was 68 years old at the time of interview and moved to ICL supported housing in November 2015. As with several members who moved early in settlement implementation, HO moved a few times after his initial move, and had a few different housemates. He recalls one housemate he had as nice, and someone with whom he could exchange daily greetings. However, he then had a housemate who "was really sick in the head." As HO recalls, he would say good morning and ask him how he was and the housemate remained silent; at other times, HO noticed him laughing on his own, in an otherwise silent setting. HO and the housemate did not agree on apartment upkeep ("he never cleaned up!") and the housemate would spend hours into the bathroom, but the two men were able to coexist for some time. HO knew his housemate could become enraged and even violent; he would scream and throw things, and in

the year prior to the men's final encounter, the housemate had grown angry at his care manager and attempted to attack her.

One evening, HO and his housemate argued over cleaning up in the kitchen. HO went to his room to lie down and was taken unawares when his housemate entered and stabbed him several times before HO gathered the strength to push past him and run out of the apartment. The details HO recalls of his wounds are horrifying; it is sufficient to say he sustained severe and life-threatening injuries to his abdominal organs, neck and arteries, and one of his arms and hand. He was hospitalized and then in a rehabilitation facility for many months. For his part, HO's housemate called 911 after the attack and told responders he thought he had done something bad. He is now in a long term, in-patient psychiatric setting.

Following the attack and HO's recovery, ICL moved him to a one-bedroom apartment in a new, nicer neighborhood (see p.18). Although HO has permanent damage and mobility limitations in his hand and arm as well as significant scars on his neck, hand, and abdomen, he reports he and his physicians consider him recovered and in good health. HO does not express blame towards his service providers – on the contrary, he speaks highly of ICL staff and their support for him over many years – but his experience is a stark reminder of the need for service providers to proactively and frequently monitor housemate matches, and to be prepared to offer safety planning and alternative housing when members (such as HO's housemate) display aggression and violence. We suggest more comprehensive measures to avoid situations like this in the Recommendations section.

Given concerns with social isolation and loneliness for the class as a whole, which has observed in the course of previous IR reports *(e.g.*, 2024 Interviews Project), it was meaningful to observe some positive housemate relationships and mutual support in the course of this review. For example:

- DM, 68 years old at the time of interview, did not describe a particularly close relationship with his housemate, though the two men seemed to have an easygoing rapport during our visit and DM said they sometimes ate meals together, especially when their shared HHA prepared them. He also explained that because his housemate could be forgetful with medications, they established a routine so he could help. During our visit, DM walked through his daily process of painstakingly removing each of his housemate's oral medications from a blister pack and placing them in a Tupperware container on the dining room table, where his housemate found it easier to remember to take them. He double-checked that he had placed all eight medications in the container, and explained that he would look back through the container at the end of the day to ensure all eight had been taken.

- CH, 51 years old at the time of interview, was initially on his own when he moved into a JBFCS (subsequently Pibly Brooklyn when JBFCS exited the settlement) apartment in September 2018. He described these first nine months as the worst because he felt very lonely. Fortunately, another KACC class member transitioned to the community around the same time he did, and after nine months, this member moved in with CH. CH spoke positively of the

time he and his housemate spend together; both attend a social day program three days/week and when home, they often hang out together. The men have three cable boxes in the apartment and sometimes watch TV together; they also used to enjoy the company of a calico cat (Cuddles) that CH's housemate brought home from a local shelter. Unfortunately, the housemate's care manager raised concerns about the cleanliness of maintaining Cuddles' litter box and CH reported being very depressed when she was taken away. Overall, CH considered that he and his housemate to get along well, if "sometimes too well" as they could get on each other's nerves and CH sometimes felt his housemate didn't hold up his share of household cleaning. However, CH also appreciated that when they bothered each other, they could talk it out and, although he contemplated living alone a few months ago, he has ultimately decided he would like to remain with his housemate.

As this review progressed, relationships between members' problems with housing and having to move multiple times became salient. We did a systematic count of the number of moves experienced by interviewed class members and found the following:

Table 5. Number of moves in addition to members' initial transition to supported housing (N=30)

Number of moves	N (%)
0 (have remained in initial apartment)	16 (53 %)
1	6 (20 %)
2	6 (20 %)
3	1 (3%)
5	1 (3%)

Just over half (n=16) members have remained housed in their initial apartment. Some of these members did report problems with their apartments, buildings, neighborhoods and/or housemates, but through their own efforts and those of service providers and other supports, they have been able to remain stably housed. Over 46 percent of members (n=14) have experienced at least one additional move after transitioning into supported housing and two members have experienced a higher number of moves (three and five moves for DL and GD, respectively). We asked members and their HCs about the reasons they were moved. Common reasons included:

- Landlord and/or management company issues, including selling off buildings and decisions not to renew leases that might or might not be attributed to the "fit" between member and landlord (RA, SL, WR, GD, SL);

- Building and neighborhood safety concerns, including drug use and other illicit activity (AM, EM, HO, AP);

- Apartment and building concerns related to the physical plant, such as the building and/or apartment falling into disrepair, a lack of needed repairs persisting, etc. (SL, VC, BG);

- Concerns with housemates and a desire to live alone after having a housemate (ECH, DL, HO, WR, VC, SJ) as well as concerns with other tenants in the building, including noise, violence, and/or substance use (EM, AP, DL).

- Member-specific concerns, such as:

    - GD was 65 years old at the interview and has lived in a total of six apartments, having moved five times subsequent to his initial transition into SIBN supported housing in May 2017. He lived in his first apartment for just three months; during this time his housemate moved out because they did not get along and GD did sufficient damage to the apartment (*e.g.*, ripping down curtains, causing holes in the walls) that the landlord declined to renew the lease. GD's first move subsequent to his transition was a single day in August 2017, but SIBN moved him again immediately because he did not like the Staten Island neighborhood. GD's second move was to an apartment where he remained until February 2021 (approximately three and half years). Though he seemed to like this apartment, GD reportedly yelled at neighbors and other tenants and broke things in the apartment, so this landlord also declined to renew the lease. GD's third move was to an apartment he lived in until July 2023 (approximately two and a half years). Again, GD's reported behavior, including stalking a female in the neighborhood, destroying parts of the apartment, and a bedbug problem, led this landlord to not renew the lease. GD's fourth move was to the apartment we visited for this review. Here as well, GD had reportedly damaged the apartment, which we could observe: the entrance door to the apartment had been broken, as had the hallway window, five times; he had removed the bedroom closet doors and placed them over the window, as he had in other apartments; etc. The landlord for this apartment had also declined to renew the lease and following our interview, GD moved for a fifth time on 2/18/25.

    - DL was 72 years old at the time of interview and had moved three times since moving to SIBN housing in June 2018. As someone who identifies as in recovery from substance use, DL's sobriety is important to him, and his moves have been influenced by the need for environments in which he can maintain his sobriety. He left his first apartment in October 2019 due to problems between his housemate and him, including hindering each other's sobriety. He moved again in August of 2022 when the landlord did not want to renew the lease, though DL also noted that the neighborhood his second apartment was in was not conducive to his recovery. His third move, to his current studio apartment, occurred in November 2024 after he had been dealing with too many problems with the physical plant of the apartment, including plumbing problems.

In sum, additional moves sometimes occur for minor reasons (*e.g.*, deciding to live alone after trying out living with a housemate) and they often have positive impacts, as the impetus for such moves is at least partially addressed by the new apartment, building, and/or neighborhood (*e.g.*, members reported feeling safer in new apartments and buildings). Further, the majority of interviewed members reported that they were satisfied enough in their current apartment that they

are willing to remain there, even though they may experience problems as described above. However, a number of member moves may also be a helpful signal that:

1) additional moves themselves are problems for members; they are major, stressful life events even when they lead to improved living situations, and thus

2) initial and ongoing apartment and housemate matching should be undertaken as carefully as possible, so as to avoid common concerns leading to additional moves; and

3) as many members themselves requested, more additional and quicker help from settlement service providers to address housing problems that do arise.

This review sampled members with longer trajectories in supported housing than prior IR interviews, and as we have illustrated in the past, early settlement housing stock and matching efforts were problematic for multiple reasons. Because some of this sample moved during the early settlement years, it is apparent that at least some of their subsequent moves were related to the more pervasive problems with stock and matching at that time (*e.g.*, VC, HO). The State and HCs have put significant effort into improved housing stock over the course of this settlement, and the State's more recent initiatives such as FCP and PCTP seem to have emphasized a more person-centered approach to matching members to apartments that truly meet their needs and preferences. We are thus hopeful that the need for subsequent moves and problems spurring them may be less likely to occur among more recently transitioned members.

Finally, continuing broader considerations for member housing, over the course of this review it became apparent that the location, quality, and upkeep of apartments we visited covered a vast range, sometimes even within the same HC. It also became apparent that housing is one of the most impactful domains in the lives of transitioned class members, and with reason; we are all literally surrounded, every day, by our housing. Housing is also the domain for which the greatest number of members (n=22) reported problems, and the greatest number of members (n=10) reported significant problems.

To further our understanding of members' housing experiences, we collected rental payment information for all sampled members' current apartments.

B. Rental Information

Of the 30 class members in our sample, 18 resided in one-bedroom apartments, 11 in two-bedroom apartments and one in a studio. The rental rates paid by HCs ranged widely:

- One-bedroom apartments: $1,285.86 to $2,257.50/month, with a median of $1,800.
- Two-bedroom apartments: $1,800 to $3,995/month, with a median of $ 2,250.
- The only studio apartment cost $1,800/month.

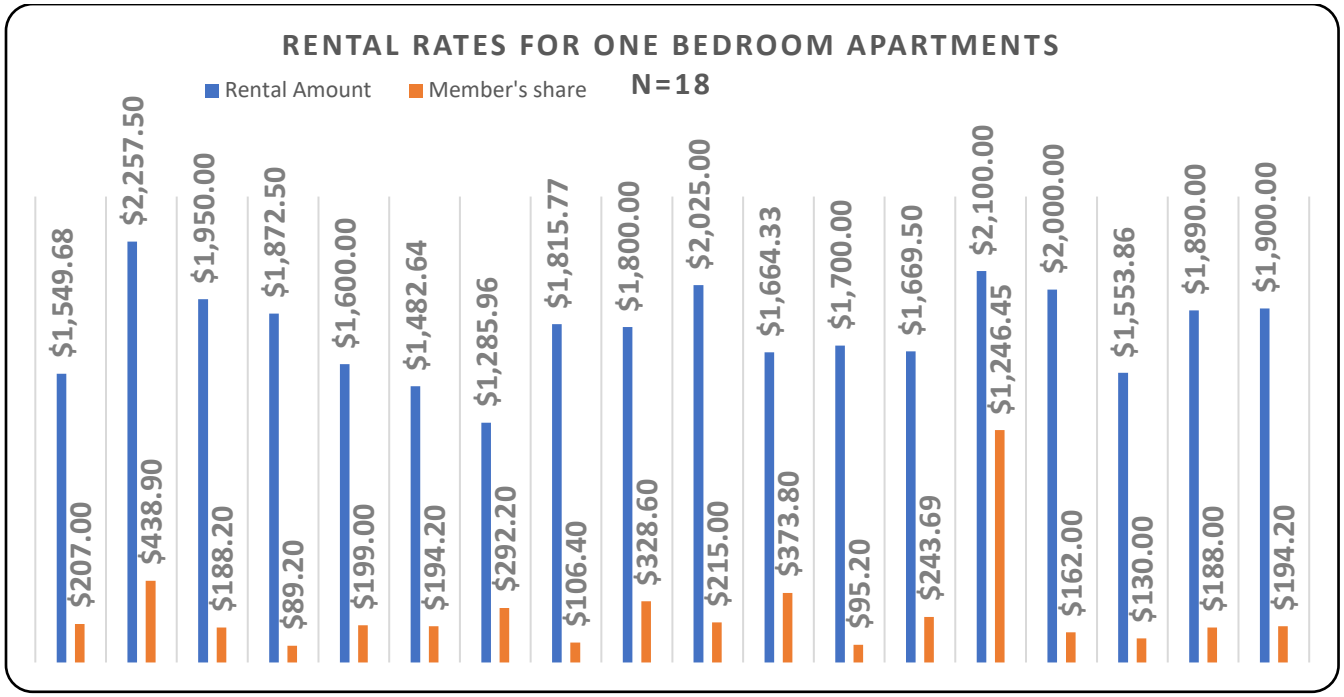


Chart 1. Rental Rates for One-Bedroom Apartments

Class members in supported housing pay 30% of their income toward apartment rent. Since the income of class members varies widely, their rental contribution also varied from a low of $89.20/month to $1,246.45/month, with a median of $232.70.

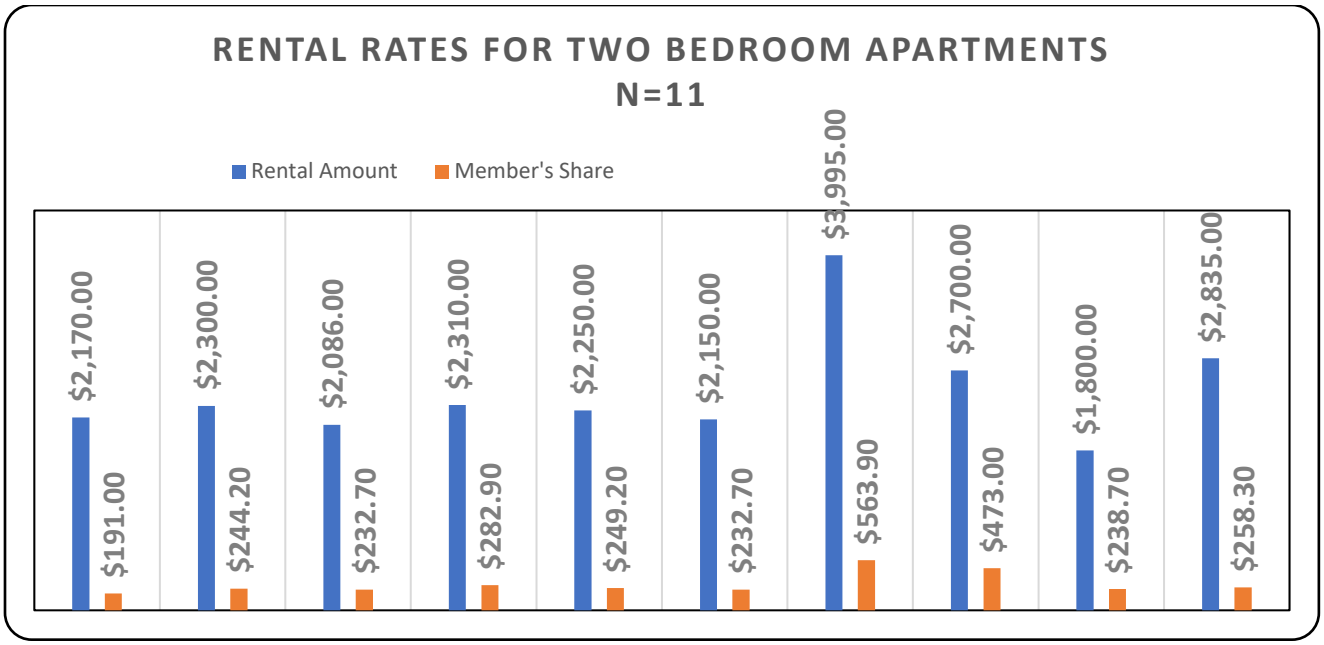
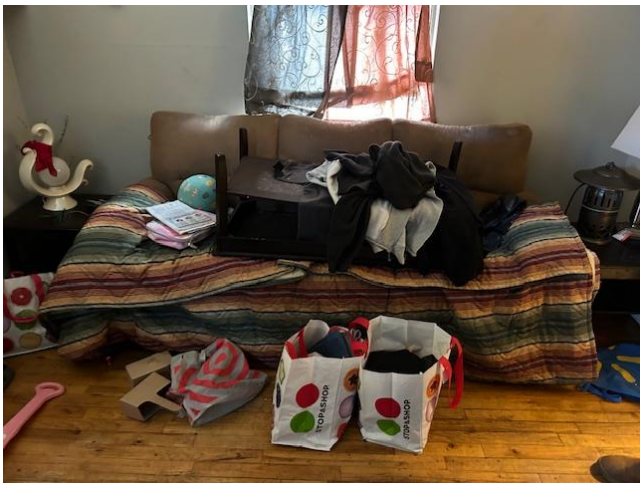


Chart 2. Renal Rates for Two-Bedroom Apartments

Neither the amount of the rent paid, nor the class member's contribution necessarily correlated to living environment enjoyed by the class member.

- VC (#40084), a 61 year-old service veteran whose rental for a one-bedroom apartment was near the upper end of the scale at $2,100/month, and whose rental contribution topped the sample at $1,246.45/month, endured some of the worst living conditions of any of the people in the sample. This class member was living in squalid conditions, with no hot water, a leaking toilet, no key to the front door, a broken stove, no food in the refrigerator, the lamination on the kitchen counter was peeling off, and there was an exposed wire in the ceiling where a smoke detector should have been. The problems with this apartment were well-known to the Housing

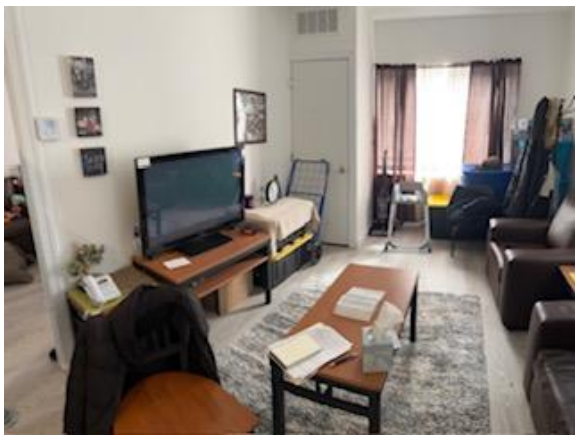


Contractor. However, a combination of inertia, indifference, internal bureaucratic processes at the agency, and the difficulty of making appointments with the class member combined to perpetuate the uninhabitable living conditions although she had substantial financial resources.

This case was an extreme among the class members in the sample. While, as discussed elsewhere in this report, a significant number of class members in the sample experienced problems with repairs and maintenance in their buildings and apartments, most were corrected within a reasonable time. On the other hand, some HCs managed to secure attractive, spacious and comfortable apartments for class members.

- EM (#36746), a 70 year-old class member has lived in a spacious one-bedroom apartment rented for the past eight years by Pibly Bronx. The current rent is $1,549.68 of which he pays $207. He is well-supported by his service providers and has had the same Spanish-speaking HHA for five years. His kitchen is well stocked with groceries and food. He has a friend in the building and interacts with his neighbors. His apartment is personalized to his taste and feels like a comfortable home.

- SJ, 58 years old, lives in a one-bedroom apartment on the third floor of a recently constructed elevator building in Staten Island near the Verrazano Bridge with beautiful views of the water from some parts of the building. The rent on the apartment is $2,000 a month and her share is $162/month. All areas of the apartment were well maintained and furnished with no maintenance problems reported.



- The most expensive apartment in the sample was a Rego Park two-bedroom rented by Comunilife for $3,995/month and for which class member DV's contribution was $563.90. This apartment is in a recently constructed, amenity-filled building that includes a 24 hour front desk, concierge services, various resident gathering spaces, and a fitness center. The building is adjacent to a shopping mall filled with big box retailers; many smaller shops and restaurants as well as major subway stops are a few blocks away. The apartment itself has expansive windows with sweeping views of the city, high end finishes in the kitchen and bathrooms, an in-unit washer and dryer, etc. Of note, this is one of the few apartments and buildings in this review – and indeed any IR review – that could be considered fully accessible for wheelchair users. As DV's fiancée/housemate uses a wheelchair, there is a rationale behind procurement of apartments at this rate for certain class members; indeed, in March 2025 ICL moved another member into this building after he had been waiting over three years past the QACC Full Court Press to tour and accept a fully accessible unit. We recognize, however, that the pricing of such units may render them an unscalable option for the class as a whole.

In the course of this and our previous visits to a sample of class members, we have observed that Housing Contractor TSINY has been particularly successful in locating attractive apartments in well-maintained buildings in desirable neighborhoods that offer safety and convenient access to nearby stores, restaurants and shopping, and at reasonable rental rates. For example:

- CV, a 77 year-old class member, was visited in a bright, spacious apartment with parquet floors in a clean and well-maintained building in a quiet Flushing neighborhood with nearby shopping and public transportation. Her daughter and granddaughter live six minutes away. The rent for this apartment was $1,669.50, of which she paid $243.69.

Model apartment in a Kew Gardens Hills complex where TSINY rents units for three class members.

Like DV's building, this complex offers amenities for residents such as ample outdoor space and a dog park, interior gathering spaces, package storage, etc. While member apartments are not furnished as shown here, they have large windows and attractive views, and include attractive flooring and finishes. Currently TSINY houses three class members in this building; their rents range from $2050 to $2450 for one studio and three one-bedroom apartments. The photograph below shows the expansive green space outside the complex.

C. Person-centered care planning: Post-transition support for IDs, financial security, food security

Table 6. Person-centered care planning: IDs and related documents (N=29)

Degree of problem	N (%)
No/low problems	15 (52 %)
Some problems	9 (31%)
Significant problems	5 (17%)

Among 29 class members interviewed for this topic, nine members reported that they had or were having some problems obtaining IDs and documents, and five reported they had or were having significant problems obtaining IDs and documents. Overall, it was encouraging to observe that many members not only reported that they were *not* experiencing problems with IDs but often demonstrated exactly where their important IDs and insurance cards were, such as in a wallet, cardholder, or specific place in their bedroom. At the same time, it was concerning to learn that IDs -- one of the most discussed aspects of transition preparation and post-transition supports over the life of this settlement -- still remains and/or has reemerged as a problem for almost half of members in this sample. More concerning still is that missing IDs and documents apparently

continue to be viewed by a variety of service providers as a non-urgent matter, as if it is acceptable for members to languish months and even years without IDs. For example:

- SB was 59 years old at the time of interview, served by HC SJMC Brooklyn, CBC mainstream HH, and MLCT ArchCare. He stated that he did not have any photo IDs when he transitioned into the community as his passport and expired Green Card, among other documents, had been stolen from his room in Brooklyn Terrace while he was hospitalized following a stabbing there. He was unsure of the date they were stolen, but as he moved in early 2020, it was prior to this date. During our interview, SB was only able to show an EBT card without photo. From pretransition call notes (11/16/2020), it seems that at the time of transition SB had a half-fare Metro card with photo and his Pathway Home Postgraduate AH+ care manager stated he was working hard to get him a non-drivers ID. However, post-transition call notes (12/30/2020) indicate only that SB had attempted to get his own ID and had been turned away from the DMV due to pandemic restrictions. At that time, his care manager reported he had a Medicaid card and Social Security card, and he (the care manager) continued to work on obtaining a non-drivers ID for SB. It is unclear if this ID was ever obtained; it is also unclear what may have happened to SB's Medicaid and Social Security cards, particularly because SB himself believed all his IDs were stolen prior to transition. Following interview, IR staff contacted SB's current care manager at CMA Catholic Charities; she reported SB's mother has his IDs but she herself has dementia and resides in a nursing facility. SB's aunt has attempted to obtain them but has not. SB also lacks a birth certificate. As he was born in Trinidad, it may be an understandably more complicated process to obtain this document, but given SB has been receiving care management services for over four years since transition, including one of the most intensive forms of care management available to the class (Pathway Home), it is concerning that this and so many forms of other, necessary IDs are either missing and/or have not been obtained.

- WR was 81 years old at the time of interview, served by HC Risewell, CBC mainstream HH, and MLTC Molina Senior Whole Health. WR is originally from Puerto Rico and, at the time of interview, reported that has no IDs as he had lost them in the past; he also reported he did not have his birth certificate and had at some point (unclear when) tried to get it from Puerto Rico but had not been able to. Although he had gone to the DMV on his own at some point, he was told that without his birth certificate he could not obtain an ID. He also reported that although he had asked his care manager for help, nothing had come of his request. IR staff followed up with WR's care manager and she stated that he did in fact have IDs including a NYC non-drivers ID, a Medicaid card with photo, and a Social Security card. She also stated they had not been able to obtain his Puerto Rican birth certificate. As it was unclear why WR would be unaware of IDs he might have, IR staff requested that his care manager and/or Risewell case manager check again and provide photos of these IDs. His Risewell case manager subsequently confirmed that WR had in his wallet a Social Security card, an EBT card without photo, a Direct Express card for his SSI, and two insurance cards. None of these IDs has a photo, but it seems WR had no difficulties cashing his SSDI check; providers report getting access to his benefits has not been a problem. However, he does need necessary IDs in order to apply for a one-shot deal to pay his rent arrears, discussed below. As of the circulation of this report we had not heard back from his HH care manager so it is unclear what their awareness of WR's IDs and related financial situation is.

- GW was 70 years old at the time of interview, served by HC Risewell, Northwell mainstream HH (with CMA Risewell), and MLTC CentersPlan for Healthy Living. In Fall 2024, he was hospitalized due to cardiac concerns and, while empty, his apartment was burglarized. GW lost what he estimates to be $800, some gold jewelry, and several IDs which he believes included his birth certificate, Social Security card, and a NYS ID (he previously had a driver's license but believes a non-drivers ID is a better replacement at this time). At the time of interview – approximately four months after the burglary – GW was still without any IDs other than what he believed was a Medicaid card with no photo. This has compounded the trauma of the burglary itself, as GW has had problems cashing checks, obtaining prescription drugs, and even getting his mail (as he has no key to his mailbox and USPS staff will only hand off mail if can prove his identity and address).

  GW and his Risewell housing case manager reported that they each asked his Risewell CMA care manager for help obtaining replacement IDs several times, she in turn stated she was working on it, but she is also difficult to reach and GW has remained waiting to actually go obtain and/or receive IDs. GW is a savvy, motivated member who is able to describe what he thinks he needs to do to obtain IDs (*e.g.*, he has bills saved to show proof of residency and says his PCP can provide a letter stating he has known GW for a number of years and he is who he claims to be, *i.e.*, a professional letter as proof of identity). However, because of increasing cardiac concerns culminating in bypass surgery in May 2025, GW is unable to navigate the logistics of setting up and attending benefits appointments on his own. He is thinking about asking his HHA to help, as she has done in the past, but because his care manager continues to say she is working on his IDs, he is confused and anxious about how to proceed.

  During follow up calls in 5/14/25, GW and his Risewell case manager reported that the care manager had visited him following the IR interview and again stated she would work on obtaining IDs. Unfortunately, now approximately seven months after the burglary, GW remains without IDs. He also reports that while he does believe his care manager has ordered a replacement EBT card to be delivered via postal mail, because he has had no mailbox key for months he is worried he will not be able to intercept the ID upon delivery. As of 5/14/25, his Risewell case manager stated she will work on providing GW with a mailbox key.

Table 7. Person-centered care planning: Financial security (N=29)

Degree of problem	N (%)
No/low problems	11 (40 %)
Some problems	11 (40 %)
Significant problems	7 (20 %)

Among 29 class members interviewed for this topic, 11 members reported and/or evidenced that they had or were having some problems managing their finances and seven reported and/or evidenced they had or were having significant problems managing their finances. Of all

the domains we asked about, this was the second most problematic[10] reported and/or evidenced by members; member accounts, provider accounts, and/or records also indicated that in several cases this was a particularly entrenched or ongoing problem. In some cases, it was not clear exactly what members were spending their money on, making it understandably more difficult to tailor supports to try to help them. At the same time, we saw few instances in which a member was offered money management education and ongoing support to help address their financial insecurity. For example:

- RT was 69 years old at the time of interview and reviewed records indicated that since his initial discharge to supported housing in 2016, his HC Pibly's service plans noted he has a hard time prioritizing expenses and budgeting his funds, and they have included goals to address money management. Progress notes also reveal an undercurrent of suspicion that he has been engaging in drug use, including marijuana and crack cocaine, and most of the calls initiated by RT to his case manager are about getting his allowance. RT has refused to acknowledge to Pibly that he may be using drugs, thus their staff have not been able to speak openly with him about how his use may contribute to running out of money. Instead, they engage in more lofty discussions such as "a profound exploration of his financial landscape,"[11] as a 5/3/24 progress note of a 30-minute visit describes. Tangible next steps to address his money management problems are absent.

  On the other hand, RT's Vibrant Emotional Health ACT Team records indicate that they have received multiple reports that he has been observed buying drugs, and his HHA reported he has been using crack or cocaine. Records also note that RT himself has admitted to his ACT Team Lead and Nurse Practitioner that he was using crack cocaine. A 10/14/24 note indicates that the ACT Team attempted to engage him in discussions about his drug use and to urge him to accept treatment, but he was unreceptive. During a 4/1/25 home visit following discharge from a rehab facility, RT became angry and expressed frustration that he was being advised to

[10] Financial security and settlement service providers "tied" as the second most problematic domain for interviewed members, with 18 members reporting some to significant problems for each domain. More interviewed members (n=7) reported significant problems with financial security as compared to settlement service providers (n=4).

[11] During my recent visit with Robert today at about 4 pm, our conversation evolved into a profound exploration of his financial landscape. With empathy and curiosity, I delved into the depths of his spending habits and financial history, seeking to uncover not just the numbers but the underlying stories and emotions behind his financial choices. Our dialogue transcended the surface level, venturing into the intricate web of beliefs, experiences, and aspirations that shaped his relationship with money.

By immersing ourselves in Robert's values, fears, and dreams, we embarked on a transformative journey towards financial empowerment. Together, we co-created a personalized budgeting strategy that not only addresses his immediate financial needs but also aligns with his long-term vision for a fulfilling life. This strategy serves as a roadmap for both financial success and personal growth, empowering Robert to make conscious, empowered decisions about his money.

In our ongoing dialogue, I remain resolute in my commitment to providing Robert with comprehensive support and guidance. Beyond the realm of financial matters, I offer a compassionate ear to listen to his concerns, a source of encouragement to bolster his confidence, and a beacon of hope to illuminate his path forward. Together, we will not only celebrate victories and navigate challenges but also explore opportunities for personal growth and fulfillment. With each step taken together, we move closer towards manifesting Robert's dreams of financial security, abundance, and holistic well-being.

stop using drugs. However, there is no evidence in their records that the ACT Team was aware of the Pibly case management goal to address his ongoing problems with budgeting through money management. There is also no evidence that the ACT Team raised with RT how his drug use was contributing to his money problems, which seems a missed opportunity given that they are the provider with whom he has been willing to at least disclose drug use. If the ACT Team had raised the connection between drug use and money with RT, it may also have made him more receptive to considering their treatment recommendations.

- SG was 68 years old at time of interview and is served by HC Pibly Bronx, CBC mainstream HH, and MLTC Anthem. He travels independently to see his medical and other providers, using public transportation. He does not have a half-fare card or Access-a-Ride and did not seem to be aware of these options to lower transportation expenses. His HC service plan refers to the need for budgeting his personal allowance as he has occasionally reported running out of money to be able to purchase food and do his laundry. However, there is no documentation of specific budgeting education or support. SG also does not receive all settlement supports that could lower his expenses; for example, he does not receive transportation assistance from his HH nor is there any indication that he was informed or encouraged to obtain a half-fare card to reduce unnecessary transportation expenses.

- AP was 55 years old at the time of interview and served by HC Pibly Bronx and MLTC Riverspring; he was also in his final days of BAHN mainstream HH care management, from which he was disenrolled on 2/28/25. AP also runs out of money periodically and asks his HC case manager for help with additional food shopping, or for a loan until his SNAP benefits are replenished. He also makes use of a food pantry when he runs out of money. At the same time, he spends $60 a month on his cell phone and makes heavy use of social media on it. He previously had a low cost cell phone with limited usage allowance, but no longer has it. He has asked for assistance in applying for Meals on Wheels and at the time of the interview on 2/11/25 did not have an outcome. Subsequently, on 2/28/25, he was disenrolled from his HH.

- SB was 59 years old at the interview, served by HC SJMC Brookly, CBC mainstream HH, and MLCT ArchCare. He complained he was always running out of money and in order to "earn a few bucks" he would go every morning to sweep and run errands at a nearby bodega. He receives $967 SSI and $87 State Supplement Payment (SSP) per month for a total of $1054; his rent is $243 per month. SJMC is his representative payee and takes rent monies before providing him with a check for the balance of his income, which he then takes to his aunt who provides him an allowance of $100 each Thursday, then $200 once per month. SB had gotten $100 the day prior to interview, but reported he only had $2 left after buying fast food and "eating like a pig." He noted he needs cleaning products but has none; some of his recurring purchases are for cleaning supplies, toiletries and clothing and shoes, which he considers expensive. SB smokes but says he only buys one pack of cigarettes per week.

  Although SB has a prior history of alcohol and substance abuse, he denies recent use and records and provider accounts support this; it seems unlikely he is running out of money because he buys alcohol or drugs. His aunt believes that he has a habit of selling his groceries, cell phones, and televisions in order to have money to buy cigarettes. SB stated he lost his phone several months ago and had not yet gotten a replacement, impacting his ability to contact

and be contacted by providers, including his therapist who used to speak with him weekly via telehealth. It seems to be a puzzlement how exactly SB spends the money he receives, and even with the support of his aunt managing an allowance for him, it seems he has need for money management education. Following our visit his aunt provided him with a new phone.

- WR was 81 years old at the time of interview, served by HC Risewell, CBC mainstream HH, and MLCT Molina Senior Whole Health. He has a beleaguered history with Risewell as he has not paid rent for several years and owed them over $5,000 at the time of the interview; Risewell's attorneys had reportedly sent him a letter of planned eviction in January 2025. WR denies current drug or alcohol use and gives various explanations for his efforts to pay the rent, including describing trying to send his benefits check to Risewell once, which they sent back to him. Despite this, WR is his own payee. Risewell refuses to serve as representative payee for class members but has stated they can connect WR with a third party agency to serve in this role. They informed IR staff that they have recently obtained WR's consent to initiate efforts to have him assigned a representative payee.

  WR gets two checks from SSI and SSD for $496 each month, the first of which goes to his prior address (requiring him to go there the 2nd of each month and intercept the check from the mail carrier), the second of which loads onto his benefits card. WR's current rent is $244.20 per month. He said that during the pandemic he bought a lot of clothing from a nearby street vendor and he is now paying him $200-$250 a month to pay off debt from this clothing. WR has a well-documented history of gambling, but when asked during interview about this, he stated he doesn't gamble anymore, though he used to go to a casino near the Aqueduct Raceway. He said his former HHA, who had a car, would transport him there. WR seemed genuinely fearful of losing his housing and stated that he is involved in a personal injury lawsuit that is awaiting trial; he believes he could receive a little less than $100,000 from this suit and use the funds to pay rent he owes Risewell. His Risewell case manager described current efforts to apply for a one-shot payment for rent through Access NYC, though they are waiting for his care manager to obtain necessary IDs for this.

- DL was 72 years old at time of interview, served by HC SIBN, CBC mainstream HH, and MLTC Anthem. He reported money is a longstanding problem; he smoked up to a pack of cigarettes a day in the past, though estimates he now smokes about 10 cigarettes a day. In the past, he spent on cocaine and marijuana. Despite these lessened expenditures, he struggles with managing his money and is often in arrears. DL's benefit checks total $1,074 per month, and his rent is $210.20 per month after a utilities rebate of $122. At present, he owes $770 and pays his utilities on his own. He recently signed a repayment plan with SIBN to pay an additional $100 a month in rent. DL spoke of saving money for shoes he wants to buy for an upcoming wedding, and he admits he enjoys buying gifts for his granddaughter. Although DL's current financial situation is problematic, based on our review of housing progress notes he has a history of falling into debt for several months then slowly paying them back in full.

- AS was 73 years old at time of interview, served by HC Comunilife and MLTC VillageCareMax; she had been disenrolled from CBC mainstream HH (with CMA New Horizons Counseling Center [NHCC]) on 12/30/24 despite her expressed wishes to remain enrolled. Her situation is also described on p.46 and includes the significant challenges she

faces due to medical and credit card debt, the key areas she feels she needs care management support. AS is in many ways a highly independent class member with a high level of education and financial wherewithal, and she evidences thoughtfulness around her finances. For example, her Comunilife case manager reports she is not in rent arrears; she is careful to pay this and other bills each month, despite also grappling with debt. As AS describes it, it is simply very difficult to live on the very limited income she receives, compounded by the difficulty of navigating complicated health care systems and finding herself in situations in which certain forms of insurance (i.e., Medicare) have rejected certain claims (i.e., mammography) she thought would be covered. AS evidences – and some service providers noted – secretiveness around her financial specifics and debt. However, she also reports that prior to being disenrolled she was working with her HH care manager to explore debt consolidation options. If she was willing to be slightly more open with a certain provider about her financial challenges it is especially unfortunate that this is also the provider that chose to conclude services with her, even with the documented awareness of her ongoing debt.

While almost all class members in our sample had incomes below the federally established poverty line and were eligible for Medicaid-funded services, having a more substantial income did not insulate them from financial difficulties.

- VC, 61 years old and an Air Force veteran, receives a VA pension of approximately $3,000/month as well as SSDI payments of $1,248/month. Her income makes her ineligible for Medicaid and at one third of her income, her monthly rental share for her supported housing apartment was $1,246.45, the highest paid by any class member in the sample. According to the Housing Contractor case manager who was present during the interview, her money was managed by a rep payee whom she did not know how to contact. As described on pp.13-14 she lived in an apartment with multiple, significant problems, without a TV or telephone, which she was told she could not afford from her personal needs allowance, while also being encouraged to save a portion of it for her funeral expenses. Her stove did not work, she had no food in the apartment, and the water was not potable, so she went out daily to purchase food and drink from a nearby deli, frequently running out of money and resorting to panhandling in the neighborhood. At the same time, she had savings in excess of $200k.

Table 8. Person-centered care planning: Food security (N=30)

Degree of problem	N (%)
No/low problems	17 (57 %)
Some problems	9 (30 %)
Significant problems	4 (13 %)

Among 30 class members interviewed for this topic, nine members reported, provider records and/or accounts indicated, and/or IR staff observations indicated that they had or were having some problems obtaining sufficient food and/or preparing it, while five members reported

and/or provider records and/or accounts indicated that they had or were having significant problems obtaining sufficient food and/or preparing it. As obtaining food is closely related to two of the areas sampled members reported the second highest number of problems (financial security and settlement service providers), it is understandable that a good number of members would also report problems with food security. In a sense, it was encouraging to observe that despite broader problems such as lack of funds and inadequate settlement services and supports, multiple sampled members still found ways of obtaining and preparing food. We observed three broad trends in food security among this sample.

First, highly independent members tended to obtain their own food, typically using SNAP, sometimes supplemented by Over the Counter (OTC) cash cards from insurers. Some independent members also received home-delivered meals and visited local food pantries to supplement what they cook for themselves, but they tended to shop for and prepare food almost entirely on their own. For example. SJ (58 years old) had a full refrigerator, freezer, and cabinets at interview; was able to describe the $280 in SNAP she received and how she uses it; and reported she cooks for herself, giving the example of having cooked grits and sausage for breakfast that morning as well as eating some yogurt and fruit. HO (68 years old), similarly independent, reported that he cleans and cooks entirely for himself. He likes to get up early, make coffee and eggs, then makes simple meals often influenced by Puerto Rican cuisine: pork, rice and beans, chicken, etc. He lives near a section of Myrtle Avenue with many stores and uses his $290 in SNAP for most food purchases. He noted he also speaks regularly to his primary care physician (PCP) about his diet and knows how to limit dietary salt to keep his cardiovascular system healthy.

Second, we observed many members who need and seem to have in place a sufficient system of supports to maintain food security. These members also relied on SNAP and/or OTC cards to finance food purchases, often had some home-delivered meal services, and some also reported occasional visits to food pantries. Unlike more independent members, these members did not do much of their own food shopping and preparation, although many did some (*e.g.*, they spoke of buying takeout or prepared foods, could reheat meals already prepared for them, could make sandwiches, etc.). HHA services, home-delivered meals, and help from friends and family were important in maintaining their food security. For example:

- CV is limited by her age (77 years old) and pain and mobility problems, but she and her HHA, both of whom are from South America enjoy preparing Latin cuisine together, and although

CV stated she could walk to the supermarket from her apartment, her HHA is present 32 hours/week to help her. CV also reported that in addition to SNAP, her $280/month OTC monies card helps her purchase food; at the time of interview, her kitchen was clean and well stocked.

- AS (73 years old) also feels her age and health conditions limit her ability to cook as she once did. As depicted above, she is also extremely concerned about debt, compounded by what she was told was her ineligibility for SNAP due to income. Fortunately, she receives God's Love We Deliver lunches that are large enough that she can eat lunch and have some extra food for a second meal. AS also purchases food and prepares some simple meals for herself, and occasionally eats at a restaurant around the corner from her apartment. She has an HHA for three hours, three days per week who can also help her with shopping and cooking. Although AS has contemplated going to food pantries, her health limits how far she can walk and her ability to carry food home.

Both CV and AS – among other class members – also have family (daughters) living nearby and can ask them for help with food.

Finally, there were 14 members experiencing some to significant food insecurity. In this sample, such members spanned a range of food preparation abilities; most seemed to rely largely on HHA support and/or home-delivered meals but it was not inability to prepare food that put them at greatest risk. Instead, care management problems, typically low or disconnected SNAP and overall money management support needs, put members at risk of food insecurity. For example:

- DW (age 70) is limited by vision impairment (he is legally blind) but maintains a highly independent lifestyle. He usually buys himself breakfast from a coffee cart near his apartment, then relies mostly on his HHA to prepare meals he can reheat in the microwave. However, DW has experienced multiple problems with his SNAP benefits since his October 2022 move. It is unclear when after his move his then-care manager applied for his full benefits, but neither she nor other providers explained to him that there could be a period during which his SNAP benefit amount would be very low. Because DW didn't know this, he rang up a $300 bill he could not pay the first time he visited the grocery store. More recently, his EBT card stopped working and although he verified he was supposed to have $291 loaded onto it each month, he could not access any of it. DW called and obtained a replacement card on his own, but his new card also does not work; DW speculated it might not be properly activated despite his attempts to do so. He has asked his CBC mainstream HH care manager for help but at the time of interview, she had not yet done so. DW was hopeful she would visit him possibly as soon as the day after our interview, noting "I want to talk to a real person" as automated systems and other phone communication had left him frustrated.

- ECH (72 years old) said she was never without food, though it was difficult to have enough. She has a HHA who does most of her shopping and cooking, and ECH is very happy with the food she cooks. On the day of the interview, she had plenty of food in her kitchen and she said

she was never without food, but that it was difficult to have enough. Like several other members, her key problem is with her SNAP and provider support around it. More specifically, ECH did not get her SNAP in February 2025 and had gone to a January 2025 recertification appointment with her CBC mainstream HH care manager, where she was turned away due to missing documents including documentation of her rent bills. At the time of interview ECH was aware she needed to present these documents by 3/28/25 to maintain SNAP, but it was also unclear if she and/or her care manager have a specific plan to meet this deadline. Simultaneously, her Risewell case manager was unaware until just prior to the IR interview that ECH had missed her February SNAP; neither she nor her care manager had initially informed the case manager, though the case manager brought ECH a $204 Stop and Shop gift card once she learned about the issue and stated she would continue to do so until SNAP was restored. On 4/16/25 the Risewell Program Supervisor confirmed that ECH's care manager had accompanied her to a SNAP appointment on 3/26/25 and benefits were now in place.

D. Medication training and ongoing support in the community

Table 9. Medication training and ongoing support (N=30)

Degree of problem *as recalled/reported at time of interview*	**N 30 (%)**
No/low problems	24 (80 %)
Some problems	3 (10 %)
Significant problems (including X members with a history of refusing to take their medications)	3 (10 %)

Among 30 class members interviewed about medication, three reported and/or providers and records indicated that they had some problems managing their medications and another three reported and/or providers and records indicated that they had significant problems managing their medications. Given myriad problems with medication training and self-management we have noted in prior IR reports, it was heartening to observe that among this sample most members seemed able to handle their medication regimens when settlement services and supports were in place. However, we caution here that as described on p.3, this sample represents a certain kind of transitioned member, specifically one who has done well enough in their time in supported housing to have remained at this most independent level of housing for years. If we had included transitioned members who subsequently moved to Level II or specialized care facilities, returned to adult homes, died, etc. the overall medication management situation might look more complicated than seen among these 30 members who have remained in supported housing.

As it is, however, we observed among this sample members who were highly independent with the medication regimens, managing them nearly to completely on their own (RA, HO, AS, DV, EM, SF, SL) as well as many members who were conversant on their regimens and also benefitted from supports such as HHA, housemate, family member, and/or housing case manager check ins and reminders to take their medications on time (DM, GW, CV, AP, DW, BG, MB, ECH, AM)). It was particularly impressive to observe some older adult class members, members with vision limitations, and members for whom records, provider accounts and/or observations might suggest minor cognitive decline still be able to manage their own medications. For example:

- DM (67 years old) takes seven medications daily, including a daily insulin injection and an oral diabetes medication. He also takes a weekly Ozempic injection for Type II diabetes. DM evidences – and his Comunilife case manager pointed out – age-related health declines, including potential hearing and vision loss, and declining mobility. As such, tasks associated with self-managing his complex medication routine may get harder for him. At present, however, DM seems to manage his routine well. He picks up his own medications at a pharmacy close to his apartment and speaks to the pharmacist there; he even keeps the pharmacist's card in his wallet. He also keeps all his medications organized in his room and seems to prefer leaving them in bottles (or, in the case of injections, their original packaging) instead of using blister packs. At the start of interview, unprompted, he brought out all his medications and showed them to IR staff; he seemed to be able to differentiate among most of the seven pills he takes. He also manages his own diabetes injections and was clear on the difference between his daily insulin glargine and weekly Ozempic injections. Further, DM also assists his housemate with managing his eight daily medications.

- Although AP is fairly young (55 years old), he takes nine medications each day in addition to a monthly Abilify injection. One of his daily medications is a Lantus insulin injection; he recounted that as he was preparing to transition from The W in October 2019, delays in medication training led him to learn how to inject his own insulin from another resident. He has maintained this routine in supported housing, and has a reliable, obviously caring HHA who keeps all his medications and accompanying information sheets organized on top of the refrigerator; she offers him reminders to take his medications when needed.

Some interviewed members and/or records and providers did indicate some member problems with medications. Common problems reported were: confusion about specific medications, when to take them, how often to take them, telling medications apart, etc.; running out of medications and/or evidence of expired medications; purposely not taking medications for some length of time; and combinations of these problems experienced at once. For example:

- RT (69 years old) knew at the time of interview that he received monthly Haldol injections but was unclear about what other medications he was taking. Because he was interviewed while in a rehabilitation facility, it is possible some of his confusion derived from a different routine, and that he no longer manages his own medications. Possibly related, while RT still resided

in supported housing, Pibly Bronx and Vibrant Emotional Health Older Adult ACT Team records indicated that at least during some period from September 2023 to March 2024 RT was not taking medications as prescribed, instead as he felt he needed them, and that he was "neglecting" his medication regimen. While compliance with his prescribed routine may not be a problem while he remains in the rehabilitation facility, if he is to return to his apartment there needs to be a discussion with him around why he does not want to take his medications as prescribed, as well as further education on what they are and how they should be taken.

- DL (72 years old) also reported that in 2024 he went through a "long" period of time not taking his psychiatric medications because he did not like the way they made him feel. He was able to discuss this with his therapist and psychiatrist, who in turn made some changes to his regimen. At time of interview, DL reported he was again taking these medications. GD presents a similar on/off again pattern with his medications, also citing concerns with the way they make him feel (see p.46 for more detail).

E. Community integration, isolation, loneliness

Among 30 members interviewed, six reported and/or records and providers indicated that they had or were having some problems with isolation and/or loneliness, while two had significant problems. Of note, several members described themselves as "loners" and/or described isolated lifestyles, but as they themselves did not consider their isolation to be a problem and seemed mostly satisfied with limited social engagement, our ratings reflect that their level of community integration is not problematic to them.

Table 10. Isolation, loneliness in the community (N=30)

Degree of problem *as recalled/reported at time of interview*	**N (%)**
No/low problems	22 (73%)
Some problems	6 (20%)
Significant problems	2 (7%)

Members who raised feelings of loneliness or isolation provided examples of specific barriers to socializing. Some are highly individualized, such as behaviors that may put off others, while others are shared across several members, such as transportation barriers and lack of funds for social activities (sometimes also related to lack of funds for transportation to activities). Here again, the aging of the class is salient, as several members reported their physical health and mobility limited getting out and socializing. For example:

- GD is 65 years old and has lived in supported housing since May 2017. Although he is originally from Staten Island and lives there now, he does not seem to have connections to

many other people. He does not attend a day program, though during his interview he was open to hearing about Venture House. However, when SIBN offered to facilitate a tour there he declined, stating he would not be like the other people who go there. Though he goes out to local stores, GD describes himself as mostly alone – and lonely -- in his apartment, 24/7. He has a problematic tenancy history, having damaged a series of supported housing apartments to the point that landlords refuse to renew his leases. He would like to meet "a nice lady" but he was recently accused of stalking a woman in his previous neighborhood, suggesting his approach to interacting with others may be a barrier to building relationships. GD has hobbies, including music and playing the drums; he has a drum kit in his apartment and played an impressive set during our interview. He used to play drums in area clubs but his bike was stolen last year, further limiting what little outside pursuits he had. GD would like to save up for another bike but doesn't have the money now, and in fact owes a lot of money in back rent and utilities, suggesting finances are another barrier to socializing. He does attend SIBN events like holiday parties.

- BR is 67 years old and has lived in supported housing since September 2015. Both prior to and for at least a few years after her transition, she was a peer advocate for CIAD, attended meetings in Manhattan, spent time with a class member neighbor who lived down the street in Staten Island, and even was interviewed by WNYC in 2017. However, her recent experience in supported housing has been isolated and sad. BR said she spends her days watching TV and crying, due at least in part with a long term, on again-off again relationship with a man who, at one point, she considered getting an order of protection against. She said she doesn't have others in her life she can call family or friends, and she spoke openly about wanting to improve her socialization and coping skills, but also noted she was rebellious.

  BR also noted her physical health is very poor at present, including COPD severe enough to require her to use oxygen. She would like to go to the library and said, "I love to eat and would like to go to restaurants and also like to go to church, but my health hasn't allowed me to get up and do these things." However, she feels her health is big barrier to her getting out.

  During BR's interview the Baltic Street peer bridger present invited her to a monthly Snack and Paint event he was holding the following Friday and said he would inform her SJMC SI case manager about it. During a post-interview conversation, the peer also noted that BR had been speaking often with class members living nearby, whom she knew from their time at The Veranda. She has piqued BR's interest in learning to crochet and attending the nearby Happy Island senior center. Although BR has again expressed that her health is a barrier to her getting out and socializing, the class member friend has pointed out she could take a portable oxygen tank with her. Unfortunately, due to the number of HHA hours she currently receives, she was determined to be ineligible for this program by her MLTC.

Among class members who reported low to no problems with isolation and loneliness, three areas of social connection were mentioned several times. First, several members had family support, including family who lived in the area. Some members reported family visited with them regularly; others seemed to have less face-to-face contact with family but they were in touch over the phone and, importantly, gave examples of family helping them when they had problems in the

community. Second, several members attended day programs and seemed to enjoy them and people they got to know there; this seemed especially true among older members we interviewed. Third, HHAs seem to play an important role in the social lives of class members. In addition to fulfilling tasks including cooking, cleaning, shopping, and other ADL assistance, when they become a consistent presence in the lives of class members, their social support eases possible loneliness and isolation. For example:

- EM transitioned to supported housing in 2016. For the past five years, he has had the same Spanish-speaking HHA who is with him five days a week from 9 AM to 1 PM. They enjoy an easy-going camaraderie and working relationship.

- When AP, who is otherwise fairly socially isolated, was asked what he does with his days, he said he waits for his HHA to come and hangs out with her. She has been with him for two years and her careful attention to many aspects of AP's life was evident during our visit; we observed her out on the street, hurrying to get groceries, cleaning the bathroom vigorously, and when AP was asked about his medications, she immediately collected all of them from a neatly organized spot on the top of his refrigerator.

- CV and her HHA are respectively from Ecuador and Colombia and their easygoing rapport is evident; they speak in Spanish with each other and enjoy preparing and eating a variety of Latin cuisine. Similarly, ECH, whose primary language is Spanish, mentioned her HHA is Spanish-speaking and that in addition to all the help she provides, she and ECH have a nice relationship and she enjoys her company.

- GW transitioned from Central Assisted Living in 2020 and his current HHA was formerly employed at the same adult home; perhaps because of this, she seems especially supportive of GW and the challenges former adult home residents may face in the community. During interview, it was apparent that GW relished the conversation and companionship his HHA offered him. As his physical health has declined, he also finds himself relying more on his HHA, noting "From 9am to 1pm, when she's here, I know I'm okay. It's only after that I worry." Following his May 2025 bypass surgery, GW also stated that he feels he needs more HHA hours, especially because she has stepped in to help him with care management tasks such as setting up and accompanying him to benefits and medical appointments. He said he wanted all his providers to know that his current HHA is "the best, she's the best I've had, and she deserves to be recognized."

- SG has been in the same supported housing apartment since September 2017. He has also had the same HHA for nine years. The HHA keeps an odd schedule, visiting him Mondays, Wednesdays and Fridays from 5:30 AM to 12:30 PM, and on Thursdays from 11:30 AM to 6:30 PM. SG reports that he does not mind the early hours as he wakes up early and sleeps very little. He enjoys the company of the HHA whom he describes as very kind and thoughtful. It appears that the social support she provides makes up for the deficiencies in her housekeeping. The apartment felt grimy, stark and messy. There were piles of clothes on the unmade beds in both bedrooms. There was a noticeable odor entering the apartment, probably

attributable to the presence of a cat. HC Pibly Bronx inspections have also noted the odor, attributed to dirty cat litter boxes, and arranged for a house cleaning service to thoroughly clean the apartment.

Finally, some class members evidencing more robust community integration may serve as examples to try to support members who feel more isolated. As these examples illustrate, even engaged members may experience loneliness and challenges with socializing, but they have found and persisted with ways of socializing that they enjoy:

- SJ is 58 years old and transitioned to SH in April 2016 after living in Harbor Terrace for more than ten years. She lives alone and, when asked if she ever felt lonely, she said "even if I am in a crowd of people I feel lonely," but her answer was to keep busy. When asked how she spends her days, she said she goes to Venture House a few days a week and loves it; she helps with cooking and cleaning there and often works at the front desk. She also participates in Venture House trips and special events. SJ also keeps busy with hobbies like needlepoint, jigsaw puzzles, and painting. She is from a family of seven siblings and family contact also helps her feel less lonely.

- AM is 64 years old and has been in the community for over 10 years. She attends TLC Adult Day Care program three days a week. She enjoys jewelry making and painting. She eats breakfast and lunch there. She goes on shopping trips, to restaurants, for a BBQ, and on Fridays they do Karaoke. AM likes to sing and enjoys her program. She said she has a man she met there for five years who she sees outside the program too. They go to the movies together. She goes to church on Sundays and likes to shop. She said she never feels lonely.

- SF is 52 years old and has lived in supported housing (now with SJMC Brooklyn) since July 2015. He had a roommate who recently moved out. He said he enjoys living on his own and enjoys being independent. He is active in his community. He belongs to a gym, goes to the library often, visits a cousin who also lives in Brooklyn and talks to his brother and sister-in-law who live in Florida and another cousin in Queens. He said he attends a monthly community meeting at the SJMC offices where other members attend and they discuss health issues, eat and socialize. They can discuss any problems they may be having. SF also mentioned he is planning to get his driver's license. He has identified a place to take driving lessons after he gets his permit. He plans on moving to Florida to be near his brother when he turns 55. That is his primary motivation to get his license. He went to visit his brother, sister-in-law and niece and nephew for one month around Christmas time (2024). He went to Disney World for the first time.

- SL is 43 years old and has lived in supported housing (now with SJMC Brooklyn) since March 2015. She moved into her current apartment a few months ago, and is still getting used to her new neighborhood. She said she keeps busy by cooking healthy meals and cleaning, and doesn't feel lonely. SL has a cat that provides her emotional support, and she and a friend take turns visiting each other. She also writes poetry and shares her poems

online; she hopes to have her poetry published one day. She loves to read novels and watch movies. She said she has a laptop and does some online shopping and has friends on social media.

F. Changing and increased needs around physical health and mobility needs

Table 11. Physical health and mobility needs (N=30)

Degree of problem	N (%)
No/low problems	13 (43 %)
Some problems	13 (43%)
Significant problems	4 (13%)

Among 30 class members interviewed, 13 reported and/or evidenced some physical health and/or mobility problems and four members considered this to be a significant problem they faced. Of the remaining 12 members who reported and/or evidenced no to low problems with physical health and mobility, most did have chronic health conditions and some had mobility limitations as well. They are considered to have no to low problems because their health was mostly stable and not a major concern to them at the time of interview. However, it is necessary to underscore the issue of the aging of the class here; just because physical health and mobility is not a concern for certain members at present should not minimize the need to monitor and support them as their health and mobility needs may increase at any time. For example:

- AP is 55 years old and considered to have no to low problem at this time because his health is stable. However, records indicate he has cataracts, a history of seizures, hypertension, and Type II diabetes serious enough to require daily insulin injections; he also takes eight other medications daily. His fairly young age may be protective against some of the more severe symptoms of his conditions but, as he ages, it seems likely these conditions will take a further toll on his overall health. AP was disenrolled from CBC mainstream HH services on 2/28/25.

- Similarly, VB is 73 years old and considered to have no to low problem at this time because her health is stable. However, she has myriad diagnoses including anemia, COPD (while continuing to smoke), Hepatitis B and C, hypertension, high cholesterol, etc. She uses a rollator and reports she likes going to nearby stores for groceries although she doesn't like to use her rollator during inclement weather. While it is encouraging VB remains active and her health is stable overall, given her age and the typical course of her many chronic conditions, her health and wellbeing should be monitored closely.

By comparison, members with more significant health and mobility problems had many of the same chronic health conditions but they seemed more advanced, sometimes without a corresponding level of advanced services and supports to help manage them. For example:

- BR is 67 years old and has been living in supported housing since September 2015. She described her health as "terrible," as during the past year her COPD has made it hard for her to breathe; indeed, she was wheezing constantly throughout the interview. She was hospitalized for pneumonia and COPD in January 2025 and uses a nebulizer and a portable oxygen tank (one hour per day). She stopped smoking about a month ago, and while she struggles with this, she is aware it is better for her COPD and reduces the risk of a fire due to her oxygen tanks. Instead, BR uses a vape pen which costs about $20, can be recharged, and lasts about six months.

  BR also complained about her osteoarthritis which makes it difficult for her to walk outside and even in the apartment; she uses a rollator in both settings. She needs an HHA to help her into the shower and uses a bath chair; she also sponges herself off in the sink sometimes. When asked when her HHA last helped her shower fully, BR said "that's not their job," repeating that she just sponges herself off. BR also said she has trouble cooking now, as she cannot stand for extending periods or hold pots and pans due to her arthritis. She relies more on microwavable frozen meals. She also reported that while her HHA shops and cleans for her, she does not cook or help her with other ADLs. BR was planning to go to physical therapy (PT), with an appointment set for 3/19/25. She said it was a long time since she attended PT and hopes it will be able to help her to walk on her own again.

  When IR staff shared concerns about BR's health and mobility with HC SJMC SI, they stated she has a shower chair and grab bars and will "positively reinforce her in this area." Her SJMC case manager discussed cooking with BR's HHA who said she will do so in the future.

- AS is 73 years old and has lived in supported housing since April 2021. She is diagnosed with cardiovascular disease including cardiac arrythmia, high cholesterol, hypothyroidism, glaucoma, osteoarthritis and some urinary incontinence, among several other diagnoses. She also reports a history of breast tumors or cancer, although records received do not speak to this. AS takes eight oral medications daily as well as one topical medication and eye drops. Although she has an active mind and stays connected to the outside world through her cell phone and laptop (including speaking with family members and taking online coursework), she feels she is limited in how far she can travel and what she can do on her own because of her declining cardiovascular health.

  AS's most pressing health concerns, however, are not with her conditions but her need for more services to better manage her health and health care. One concern she is facing is medical debt resulting from a recent mammogram and related imaging; she was under the impression going into these procedures that they would be covered by Medicare but she then received a claims denial. She doesn't understand why her claims were denied, particularly because she believes she previously had breast cancer. AS is private about her finances but stated she has ongoing debt for these procedures and broader credit card debt, both of which are sources of immense stress for her. She has pursued a Medicare appeals process on her own, but it is confusing and time-consuming, and the timeline for resolution is unclear. AS would like help

with her Medicare appeal and her broader debt, but in December 2024 CBC disenrolled her from mainstream HH services despite her explicit wishes to remain enrolled, including asking her New Horizons care manager for more help with her Medicare claims, debt, and other health needs. As AS described it, "They told me I was being 'promoted," and I said 'Promoted to what? Promoted to the streets? Because that's where I'm going to end up if you do this!'"[12]

G. Changing and increased needs around cognitive and mental health, and substance use

Table 12. Cognitive and mental health, substance use needs (N=30)

Degree of problem	N (%)
No/low problems	18 (60 %)
Some problems	7 (23%)
Significant problems	5 (17 %)

Among 30 class members interviewed, seven reported and/or evidenced some medical, mental health, and/or substance use problems, and five members considered this to be a significant problem they faced. Of note, there were some members who did not consider their mental health or substance use to be problematic, or in the case of substance use denied it entirely, but provider records and conversations, as well as our own observations, suggested there had been and/or continue to be incidents of concern for some members. Additionally, what is described above for physical health is also relevant for mental health: members who were rated no to low problem for this domain do have mental health conditions and symptoms and problems, but they are at baseline/stable, or even feel their mental health has improved while living in the community.

Overall, it was promising to observe that many members did feel their mental health and substance use were not problematic for them; it was also promising to observe that many members had at least one service provider, often a therapist or peer, to whom they could talk and receive mental health support. Members with substance use concerns tended to speak in terms of either past usage that had not been a problem for some time (*e.g.*, DL) or reluctance to speak at all and denial of ongoing problems (*e.g.*, RT). Members who deny or decline to engage in conversation about their mental health and substance use are obviously one of the most complex groups to serve. The examples below illustrate some of the complexities of trying to support such members, as well

[12] Following our interview, IR staff asked the State to look into the recent disenrollment of AS and another interviewee (AP); we remain awaiting more information.

as some promising approaches (*e.g.*, peer outreach, supporting social connections) that may be helpful to additional members of the class.

- DL is 72 years old and says he struggles to stay compliant with his psychiatric medications and treatment as he doesn't always feel that they help him. He has gone long periods, including most of 2024, not attending a mental health clinic or taking medications but has taken them for the last few months. DL says he recognized that he was struggling more last year and thought reengaging with a therapist and medications might help; he likes his current therapist whom he sees weekly, but she is leaving the clinic soon. He also sees a psychiatrist once per month. DL has an extensive past history of using crack cocaine and used most recently in early 2024. He went to a rehab facility in June 2024 and although he did not complete a full 30 day stay – he said it "was not for me" – he also says he has not gone back to using although he sometimes smokes marijuana "to take the edge off."

- GD is 65 years old and in 2024 had multiple visits to the ER as well as psychiatric hospitalizations for disorganized thinking and signs of mania, following complaints from neighbors about erratic behavior such as yelling in the streets. GD complained about the medications he received while hospitalized; he did not like how they made him feel, particularly Haldol. He also stated that in the past he has not engaged with psychiatric treatment or taken his medications. However, since July 2024, he has been seeing a psychiatric NP he likes once per month. He is now prescribed Risperidone and Calypta and reported that he takes his medications, which he displayed during interview, and prefers to manage his medications using pill bottles instead of blister packs. He denied using alcohol or drugs but said he likes an occasional beer.

  Although GD said he was feeling better with the medication he currently takes, record indicate that many of the encounters that required psychiatric intervention occurred after July 2024, *i.e.*, after he had started his current medication regimen. Records indicate HC SIBN submitted an AOT application on 10/28/24 and was approved by the court on 2/18/25. In fulfillment of this order, GD was enrolled with the SJMC ACT Team on 2/25/25. Currently the ACT Team sees GD once per week, as does his SIBN case manager, often accompanied by the Program Director. SIBN staff have provided much needed care management services to him, in the absence of the more intense services that he has required for some time. It should be noted that GD was stepped down from AH+ to CBC mainstream HH care management with JBCF on 4/1/2018; at that time, the HH+ program had not been implemented for class members. Records indicate GD was still enrolled in HH care management in January 2025, but these records also indicate the last documented face-to-face visit with GD took place in December 2023. While it appears multiple attempts (extending as recently as 1/7/2025) were made to see GD in person, his mainstream HH care manager had not been able to do so. GD's overall situation begs the question of why, given years of mental health and substance use concerns, GD was not previously stepped back up to a higher level of care management. It is especially unfortunate that he would be allowed to falter to the point of having an AOT order now, in the absence of any number of incremental care management enhancements (*e.g.*, HH+, AH+) that could have been tried before resorting to this more extreme step.

- BR is 67 years old and has lived in supported housing since September 2015. She is served by HC SJMC, CBC mainstream HH, and MLTC VillageCare Max. She describes her mental health as "bad, real bad"… I cry all day, I feel terrible. I need something for my mood… I'm too up and down." She notes she stopped smoking about a month prior to the interview and finds it very hard and has trouble with her moods when she wants to smoke. She sees her therapist, whom she likes, every Wednesday and sees her psychiatrist once a month, mostly for medications.

  Although BR transitioned well before the peer bridger program was implemented, Baltic Street was asked to outreach her in 2024 due to her struggles. During a 2/7/25 visit with her peer, BR voiced thoughts of harming herself. The peer called 911 and she was taken to RUMC for a mental health evaluation and released the next day. HC SJMC attempted to send BR to SJMC respite care but because she uses oxygen, they were told they could not accept her and she returned to her apartment. SJMC advocated for BR to receive more HHA hours, and they have recently been increased to five hours per day, five days per week.

  In subsequent visits with her peer, most recently on 3/11/25, BR's outlook seems to have improved. The peer reports she has reconnected with another class member she knew from The Veranda who lives nearby, and BR was interested in attending a nearby senior center (Happy Island) with her, which unfortunately was not approved by her MLTC due to the number of HHA hours that she currently receives.

H. Emerging provider considerations: Connections to outside providers, connections to settlement service providers, and shifting provider roles and responsibilities

Table 13. Help from mental health, medical providers (N=30)

Degree of problem	N (%)
No/low problems	18 (60 %)
Some problems	7 (23%)
Significant problems	5 (17 %)

Among 30 class members interviewed, seven reported they were having some problems with at least one mental health and/or medical provider and five reported they were having significant problems with a mental health and/or medical provider. It was noteworthy that multiple interviewed members mentioned regular appointments with therapists, and generally liking their therapists. A few members also mentioned other providers they liked; for example, GW mentioned he appreciated that his PCP seemed willing to spend time talking to him both about his health and other topics, such as history and politics.

As noted in the prior Semi-Annual Report, problems with medical and mental health providers tended to have more to do with logistics rather than the providers themselves. Such

problems included finding providers in the community, setting up and remembering appointments, transportation to providers, and tasks members needed help with to expand services. In other words, many transitioned members need help with tasks that would seem to be the purview of care managers, so that they can in turn enjoy more consistent, comprehensive services from medical and mental health providers. For example:

- SL (43 years old) moved to her current apartment and neighborhood in August 2024. When visited in February 2025, she was still in the process of finding a new PCP in her neighborhood. This was a service plan goal and her SJMC Brooklyn case manager gave her a list of providers in her area who take her insurance. However, SJMC records indicate that the goal was discontinued due to SL feeling anxiety about leaving her apartment to attend an appointment in the community. Although locating and connecting members to community-based providers is one of the often-cited roles of HH care managers, SL was disenrolled from HH mainstream care management in January 2016, is not currently enrolled with an MLTC, and she only receives care management-like supports from her SJMC (housing) case manager. SL reported that she continues to see her psychiatrist once a month and therapist once a week via telehealth and was encouraged to reach out to her providers with any concerns.

- NL (70 years old) is experiencing a great deal of pain in her feet and legs. She would like to see a podiatrist and records from BAHN mainstream HH indicate that her care manager is aware of this. However, given how long she recollects she has had pain and mobility problems with her feet and legs, it is unclear why she has not recently seen a podiatrist. NL herself noted, as did her HH records, that she sometimes forgets she has appointments. Again, both NL and her HH records note that her care manager has told her she will remind her of her appointments, but this appears to happen sporadically, and it may not be happening much; documentation is not clear on actually realized appointment reminders, rather notes indicate the care manager *will* make a reminder call.

- SJ (58 years old) is not yet comfortable using NYS's Medical Answering Services (MAS) for transportation and said she does not know what to say when she has to call for it 72 hours in advance of her appointments, though she showed IR staff printed directions on how to call. She said her sister sometimes calls for her, but it seems she still needs help as she most often takes two buses with her half-fare card to get to appointments. SJ, like multiple interviewed members, would seem to benefit from care management services and HC SJMC SI has encouraged her to enroll. However, at present SJ feels that what a care manager might do would conflict with what her sister was already doing for her and she has declined to pursue enrollment.

- EM (70 years old) reported on 9/19/24 that he did not go to his cardiologist appointment because his WellCare card, which was to be used for transportation to and from the appointment, was not active. He also said that he needed more HHA hours so his HHA could accompany him to his medical appointments.

- RT (69 years old) missed his orthopedic appointment on 6/23/23 due to a lack of transportation, according to ACT records.

I. Settlement Service Providers

Table 14 . Help from settlement service providers (N=30)

Degree of problem *as recalled/reported at time of interview*	**N (%)**
No/low challenges	12 (40 %)
Some challenges	14 (47 %)
Significant challenges	4 (4 %)

Turning to settlement service providers, 14 out of 30 interviewed members reported that they had or were having some problems with at least one provider.[13] Four members reported a significant problem with a settlement provider. Of all the domains we asked about, this was the second most problematic[14] reported and/or evidenced by members. Problems reported were diverse. As one indication of potential problems with provider availability and communication, members were asked to identify their providers by name, and describe contact they had (or could have, *i.e.*, how to get in touch) with them.

Table 15 . Member ability to name and contact settlement service providers (N=30)

Degree of problem *as recalled/reported at time of interview*	**N (%)**
No/low challenges	22 (73 %)
Some challenges	8 (27 %)
Significant challenges	- (%)

Eight out of 30 interviewed members reported and/or evidenced some difficulty in identifying their providers. The other 22 interviewed members ranged in provider awareness but are rated no to low problem because they were able to identify most if not all of their providers

[13] 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.

[14] Financial security and settlement service providers "tied" as the second most problematic domain for interviewed members, with 18 members reporting some to significant problems for each domain. More interviewed members (n=7) reported significant problems with financial security as compared to settlement service providers (n=4).

and demonstrated at least some awareness of how to contact at least some of them. Overall, provider connectedness ranged from members such as:

- AS, DV, DW, who could name the agencies and specific providers they had been seeing and knew how to contact them on their own, which they felt comfortable doing; to

- Members like RA and DM, who might not be able to name all providers spontaneously but were able to either name a provider or locate an agency contact card or list of providers (although some members also knew at least some of the providers listed were no longer working). In some cases, members were not always clear on what certain providers did or could do for them;

- Members like NL who might be able to name some providers, likely HC staff, and have a sense of their role and how often they were in touch, but did not have a clear sense of their overall provider types (*e.g.*, were unsure if they were enrolled in a HH and/or MLTC) or what a particular agency or individual provider could or should do for them. As an example, a member might know that "Ana" talked to them about their health and their doctors' appointments, but they could not say who Ana was (a care manager), what agency she worked for (a HH), or elaborate on what else Ana could do for them.

A particular concern with the latter two groups of members was their lack of awareness of and level of comfort around asking for the types of settlement services and supports they could receive, particularly as their needs may change and intensify with age. For example:

- RA is 74 years old and transitioned in December 2015. While his length of tenure in supported housing and ongoing independence is admirable, with age he may be showing signs of lessening mental acuity. However, he currently has no HH nor MLTC care management. In the absence of these key providers, he seems to have three means of addressing his needs: he might receive support from his ICL (housing) case manager, of whom he speaks well but thinks of in terms of only some of his needs (*e.g.*, housing); he might try to undertake tasks himself even if he is uncertain about how to go about them; or he is resigned to having needs go unaddressed. At time of interview, for example, he shared that he was having problems with his teeth including having lost teeth, having some pain and difficulty eating without them, and desiring dental implants. He recalled having dental insurance in the past but decided he couldn't afford it and doesn't recall when he last saw a dentist ("it was a long time ago."). RA would like to know what his options are for dental insurance and finding a dentist, but he doesn't know how to go about it. Although he was disenrolled from mainstream HH care management on 9/30/2021, when the role of a care manager is described to him, RA is open to receiving such services and getting help for his dental problems.

- SG is 68 years old and transitioned to supported housing in September 2017. Although he is familiar with his HC Pibly Bronx case manager and his HHA, who has worked with him for a remarkable nine years, he has had a rapid succession of CBC mainstream HH care managers who have not been around long enough for him to get to know them or vice versa. Although there is care manager contact information posted on his refrigerator, he pointed out that it is out of date and no one has replaced it for him.

- GD's care management situation, described on p.46, is also relevant here. He is 65 years old and transitioned to supported housing in May 2017. Despite a particularly challenging tenure in supported housing, including mental health concerns, five moves, and problems in the community, he was stepped down from AH+ to HH mainstream management in April 2018 and remained enrolled at this most basic level of care management until his challenges became so severe that an AOT order mandated a much higher level of care management through ACT Team enrollment, which began 2/25/25.

While these examples underscore the care management gaps, other members who reported service provider problems expressed they needed help with HC staff and/or home health HHAs. Problems with HC staff are described in depth on pp.11-16, with many involving apartment maintenance and repairs going unaddressed, sometimes for extensive periods of time. Problems with HHAs include the following examples:

- SB is 59 years old and his apartment conditions are described in full on p.13; it is an overall poorly maintained apartment despite records documenting he receives HHA services four hours per day, Monday through Friday. SB said that his HHA only brings him home cooked meals, as "she has others to see, and plenty to do." Based on HC SJMC Brooklyn and CBC mainstream HH care management notes, this situation is an ongoing problem, caused in part by SB's not wanting the HHA to do more than drop off food. While SB insists that he can maintain the apartment on his own, its poor conditions could be helped by HHA assistance. It is unclear what MLTC ArchCare may be aware of and/or doing to address this situation.

- WR was 81 years old at the time of interview and had a newly hired HHA from Tri-Med, where he also attends a day program daily. His HHA works for him seven hours per day, seven days per week. However, given that WR is extremely active, attends program daily, and by provider accounts is rarely home, it is unclear what services she provides for that many hours. WR's care manager reported that his HHA stays at Tri-Med while he is in day program. It should be noted that according to his housing case manager, in his last apartment one of his former HHAs had lived in the apartment and paid him rent as she needed a place to stay.

- SG's (pp.41-42) and MB's (p.16) relationships with their HHAs exemplify the complexities of enjoying the companionship HHAs can offer (nuanced further by MB employing his family member as his HHA) while also experiencing what seem to be problematic shortcomings in fulfilling key tasks such as cleaning and apartment upkeep.

In exploring members' relationships to settlement service providers, we also encountered examples of providers going to great lengths to attempt to help members remain safely and stably housed in the community. For example:

- RT is 69 years old, transitioned to Pibly Bronx supported housing in September 2016, and has remained stably housed there despite multiple admissions in the past two years to hospital and rehabilitation facilities. He has significant mobility impairments as a result of an injury and uses a walker or wheelchair. He has presented challenges as providers attempt to support him in the community including: suspicion of substance use leading to unknown individuals hanging out in his apartment and building, raising safety concerns; his denial of his substance use, which further complicates how to support him; problems with money management that may be related to substance use; and sexually inappropriate behavior with female staff. He has also canceled PT appointments to address his mobility concerns and records indicate he does not follow his prescribed medication regimen, though he was conversant with it during our interview. During a hospitalization in March and April 2023, his physical condition deteriorated and he required the use of a wheelchair; when he subsequently returned to his apartment on 4/17/23, Pibly arranged to install grab bars, a shower chair and procure a wheelchair for him. Due to his limited mobility, his personal needs allowance was delivered in cash to avoid the difficulties cashing checks might pose. He was hospitalized again on 10/29/24 for hyperglycemia and complaining of pain in his left hip. He was transferred to the Citadel Rehabilitation and Nursing Home on 11/5/24 for subacute rehabilitation and was interviewed at that facility. During his hospitalizations and rehabilitation stay, Pibly not only maintained his apartment for him but replaced furniture and sent staff to feed his cat. He was discharged back to his apartment on 3/24/25 with HHA support six days a week, and resumed using cocaine shortly thereafter. On 4/9/25, he was hospitalized once again with a very bad UTI and high e. coli count.

- BG is 59 years old and transitioned to supported housing in March 2017. Utilizing CDPAP, she has HHA service eight hours per day, seven days per week: four days with her aunt and three days with her niece. Additionally, her aunt stays overnight three days per week although this is not part of her paid work, because BG gets nervous staying alone. BG's aunt said she has her own apartment and does not live with BG. The apartment was clean, and BG described all that her family member HHAs do to assist her: grocery shopping, meal preparation, laundry, cleaning, and accompanying BG to appointments. Her aunt, who was there the day of the visit, seemed to know BG's providers and know everything that was going on with her and what she needed assistance with. For example, she knew that BG had lost her dentures and her care manager was trying to assist with getting new ones even though she was not yet eligible through Medicaid. She also was aware that BG had missing IDs and stated that her manager was working on that too.

A final type of settlement service providers are peer bridgers. A unique feature of this sample is that the majority of members (n=16) have had no contact and some of the remaining members (n=14) have had minimal contact (*e.g.*, one or just a few engagement attempts) with the peer bridger program. This reflects the review's longer look back at settlement implementation

history, with the average length of member stay in the community slightly over seven years. In other words, most members transitioned prior to the implementation of the Supplemental Agreement and peer bridger service provision, which began in March 2019. Further, as the Supplemental Agreement did not specify that peers accompany members pre- to post-transition calls or meetings, even the members who transitioned more recently may not have had much contact with peer bridgers, as only in the past two to three years has the program evolved to include a more systematic post-transition role for the peers, now consisting of a minimum of 90 days of post-transition support.

Given the limited overlap between the peer bridger program and sampled members, it was promising to observe that multiple members have been connected and/or reconnected to peers recently. Specifically, at least six sampled members[15] have been outreached by the peer-run agencies and some have reported supportive relationships already. For example:

- DV is 62 years old and is a highly independent class member whose transition would seem very successful on its face; among other impressive pursuits DV is studying for a Masters degree in Disability Studies and even supports others as a CIAD peer herself. However, she also reports that she has "good days and bad days," and that her current level of CBC mainstream HH care management does not meet all her needs. In late 2024, she was reconnected to Community Access peers and reports that they have invited her to several activities in the community and given her an outlet for conversation and reflection that has helped her emotional health.

- As described on p.40, after achieving over eight years in supported housing BR (who is 67 years old) has suffered significant mental and physical health concerns. Her Baltic Street peer who began visiting her in January 2025 has been a consistent, caring presence in her life and with his support, she is considering participating in community activities such as monthly Snack and Paint meet ups and a senior day program.

It is very promising to observe the peer-run agencies outreaching new-to-them members in the community in addition to continuing to support more recently transitioned members and convene community-based activities. As the role of the peer program evolves and grows as the post-settlement plan is finalized and implemented, we encourage the State to create a more systematic process through which members with longer tenures in the community are screened for and offered peer services. We also encourage the State to consider the capacity, in terms of both person-power

[15] As of 4/15/25 we are aware of six sampled members who have been outreached by the peer-run agencies, but because the post-settlement role of the peers is still being designed it seems likely that more outreach will occur even in the brief period between now and the final submission of this report to the Court.

and funding – to facilitate the expansion of peer services to meet the changing and increased needs of the class in the future.