UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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

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

ANNUAL REPORT SUBMITTED BY
CLARENCE J. SUNDRAM
INDEPENDENT REVIEWER*

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

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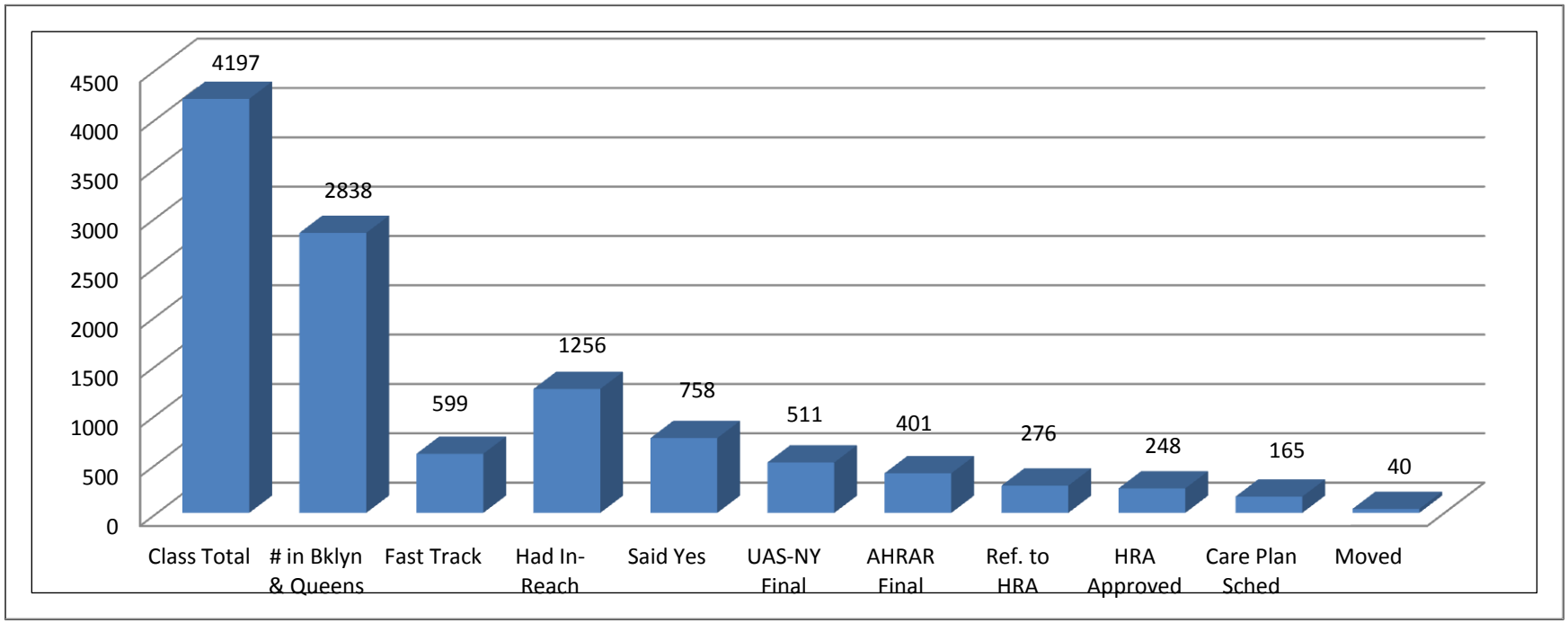
Executive Summary

Fig. 1. Overview of Implementation Activities July 23, 2013-March 13, 2015[1]



[1] The data in this report are largely drawn from the Defendants' weekly reports up to Week 52, the most recent available at the time of drafting the report.

In the quarterly report filed with the Court on January 16, 2015, the Defendants expressed the opinion that the five-year goal of the Settlement Agreement to transition all qualified and interested class members to the community "is attainable." (The State's Third Quarterly Report, p. 5) In order for that to happen, the pace of implementation will have to increase dramatically and be sustained for the remainder of the five-year period.

Out of the 4,197 class members identified as of March 13, 2015, 1,256 have received in-reach by a Housing Contractor, and 758 (60.35%) of those class members have expressed an interest in moving to supported housing. Assuming that the rate of interest remains at this level for the total class over the duration of the Settlement Agreement,[2] 2,533 class members will have to be assessed and moved. As of March 13, 2015, 40 have been moved over the first six and-a-half quarters that the Settlement Agreement has been in effect.[3] This leaves 2,493 class members to be assessed and moved in the remaining 13.5 quarters.[4] In the 90 day period ending March 13, 2015, 30 class members were moved. In the remaining 13.5 quarters, the rate of movement will need to average 185 per quarter or six times the rate achieved in the most recent three month period.

Although the State has been closely monitoring the implementation process, and implementing changes and refinements as obstacles have been encountered and identified, the magnitude of the task ahead is obviously substantial. Thus far, the modest tweaks to the existing processes for implementation have not achieved the quantum leap in performance that will be required to attain the goals of the Settlement Agreement.

[2] There is good reason to expect that as class members see other residents move out of the adult home and settle successfully in the community, the rate of interest in moving out will increase substantially, especially if the recommendations offered in this report regarding in-reach and care planning are implemented. (See Report, pp 67-71)

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

[4] The State expects that the number probably will be less than 2,493, given that the initiative has thus far focused heavily on class members with a high level of interest in moving, and yet many of them have changed their minds during the process.

Introduction

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

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

The Court's final approval of the Settlement Agreement was filed on March 17, 2014. Based on that date, the Independent Reviewer prepared and submitted to the parties a schedule for the preparation of the required five annual reports. For the first year, the schedule requires that the Independent Reviewer's draft be provided to the parties by February 13, 2015, with their comments due by March 17, 2015, and the Final report submitted by April 1, 2015.

A draft of this report was provided to the parties on February 13, 2015. Subsequently, on February 24, 2015 and March 2, 2015, the Independent Reviewer submitted supplementary memos to the parties regarding the report. Comments were received from the parties orally and in writing by March 17, 2015. In addition, a parties' meeting was held on March 25, 2015 to discuss the report and its recommendations in anticipation of the status conference. The Independent Reviewer has carefully considered all the comments received from the parties in the preparation of this report and has made such changes as appeared to be warranted.

The Settlement Agreement also requires the Independent Reviewer to develop a "written plan with regard to the methodology to be used by the Reviewer to assess compliance with an implementation of the Agreement." (Settlement Agreement, ¶ L. [10] hereinafter "Monitoring Plan") Although the Settlement Agreement provides that the annual report "shall detail with as much specificity as possible how the State is or is not in compliance with particular provisions of the Agreement" (¶ L [14]), in the Monitoring Plan submitted to the parties shortly after the Court's final approval of the Settlement Agreement, the Reviewer recognized that most of the specific compliance measures in the Agreement would not be relevant until the later years in the implementation process. Therefore, the Independent Reviewer advised the parties that in the initial year, the Reviewer would focus on monitoring the development of the building blocks that are necessary for successful implementation of the Settlement Agreement. Many of these activities described in the Monitoring Plan are not specifically required by the Settlement Agreement nor are they compliance measures themselves. The purpose in performing these activities is not to conclude that the State is or is not in compliance with the Settlement Agreement at this time, but to examine what is helping or hindering implementation of the

Agreement, consistent with the directive in the Agreement to "pursue a problem-solving approach." (¶ L [7])

Methodology

The Settlement Agreement identified some of the potential monitoring methods, e.g., visiting individuals' residences with their consent and conducting interviews. (Settlement Agreement, ¶ L. [10]) The Settlement Agreement also required the State, in consultation with the Independent Reviewer, to develop a work plan to guide its implementation of the Agreement within 120 days after the Reviewer is engaged by the State.

Although the Independent Reviewer and his associates (Thomas Harmon and Stephen Hirschhorn) began monitoring activities shortly after their appointment, it made sense to defer the development of the written plan required by the Settlement Agreement until the State's development of its work plan to guide its implementation of the Settlement Agreement.

As required, the State finalized its work plan on February 7, 2014 after consulting with and receiving written comments from the Independent Reviewer. To achieve its goal of offering nearly 4,200 class members in 23 Adult Homes an informed choice and opportunity to transition to integrated supported or other housing appropriate to their needs within five years, the State's work plan outlined phases and major tasks that must be accomplished, and identified goals and targets with the intention of adjusting targets and modifying the plan in light of experience gained through the implementation process. Among the critical components of the State's work plan were:

- identification of residents who will be offered in-reach, assessment and the opportunity to transition;
- education of residents through in-reach;
- enrollment and assessment of residents by Health Homes (HH) and/or Managed Long Term Care Plans (MLTCP) resulting in the development of a person-centered plan of care;
- development of supported housing units by Housing Contractors;
- training to educate Health Home and MLTCP personnel (assessors and care managers) and Housing Contractors in the goals and skills necessary to properly perform their roles in the Agreement; and
- transition to Supported Apartments or other community housing as appropriate and preferred by the resident; and
- monitoring and quality control.

The Independent Reviewer's Monitoring Plan called for:

- Reviewing training materials and strategies for the front-line workers who will be performing tasks such as in-reach, assessment, person-centered planning and care

coordination; participating in and observing such training; and speaking with the staff who have received the training;
- Reviewing and evaluating informational materials and data regarding in-reach activities to the class members;
- Evaluating assessment tools, reporting mechanisms and formats, and data base structures;
- Reviewing and evaluating data regarding the enrollment of class members in Health Homes and MLTCPs;
- Visiting mental health programs serving class members and interviewing staff and adult home residents regarding their understanding of the Settlement Agreement to assess the effectiveness of information and outreach that has been provided; and
- Visiting adult homes to interview staff and residents for the same purpose.

As the State's implementation entered and progressed through the various stages of in-reach, assessment, care planning and management, and transition, the Independent Reviewer's plan also called for the monitoring of these processes through direct observation, record reviews and interviews with individuals and staff on a sample basis. It also called for reviewing and analyzing reports by the State and its contractors concerning these activities and the development of supported housing beds.

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

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

1. Participated in and observed at least 20 training sessions sponsored by the State for Housing Contractors, Health Homes and MLTCPs. These educational sessions focused on the goals of the Settlement Agreement and the skills these frontline staff required in conducting in-reach, assessment, care planning and care management. Also participated in State sponsored training for mental health providers designed to acquaint them with the Agreement.

2. Reviewed materials prepared for in-reach to class members to educate them about their options and opportunities including MOVING TO SUPPORTED HOUSING: *A User's Guide for Adult Home Residents* created by the Adult Home Research Group at the Nathan Kline Institute of the Office of Mental Health.

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

recommendations regarding the same.

4. Reviewed the tools and guidelines developed for assessing class members and developing care plans.

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

6. Met with New York City Human Resources Administration (HRA) and the Center for Urban Community Services (CUCS) both of which have a role in the implementation process, with HRA reviewing and approving applications for community housing and CUCS serving as a gateway for entry into housing for individuals who are not recommended for supported housing but require other Office of Mental Health licensed programs.

7. Met with administrators and staff of nine adult homes to discuss their understanding of and experiences with the Settlement Agreement implementation process.

8. Met with managers and staff of mental health programs serving class members to discuss their understanding of the Settlement Agreement and the capabilities and needs of class members.

9. Met with representatives of the Coalition of Institutionalized Aged and Disabled (CIAD) which provides advocacy services on behalf of adult home residents and is active in homes covered by the Settlement Agreement.

10. Met with more than 600 adult home residents at their adult homes, in their mental health programs or in other venues to learn more about their understanding of the Settlement Agreement and the transition process, their desires and to answer questions, or relay their questions to the appropriate parties.

11. Observed, by participating in, more than 120 individual in-reach, assessment and transition/care planning sessions with class members and their Housing Contractors and HH/MLTCP assessor and care management staff.

12. Additionally, participated in more than 40 pre-transition conference calls in which Housing Contractors, HH/MLTCP staff and DOH and OMH representatives confer to ensure that all elements of a successful transition (housing, utilities, community supports, entitlements/benefits, etc.) are in place for an individual. Such calls usually happen about three weeks before an individual moves. In addition, as the State has started post-transitions calls to check up on implementation of the plan, members of the Independent Reviewer team have been participating in these calls.

13. With their permission, made 16 visits to the apartments of individuals who had transitioned to observe their new environs and to hear their perspectives on their transition, their new living arrangements, the adequacy of services/supports, and matters that might be improved.

14. Reviewed the records of 21 individuals and spoke with 14 individuals who had said they were interested in supported housing during in-reach but subsequently declined to be assessed or to transition, to better understand why they changed their minds.

15. Conducted a more in-depth review of a sample of 11 cases of class members who appeared to be encountering difficulties in the transition process, such as being found questionable or unsuitable for supported housing. This included interviews with their clinicians and assessors/care managers and reviews of key documents including in-reach records, UAS-NY nursing assessments, comprehensive psychiatric evaluations, other clinical records and HRA applications and determinations. Eight of these class members were also interviewed.

16. In the process of observing and participating in individual in-reach, assessment and transition/care planning sessions, spoke with staff of all six Housing Contractors and 12 HH/MLTCPs and/or their downstream providers, inviting their input on the adequacy of their preparation for their roles and feedback on how well the process is progressing, barriers encountered and what could be improved.

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

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

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

20. Participated in three status conferences and hearings convened by the Court.

21. Met with researchers from the Nathan Kline Institute who have been conducting research on adult home residents' community transition and working on the development of a

handbook for adult home residents on the Settlement Agreement and the transition process.

Throughout the monitoring process, the Independent Reviewer and his team have had the cooperation of the staff from the Department of Health and the Office of Mental Health. They have been generally responsive to requests for information that has been needed to perform our monitoring functions, and have intervened when requested to address issues of access to adult homes and mental health programs. The Independent Reviewer would especially like to acknowledge the assistance provided by Valerie Deetz, Director of the Divisions of Assisted Living & Community Transitions Program in the New York State Department of Health, and Rebecca Briney, Director of Special Projects of the New York State Office of Mental Health. They, as well as their respective staff members, have been of immense help to the Independent Reviewer team. The staff of the Housing Contractors, and many Health Homes and MLTCPs have also been cooperative with the Independent Reviewer and generous with their time.

Nevertheless, due to concerns expressed about the confidentiality of records, the Independent Reviewer has experienced difficulty in obtaining access to plans of care for class members and information about the processing of complaints from adult home residents by the New York Justice Center for the Protection of Persons with Special Needs. These concerns have limited the Independent Reviewer's ability to fully perform the monitoring functions. Similar concerns have been raised by the NYC Human Resources Administration which processes applications for approval of recommendations for community housing of class members. As this report is being drafted, the Independent Reviewer is working with the parties to draft a supplementary court order to resolve these access issues.

Findings

a. Preparatory actions

The Settlement Agreement recognized that many preparatory steps would need to be taken for implementation of its provisions. These included:

1. The identification of all class members, which has been an on-going process.

2. The enrollment of class members in Health Homes or MLTCPs, or both. The State's work plan stated that 1,817 class members were already enrolled (p. 5) and that further enrollments were anticipated at the time of the assessments of individual class members. As of the December 31, 2014, the state reported a total of 1,821 class members enrolled in Health Homes or MLTCPs (1,190 Health Home enrollees, 1,228 MLTCPs enrollees and 597 dually enrolled in both programs).

3. Entering into contracts for the development of supported housing units to enable class members to transition to the community. It recognized that**,** pursuant to a Request for Proposals issued on August 10, 2012, OMH had entered into contracts to fund the

development of 1,050 supported housing units in Kings and Queens counties over a three year period and will enter into additional similar arrangements as necessary, including the issuance of one or more RFPs for the development and operation of supported housing units in Staten Island and the Bronx within two years of the execution of the Settlement Agreement. (Settlement Agreement, ¶ D (1) (2)). In the initial phase, contracts were awarded in February and March 2013 for 350 supported housing units to six Housing Contractors, and on January 28, 2015, the State issued an RFP for 900 additional supported housing units in Staten Island and the Bronx with a target date for contracts with the successful bidders of April 1, 2015. As will be discussed later in this report, as of March 13, 2015, 29 of these supported housing units have been occupied by 40 class members.

4. The development of training materials and the provision of guidance and training through webinars, computer–based instruction, and in-person training sessions to Housing Contractors, Health Homes and MLTCPs regarding the in-reach, assessment of class members and the development of person-centered care plans, including the presumption that class members can live in supported housing with appropriate supports. (Settlement Agreement, ¶ F)

The process for implementation of the Settlement Agreement has multiple steps and required actions by the two state agencies primarily responsible for its management – the Department of Health (DOH) and the Office of Mental Health (OMH), as well as Housing Contractors, and Health Homes and MLTCPs, many of which have relationships with "downstream providers" with which they contract for the performance of class members' assessments, and other providers which deliver medical, mental health and support services.[5] The graphic developed by the DOH and used in training for Health Homes and MLTCPs depicts the process.

[5] In addition to the six housing contractors, there are six Health Homes which directly and/or through 13 "downstream providers" provide care management. It should be noted that some of these downstream providers work for more than one Health Home and some are even part of Housing Contractor agencies, like FOO, FEGS and JBFCS. There are 25 MLTCPs and seven managed care plans also involved in providing care management to class members. Some class members are enrolled in both Health Homes and MLTCPs.

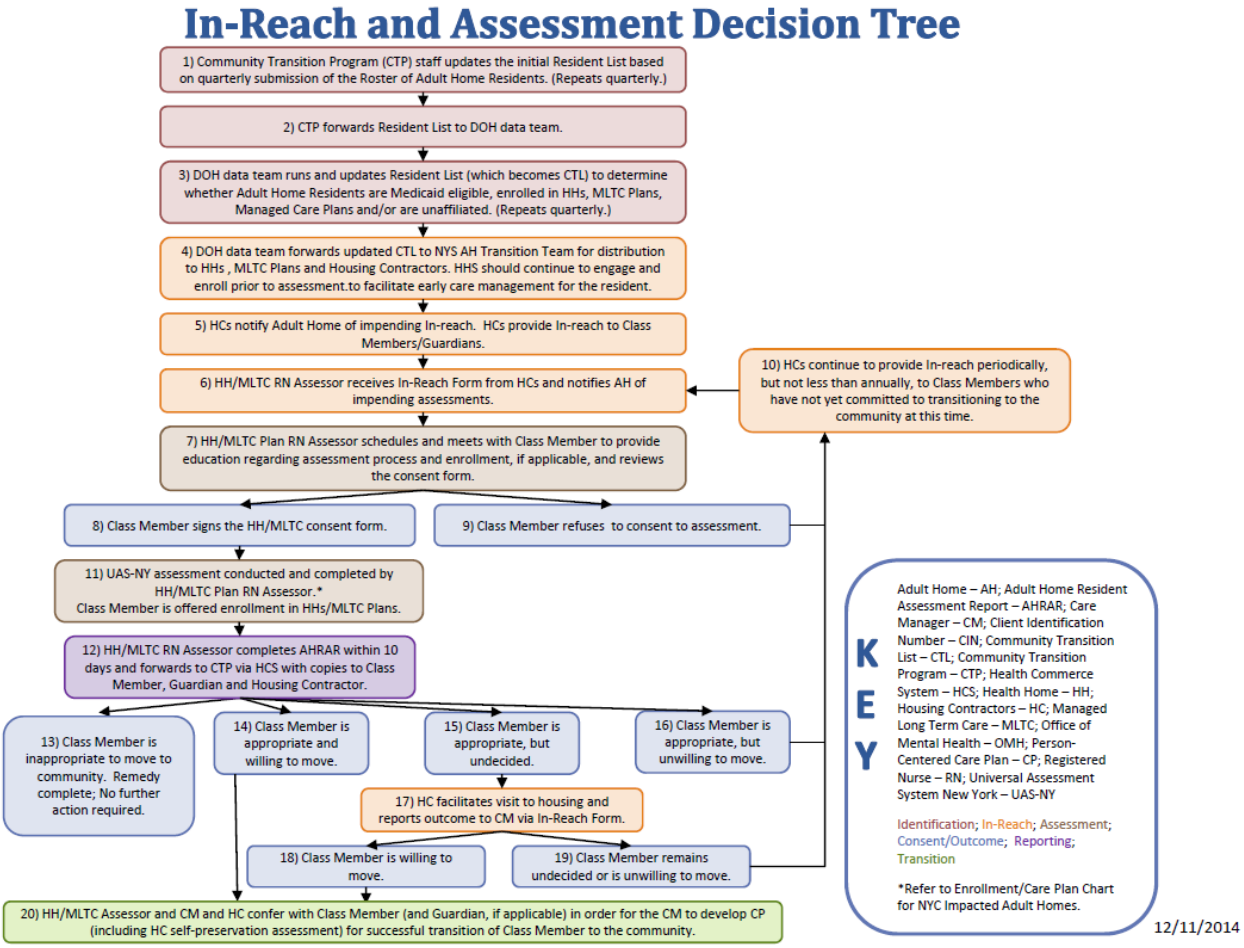


Fig. 2. Decision Tree

An overview of the major implementation activities conducted over the report period is depicted below.

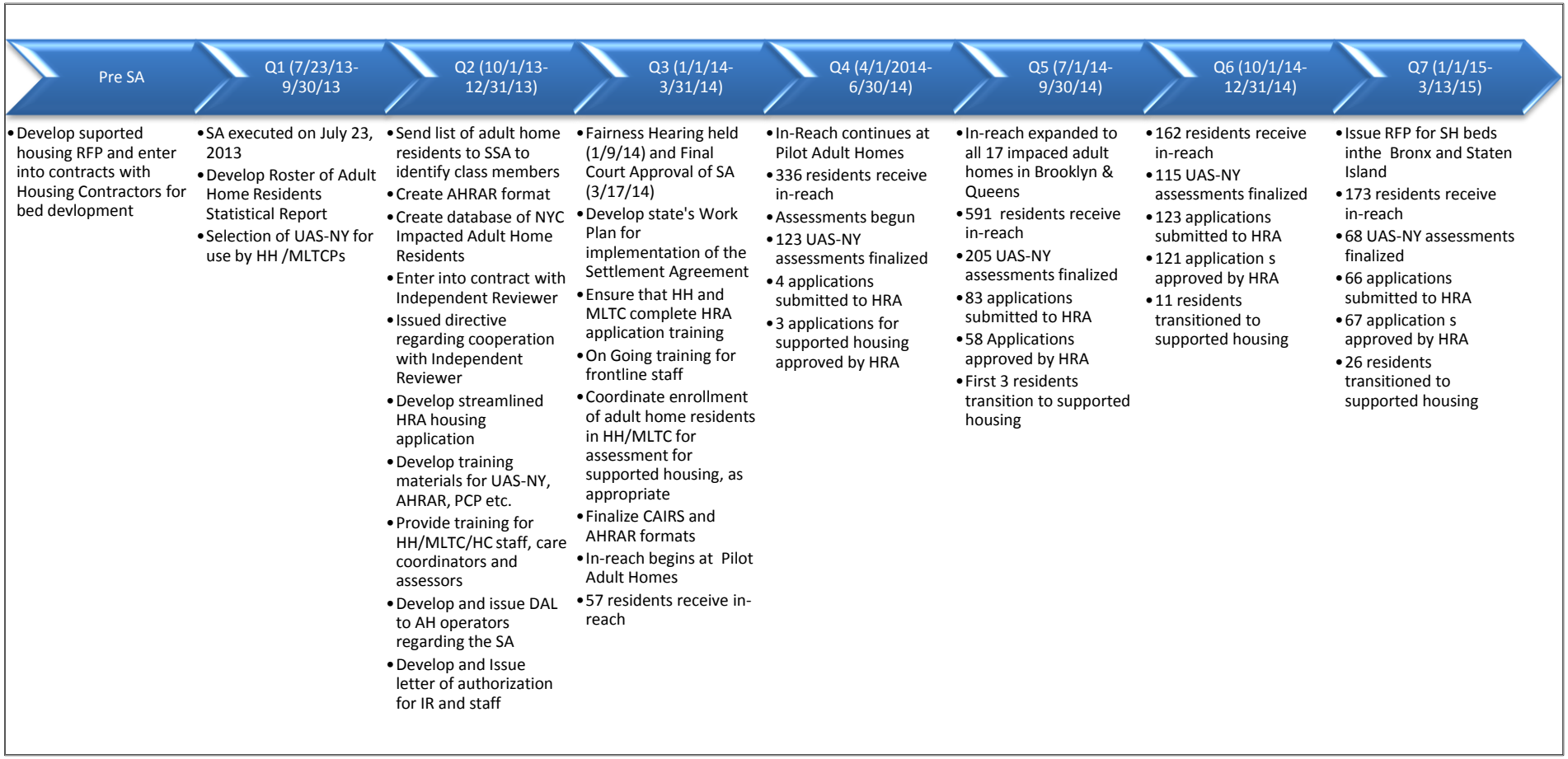


Fig. 3. Timeline of Implementation Activities

b. In-reach.

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

The State's work plan target was to complete in-reach for 558 residents of the Stage I homes and 1,000 class members in the first year. As of March 13, 2015, the State reported that there had been at least one in-reach contact with 1,256 class members in 17 impacted adult homes. For the first three months of the first year, the in-reach efforts were limited to three Stage I pilot homes assigned to one Housing Contractor, to test the process and identify and address any issues that surfaced before extending the effort to the remaining adult homes.

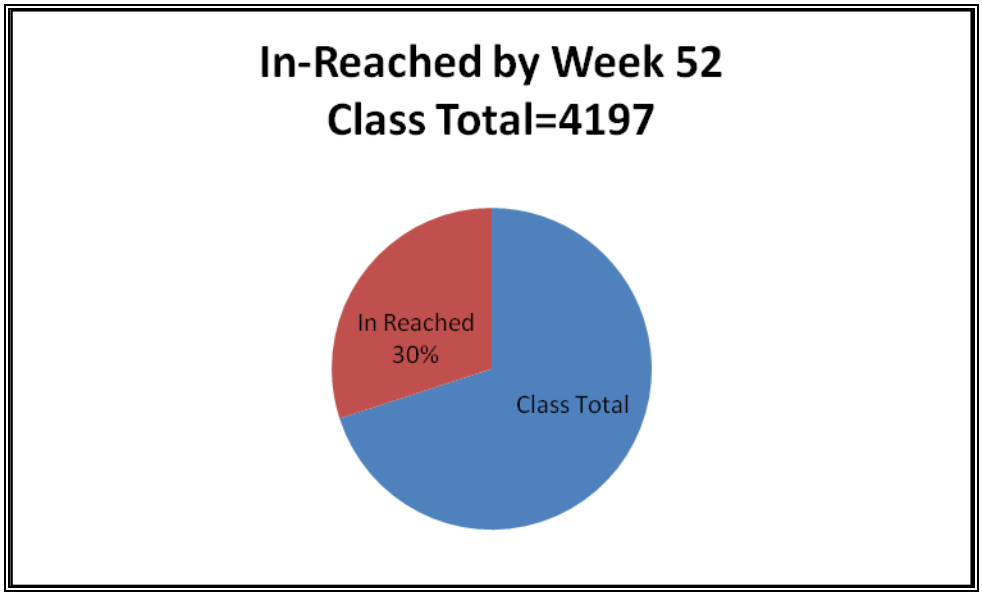


Fig. 4. Class members receiving In-Reach

While this is an understandable strategy, the Independent Reviewer had recommended a different approach to in-reach, by extending the initial effort to ***all*** class members who had expressed an interest in supported housing, regardless of the adult home in which they resided, recognizing that there were likely many class members who had been waiting for a long time to move to the community and did not require substantial in-reach or education about supported housing.

The Independent Reviewer identified several benefits both to the class members and to the implementers in pursuing this strategy. First, it would be responsive to the class members' expressed desires to live in supported housing. Second, it was likely to provide early momentum for this initiative and some concrete outcomes in the first year. This is particularly the case given the substantial educational effort that seemed to be necessary for the feasibility of supported housing to be more broadly embraced, especially among mental health program staff that provides services to class members. Third, it was likely to engage a broader range of supported housing providers, Health Homes and MLTCPs in implementation of this Settlement Agreement. There are many parties who had essentially been waiting on the sidelines for this initiative to start since the supported housing contracts were first let out in February and March 2013, and this would jumpstart the implementation process beyond the initial three homes. Perhaps most importantly, the Independent Reviewer believed that adult home residents are most likely to learn about the potential of the option of supported housing as they see people whom they know making this transition. This would be an important educational tool to supplement the in-reach activities required under the Settlement Agreement.

The State adopted a modified version of this recommendation by initiating a "fast track" process ***within*** the three pilot homes for class members who had previously expressed an interest in supported housing.

During observations by the Independent Reviewer Team of the in-reach process, several recommendations were made to the Defendants. These included requiring the in-reach workers to use a script or checklist to make sure that they covered all essential information about the Settlement Agreement, about the choices available to the class member, about the services available in supported housing, and about the financial implications of the decision. We also recommended the use of brochures and the handing out of business cards so that class members would have a ready resource to access as questions arose subsequent to the in-reach meeting. We also noted that in some of the adult homes there was inadequate privacy for the discussion with class members, and recommended that the adult homes be requested to provide a private space for in-reach workers to meet with class members. The Independent Reviewer also recommended that the in-reach workers consider holding group meetings with adult home residents to explain the Settlement Agreement and the choices available to them, followed by individual sessions. Each of these recommendations was implemented by the state and by the Housing Contractors.

On July 1, 2014, authorization for in-reach was extended to 14 additional adult homes in Brooklyn and Queens by the remaining five Housing Contractors, although the actual in-reach activity did not commence immediately. Initially, in-reach was limited to adult home residents on a Fast-Track List (FTL), who had previously indicated an interest in supported housing by serving as a named plaintiff, speaking at the fairness hearing, writing a letter to the Court, or otherwise making an affirmative effort to seek supported housing. In these 14 homes with 2,452 class members, there were 415 (16.92%) residents on the FTL. Due to concerns about the capacity to complete assessments reasonably soon after the in-reach (which is discussed in greater detail in the following section of the report), the pace of in-reach to these additional homes was later restricted to no more than 10 residents per home per month who consented to

assessment for supported housing. However, in actuality the pace of in-reach was substantially less than that. While the restricted pace would have permitted 140 new in-reaches and referrals for assessment per month at the 14 additional adult homes, for most months there were less than half that number of new cases in in-reach.

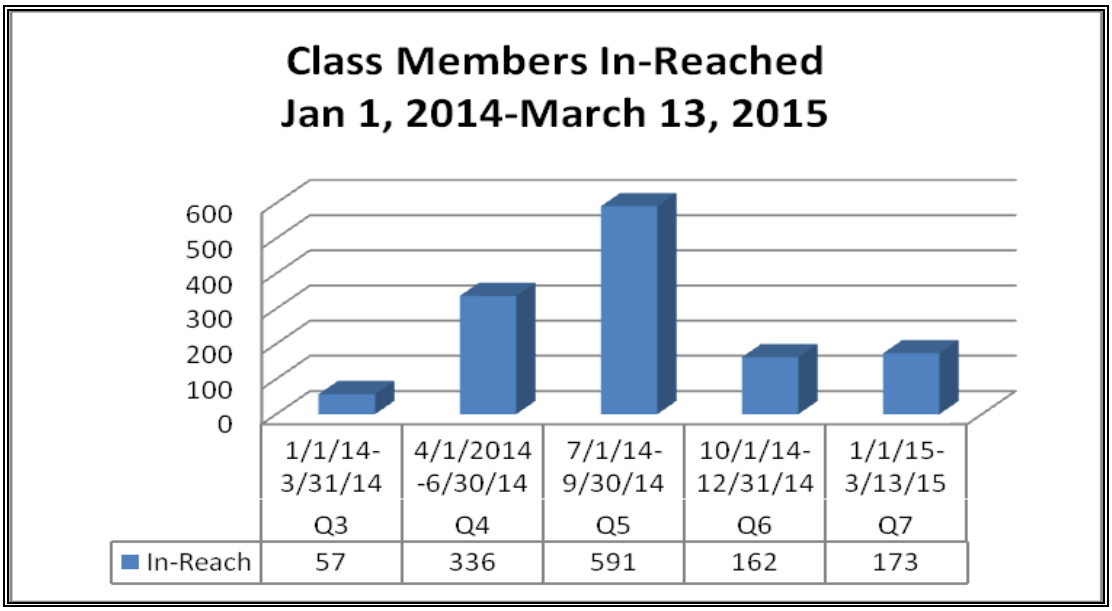


Fig. 5. Number of class members in-reached by quarter

The effect of these decisions has been to slow the pace of the work that needs to be done. While the concern to avoid exacerbating the assessment bottleneck is understandable, the strategy of deliberately slowing down in-reach has had the effect of postponing this task to a later time when the Housing Contractor staff also will be busy with the heavy workload of transitioning residents who have been approved for supported housing. The allocation of work responsibilities is such that the Housing Contractors have workloads at the front-end of the process (in-reach) and the back-end after assessments are completed and HRA approval is obtained (conducting intake interviews with residents approved for supported housing, arranging visits to prospective apartments, locating apartments, furnishing them, working out landlord-tenant issues, utilities, and facilitating movement to supported housing). Keeping Housing Contractors idle during the assessment phase which occurs in the middle simply puts off work that could be done to a later, busier time.

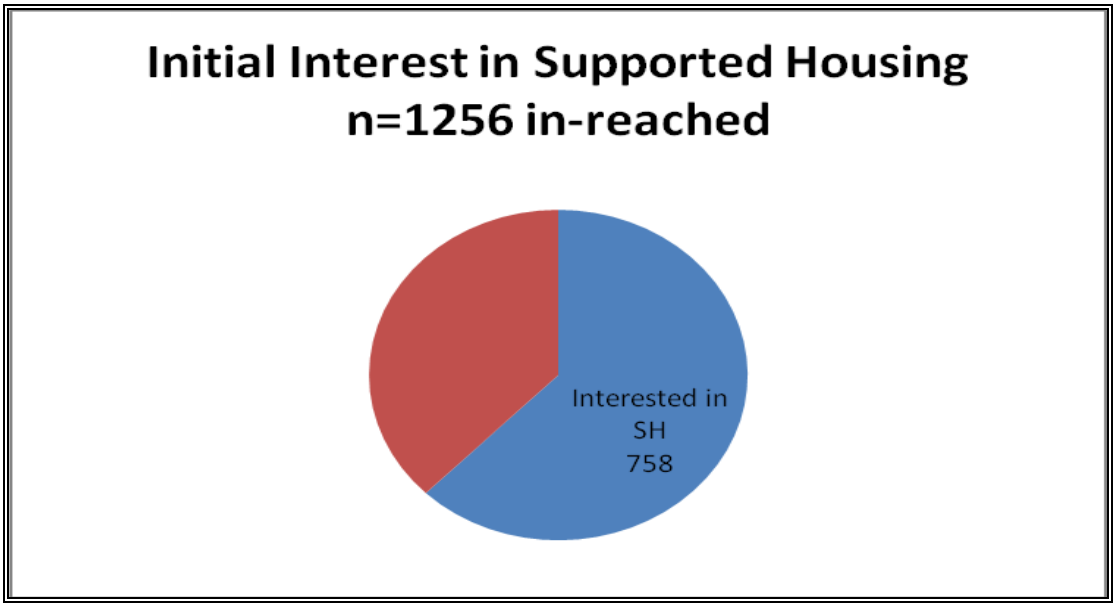


Fig. 6. Class members expressing initial interest in supported housing

Forty percent of the class members receiving in-reach did not express interest in supported housing. Under the terms of the Settlement Agreement, they will have at least an annual opportunity to receive additional in-reach to discuss their option to move to supported housing or another less restrictive community living arrangement. The Independent Reviewer anticipates that the rate of positive response at in-reach will increase substantially as adult home residents have greater opportunities to learn about the successful transition to supported housing of people they know, and as the recommendations made in this report regarding the method of in-reach and care planning are implemented.

In a number of cases, residents came to the meeting with the in-reach staff and quickly announced that they were not interested in moving or discussing their options any further. During some observations, the residents immediately said they did not want supported housing. In one case, the worker probed for the reasons, and discovered that the resident had a job in the deli, a roommate he gets along with and is happy. She thought he had a well-reasoned decision for now.

There are indications that some residents have been discouraged by other residents from exploring their options to leave the adult home. The Independent Reviewer has had reports that at one adult home the president and vice president of the resident council have been actively discouraging residents from moving by fanning their fears of being "stuck" in housing they don't like, and being unable to return to the adult home once they leave. There have also been reports that adult home staff has been contacting family members to raise concerns about the prospect of their relatives leaving the adult home. The Independent Reviewer heard the outcome of one such contact when a resident loudly refused to meet with the in-reach staff, and proclaimed "My mother said it's not for me and I'll never amount to anything."

As will be discussed later in this report, approximately 15% of those who initially expressed interest in supported housing changed their minds either during the assessment process or subsequently.

c. Assessment

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

The assessment phase of the transition process consists of three components: a face-to-face assessment of the individual by a registered nurse who completes the mandated report: UAS-NY; securing and reviewing a comprehensive psychiatric evaluation conducted by the individual's psychiatrist within the past six months; and formulating recommendations for housing and community services, based on the UAS-NY assessment and the current comprehensive psychiatric evaluation, which are recorded on an Adult Home Resident Assessment Report (AHRAR). Beginning in August 2014, all three documents are forwarded by the assessing entity to DOH for review. Upon DOH's approval, a final AHRAR is prepared by the assessing entity and distributed to DOH, the Housing Contractor, the Care Manager and other appropriate parties. The final AHRAR, UAS-NY and psychiatric evaluation are forwarded to the HRA along with an HRA application by the assessing entity, thus beginning the HRA review phase of the transition process.[6]

In the training provided by DOH in December 2013 for Health Homes/MLTCPs, the assessment and care planning process was depicted in the graphic below:

[6] For the purpose of reporting data in this report on timeframes for the assessment phase, two points in time are utilized: the date that the UAS-NY is completed by the nurse assessor and the date the final AHRAR is distributed to appropriate parties.

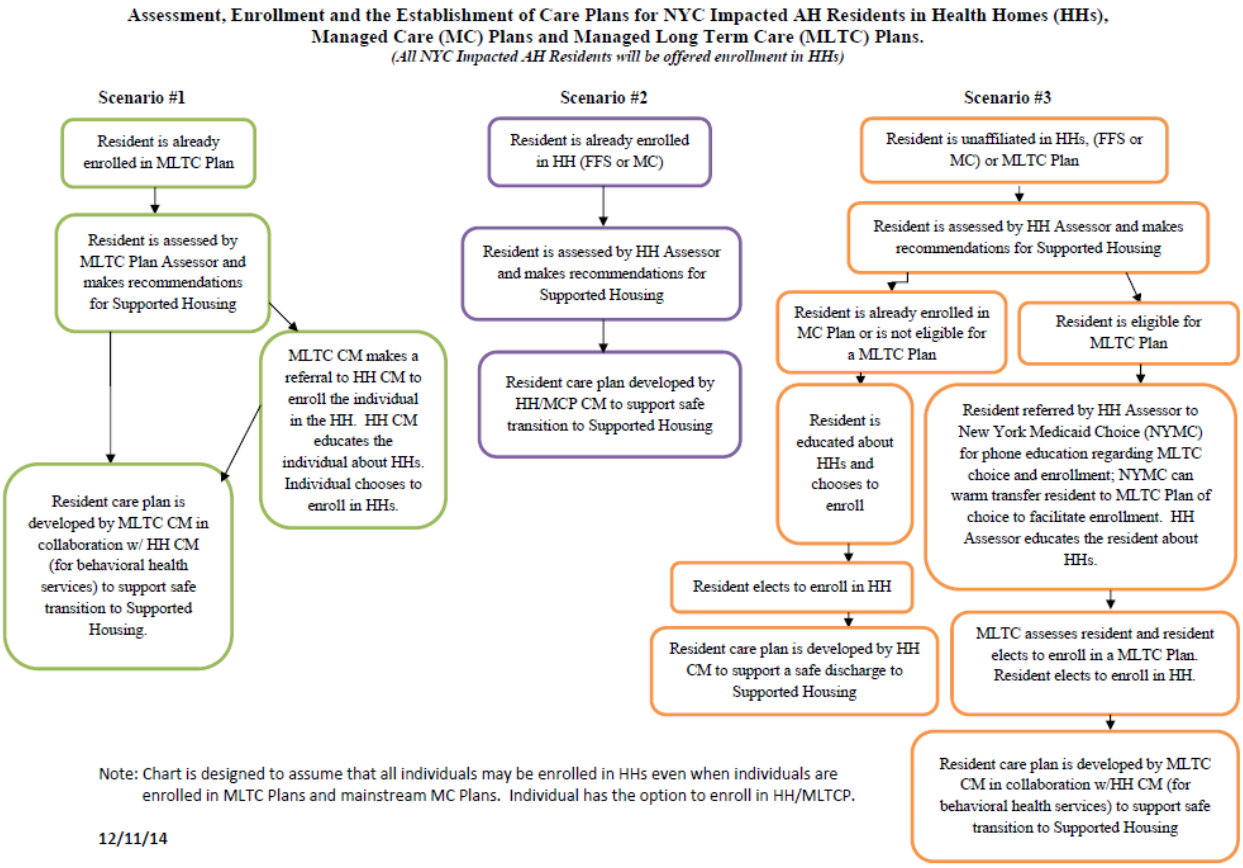


Fig. 7. Flow Chart

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

Although the state's work plan had anticipated starting assessments in mid-February 2014, and completing them within 15 business days of receipt of the in-reach forms submitted by the Housing Contractors, this expectation ran into numerous unanticipated difficulties. The State's work plan anticipated conducting a quality assurance review of 10% of the assessments for the first six months, but due to the issues the DOH encountered in the course of their review of the Adult Home Resident Assessment Reports (AHRAR) which summarize the results of the assessment conducted by a registered nurse, this plan was altered to review 100% of the AHRARs, and later, at the recommendation of the Independent Reviewer, extended to review additional supporting documentation underlying the AHRAR. The initial goal of completing 558

assessments within 180 days and 750 within the first year (30% of the four-year requirement of 2,500) was not met. As of 3/13/15, 401 final AHRARs were submitted to DOH, which require the completion of the UAS-NY Assessment as well as submission of a recent psychiatric evaluation. This is 53% of the 758 cases of people who said yes to supported housing at in-reach and were referred to HH/MLTCPs for assessment.

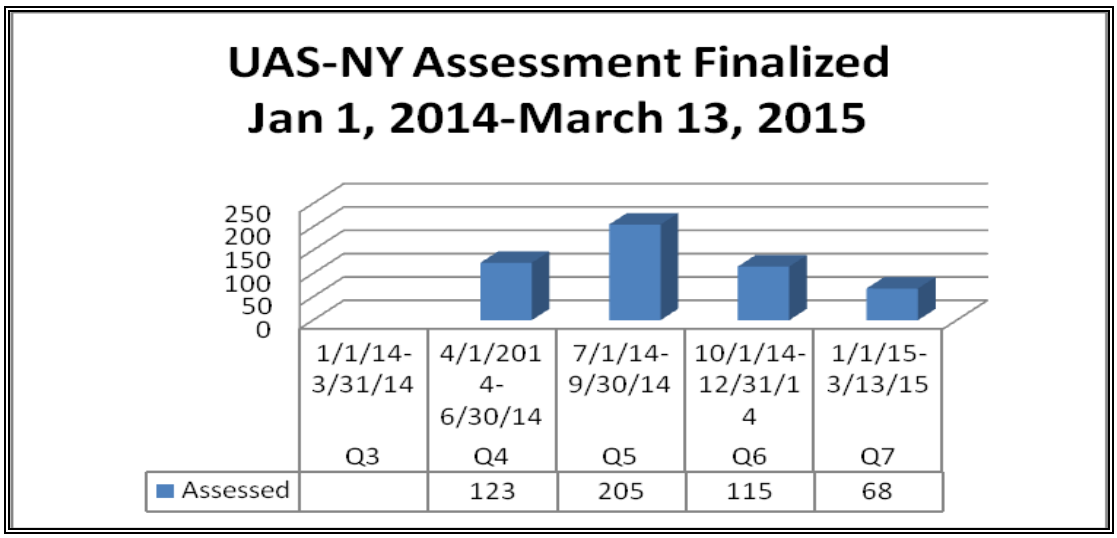


Fig. 8. Class members assessed, by quarter

1. Delays in completing assessments

There are many circumstances that slow down the assessment process including difficulties in assembling all of the documents necessary, such as obtaining a current psychiatric evaluation including an adequate psychosocial history; incomplete UAS-NY or AHRAR reports submitted by the assessors and repeated re-submissions of these reports to DOH for approval; and the ambivalence of some class members about the decision to seek supported housing.

As Fig. 8 indicates, the pace of scheduling of assessments has slowed significantly.

> *Robin G.,*[7] *a 55 year old woman, expressed an interest in moving after hearing a presentation about the Settlement Agreement from a member of the Independent Reviewer team at her PROS program in March 2014. She wanted to spend more time with her daughter and was placed on the Fast Track List, leading to her in-reach visit on 4/1/14 and UAS Assessment shortly thereafter on 4/9/14. An assessor from her Health Home submitted six AHRARs between 4/9/14 and 11/5/14, when it was finally approved by DOH. The earlier AHRARs were rejected for a variety of reasons: The UAS assessment done in April did not contain the needed comments on Sections D, E, and F in the Mental Health*

[7] All the names of class members in this report are pseudonyms. A Reference Table with the correct names has been provided to the parties.

Supplement, to address any possible histories of substance abuse; fire-setting; and domestic violence. Her comprehensive Psychiatric Evaluation was submitted on 8/5/14, but required more detailed history, which was received on10/20/14. Her HRA application was submitted and approved on 11/17/14. Her full package was sent to the Housing Contractor on 12/3/14 and six days later she was interviewed. The Housing Contractor began the search for a two-bedroom apartment for her as well as a compatible roommate.

When the Independent Reviewer team member met Robin again at the adult home on 1/13/15, she said that she had seen a sample apartment and liked it, and "was willing to live anywhere they found for her." When asked about the length of time the process had taken she said it had "not taken too long." She said she had been in the home for five years and "it was time to move on" but she was not anxious to move. She said that her Care Manager at the Health Home had kept her informed of the process once a month and she was fine with that. She looked forward to having her independence and would go grocery shopping and cook her favorite meatballs and spaghetti. She had cut her PROS visits to once a week, but said after she moved out she would go back to five days a week. Although the process had taken a long time, Robin took it all in stride and to her it "didn't seem long at all." Robin and a friend of hers from the adult home subsequently saw a two-bedroom apartment they liked and moved in on 3/23/15. In all, it took a little less than one year from the date of in-reach to the date of her planned move to supported housing.

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Carl P., a 52 y/o African American male, has been at an adult home for15 years. He appears to have been put on the Fast Track by a mental health program on site at the adult home, which also provides psychiatric coverage. He was assessed on 8/22/14. He attends a PROS program three days a week. His short term and long-term memory were impaired and he was a poor historian. He was very interested in moving out as he felt that the other residents gave him a hard time at the adult home and he wanted to live with another adult home resident, but had not asked him yet. He denied active psychiatric symptoms, or being hospitalized "recently," but again it was unclear from what was presented or reviewed by the assessor. Carl wanted to attend program every day when he moved out, so he wouldn't be home without anything to do. He was not concerned about cooking, budgeting or taking his meds, although he had no history of managing these tasks. He did attend the cooking class at the adult home, but only went once a month. An initial AHRAR had been submitted to DOH on 9/3/14 but as of 3/13/15, more than six months later, a final AHRAR had not been approved due to an incomplete psychiatric evaluation, and a psychosocial evaluation was being requested to supplement this information.

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Arlene F., 59, & Joan M, 61, who were roommates at an adult home, heard about the Settlement Agreement at a PROS program in March 2014 and asked to be on the Fast Track list as they were eager to move and share an apartment. They had lived in community housing with ICL together before admission to the adult home four years ago.

Arlene had received in-reach on 3/31/14; was assessed by a RN assessor on 4/17/14. There had been multiple AHRAR's submitted and psychiatric evaluations due to lack of adequate history. An addendum to the psychiatric evaluation was accepted more than six months later on 10/30/14, and the HRA application was submitted and approved on 11/17/14. The Housing Contractor interviewed her on 11/28/14. Similarly, Joan had received in-reach on 3/27/14; and was assessed on 4/11/14. The first of many AHRARs was submitted on 5/29/14 and another on 6/27/14, which DOH approved on 7/11/14. On 9/12/14, the Health Home informed DOH that the delay in proceeding with the application was because its downstream provider, Services for the Underserved (SUS), had not received the HRA training to complete it. Subsequent AHRARs were submitted to DOH on 9/25/14, 10/30/14, and 11/5/14, before it was finalized and submitted to HRA on 11/13/14. On 11/14/14 the application was found to be Unable to Complete (UTC) due to an incomplete Comprehensive Psychiatric Evaluation and it was noted that "the assessment of 9/4/14 is missing all even numbered pages." The application was resubmitted and approved for Supported Housing on 11/18/14, seven months after the date that she was assessed. The Housing Contractor interviewed her on 12/9/14.

They approved of a two-bedroom apartment and were slated to move in on 1/22/15. A 21 day Transitional Call for Joan was cancelled on 1/9/15 because she had been admitted to the hospital for pneumonia, and later developed sepsis and was in the ICU. Arlene had informed JBFCS that she would not move alone at this time and they agreed to hold the apartment until the situation was clarified. JBFCS was concerned that if Joan did not make it, Arlene would not take it well and become very depressed.

When the Independent Reviewer team member met with Arlene on 1/12/15, in speaking of the process that has delayed the move this many months she said, "some of the paperwork got messed up" and "the nurses didn't know how to resolve the problems." She said she was frustrated with the wait, and while she "didn't give up" she "started to doubt it." She mentioned getting negative feedback from other clients at the adult home who would tell her "it was never 'gonna' happen." She did say that she was kept apprised of the progress by regular contact with her care manager, and sometimes from the Housing Contractor. She said that her care plan called for Meals on Wheels until her Food Stamps kicked in, but most other things, like cooking, cleaning, budgeting and

shopping she could do by herself. She said she might miss some of the friends here, but little else.

She said she had visited Joan in the hospital and had no intention of moving until Joan was better. Joan subsequently passed away on 1/18/15. Although Arlene initially wanted to put off her plans to move, she viewed another apartment with her friend Robin from the adult home, and they moved on 3/23/15. In all, it took almost one year from the date of in reach to the point of her transition to Supported Housing.

2. Cases in Limbo

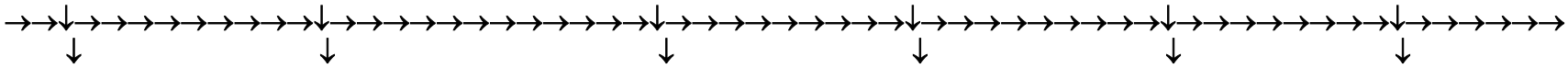
As of 3/13/15, a UAS Assessment has been finalized for 511 class members. Of those that had a UAS Assessment finalized, 17 were noted as having refused the assessment and 13 as having refused transition. Of the remaining 481 class members with a finalized UAS, 276 had a complete assessment package (UAS; the comprehensive psychiatric evaluation; and the AHRAR) submitted to HRA by 3/13/15, leaving 205 class members waiting for their applications to go forward. Of these class members, 127 or 62% had their UAS finalized between 4/11/14-10/31/14, and have been waiting in limbo for a median number of 190 days for their applications to be completed and for it to be sent to HRA. Given that the UAS and the psychiatric evaluations expire after 180 days, most of these class members will have to be reassessed, further delaying the process. All of the 205 class members with a finalized UAS have been waiting a median of 158 days for their applications to proceed. In fact, 145 of the 205, or 71% of these class members, have not yet had an initial AHRAR submitted to the DOH Community Transitions Program (CTP). ***As of 3/13/15, 100 of these class members had a finalized UAS more than 165 days ago, and would most likely need a new UAS as of the filing of this report. In light of these findings, the Independent Reviewer recommends that the HH/MLTCP be advised to begin the process of updating the UAS for these class members and all others whose assessments are expiring.***

On 7/29/14, a member of the Independent Reviewer's team observed the assessment of Oscar V., 63, a Vietnam Veteran who is a paraplegic, post Stroke, using a motorized W/C. He had a friend, Diane, sit in on the interview to assist him as he said he could not read. Throughout the assessment he seemed a bit confused, and appeared to have some memory/cognitive deficit, making him very susceptible to being led to answers, which Diane corrected several times. For example, he talked about his wife dying in June. The Nurse, asked "last June?" to which he said yes, and his friend corrected him, saying it was before she was in the home four years ago, or when he first came to the home seven years ago. So a lot of what he reported, including not having a mental illness, or having received treatment by a psychiatrist, did not seem to be accurate (he reportedly sees a therapist who contracts with the AH, weekly on-site).

Following the completion of the UAS assessment, the nurse assessor informed the reviewer that she did feel that Oscar could live in supported housing with sufficient supports. Oscar reported that he had a girlfriend in the home that he wanted to live with, who is also a class member (although he didn't think she was). Living with her would address some of his needs that living alone would challenge. Oscar needed a psychiatric evaluation, as he apparently has not had one in some time. When the Social Worker at the Adult Home called the psychiatrist that they contract with about doing an evaluation of Oscar, he said to have the MLTCP call him to arrange for compensation, as it will take an hour, as opposed to just billing Medicare/Medicaid. On that date the Adult Home's Administrator said he would arrange for another psychiatrist to do the evaluation, which apparently never happened. The UAS was finalized on 7/30/14, but as of 3/13/15 an initial AHRAR has not been submitted to DOH. On 3/27/15, DOH reported that they last spoke to the Social Worker at the Adult Home on 12/9/14 and was told he had to speak with the psychiatrist, and the MLTCP last called the home on 11/14/14. Oscar is still waiting for the psychiatric evaluation as he sits in limbo, 240 days since he was assessed, or 60 days since the assessment that was conducted has expired. The difficulty getting psychiatric evaluations for class members who are treated by the psychiatrist at this home has been reported to DOH and is under investigation.

Median Length of Time in Days from In-Reach, through Critical Stages in Transition Process, to Placement (with number of cases and range of days for each stage)[8]

From In-reach
By Housing Contractor
(Day1) to:



Referral to MLTC/HH For Assessment & Housing/Service Recommendation*	UAS-NY Assessment by Nurse	Final MLTC/HH AHRAR Report/ Recommendations to DOH	MLTC/HH Application to HRA	HRA Approval**	Transition to Community
Median: 1 Day N=751 Cases Range: 0-24 Days	Median: 41 Days N=502 Cases Range: 1-280 Days	Median: 127 Days N=392 Cases Range: 1-337 Days	Median: 132 Days N=273 Cases Range: 22-316 Days	Median: 140 Days N=246 Cases Range: 23-321 Days	Median:203.5 Days N=40 Cases Range: 131-360 Days

*The assessment and recommendation phase by MLTC/HH entails: conduct of an assessment by an RN using the UAS-NY form; securing/reviewing a recent (within six months) comprehensive psychiatric evaluation and other documents deemed necessary; preparation of an Adult Home Resident Assessment Report (AHRAR) with housing and service recommendations; submission of these documents for DOH QA review and approval; remediation of any deficiencies identified by DOH; and distribution of the final AHRAR to DOH, the Housing Contractor, the class member and other parties.

** Post HRA approval activities include: Interview of client by Housing Contractor (HC); selection of apartment; furnishing it; arranging for utilities, community medical and mental health services, and Food Stamps as needed; transition/care planning involving client, MLTC/HH, HC and others as appropriate; client submission of 30 day notice to adult home; and final pre-placement call to assure elements of transition/care plan are in place involving DOH, OMH, MLTC/HH, HC and others as appropriate.

[8] The total number of cases (and thus the range/median # of days) is based on the availability of accurate dates for the two points in time being measured. For example, the weekly report for week 52 indicated that 511 UAS-NY Assessments were done, but we only had both dates (and accurate ones) for In-reach and UAS-NY RN assessment in 502 cases. The data reported are the best available and should be regarded as a close approximation of the actual performance.

Significant delays in the process occur between the time an in-reach referral is made to an HH/MLTCP for an assessment, and the whole assessment process described above has been completed. This process took a median of 127 days for 392 cases, and as long as 337 days –both of which are significantly longer than the 15 business days the process was anticipated to take in the state's initial work plan. As this report describes, there have been many factors that have contributed to the overall delays in the assessment process, leading the state to conclude that the target of 15 days for completion of the assessment was unrealistic. While this expectation has been modified to require the *scheduling of a visit* by an assessor within 15 days of receiving an in-reach form, it has not been replaced by a target time for completing the whole assessment process and submitting a final AHRAR.

Other aspects of the process accounted for lesser delays. The HRA approval process took a median of three days for 248 cases, and the transmission of the HRA approval to the Housing Contractor took a median of four days for 223 of these cases. From the Housing Contractor's receipt of the housing package to the actual move to supported housing took a median of 96 days for the 40 cases thus far, including the 30 day notice of the move to the adult home.

3. Declinations of Assessment or Transition

As of March 13, 2015, 113 of 758 (15%) class members who expressed interest in transitioning upon in-reach declined either assessment or transition during the assessment phase of the transition process. To better understand this phenomena, Independent Reviewer staff reviewed AHRAR reports for 21 of these individuals. Additionally, some class members and Housing Contractors were interviewed.

In all but one of the AHRARs reviewed, the assessor provided a narrative description of the reason for the declination. In many cases, the explanation was a brief one-liner, e.g., "Member doesn't want to transition at this time" or "Member stated 'I don't want to move anywhere. I want to live here.'"

In other cases, the explanations were longer and described the residents' reasons. In some of these cases, the resident's choice seemed reasonable. For example, one individual indicated that she wanted to move, but only if she could return home to her husband if he would have her back. In another case, the resident did not want to move because of her medical condition; she was undergoing chemotherapy for cancer at the time.

In other cases, however, the class member's decision appeared to require follow up. One individual who expressed an interest in moving at the time of in-reach told the assessor at the time of the assessment that he did not "feel ready to be on his own," yet there was no information about what would help him to get ready or support him if he moved. In another case, the individual wanted to move, but to a different state. In two other declinations, it appeared more work needed to be done by or with guardians. In one case, the guardian had reportedly not received in-reach

information needed to make an informed decision; in the second case, the guardian reportedly indicated that a court order would be necessary to facilitate transition given the individual's history.

> *Patrick F, 57years old, has lived in the adult home for seven years and another home before that. He last lived alone 30 years ago "before I got sick." When the assessor and the Independent Reviewer's staff arrived the day of the assessment he said he had changed his mind. He was concerned that "if something goes wrong, there wouldn't be anybody (the staff) to help me." He spoke of the Settlement Agreement being "very seductive", and acknowledged that he was not perfectly happy (here), but liked having an aide who did his laundry and put his clothes in a drawer and said, "I am treated like a king here." He mentioned that he has known the Asst. Administrator for 22 years from his current and prior adult home, and that she brought him here. "I think she kind of wants me here," and when asked if she spoke to him he said: "she gave me a look and that was enough." He acknowledged that if he left it would disappoint her. Then he said his psychiatrist is also against it. When asked to explain, she said, "she told me all about it, and reading between the lines she is telling me don't go."*
>
> * * *
>
> *Freddie C., 46 years old, said he has lived in the adult home since July 31, 2003. He was placed on the Fast Track when he expressed an interest in moving to staff from CIAD and affirmed his interest during in-reach July 2014. However, he refused to be assessed, saying he had changed his mind. When meeting with the Independent Reviewer's staff, he spoke of not being happy in the adult home and "wanting to be independent and have a normal life." He said he had never lived on his own and had been psychiatrically hospitalized many times, starting at age 13. He said he lived alone for one month in his family's apartment after his mother passed away, "but I had no money, just $300 SSI, so I came here (adult home.)" When asked why he refused the assessment, he said his psychiatrist and his therapist said he was not ready because of his problems with taking his oral medications, as he does receive a long-acting injection every three weeks; and he acknowledged that that he "stops from time to time…last week I didn't take my meds," which he attributes to the side effects, including difficulty having an erection. He was proud that he was one of only a few residents that had his own Direct TV account that he maintained from money he saved with his therapist's help. His therapist said he could move with his roommate, Michael, when they are both ready; but Michael's mother is preventing him, saying: "when I'm gone you can do whatever you want."*

* * *

> *Jack E., 57 years old, has been living at the adult home since 2006. He agreed to in-reach in August and was assessed in September 2014, after which he changed his mind about moving out. When interviewed by the Independent Reviewer's staff, he said that he originally was interested in moving. "I liked the idea of having my own place." Jack said he changed his mind because "I have medical issues that would make it hard for me to get around (if living on my own)." Although he didn't want to discuss what his medical concerns are, he said he liked that the adult home took care of his medical needs and a van took him to appointments. He said "I feel better here than (when I was) on the outside." When asked about his life in the community, he said, "when I lived alone I was up and around more."*

Interviews with residents and others raised the possibility that assessors may influence class members' decision to decline assessment/transition.

While mentioning her own concerns about her health and her sister-in-law's opinion of her inability to live on her own, during an interview with Independent Reviewer staff, Joyce C. also related that *"the nurse who came to assess me had some comments about my ability to live on my own."* She indicated this was a contributing factor to her decision not to move.

> *Carol C., who had sustained multiple injuries following an assault in the community a year earlier, reported she initially told the nurse assessor that she was not interested in supported housing as she was using a walker and she walked away from the assessor. But when she learned she could get an apartment in a building with an elevator, she contacted the assessor and told her she was interested and wanted to be assessed. She said the assessor "started going on about the trouble I would have going to the supermarket, the bank, the Laundromat" and "she said that I wouldn't be able to do it." She said the assessor told her to call the Housing Contractor back in January (2015) and tell them you are interested. Carol reported that she didn't see the point of calling in January, since she would still be on a walker, most probably until April 2015. When asked if the assessor had told her that she could get services in her apartment that would help her with cleaning, laundry, cooking, banking, etc., she said "no, why didn't she tell me that?" Carol told Independent Reviewer staff she was very much interested in moving now, with or without her walker.*

Staff from the Housing Contractor, CommuniLife, reported that Aldo B., who had expressed interest in moving during an August in-reach session and was scheduled for assessment in October 2014, told them that the assessor told him *"this program is not for you."* The Housing Contractor staff wrote up Aldo's report and sent it to OMH which shared it with

DOH. It is their understanding that OMH and DOH were going to wait to see what was reported on the AHRAR. As of March 13, 2015, an AHRAR has not been submitted to DOH.

In early 2015, the Independent Reviewer noted that a disproportionate percentage of declinations were coming from a single assessment entity and a particular nurse assessor with the entity. The concern was shared with the State which has initiated a review of the matter.

As indicated in the foregoing, factors influencing class members declinations of assessment or transition are varied – ranging from well-founded resident choices such as the desire to be reunited with one's husband or to move after a medical condition has been resolved, to residents' own sense of readiness or perceptions, perhaps shaped by their interactions with an assessor, to more concrete factors such as the need for information or action for or by guardians.

Of concern to the Independent Reviewer is the fact that Housing Contractors and/or care managers who are in the position to address reasons behind the declinations are not informed of them for months. Typically Housing Contractors and care managers learn of assessment outcomes, including declinations, upon receipt of a final AHRAR distributed by the assessing entity. On reviewing the 21 cases declining assessment/transition, the Independent Reviewer found that it took anywhere from 1 to 167 days from the point of assessment until the final AHRAR was distributed. The average number of days was 59; the median number of days was 56.

As of March 13, 2015, three of the 21 individuals who declined assessment or transition when they first met with a nurse assessor have had a subsequent in-reach session during which they expressed a desire to move. They have again been referred for a nursing assessment.

The remaining 18 individuals who declined assessment or transition have not had a subsequent in-reach session as of March 13, 2015. It has been anywhere from 164 to 273 days since they declined assessment or transition when they first met a nurse assessor after initially expressing a desire to move.

The Independent Reviewer recommends that when a class member declines assessment/transition after having expressed an interest in moving at the time of in-reach, the Housing Contractor and care manager should be immediately informed of the declination and the reason so they can take timely and appropriate follow-up action.

> *Joe I. . 57, has lived in the adult home for 11 years. He explained that he separated from his wife and family when they lost their home to foreclosure. He then became homeless and came here. When asked why he originally expressed an interest in supported housing, he responded "because everyone was doing it; it was the thing to do…I got caught up." Joe said he wanted "to cook my own food . . . buy things that belong to me . . . do things with my 21 year old twin sons." On changing his*

mind at the point of assessment, he said: "if it was five to seven years ago I would have done it." He explained that four years ago he had heart surgery and a stent was inserted. "Now I can stay here at my leisure, not worry about going shopping for food…I am comfortable here." Joe said he has a few friends here, attends the Ocean View Lodge Program three days a week in Staten Island where he socializes and attends AA meetings and group therapy. The adult home Administrator noted he also has a girlfriend at the adult home that may have influenced his decision.

* * *

Barry L, 52, has been living in adult homes since 1997 and had previously met the Independent Reviewer and his team at his Mental Health Clinic (MHC) in December 2013, when they were first meeting with class members and talking about the Settlement Agreement. Although he was mildly interested at that time, saying "maybe in three to five years," he was ambivalent because of prior bad experiences with roommates when living in independent housing. However, he was a Fast Track member who spoke at the Fairness Hearing and told the in-reach team that he was interested. When asked why he had refused the assessment, Barry explained that he was on his way to his day program when the Administrator came out to tell him the assessor was here. He said he told the Administrator he had important things to discuss at program and "had to go." Since that time he often hangs out with the in-reach team on the day they visit the home, and he said he has spoken to them about wanting to be assessed.

* * *

Genevieve F., 58 years old, has been at the adult home for 15 years, and attends the on-site Mental Health Clinic (MHC). She was placed on the Fast Track by MFY, which led to her in-reach in April 2014. However, when she was to be assessed by the assessor from her Health Home, she refused. When she met with the Independent Reviewer's staff, she said she had a problem with "having to declare ourselves as disturbed" to qualify, and that she is "not disturbed." When asked about her initial interest, she said "I want to get back to my own housing, be independent." But she was concerned about the neighborhoods where the housing would be offered to her, and expressed an interest in living in Bedford Stuyvesant, where she has lived in the past. She said she would think about it and let the Housing Contractor know if she changed her mind.

4. Referrals to other types of community housing

When the assessment recommends that class members require OMH housing other than supported housing, generally they are referred to the Center for Urban Community Services ("CUCS"), which is an OMH-funded referral program for various housing programs and provides administrative support for the NYC Single Point of Access housing program. [9] It receives about 30 referrals a week from all sources and reports there has been a recent surge in referrals from the Adult Home settlement. Several of the class members initially referred to CUCS were reassessed after a review of the AHRAR by DOH, and the recommendation was changed to supported housing, returning them to the process under the Settlement Agreement. Although referral for OMH housing other than supported housing are supposed to be sent to CUCS, the Independent Reviewer has encountered cases in which the care manager has made a direct referral to a specific housing program, by-passing CUCS.

CUCS receives referrals from various sources which are searching for housing, including the NY/NY program, the nursing home settlement, prison discharges, Assertive Outpatient Treatment, psychiatric center discharges, etc., including this Settlement Agreement. While the adult home referrals are supposed to get priority, so too do all the other referrals. Further diluting the effect of the priority is that this is not the only way in which referrals get to housing providers. In fact, CUCS estimates that 80% of the referrals that providers receive come to them from other sources which approach them directly.

The applications for alternate forms of OMH housing are made by the HH/MLTCPs, which are given three referrals to housing providers. They are expected to contact the providers within five days and the providers in turn are expected to interview the resident within 21 business days.

The burden is on the HH/MLTCP to follow up on the referrals that are made, but CUCS reports that there is no sense of urgency in doing so, perhaps because of the unfamiliarity of the MLTCP with OMH Housing and perhaps because there is no other urgency for doing so under the SA. There is no consequence for failing to comply with these timeframes, except for CUCS to report to the provider's funding source.

The referrals are a bottleneck because there are not a lot of vacancies and a high demand for those that do exist. Unlike supported housing which is permanent and for which there is a specific commitment for bed development under this Settlement Agreement, most of the alternate housing is transitional with an anticipated length of stay of 18-24 months, and there is no specific requirement to develop additional beds to meet class members' needs. The anticipated difficulty of transitioning adult home residents after 18-24 months may also play a role in the providers being reluctant to serve them. The provider can decide to accept the referred resident, wait list them or

[9] If class members are referred for non-OMH generic housing, such as senior housing, the responsibility rests with the MLTCP or Health Home care manager to follow up on the recommendation.

reject them as not suitable. In the last instance, CUCS or OMH may follow up to find out the reason for a rejection and may advocate to change the decision by helping think through how the resident's needs might be met with additional services.

Most people so far have been wait-listed, not rejected. But the wait list may expire when the HRA Approval does (180 days) and necessitate a fresh application and new psychiatric evaluation, which may lead to a referral for a different type of housing. CUCS does not know how fast this wait list moves, and applicants may choose to continue working directly with a housing provider after the referral expires, without informing CUCS of later developments. A person might be on multiple wait lists at different agencies but there is not a central place to keep track of this.

CUCS does training on filling out the housing application for different types of housing options. They report that they have provided training for staff of Health Homes but have not yet had a request to do such training for the MLTCPs.

The Independent Reviewer is concerned about the class members who are referred to CUCS to find housing. Their rights under the Settlement Agreement may be extinguished and there seems little likelihood that they will get housing anytime soon, as there is no dedicated allocation of beds other than for supported housing. ***The Independent Reviewer has recommended that notice be provided to class counsel prior to referring any class members for alternate housing. This recommendation recognizes that in the early phases of implementation there have been several such referrals for alternate housing that were poorly supported by the assessor, and later changed to supported housing.*** (See discussion *infra*, pp. 38-41) The State has added this information to the weekly report which is distributed to class counsel.

5. Training for Nurse Assessors

The State OMH and DOH have made a considerable investment in providing training for Housing Contractor, Health Home and MLTCP staff regarding the Settlement Agreement and the plans for implementation, and the various processes they entail. This training has been made available on multiple occasions to managers and executives, as well as to the frontline staff who will actually be involved in direct contact with class members, including peer advocates, in-reach workers, nurse assessors and care managers. While many of the training sessions were targeted at specific audiences such as HHs, or MLTCPs, there have also been training programs which brought the different groups together to encourage interaction and the formation of working relationships.

Nurse assessors must complete an online training program on the UAS-NY before they are authorized to perform assessments. In monitoring the assessment phase of the process, it appears there is a need for ongoing training for nurse assessors. While the Independent Reviewer's team met several assessors who had a strong and working knowledge of mental health programs and available community services, others indicated they are not comfortable making a specific

recommendation for the type of housing that is most suitable for the resident, due to their lack of familiarity with the various housing choices and the array of services that could be available to individuals. Initially, they were forwarding their AHRAR to the Housing Contractor for input. However, without more detailed information and supporting documentation regarding the assessment, the Housing Contractor was not prepared to make a recommendation.

The review team has also encountered cases in which the assessors indicated that the individual was not appropriate for supported housing and recommended another housing option. Yet the AHRAR completed by the assessor did not provide a sufficient explanation to justify the recommendation, or the conclusion was not supported by the clinical records. The assessors seemed unaware of and could benefit from additional guidance regarding the frequency and intensity of services that can be provided in supported housing as it appears that some recommendations for other types of housing were based on needing a significant level of supervision/support or nursing services. (DOH, understandably, requested that such individuals be re-assessed, thus adding to delays in the transition process.)

The DOH has taken steps to address this issue. Before the AHRAR is sent to the Housing Contractor it is sent to DOH for review. As recommended by the Independent Reviewer, in August, 2014, DOH began reviewing the complete assessment package: the AHRAR and the underlying documents - the UAS-NY and Comprehensive Psychiatric Evaluation - which should support the AHRAR's conclusions and recommendations.

DOH has also provided one-on-one training for the assessors whose cases needed re-assessment and more general training for all assessors, including a case-study style of training as recommended by the Independent Reviewer. The Independent Reviewer, however, believes more can be done to assist assessors and bolster the assessment phase of the process.

Currently, the assessment process is fragmented among many different direct and downstream providers, some of whom contract on a per diem basis for nursing assessments. Some assessing staff have little working experience with a mental health population, and assessing class members for transition may be just one element, and perhaps a minor one, of their routine daily duties. ***The Independent Reviewer stands by a recommendation offered on several occasions previously, which has received no clear response, that the State arrange for the performance of assessments under the Settlement Agreement to be assigned to a dedicated team of experienced psychiatric nurses to promote consistency, quality and timeliness of this critical function. This would also enable the State to better monitor caseloads, work assignments and performance expectations relative to the timelines and demands of the Settlement Agreement.***

The Independent Reviewer team has also noted that many adult home residents are not good historians about their medical and health care histories, and are frequently unable to identify their providers or the types of services they have received or when.[10] Although in-reach and

[10] The State's response to a draft of this report acknowledges that the "State has found that class members are often unable to accurately identify or provide contact information for their mental health provider."

assessment workers make efforts to obtain records from adult homes and other providers, the results of these efforts are highly variable. ***As has been recommended on several occasions, the Independent Reviewer believes that both the assessment and the care planning process could be aided greatly by conducting a review of the Medicaid data to identify current medical and mental health providers of the class members, and develop a snapshot of the services provided over the past 6-12 months which would be highly relevant to identifying their needs.*** This information should be provided to the assessors and the care managers responsible for the personal planning process.

6. Linguistic competence

The Independent Reviewer has heard of reports that language barriers have impeded the assessment/transition process. Reportedly, there have been instances in which it was believed that an individual was refusing the opportunity for assessment and transition, perhaps due to a language barrier.

The OMH has acted on this concern by instructing in-reach staff to document the preferred language of individuals on in-reach forms forwarded to assessing entities. Moreover, OMH also had the brochure used by in-reach workers translated into nine languages, and made these available to the Housing Contractors. During OMH and DOH trainings, both in-reach and assessment agencies have been instructed to avail themselves of translation services through language lines or other means. During these sessions, the agencies indicated that they either have translators on staff or use language lines. They have also indicated that these means are preferable to using adult home staff as translators/intermediaries in the in-reach and assessment stages of the process.

7. Access to current, comprehensive psychiatric evaluations

Completion of the AHRAR requires that the nurse assessor conduct the UAS-NY assessment and receive and review a Comprehensive Psychiatric Evaluation that has been completed within the past six months. The complete assessment package - UAS-NY, Comprehensive Psychiatric Evaluation and AHRAR – is required by HRA and is reviewed by DOH, to ensure its quality and completeness, prior to being sent to HRA.

The Independent Reviewer has received reports that assessing entities have had difficulty securing current and complete Comprehensive Psychiatric Evaluations. Reportedly, requests for such were not acted on in a timely manner or the evaluations submitted were not comprehensive or were older than six months.

Since the initiation of the assessment phase and reports of these problems, OMH and DOH have taken action to address the issue. OMH has provided guidance and training for agencies/psychiatrists it regulates concerning the Settlement Agreement, the need for timely and comprehensive psychiatric evaluations and their duty to respond to requests for such. (It should be

noted that at the time of in-reach, class members interested in transitioning provide consent for their psychiatrists to release evaluations to assessing agencies.) DOH has requested that adult homes provide it with the names of psychiatrists treating class members which are shared with in-reach agencies; previously, in-reach agencies would ask the individual for the name and contact information for his or her psychiatrist and the information received was not always accurate. And, on a case-by-case basis, both agencies have made follow-up calls: OMH to providers it certifies to ascertain the status of requested evaluations; and DOH to HH/MLTCPs regarding the status of evaluations they have requested and their efforts to follow up and secure such.

Nevertheless, the problem persists.

Reportedly, it is a larger problem with independent psychiatrists who are not affiliated with an OMH certified/regulated program but who work under contract with the adult home. These psychiatrists have relationships with adult home operators and may have a conflict of interest in facilitating the departure of a resident by complying with a request for a comprehensive psychiatric evaluation. For example, the Independent Reviewer reviewed a case from an adult home in which the psychiatrist made it clear in the evaluation "that writer is questioning patient's ability to live independently" although there is nothing in the assessment to indicate that he met any of the exclusionary criteria for supported housing. In speaking with the representative from the Human Resources Administration, he made it very clear that statements like this by the treating psychiatrist on the comprehensive psychiatric evaluation weighs heavily in their decision to not approve the individual for supported housing and to recommend a more supervised setting.[11] In another evaluation, the same psychiatrist made it clear that the resident was not taking her medications and listed this and an altercation with another resident as the reason for the evaluation, rather than the need for an updated evaluation pursuant to the Settlement Agreement. A third resident at this home refused the assessment and attributed the refusal, in part, to his "reading between the lines" and knowing that the same psychiatrist did not think it would be good for him.

It should be noted that, despite requests from both the Plaintiffs and the Independent Reviewer, the state had not provided any information on the extent of this problem, namely how many assessments have not yet been completed due to problems with receiving timely and comprehensive psychiatric evaluations and which providers/psychiatrists are involved. In its response to a draft of this report, the State estimated that approximately 250-300 class members who have said yes at in-reach are awaiting the completion of comprehensive psychiatric evaluations. In addition to the measures discussed earlier, the State also reported that it has asked a

[11] It should be noted that the statement of the psychiatrist in this case did not identify one of the exclusionary criteria that would overcome the presumption in the Settlement Agreement that class members are qualified and appropriate for supported housing. The exclusionary criteria are: 1. Significant dementia; 2. Would be a danger to self or others in supported housing even if receiving the services available under the NYS Medicaid program, Medicare or another available program; or 3. Needs skilled nursing care that cannot be provided outside a nursing home or hospital. (Settlement Agreement, ¶ F. (5))

psychiatrist in the DOH Office of Professional Medical Conduct to call certain unresponsive or reluctant private psychiatrists to request the missing psychiatric evaluations.

If the data supports the contention that this is more of a problem with private psychiatrists working under contract with adult homes, the continued reliance on such physicians for quality and timely information requires attention. One alternative might be to arrange for a comprehensive psychiatric evaluation to be conducted by an independent practitioner, such as the individual's HH/MLTCP or a program certified by the OMH.

At one adult home it was reported that since July 2014 the psychiatrist contracted by the home, who treated almost all of the class members, was asking to be paid by the HH/MLTCP to do the evaluations. It was reported that the home recently contracted with another psychiatrist who, the Housing Contractor reports, is unaware of what is needed for these evaluations. As of 3/13/15, of the 25 class members at this home that said they were interested in supported housing, 11 have been assessed, some as early as July 2014, but only two who were assessed have had a Final AHRAR approved by DOH. As of 3/13/15, no applications have been submitted to HRA for any of the class members at this home. DOH has reported that the matter is under investigation.

8. Disenrollment from MLTCPs

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

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

It is expected that when an individual is disenrolled, the MLTCP will refer the individual to the Health Home that he has been matched with through DOH's loyalty match process. The MLTCP must also inform the Health Home where the individual stands in the assessment process and share any applicable documentation. Also, the MLTCP must notify the Housing Contractor of the change and the contact information of the Health Home. Sharing of information by the MLTCP is complicated when there is not an Administrative Services Agreement between the MLTCP and

the HH, as is reportedly the case with Centerlight and many of the Health Homes involved in this initiative. In addition, the consents signed by the individual do not routinely include the DOH or OMH. So in instances of disenrollment, including those by Centerlight, referenced above, while DOH may have all of the prior documents, including psychiatric evaluations that took months to acquire, they cannot share them with the new HH, which may have difficulty obtaining them from the MLTCP.

On November 3, 2014, DOH directed all MLTCPs to report the disenrollment of any class members to DOH to allow the State to immediately intervene and facilitate the smooth transition to another care plan and reduce the negative impact resulting from a gap in care management services. Most of the disenrollments to date have been from MLTCPs, primarily Centerlight, followed by subsequent loyalty matching and enrollment with a HH. Therefore, it would make sense to offer enrollment in the matched HH to the class member at the time that the class member says yes during in reach. This would jump-start the process, since the HH has particular expertise in working with individuals with behavioral health issues.

> *Julio S., 60 years old, said yes to in-reach by JBFCS on 4/2/14 and was assessed by Centerlight on 4/19/14. AHRARs were submitted on 7/1/14 and 7/8/14 and a Final AHRAR on 8/2/14, recommending him for supported housing. On 8/14/14, the HRA application was submitted and was Unable to Complete (UTC), as the psychiatric evaluation of 5/5/14 was not comprehensive enough and the UAS lacked a statement addressing the risk of arson. On 10/24/14, DOH asked Julio's mental health provider, to send an updated psychiatric evaluation and they faxed a 24 page evaluation dated 9/9/14, and sent it to Centerlight, However, on 10/16/14, the UAS expired as 180 days had elapsed. On 11/30/14, Centerlight disenrolled him. DOH reported that Alpha Care was the new MLTCP and as of 12/1/14 Julio was also loyalty-matched with CBC-HH. As of 2/10/15, CBC has reportedly received none of the materials from Centerlight, including the psychiatric evaluation that will expire on 3/6/15. DOH, which has copies of the prior UAS and the psychiatric evaluation, is unable to share it with the HH due to the absence of consent. Julio, whose application had been UTC for six months, needed a new UAS completed and submitted to HRA before 3/9/15, or an updated psychiatric evaluation would be required.*
>
> *Charles Z., 47 years old, said yes to in reach on 4/9/14, and was assessed by Centerlight on 5/1/14. An initial AHRAR was submitted to DOH on 7/9/14, and a final AHRAR on 8/18/14, which recommended him for supported housing, An HRA application was submitted on 8/27/14 and on 9/5/14 there was a conference call with HRA, which included Centerlight and DOH. The HRA representative informed them that they required more information about the class member's history of violence and intimidation of others, which was noted on the UAS. On 10/15/14, the HRA application was resubmitted, and included a revised comprehensive*

psychiatric evaluation dated 8/18/14, which was also UTC. On 11/10/14, HRA issued a final determination that the application was UTC and that the issue of prior history of violence and intimidation needed to be addressed. On 11/30/14, Centerlight disenrolled Charles, who was loyalty matched with CBC-HH. DOH reports that as of 2/2/14 CBC has been unable to acquire any of the materials that Centerlight has on this class member. Post Graduate Center for Mental Health, the downstream provider for CBC, will need to conduct a new UAS assessment and acquire an updated psychiatric evaluation, as the current evaluation expired on 2/14/15. As of 3/13/15, almost one year since he first said yes to supported housing, Charles is beginning the process anew.

d. HRA review process

At the beginning of October 2014 the Independent Reviewer team met with the Acting Assistant Commissioner, Office of Clinical & Service Systems Integration at the NYC Human Resources Administration (HRA), whose unit is responsible for the review of the HRA applications for housing. In 2013, before the Settlement Agreement, it handled 22,500 applications for housing arising out of mental health sectors and the NY/NY agreement. Major referral sources are psychiatric hospitals, shelters and correctional facilities. Many applicants are repeat HRA customers and their prior applications/histories are retained by HRA and reviewed as part of the process of reviewing a current application. According to the HRA representative, applications are reviewed and generally turned around within 1-3 business days.

In anticipation of the Settlement Agreement, in mid-2013, HRA and DOH/OMH began discussions on the role of HRA in the Settlement Agreement process. Consistent with the State's work plan, HRA did develop a streamlined HRA application process, specifically to be used when applying for housing for the adult home residents included in the Settlement Agreement. HRA participated in DOH/OMH training sessions for partners in the Settlement Agreement initiative and training was initiated and is ongoing for those responsible for completing the HRA application. HRA initially had weekly telephone conferences with DOH/OMH re problems that arose. Most commonly those were about applications that lacked sufficient information to complete a HRA review. At the time of the meeting, there had been HRA applications for 84 Class members and 27 were Unable to Complete (UTC). In most of the cases that were deemed UTC, the deficiency was an inadequate psychiatric evaluation. Other problems, but to a lesser extent, were: need for clarification of items in the UAS-NY; staff error; did not upload needed information; and technical glitches in the electronic transfer of information. Soon after our meeting, HRA gave DOH access to its computer system to follow cases/retrieve information, no longer requiring weekly problem solving teleconferences.

When the Independent Reviewer's team spoke with the HRA representative on January 30, 2015 regarding the average length of time it has been taking, he explained that the total number of

UTC cases has remained fairly constant, around 30, while the number of processed applications continues to increase. HRA has noted improvements in the quality of the psychiatric evaluations being submitted and those making the referrals are better at providing what is needed, that they had been getting far fewer incomplete applications, which appears to be due in large part to the 100% Quality Assurance Review on all three parts of the application by DOH since August 22, 2014. In discussions with DOH staff in following up on the status of those cases that are Unable To Complete or are not even submitted, most of the delays seem to be in the area of the psychiatric evaluations. The specific problem appears to be that the standard psychiatric evaluation is an assessment of the individual's presentation and mental status at a given point in time. Most of the evaluations are cursory and do not routinely include a detailed psychiatric history that would provide the kind of background information that HRA or a Housing Contractor, would need to adequately evaluate an individual for community housing.

Based on our review, as of March 13, 2015, there had been 276 case applications submitted to HRA, 248 approved by HRA, and 28 Unable To Complete (UTC), including one resident who is incarcerated.

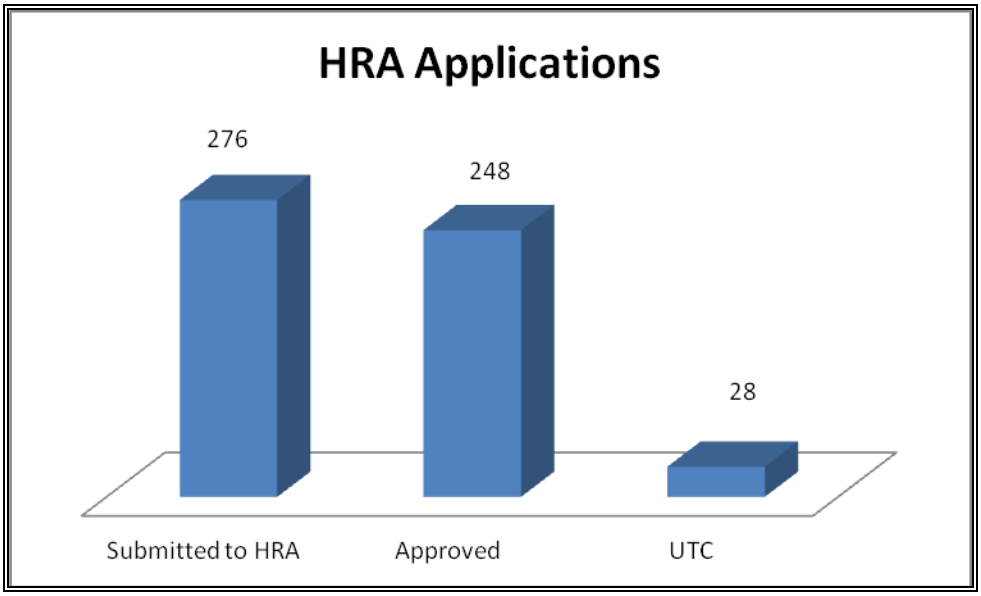


Fig. 9. HRA Review of Housing Applications

However, despite the relatively low number of cases noted as UTC on the weekly reports, most applications submitted to HRA are initially unable to complete before the issue is resolved, and a second, or sometimes more, application needs to be resubmitted. Based on the most recent HRA report of 3/23/15, the 276 distinct class members required a total of 426 submissions, before 248 were approved and 28 were left UTC. Of these, 99, or 36% required two or more submissions. As stated above, many of the issues are minor and can be resolved rather quickly.

Overall, for the cases approved, the median length of time from submission to approval was three calendar days, while the range was from 0-191 days due in large part to applications that were UTC for several months prior to approval.

As indicated below, since the initiation of DOH's 100% Quality Assurance review of applications before they are sent to HRA, there has been a reduction in the number of days it takes for HRA to complete its review of an application.

	Pre-Aug. 22, 14	Post -Aug. 22, 14
# of Cases	36	212
Range in Days	0-191	0-167
Median # Days	7	2
Average # Days	33	10

Table 1. Length of Time for HRA Determinations from Submission of Application to Determination

As of March 13, 2015, there were 28 UTC cases. Of the 28 UTC cases, two were submitted prior to 8/22/2014 and have yet to be resolved; the remaining 26 were submitted after 8/22/2014. Based on regular discussions with DOH staff, most had problems with the psychiatric evaluations. Most commonly the problem was an inadequate psychiatric history; but some were missing the psychiatric evaluation altogether, or did not sufficiently address specific concerns like history of prior violence noted on the UAS, recent psychiatric hospitalization, hoarding of medications or prior history of fire-setting noted in HRA archives.

> *Eduardo G.'s HRA application has been UTC since 11/25/14. Unbeknownst to the adult home or his treating psychiatrist of four years, he had a history of fire setting documented in prior HRA applications dating back to 2000. According to HRA, there were multiple instances of fire setting in his past which was viewed as a symptom of his psychiatric de-compensation. HRA viewed this as serious and would not approve the resident for placement until his current capacity for this type of high-risk behavior had been assessed, despite the time that had elapsed since the last documented occurrence. In order to address this issue, at HRA's recommendation, OMH had clinical staff from the NYC Field Office conduct a risk assessment of EG related to this behavior. On 2/27/15, three months after the initial submission, Eduardo was approved by HRA for supported housing and was*

interviewed by the Housing Contractor on 3/3/15, to begin the search for an apartment.

The outstanding UTC cases have resulted in multiple requests to psychiatrists, by the MLTCP by certified letter, and multiple calls by DOH staff. In eight instances, in addition to needing a new or more comprehensive psychiatric evaluation, the UAS also expired (since 180 days had elapsed since it was completed), including six that were due to disenrollments by Centerlight Healthcare (which as discussed above, has disenrolled approximately 90 class members to date). In these instances the class members were reassigned to another MLTC, or were loyalty-matched to a Health Home, which has to re-start the process and prepare a complete package (UAS, Psychiatric Evaluation; AHRAR) for submission to HRA. Additional problems included incomplete UAS, or wrong HRA application submitted. Most disconcerting is the length of time that the majority of the cases have been UTC. The median number of days that the 28 applications have been UTC, as of 3/13/15, is 120.5 days. Considering that the psychiatric evaluations and UAS expire after 180 days, the cycle of having to reassess residents and have often reluctant psychiatrists conduct new psychiatric evaluations to be retrieved by assessors and/or DOH staff, compounds the delays. As this report is being drafted, there are on-going discussions between the parties about strategies to address the delays in obtaining adequate psychiatric evaluations.

The underlying presumption of the Settlement Agreement is that any adult home resident with a Serious Mental Illness would be eligible for supported housing. The four exceptions were detailed in the Settlement Agreement (Para. F(5)), with the stipulation that if an assessor determined that a resident was inappropriate for supported housing the reasons would be clearly documented, and the resident would be given an opportunity, if interested, to seek other appropriate community placement. Of the 248 approvals by HRA as of 3/13/15, 229 (92%) were approved for supported housing, while 19 (8%) were Approved for Level II, or other than supported housing. Level II approval is for other types of OMH Housing, including Community Residence-Single Room Occupancy (CR/SRO); Supported Single Room Occupancy (SP-SRO); Congregate Treatment; Apartment Treatment; Family Care; or Senior Housing. In four of the 19 cases that HRA approved for level II, the Assessor had recommended Supported Apartment, but HRA approved the resident for Level II only. According to HRA, in each of the four cases information that they had received during the application process, often in the psychiatric evaluation or UAS, led to a determination that the resident would not be safe in supported housing, and the class member was approved for Level II only.

Robert B. was assessed on 9/18/14 and an HRA application was submitted on 11/17/14 with a recommendation for supported housing. It came to the attention of HRA that he had been hospitalized from 9/25/14-10/9/14 due to suicidal ideation with command hallucinations to kill himself. On 11/19/14, due to concerns for Robert's safety to live independently, HRA approved the application for Level II only.

* * *

> *Salvatore G. was assessed on 9/5/14 and an HRA application was submitted on 11/12/14 with a recommendation for supported housing. On 11/20/14, based on information in the psychiatric evaluation, HRA determined that Salvatore was not suitable for independent living and approved the application for Level II only. According to HRA, the psychiatric evaluation of 10/13/14, documented that "psychiatric symptoms prevent the individual from living in an independent setting." In the absence of an amended psychiatric evaluation or a new evaluation by another psychiatrist the determination cannot be changed.*
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> * * *
>
> *Elena O. currently lives in an adult home with her husband Vito, a class member who was approved for supported housing. She was assessed on 9/12/14 and an HRA application was submitted on 10/29/14 recommending supported housing. On 11/18/14, Elena was approved for Level II only. HRA said it came to their attention that she had a stay in a psychiatric Emergency Room in 2013; a history of prior failed attempts to live independently; and her psychiatrist had written in her psychiatric evaluation of 9/22/14 that she was not medication compliant and "is not a good candidate for independent living without direct supervision."*

In reviewing the mental health clinic records of five residents that were previously found inappropriate for supported housing, by an MLTC assessor with a disproportionate number of recommendations for other than supported housing, the Independent Reviewer's team found insufficient evidence to support the assessor's conclusion that the individual would pose a danger to themselves or others in supported housing. Four of the class members were subsequently reassessed and found appropriate for supported housing; three have been referred to the Housing Contractor for placement (DP, GS and RP); and one of these is currently UTC (JJ), pending a new updated psychiatric evaluation. The fifth (JB) was reassessed, with no change in determination and was referred to CUCS for community placement in a CR/SRO.

> *Jesse J. is a 65 year-old black male with a long psychiatric history who has been living at an adult home for five years. He was assessed on June 13, 2014 and found "inappropriate for supported housing" with a recommendation for a CR/SRO. He had been approved by HRA for Level II only, and his MLTCP, had submitted an application to CUCS on 11/4/14. The Independent Reviewer's staff visited the Continuing Day Treatment Program on 12/4/14 to review Jesse's record, meet with him and talk to those that knew him. Jesse, who attends the day treatment program daily and participates in a full range of classes, was neatly and appropriately dressed and was very friendly. He was responsive to questions, though at times it was a bit hard to follow him without asking additional questions. He expressed an interest in moving out of the adult home to supported housing, but had reportedly told his psychiatrist that he was not interested, as noted in the record. Although some ambivalence was noted, in general he seemed interested if he found the right*

apartment, lived alone or had the right house mate, and was in a safe and comfortable neighborhood, as he was fearful of being hurt or having his things stolen.

The assessor's justification that the transition would present "a danger to self or others in supported housing" lacked specificity. Poor insight and judgment and "poor processing skills" did not seem to support that the transition to supported housing would present a danger precluding this as a housing option. Significantly, and similar to the other cases that the Independent Reviewer's staff had reviewed, Jesse did not have any awareness or knowledge that he had been recommended for CR-SRO or for anything other than supported housing, or that an application had been submitted to CUCS to obtain supervised *housing. The mental health Program Director believed that Jesse could make it in supported housing if he maintained the level of stability he had recently achieved following changes in his medication regimen. He was reassessed on 11/25/14 and the assessor recommended supported housing on the new AHRAR. However, on submission to HRA on 1/6/15, his application was found to be "Unable to Complete" pending the receipt of a new comprehensive psychiatric evaluation and remains UTC as of 3/13/15.*

e. Person-Centered Care Planning Process

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

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

According to the DOH, care planning begins upon the class member's enrollment in a Health Home or MLTCP.[12] Person-centered care plans are based on individual needs and desires,

[12] Although the development of care plans and the provision of care management to shepherd the plans are integral components of HH/MLTCPs, in the early stages of the Settlement Agreement 1,817 adult home residents were enrolled in HH/MLTCPs. For these individuals, existing care plans would have to be revised with the prospect of their transition from an adult home - where many services such as medication management, meals, housekeeping services and sometimes mental health and health services - are offered on site, in order to support them in more independent living upon transfer. As additional residents are identified as interested in transitioning and enrolled in HH/MLTCPs, care planning and management begin and are orchestrated by the HH/MLTCP.

and focus on attainable goals. When a class member expresses a desire to move to the community, transition care planning should begin. Upon approval of the HRA application, the HH/MLTCP care manager should notify the Housing Contractor and send him/her a copy of the referral package and with the class member and Housing Contractor work toward developing a transition care plan that identifies and arranges for the supports needed by the class member to successfully move to supported housing. Care planning for transition involves numerous service providers who provide and/or coordinate the services/benefits that the class member needs, as identified in the assessment process as well as by the individual. Services to be coordinated can include SNAP benefits (Food Stamps), furniture, transportation, mental health programs, psychiatric and medical visits, aide and visiting nurse services, etc. Care planning is not a one-time event that is "completed," but is a continuous and fluid process. Once a supported apartment is secured, the care manager with the support of the care team, which includes the class member, works to coordinate all necessary services and benefits to meet the class member's needs in the community. Care managers must coordinate care before, during and after transition, serving as the class member's point-of-contact 24/7.

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

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

- Has a Transition Care Plan Meeting Occurred?
- Review of Recommendations on AHRAR and the HRA Decision
- Securing Required Documents (e.g., picture ID)
- Medication Management and the Need for Assistance
- Scheduling of Medical Appointments
- Scheduling of Mental Health Appointments
- Enrollment in Mental Health Programs
- Emergency Contacts
- Arrangements for Meals
- Furniture and Household Items in the Apartment
- Telephone Services and Utility Set-ups in the Apartment
- Need for Transportation Services
- Representative Payee if Applicable

- Securing of Essential Benefits and Entitlements (SNAP, etc.)
- First Scheduled Meeting with care manager Following Transition
- First Scheduled Meeting with Housing Contractor Following Transition

As of March 13, 2015, 165 transition care planning sessions have been scheduled and/or conducted for individuals approved by HRA to move to supported housing. Additionally, the status of transition care plan implementation for most if not all the individuals who have moved to supported housing since November 2014 has been reviewed in at least one 21-day pre-transition call; oftentimes, a second or third transition call is made in the days/week prior to a move in those cases where it appeared that not all of the essential elements of a care plan were in place at the time of the first call.

The Independent Reviewer team attended care planning sessions for 14 individuals and participated in 40 initial and follow-up transition calls. Generally, the Independent Reviewer team found many positive aspects to the care planning sessions observed. There has been a good representation from HH/MLTCP care managers, Housing Contractors, adult home case managers, class members and occasionally other parties such as mental health providers. The planning team members seem enthusiastic and committed to assisting class members make a successful transition to supported housing, and recommending a package of services to ensure the individual has adequate support and assistance initially, with a view to re-assessing the continuing need for these services as time passes. Class members were excited that they had reached this stage of the transition process and were consistently encouraged to give their opinions and voice questions when they felt the need to.

Among the items discussed, in the context of the individual's needs and desires, were: medication administration/management and proficiency/need for assistance; basic ADL skills – cooking, shopping, laundry, housekeeping skill, bathing/self-care, etc.; current array of health and mental health providers and the need for change in such upon transition; housemate arrangements; entitlements/needs (SNAP, Meals on Wheels, etc.); and representative payee status/situation. During these meetings there was generally agreement on a division of labor as to who, the HH/MLTCP or Housing Contractor, would take the lead in arranging for needed services, such as securing in-home aide/nursing serves, scheduling appointments with new health/mental health providers, applying for SNAP (Food Stamps), changing representative payees if needed, etc.

Care managers appeared to be diligent in ensuring adequate supports for individuals even when the need for such tended to be downplayed by the individual. When offered the opportunity of aide or nursing services to assist in such things as shopping, meal preparation or medication monitoring, a number of individuals would respond saying, "but I don't need it." The care managers would explain that these services could be faded/discontinued as time goes on and all goes well. They explained that it is easier to put such services in place from the beginning to assess how well the transition is going and then discontinue them, rather than trying to arrange for them after transition when it is realized the services are needed.

Monitoring activities, however, did raise concerns about the care planning process which the Independent Reviewer has shared with the parties.

1. Delays in arranging necessary services

While there appeared to be general agreement during care planning meetings as to who would do what to ensure that necessary services, supports and benefits are in place at the time a class member transitions, transition calls revealed delays in arranging for these services. A number of 21-day calls needed to be followed up with additional calls because not all the services agreed to had been arranged 21 days before the move. In some cases, during follow-up transition calls made just a few days before the scheduled move, it was found that necessary services still had not yet been secured or put in place. The following cases are illustrative:

> *Cliff F. This follow-up transition call occurred on 1/15/15, three business days (considering the Martin Luther King Holiday) before the individual's scheduled 1/20/15 transition date. As of 1/15/15, the individual had not yet applied for Food Stamps as he goes to a mental health PROS program Monday through Thursday and did not want to miss program. The care manager was planning to take Cliff to apply for Food Stamps the next day, Friday 1/16/15. It is laudable that the care manager did not interfere with the individual's desired attendance at his PROS program, but considering that the individual had given the adult home notice of his intent to move at least 30 days before the 1/20/15 scheduled move date, one would question why weren't the Fridays in the weeks preceding 1/16/15 used to assist the individual in applying for Food Stamps? During the call, the care manager reported that, absent Food Stamps, he would stock the apartment with food he could get from a food pantry that his agency knows of. He also asked the Housing Contractor if his agency knew of or operated any pantries in the area.*
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> * * *
>
> *Goral G. This second follow-up transition call was held on 12/31/14, three business days before a 1/6/15 anticipated move. At this time, as with the earlier transition call, a mental health provider had not been identified nor an appointment scheduled. Reportedly, there were difficulties getting through by phone to the provider with whom the individual wished to make an appointment. Others on the phone call found that highly unusual given the reputation of the provider. The care manager was again given the contact information for this provider and OMH staff instructed her to call them immediately if she ever has problems contacting a provider in the future. As the conversation progressed it was not clear who attempted to contact the provider or when. At one point the care manager indicated she encouraged Goral to call the provider. But she also said she asked a member of her staff to assist him in making the call to the provider. In the end, she didn't know*

> *if the client alone, or with staff assistance, called the provider to schedule the appointment or when such was attempted. She was urged to immediately assist Goral in calling the provider at the number provided to schedule an appointment and to report back to the parties that afternoon whether an appointment had been scheduled as such was deemed critical for a safe transition the next week. She did, was successful and the move happened as planned on 1/6/15.*
>
> * * *
>
> *Jerry L. This follow-up call was made on 12/29/14, the day before Jerry's scheduled move on 12/30/14. At the time of the call, two items that were outstanding during the previous 12/12/14 call were still outstanding: Jerry did not have Food Stamps nor did he have a mental health appointment. However, he did have some Personal Needs Allowance funds which he was willing to use to purchase food until the arrival of Food Stamps. The mental health appointment was a bit more complicated. During the earlier planning sessions, Jerry indicated that he did not want to continue at his Continuing Day Treatment Program (CDTP) as he wanted to get a job and regular attendance at the program (or a PROS program) would interfere with work availability. By 12/12/14, the plan was to find a mental health clinic and also vocational programs/opportunities. By the time of the 12/29/14 call, the issue still remained unresolved – referrals for mental health and vocational services had not been completed. However, Jerry would be leaving the adult home with a 30-day supply of medications and his CDTP was willing to provide a new prescription if he had not found a clinic or psychiatrist by the time the supply ran out. With this assurance, the move proceeded as scheduled. Following the move, Jerry actually agreed to attend the PROS program that his care manager had recommended.*

Delays in applying for SNAP benefits and arranging for new mental health providers seemed to be the most recurring problems.

With regard to SNAP/Food Stamps, there appeared to be confusion and disagreement among care managers and Housing Contractors as to when one can apply – before or after the move – and how to secure emergency Food Stamps.[13] Consequently, individuals transitioned to their supported apartments without this benefit and staff scrambled to make sure the class member had food: Housing Contractors provided the individual with funds to buy groceries and HH/MLTCP care managers searched for Food Pantries and Soup Kitchens which could provide nutrition. In January 2015, DOH clarified the SNAP issue in a Frequently Asked Questions fact sheet provided to all involved: SNAP benefits can be applied for 30 days prior to a move as long as one has a new address and transition date (which is usually the case as the individual has to give the adult home operator a 30-day notice prior to moving).

[13] In at least one case, an adult home was not cooperative in providing the assistance and documentation needed for an individual to apply for SNAP benefits. DOH is addressing this issue.

Despite the actions taken by DOH, the Independent Reviewer team has observed several care planning meetings and pre-transition telephone conferences where there have been problems in ensuring that SNAP benefits are in place or the class members have emergency food stamps available to them at the time of the move. These issues have arisen in 14 out of the 22 cases observed. There have also been issues with the transfer of their financial entitlements and Personal Needs Allowances ("PNA"), especially for class members for whom the adult home has been the representative payee.

The reasons for these problems seem to vary from cases to case, including applications that were made too late; difficulties getting governmental IDs required for the application; bureaucratic issues with the office processing the application, etc. In all cases, the planning teams have been creative in identifying temporary, ad hoc fixes for the problem such as locating food pantries and soup kitchens, purchasing food for a transitional period, or providing a small amount of cash to cover food purchases. While these are commendable efforts, there is something fundamentally wrong with forcing class members to rely on charity and handouts in this patchwork approach to meeting a basic need for support in the community as part of a court-ordered transition process. The Independent Reviewer is concerned that these uncertainties may contribute to class members changing their minds at the eleventh hour and declining a transition from an adult home which dependably provides three meals a day, and a monthly PNA.

It is unclear at this point whether the problems being encountered are systemic in nature or case specific. The Independent Reviewer has recommended that the State convene a small group of knowledgeable care managers and Housing Contractors to further explore these issues and determine whether they need a systemic solution or more specific guidance to the planning teams so that the outcome is dependable access to funding for food and incidental. Among the options that may need to be considered are:

- building in a transitional stipend to cover the cost of food until SNAP benefits become available:
- providing for a cash advance to the class members against the anticipated financial entitlements;
- exploring the possibility of expediting the processing of applications for SNAP benefits for class members.

Mental health appointments, particularly for individuals who need to change providers upon transition from the adult home, are particularly important. Such individuals will be leaving the adult home with a 30-day or less supply of medications and will need to see their new provider in order to receive and fill a new prescription for medications. In most cases, mental health clinics request that the individual who is in need of service call to arrange for a first appointment, although the individual can be assisted in placing this call by a case/care manager, advocate, family member, etc. In cases where the scheduling of an appointment with a new mental health provider was

problematic, it appeared that the care manager did not offer sufficient support of assistance to the individual in making the initial call to schedule the appointment.

Given that class members provide adult homes with a 30-day notice of their intent to move, there seems to be plenty of lead time to secure/arrange the necessary services called for in the care plan. To ensure that this lead time is used wisely, on January 14, 2015, DOH issued an Adult Home class member Discharge Planning Tool Guidance (Appendix A) The tool provides a detailed list of items necessary for discharge along with boxes and text areas in which one can provide dates and explanations about what has been accomplished and put in place. DOH asked care managers to complete the tool *prior* to the 21-day Transition Call as the items on the tool will be discussed during the call.

The Independent Reviewer believes this tool will be a helpful reminder to start early and remain vigilant in securing the services needed upon transition. ***However, the Independent Reviewer has recommended to DOH and OMH that a system of post-transition calls be put into place to monitor whether the services called for in plans are actually in place and being delivered now that the move has occurred.*** This recommendation was implemented by the State beginning on February 13, 2015. Post transition calls are routinely scheduled during the last call prior to the move, to occur within the first week to 10 days after transition.

2. Need for a Person-Centered Care Plan template

In December 2013, the Independent Reviewer recommended that a template be developed to guide person-centered care planning. In response, DOH forwarded a sample of care plan templates already in use by a number of HH/MLTCPs that would be involved in implementing the Settlement Agreement. A review of these indicated that they varied significantly one from the other. Some focused primarily on medical issues while others took a broader approach and in addition to medical issues focused on other dimensions of an individual's life.

Considering the large number of care management entities involved in Settlement Agreement implementation and the number of Housing Contractors that must interact with a multitude of these entities,[14] it would make sense – for staff training, care planning and implementation monitoring purposes – to develop a uniform template for care management plans for class members.

As stated in the Independent Reviewer's May 3, 2014 progress report to the parties: "This does not have to be a massive undertaking. OMH already has a complete workbook on Person Centered Planning for PROS programs, which can serve as the basis for care planning for this effort. (http://www.omh.ny.gov/omhweb/pros/Person_Centered_Workbook/)"

[14] *See*, fn. 3 *supra*.

To a limited degree, DOH's recently issued tool/guidance on discharge planning addresses this issue by identifying key items that need to be addressed to ensure a ***safe*** transition to the community, such as the availability of food, utilities, financial support, ADL assistance, appointments with health and mental health providers, etc. But it does not address other major domains in an individual's life that could ensure not just a safe, but successful and fruitful transition and quality of life in the community – issues including the individual's interests, desires and needs in such areas as continuing/adult education, employment/volunteer activities, inclusion in culturally relevant social opportunities and faith communities, civic/community activities, etc.

Considering that many class members have spent years in adult homes and other institutions that address basic life and safety needs but do not promote community inclusion, many may not have an understanding of what enriching and life-fulfilling opportunities exist in the communities into which they are being transitioned. This should be probed and addressed in the transition care planning process.

The Independent Reviewer again recommends the creation of a care planning template that ensures the wide range of dimensions of an individual's life are discussed and plans put in place to address his/her needs and preferences.

3. Absence of care plans

At a minimum, to be successful, care plans involving a multi-member team approach require that all members of the team are on the same page as to what the plan calls for and who is responsible. Although DOH has stated that care plans developed by HH/MLTCPs, with the input of the individual, Housing Contractor and other parties as appropriate, should be made available to Housing Contractors two weeks prior to transition, this is not consistently happening. In some cases, it appears that consent is an issue; in others cases there appear to be technical difficulties in sharing computer files.

Due to laws governing the confidentiality of Protected Health Information, there are barriers to sharing information among agencies that must collaborate to support class members in the community, and many of these agencies have not yet executed Administrative Services Agreements that would permit the necessary sharing of information. It also appears that this is a larger problem with the MLTCPs, rather than Health Homes. DOH is continuing to work on this matter, but it is critically important that it be resolved quickly as the number of individuals transitioned increases.

The lack of access to care plans also impedes the Independent Reviewer in his efforts to monitor the implementation of the Settlement Agreement and in determining whether services are being delivered as planned for and address the class member's needs. Without access to the Plans of Care themselves, it is not possible for the Independent Reviewer to assess their adequacy, nor to monitor their implementation. This is an issue all parties are aware of and working on. ***The Independent Reviewer regards it as an urgent matter to resolve access issues to all records and***

documents that are needed to adequately monitor the implementation of the Settlement Agreement.

4. Changing care managers and high caseloads

The HH/MLTCP care manager is viewed as the glue that holds all the pieces and parties to the care plan in place. According to DOH, he or she must coordinate care before, during and after transition and serve as the class member's point of contact 24/7. In response to inquiries from the Independent Reviewer, DOH stated although there were no specific required care manager caseload limits, on average it was anticipated that the caseloads for care managers assigned adult home residents could range from 1:12 to 1:50. The range reflects the presumption that many of the adult home residents that choose to live in supported housing will initially require a higher intensity of care management services which will decrease as they stabilize in the community.

In its monitoring activities, the Independent Reviewer team has received reports which give rise to concerns about the consistency and availability of care managers. We have encountered care managers with caseloads as high as 163 while at some Health Homes/MLTCPs caseloads as high as 80 are not unusual. Moreover, it has been reported that some care managers in MLTCPs will assist the class member up to the point of transition from the adult home, or perhaps for a month after, but at that point a new care manager from the MLTCP will be assigned to the case. This break in continuity, combined with large caseloads, is not a desirable method of supporting class members making a transition to the community. The case of J.C is illustrative.

> *Jessica C. transitioned from her adult home to an apartment on December 1, 2014. Since the time of her transition care planning meeting, she has had three different care managers through her MLTCP. The third care manager was assigned to her case about one month after her transition, at around the time of the Christmas/New Year holiday. As of February 5, 201 –more than two months since her move --, Jessica had not yet met this new care manager who had called her and promised to visit. Jessica still does not have Food Stamps, which was recognized as a need prior to transition. She was hoping the care manager would assist her in this regard and is growing increasingly frustrated that she hasn't even met the care manager.*

The Independent Reviewer recommends that if a care manager is truly intended to be the lynch pin in ensuring a successful transition and life in the community, the State must examine and establish expectations for meaningful assignments and caseloads that enable the care manager to fulfill his or her role. At a parties' meeting on January 6, 2015, representatives of the DOH stated that they were re-considering whether to establish maximum caseload limits for the Settlement Agreement class.

5. Poor Communication between care managers and class members

The Independent Reviewer's team has received numerous reports from class members and Housing Contractors that individuals who have expressed an interest in transitioning to supported housing and who have been referred to HH/MLTCPs for assessment, and perhaps even have been assessed, have had little or no contact with their HH/MLTCP care manager and are in the dark as to where they stand in the process, months after their referral and perhaps assessment. Similar concerns have been voiced directly by class members to the Court at a status conference.

As described above, the Independent Reviewer team met one individual who has yet to meet her new care manager two months after transition. In another instance, upon visiting New Haven Manor on December 9, 2014 to observe a care planning session, the Independent Reviewer team was approached by a woman who reported she was referred to a HH/MLTCP in July 2014 upon in-reach and assessed that same month, but had not heard anything else from the HH/MLTCP, now more than four months later. She broke down crying and plaintively asked what her status was, which neither the in-reach worker nor Independent Review staff could tell her, as the most recent information at that time, as provided in weekly reports issued by the State, indicated only that she had been assessed in July. (In late January 2015, her application was submitted to the HRA by the HH/MLTCP and approved; as of March 13, 2015, she has not been interviewed by the Housing Contractor.)

The Independent Reviewer team has also received reports that some class members who are capable self-advocates learn of their status in the process by calling DOH directly or CIAD or Plaintiffs' attorneys who make inquiries of DOH on their behalf. But many class members who are not as skilled at being self-advocates are left in the dark.

The Independent Reviewer acknowledges that in training sessions DOH has stressed the importance of care managers maintaining contact with the individuals they serve to keep them abreast of where they stand in the transition process. And the Independent Reviewer's Team has met individuals who reported being kept abreast of their status by care managers. But apparently, the lack of consistent communication persists, perhaps due to care manager turnover or high caseloads. This underscores the need for the State to establish expectations and meaningful caseloads for care managers, as referenced above. It is unknown what effect the lack of information on the status of one's case for the sometimes lengthy period between in-reach and personal care planning has on the dropout rate of persons who initially expressed an interest in supported housing but later withdrew from the process.

f. Community Placements

The Settlement Agreement requires the State to find sufficient supported housing units to provide any class member for whom supported housing is found to be appropriate is afforded an opportunity to do so (Para. D). The State is required to make all reasonable efforts to coordinate

the performance of assessments by Health Homes and MLTCPs with the development of supported housing units so that the assessments take into account supported housing units that are actually available or will soon become available.

As noted above, as of March 13, 2015 HRA has approved 248 class members for Community Care (supported housing). As of that date, 40 class members have transitioned to supported housing. Thus far, it has taken a median of 203.5 days from in-reach to transition to supported housing. The rate at which class members are currently transitioning and being prepared to move is clearly improving but the amount of time it is taking also has been increasing. At the time of the preparation of the draft report in February, the median length of time from in-reach to transition was approximately 187 days or 16.5 days less than at present. With the inception of in-reach to all of the other Brooklyn and Queens adult homes by the five other Housing Contractor's during July 2014, and the early issuance of the RFP for the Bronx and Staten island, the prospects for increasing the numbers of transitioned residents is promising, although the pace remains far short of what would be required to attain the Settlement Agreement goals.

1. **Changing their minds at the point of transition**

After expressing an interest in moving to supported housing during in-reach, and going through the assessment process and being approved by HRA, class members sometimes change their mind and refuse to move. Some of the residents who have gone through the HRA process and then refused are included on the State's Focus 69 table that tracked the progress of 69 class members who were slated to move to supported housing. For some it occurs after they have seen one or more apartments, and in some instances after they have given notice and have a date to move out. The reasons given for this change of heart include plans to move elsewhere, like Section 8 Housing, or to "Florida with my cousin" which, according to their mental health clinic providers is most likely delusional thinking. One woman, after cancelling twice before, changed her mind the day of the move, saying "I want to move, but not to East New York." The Independent Reviewer's staff met with some of these residents, to understand their reasons for changing their minds.

> *Gail S, 61 years old, who has been living at the adult home for eight years, is a Fast Track member who received in-reach and was assessed during July 2014. A Care Planning meeting and HRA approval occurred in September, and she met with the Housing Contractor in October when the process for finding an apartment started. She found a two-bedroom apartment she liked and gave her notice to the adult home on 11/5/14. Following two transition meetings, the planned move date was 12/8/14. However, on 12/4/14 Gail changed her mind reportedly because there was "no roommate in the apartment." She did say that she still wanted to move and the Housing Contractor agreed to move her into their model apartment, which she said she liked, in the same East New York neighborhood, with a scheduled move date of 12/29/14.*

Because of issues with turning on the utilities and the apartment lease, the move was postponed until 2/2/15. With everything in place on the day of the move, including cashing the check for her start-up funds, putting the utilities in her name, and submitting her documents to Social Security, Gail refused to move. She reportedly informed the Housing Contractor that she changed her mind and no longer wanted to move into the apartment program. When the Independent Reviewer's staff met with her and the Housing Contractor on 2/5/15, she said she still was interested in moving and "didn't want to live here anymore…I've been here long enough." When asked why she changed her mind, she said she really didn't like the neighborhood and would move to another apartment in a different neighborhood. When she mentioned neighborhoods like Bensonhurst, Bay Ridge and Sunset Park, the Housing Contractor said that the rents there were much higher, and that it would take longer to find an apartment for her. When Coney Island, Brighton Beach and Crown Heights were mentioned, she said she would be interested. The Housing Contractor said they had an apartment in Crown Heights that they could show her and she agreed to see it. After seeing the apartment and meeting her prospective roommate, Gail seemed to be initially excited about moving there, but then rejected the apartment, reportedly saying she wanted to live with "someone of her own ethnicity." The adult home Administrator did caution that Gail had been offered housing several years ago, through referral of her mental health program, and also changed her mind when it came close to moving.

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John M., 67 years old, is a veteran who has been at the adult home for three years, and receives his mental health treatment at the VA Hospital. He expressed interest in supported housing upon in-reach in September and was assessed later in the month, after which he told the assessor that he had changed his mind and said he did not want to move. He spoke of not liking the adult home as "I don't like the food" and "people pick up the cigarette butts off of the floor." When asked by the Independent Reviewer's staff why he changed his mind, John said he was concerned about the racial makeup of the neighborhoods where he believed the apartments being offered were located. He added "my friends are looking for a place for me." He explained that he had lived in Park Slope for 15 years before coming to the adult home, but it is too expensive now and mentioned being able to get a room in Sunset Park for $600/month.

* * *

Greg Y., 55 years old, was placed on the Fast Track by a resident advocate in the adult home, expressed interest in supported housing upon in-reach on 4/16/14 and was assessed on 4/22/14. However, his HRA application, which was approved for supported housing on the first attempt, was not submitted until 8/5/14. The referral

package was sent to the Housing Contractor on 9/16/14 and he was interviewed on 9/22/14. According to the Focus 69 table prepared by the State, Greg (#55) informed his care manager on 9/24/14 that he wanted to "hold off" on moving, and on 12/9/14 would not take the care manger's call. When he met with the Independent Reviewer's staff on 2/5/15, he appeared very friendly and social and was observed moving rapidly in the lobby, briefly greeting and fist bumping/elbow touching with many residents. His therapist at the program located in the home said he knows everybody, and is a real "social butterfly." When asked by the reviewer about supported housing, even though he had been approved and had gotten as far as being interviewed, Greg was difficult to understand as he spoke in disjointed phrasings with a lot of inflection. When asked why he changed his mind he responded, after several attempts, "Exactly a given, OK…a lot of friendships, dealings, connections, hanging out, hooking up…just like a given, ya know, yeah, yeah…OK?" His therapist says that it is his OCD behavior that presents when he feels "pressured." If one would attempt to make sense of this, coupled with observations of his interactions with other residents, one might infer that Greg likes being in the adult home and would miss the other residents; but that remains a matter for further exploration during in-reach in the future.

* * *

Elden C., 61 years old, has been living at the adult home for 15 years. He expressed interest in supported housing upon in-reach on 4/16/14 and was assessed on 4/25/14. His application was initially submitted to HRA almost four months later on 8/19/14; was noted as Unable to Complete (UTC); and re-submitted and approved for supported housing on 9/2/14, the same day that the referral package was sent to the Housing Contractor. However, as noted on the State's Focus 69 Table (#64), when approached about supported housing he "reported (he is) not interested in moving." Although he had gone as far as referral to the Housing Contractor before changing his mind, when interviewed by the Independent Reviewer's staff, Elden stated "he was never assessed and never wanted to go." He has a girlfriend who stood by as we spoke and she made it clear that "he didn't want to move, because I'm not moving…and he has to take his medications."

* * *

Mark P., 49 years old, expressed interest in supported housing upon in-reach on 6/18/14 and was assessed on 6/25/14. His HRA application was submitted on 8/12/14 and approved on 8/14/14. His complete referral was sent to the Housing Contractor on 8/28/14. As noted on the State's Focus 69 Table (#58), Mark has been difficult to reach and vacillates regarding his desire to move, and did not attend the scheduled housing interview on 11/28/14. When interviewed by the Independent Reviewer's staff on 2/5/15, Mark said he "wants to move" but "has no

time to do the papers with housing." He talked about going regularly to Crown Heights and Williamsburg to see friends and said he is very busy. When asked where he would like to live, Mark mentioned Boro Park and said he would need a home attendant. He also said that he would move when his friend Filip S., also of Russian Jewish extraction, is ready to move, and that they will move in to a Supported Apartment together.

When the reviewer looked into it, he learned that Filip S. 53 years old is a class member who was on the Fast Track, and expressed interest in supported housing upon in-reach on 4/18/14. According to the weekly report of March 13, 2015 it appears that he has not been assessed by Metro Plus MLTC, after the in-reach form was sent to them on the same day as the in-reach visit. In response to our inquiry, DOH reported that he was on the initial Community Transition List (CTL) in error and was not restored to the CTL until 6/16/14. However, no action has been taken on his case since that time, and that oversight is now having a negative impact upon another class member's willingness to move to supported housing.

2. Choice of housing

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

As reported by the Housing Contractors, the specific preferences of the class members, especially the location, have posed significant challenges given budgetary constraints, the current housing market, and requests to live in Forest Hills, Bay Ridge, or other neighborhoods that are highly desirable and thus costly. In addition, in some areas where class members want to live the housing stock is primarily two family homes, where reactions to being approached by Housing Contractors to rent to class members have not always been positive. While Housing Contractors do not say it is not possible to fulfill the member's specific requests, they inform them that it will most likely take longer to acquire, and continue to offer alternative areas for their consideration.

As noted on Table 3 below, as of 3/13/15, the 40 class members transitioned from 10 of the 17 NYC Impacted Adult Homes, with housing acquired by all of the six Housing

Contractors. Twenty-two of the moves occurred in the three Phase I Pilot Homes for whom JBFCS is the Housing Contractor. However, in one of the moves, the class member from Surf Manor wanted to live in the Bronx. So he was transferred to CommuniLife, the Housing Contractor who has housing in that area, and they worked with him to find something to his liking, which he accepted.

IMPACTED ADULT HOME	NUMBER OF CLASS MEMBERS TRANSITIONED	HOUSING CONTRACTOR
BROOKLYN ACC	**3**	**ICL**
ELM YORK	**2**	**TSI**
KINGS ACC	**6**	**FEGS**
MERMAID MANOR	**3**	**JBFCS**
NEW HAVEN MANOR	**1**	**FOO**
OCEANVIEW MANOR	**5**	**JBFCS**
PARK INN HOME	**3**	**COMMUNILIFE**
QUEENS ACC	**2**	**ICL**
SURFSIDE MANOR	**1**	**COMMUNILIFE**
SURF MANOR	**13** **1**	**JBFCS** **COMMUNILIFE**

Table 3. Class Members Transitions as of March 13, 2015

The 40 class members who have moved are living in 29 apartments and one three-bedroom house. Twelve are living alone in one-bedroom apartments; 20 are sharing 10 two-bedroom apartments; seven are currently alone in two-bedroom apartments; and one is in a house with three bedrooms, eventually to be shared with other class members. Fourteen of the class members have first floor apartments in non-elevator buildings; 17 are on the 2nd floor and one on the 3rd floor of walk-up buildings; and eight live in elevator buildings.

To date the Independent Reviewer's team has visited nine apartments of 12 of the 40 class members who transitioned. JBFCS was the Housing Contractor for five of the apartments, housing seven class members, all in Brooklyn; FEGS for two in Brooklyn, with three class members; and ICL , where a class member had his own one bedroom apartment in a one floor walk-up on Sutphin Blvd. in Queens; and CommuniLife, where a class member was in a two bedroom apartment in a two family home in the Rockaways, waiting for her roommate to be assigned..

All of the apartments were in residential areas in close proximity to shopping and transportation, and all were freshly painted, with new furniture and a start-up kit of kitchen utensils, bed linens, and most things one would need when moving into a new apartment. Each of the JBFCS apartments had a full size bed, one or two dressers, depending on closet space, a love-seat and couch in the living room, and a dining room table that some had placed in the kitchen and others in the living room. The furniture in each of the JBFCS apartments was identical and selected by JBFCS. In the ICL apartment in Queens, the class member had picked the furniture from a catalogue that was shown to him by the Housing Contractor. The two FEGS apartments visited were also fully furnished with items selected by FEGS, and nicely appointed, as was the CommuniLife apartment we visited.

> *On 12/30/14 the Independent Reviewer's staff participated in the move of Walter F. and Jerry L. from an adult home to their new apartment in the Seagate section of Brooklyn. Seagate is a gated community at the very end of Coney Island in Brooklyn. The two-bedroom apartment was one flight up in an owner occupied two-family home on a quiet residential block. On entering the apartment one was struck by the newly finished wood floors and the new appliances, including a washer-dryer in the kitchen. In addition to two nicely sized bedrooms, the apartment had a terrace that looked out on the street. The microwave oven was in a box, along with the other items in the startup kit. On visiting with Walter a week later, he said he liked the apartment better than the adult home as he "has his independence" and "doesn't have to share a bedroom." He also liked the quiet neighborhood and its proximity to stores and transportation. All of the apartment facilities, including heat and hot water, were working fine. But the outlet in the bathroom was out for a few days. He had not told the landlord and his care manager encouraged him to do so. He had no other problems or complaints. He was most happy about the rent. Walter said he was a private pay resident at the adult home and paid $2,000 a month to live there for the last 8½ years. His rent was now $234.*
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> *Andrew P. is a 55 y/o African American male who walks with a limp due to a hip replacement. He transitioned on December 12, 2014 from an adult home. Andrew looked right at home in his new one bedroom apartment on Sutphin Boulevard, in Jamaica Queens. He said he does not have a problem navigating the 18 steps to his 2nd floor apartment, doing laundry or shopping. While the living room, which is right off of the dining room and kitchen, is small, it all felt very homey and cozy. The room was nicely furnished with a couch and chair, with leather style seat and wood arms, and was loaded with pictures on bookcases and on walls, along with many books and CDs, as well as a stereo system. The kitchen was very modern and bright with a skylight over the dining room table. As I told him, it felt like he had been living there for years. Although his first month has not been what one would call*

> *"easy," Andrew said he was "ecstatic," "grateful," and "loves it." He likes that there is only one neighbor in the building and it gives him "privacy" and a "comfortable feeling." About the neighborhood, he said "it seems decent," and he "feels safe." It is also close to public transportation, shopping, family and his girlfriend, who still lives at his former adult home, and is the only thing he misses from there.*

Following approval of the complete package by HRA, the care manager for the Health Home or MLTCP sends it to the Housing Contractor, who schedules an interview with the class member. As of March 13, 2015 there were 211 referrals sent to the Housing Contractors for supported housing, with a median of five days to forward the package. Of the referrals sent to the Housing Contractor, 155 of the class members had been interviewed, with a median number of days from receipt of the referral to the interview of 12 days.

Although the Housing Contractors staff had previously met with the class member during in-reach to determine if they were interested in moving, the interview at this time is focused on learning more about the individual and what their preferences are in terms of where they want to live, the type of apartment they want, and what, if any accommodations will they need for a successful transition (e.g., 1st floor, elevator, or walk-up apartment). After the housing interview the process of looking for the apartments begins. Many of the residents are shown model apartments before they are shown apartments that are under lease to the Housing Contractor and available for transition. Once they are shown apartments they can either accept the apartment or ask to see another. Of the residents that the Independent Reviewer's staff met with who transitioned, most liked and accepted the first apartment they saw. However, we are aware from reports of the parties to this agreement that is not the case for all of the class members. Of the first 40 to transition, the median number of days it has taken from the date of the referral to the Housing Contractor to find an apartment and move is 96, and 104 days from the date of HRA Approval. This includes the 30 day notice that the adult home operators have requested, to ensure that the resident will not be charged for days that they do not live in the adult home.

Following transition continuity of care is to be assured through the efforts of the care manager from the Health Home and/or MLTCP and the Case Manager or Associate from the Housing Contractor. In addition, the ability of the two or three entities (in the case of those class members enrolled in both a Health Home and an MLTCP) to work successfully together is critical. Through the 21 Day Transition call that is described above in the Assessment section, efforts are made to ensure that all of the steps are in place prior to the move. Most important, as related to the medical and psychiatric needs of the individual, is that appointments are in place for follow-up with the mental health provider and their doctor. However, during some of the visits of the Independent Reviewer's team questions arose as to whether all that was to be arranged was actually in place.

Walter F. During the 21 Day Transition Call on 12/12/14, in preparation for his move on 12/30/14, DOH suggested referring Walter to a Licensed Home Care Services Agency (LHCSA) and for Personal Care Services (PCS) for medication oversight, particularly since the care manager (CM) from the Health Home mentioned he was pre-diabetic. Although not listed on the AHRAR, DOH also suggested a Certified Home Health Aide (CHHA). As some concern was raised on the call about his diet and being pre-diabetic, they felt it would be good to have it at the start; that way the CHHA could refer him to a dietician. On the follow-up call on 12/29/14, the day prior to his move, the CM reiterated that she would be referring him for a CHHA to help with medication management. When the Independent Reviewer's staff visited Walter on 1/13/15 with the CM, he explained that he was using finger sticks to keep track of his blood sugar, which seemed to surprise her. When asked about the LHCSA or the CHHA, she stated that they were not yet in place nor were they documented on his Care Plan. In fact she explained that she had called his doctor and asked the office manager to submit the necessary forms so that Walter could receive these services, but had not heard back. On follow-up, she reported that the doctor's office did not have the form and she was to drop it off. This information was subsequently shared with the Health Home Supervisor.

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Andrew P. described the whole process from in-reach to moving out as slow at first, having to wait until July for the in-reach to start in the Queens adult homes, but "relatively smooth" after that. The entire process took five months from in-reach to his move on December 10th. Andrew credited staff from CIAD and Plaintiff Counsel, from NYLPI "for keeping me informed every step of the way." The "glitches," as he described them occurred after the move. Although he had sufficient money when he left the home, he had budgeted counting on Food Stamps. However, contrary to the plan at the 21 Day meeting, his care manager, who did not transition with him into the community, had not arranged this. Although he had collected cans and bottles to redeem for food, he was always with funds, he received some provisions from a food pantry where his girlfriend's father works, and his Housing Contractor, ICL, intervened as soon as they were aware of the situation. As of the day of my visit the MLTCP social worker was handling the application process and it was expected to take 30-60 days. His community care manager from the MLTCP visited him for the first time one month after transition. In addition, the Physical Therapy Assessment that was to occur post transition apparently had not occurred. As Andrew had requested at the Transition Meeting, ICL had a safety bar installed in the shower. However the bar, which was secured by suction, gave way and he slipped and injured his wrist. He required a cast when he sought Emergency Room treatment for pain that persisted several days later. ICL then had a new bar installed that was secured to the wall. The MLTCP had planned to disenroll

Andrew due to his high level of independence, but because of the cast and ICL's request, they agreed to send in an RN and a HHA 3days a week for now, starting 1/15/15.

As helpful as the pre transition call is to ensuring that all of the necessary supports are in place prior to the move, it is equally important that there be a process to ensure follow-up with all of the members of the team following the move. ***For this reason the Independent Reviewer recommends that there be a post transition call within 10 days of the move, with follow-up calls as indicated. Unlike most of the 21 day calls, theses calls should include the class member, until the team is satisfied that the care plan and all supports are in place and that all of the participants, most importantly the class member, are on the same page***. Although the State has implemented post transition calls as of February 13, 2015, generally within a week of the move, to date these calls do not include the class member.

In general, class members who were interviewed by the Independent Reviewer's team, who had moved from the adult home, after living there from two to 20 years, responded positively when asked about their new living situation, and how getting to this point had been for them. They were excited to have the freedom to do what they wanted to do, when they wanted to. They spoke of not missing the noise, chaos and frequent fights in the adult home, and all loved having their own room. They spoke of liking their independence to go shopping and the additional money they had, compared with just the Personal Needs Allowance they received in the adult home.

Albert P. When the Independent Reviewer's staff first visited him on 10/13/14, Albert said it was a long process but he realized he was one of the first two to move (on 9/15/14) and a lot of problems had to be worked out. He said it took a lot of coordination between him, the HC and Centerlight, his original MLTCP, who disenrolled him in the middle of the process. He said he did a lot of the things needed to move and was still taking care of things. Specifically, Albert had gotten the psychiatric evaluation from his PROS Program that was needed to complete the application; he had gone to Social Security to arrange for direct deposit before the move; renewed his driver's license, and rented a car to visit family. Although the adult home managed his medications, he said he was doing that on his own now without a problem. He loved his new apartment and proudly served me cake and coffee. He spoke of his newfound independence and enjoying it. When visited again on 1/15/15, Albert said he "was doing really well" and "would change nothing." The apartment was clean, although still barren of pictures and personal touches on the walls. He had a nice bed cover and books around and near his bed. He served me juice and coffee and seemed to be well supplied. He loved the apartment, as well as the neighborhood and said: "I couldn't have picked a better spot myself." He spoke of the convenience to transportation and shopping, showed me his cart and mentioned the Laundromat he uses nearby on Surf Avenue. He takes daily walks to pick up the neighborhood papers and also uses the library nearby to borrow DVDS, as he "loves movies." He is still attending PROS once a week but is transitioning to

the mental health clinic. He called on his own and got an intake appointment February 9th. Albert said his goal in PROS was to get his own apartment and he achieved that. He spoke positively about Mark, his care manager from Post Graduate Center, who visits with him once a month. His Care Plan focused on food choices/shopping, budgeting, and coordination of community appointments.

* * *

Clinton K. On 1/21/15 the Independent Reviewer's staff visited Clinton's apartment with JBFCS-HC staff. The apartment is a one-bedroom walk-up apartment on the 3rd floor on W. 36th Street in a newly renovated walk-up building post Hurricane Sandy. He moved in on January 13th from the adult home, where he had lived for two years. Clinton is a very pleasant 67 year-old Afro-Caribbean gentleman from Jamaica, who smiled during the entire visit. He reported no difficulty walking up the two floors to his apartment. When I entered the apartment it was clearly brand new from top to bottom with nice stone tiles in the kitchen and wood floors that had a shiny finish. Clinton had received in-reach in May 2014, and the process took 8 months until he moved. When I asked him how the process was for him, he beamed and said "the process was very good…like the ticking of a clock, everything was super…a blessing." When I asked if he was kept apprised of what was going on, he said that former resident council President from the adult home, who placed his name on the Fast Track, gave him the idea to move and kept him informed. He said he liked and accepted the "first apartment he saw." He said he loved everything about his new apartment He liked that the neighborhood was "very quiet and peaceful." He has attended a CDTP for two years, and now is transported there three days a week to allow for his HHA to come on Wednesday and Friday from 2 PM- 6 PM, in contrast to the five days a week he attended prior to his transition. Clinton said he can wash, clean and cook for himself and talked of making pancakes and coffee for breakfast and steaks and chicken for dinner. However, at the present time the HHA washes dishes, cleans and shops for him when she comes. When asked about Food Stamps, he already had them from when he was in the adult home which seems to be the case with residents for whom the adult home was not their representative payee. Clinton takes medications for High BP; High Cholesterol and Osteoarthritis, on his own, which he did not do in the adult home. The Independent Reviewer's staff and the HC were both unable to get a copy of his Care Plan from the HC, as the MLTCP would not give it to the HC without a consent, which the HC obtained from Clinton during the visit.

* * *

Jessica C. & Christopher H. They moved from the adult home on 12/1/14 and share a two- bedroom apartment, in a residential neighborhood on the first floor of a pre-war, multi-story brick building, looking in good repair from the outside. The

apartment was clean and odor free. The walls were clean/freshly painted and the hard wood floors seemed clean. The apartment was well furnished with a kitchen table/chairs, pots/pans, utensils, etc.; living room furniture with lamps on end tables, TV; regular bedroom sets (beds, dressers, etc.); The apartment, however, was rather stark with no personalizing touches like pictures, wall decorations, plants, etc., (but these are items the individuals should add as they please and as their tastes suggest; they had just moved in and their discretionary cash flow at this transition point is tight.)

Each said they liked where they were living and so glad to be out of Kings ACC. Jessica said she "loved it!" Christopher was less exuberant. When asked why she "loved it," she spoke of all the nearby shops – fish market, butcher, etc. – and how she enjoys the stores/shopping. Christopher reported that he and Jessica have settled into a routine: he does all the cooking and she does the cleaning. It was then he became a bit more excited, and began talking about his love of cooking. He showed the reviewer a shelf-full of spices in the kitchen and explained: "I am Caribbean, I use them all." Jessica had mentioned a fish market and he indicated he makes fish frequently. Jessica's aide was present when we entered Christopher and Jessica's apartment and was doing some paper work at the kitchen table. Jessica was in the living room watching TV…she was going out for a routine medical appointment later. Upon entering, Christopher told the staff from FEGS-HC, that he had just called her…the apartment has had no heat since yesterday. He said: "it wasn't that bad yesterday, but it's colder today…but we put on warm clothes." The staff asked him if he had called the emergency number she had given him. He indicated that he had forgotten to do so. He had the number she had given him, which she confirmed, and reviewed with him the protocol for dealing with issues like this: the person at the other end of the emergency number can quickly get a hold of the landlord or other appropriate parties. The Housing Contractor staff said that she would handle it at this point. (The same condition also existed in the apartment of Martin E., also a former adult home resident, which we visited upon leaving. However, he had called the Emergency number and the heat was starting to come up, in both apartments.)

* * *

Scott F. On 1/21/15 the Independent Reviewer's staff visited Scott's apartment with staff from JBFCS – HC. The apartment, which was one flight up, was clean and freshly painted and the floors were recently stripped and stained. It was a two-bedroom apartment and the furnishings were standard and similar to the other JBFCS apartments previously visited. Scott, a 65 y/o Caucasian male had lived at an adult home for three years and was in a JBFCS Apartment Treatment Program for three years before that. He said: "he had to leave (the Apt. Program)" and explained he wasn't taking his medications and was hospitalized. Scott had in-reach

at the end of March, but was not assessed until August, and HRA approval occurred at the end of October. He moved in on January 9th to live with Julio V., who moved in on 11/7/14.

When asked about the process, he said it was "a long period of time…with a lot of uncertainty...I had no idea what was going on……I thought I was being rejected…but now it's over." He said he discussed his frustration and uncertainty with his therapist in the PROS program. He said he liked the apartment and the neighborhood that he was familiar with from living at the adult home and attending PROS, both up the block. He said he had no problems living with Julio V; "so far so good." He said they would share utility and telephone bills which have not come up yet, and share the refrigerator while keeping their food separated. He liked having his privacy and cooking his own food. He liked doing whatever he wanted to do and did not want to be in the PROS program more than the one hour a day he attends now. He was most frustrated by not having Food Stamps, and there was a problem acquiring the ID needed to apply. He said he had gone down and submitted the documents and would be called on 1/22/15 for a phone interview, followed by an in-person interview. After that it could take up to 30 days. His Care Plan did not provide for HHA services, as he was independent in cooking, shopping, laundry and other ADL. Julio does have a HHA, who was present during my visit, and does clean the common areas. The plan focused primarily on acquiring the IDs needed for Food Stamps and helping him with the process. The adult home was his representative payee and JBFCS serves that function now, ensuring his rent is paid.

Conclusion

In the quarterly report filed with the Court on January 16, 2015, the Defendants expressed the opinion that the five-year goal of the Settlement Agreement to transition all qualified and interested class members to the community "is attainable." (The State's Third Quarterly Report, p. 5) In order for that to happen, the pace of implementation will have to increase dramatically and be sustained for the remainder of the five-year period.

Out of the 4,197 class members identified as of March 13, 2015, 1,256 have received in-reach by a Housing Contractor, and 60.35% of those class members have expressed an interest in moving to supported housing. Assuming that the rate of interest remains at this level for the total class over the duration of the Settlement Agreement, 2,533 class members will have to be assessed and moved. As of March 13, 2015, 40 have been moved over the first six and-a-half quarters that the Settlement Agreement has been in effect. This leaves 2,493 class members to be assessed and moved in the remaining 13.5 quarters. In the 90 day period ending March 13, 2015, 30 class members were moved. In the remaining 13.5 quarters, the rate of movement will need to average

185 per quarter or six times the rate achieved in the most recent three month period.

Although the State has been closely monitoring the implementation process, and implementing changes and refinements as obstacles have been encountered and identified, the magnitude of the task ahead is obviously substantial. Thus far, the modest tweaks to the existing processes for implementation have not achieved the quantum leap in performance that will be required to attain the goals of the Settlement Agreement.

The implementation process is fraught with numerous obstacles that make navigating its course a time-consuming, treacherous and frustrating ordeal for class members.

- An assessment process that is taking months to properly complete an assessment report;
- The lack of an efficient process to timely obtain necessary mental health records to support an application for supported housing;
- Incomplete assessments that languish for months with no discernible movement;
- Care mangers with caseloads so large that they scarcely have time to keep their clients informed of the status of their cases;
- MLTCs which disenroll their clients midstream in the process, returning them to the starting point, with inadequate processes to transfer records and assure continuity;
- Psychiatric evaluations, UAS-NYs and HRA approvals that expire in 180 days, requiring them to be redone, and causing more delays; and
- Multiple service providers serving the same client who cannot share necessary information because they have failed to execute Administrative Service Agreements or obtain consents.

Due to these obstacles and dysfunctions, although 600 class members were placed on the Fast Track due to their expressed interest in transitioning to supported housing, and despite funding being available for 1,050 supported housing units, and contracts in place for 350 beds, after 18 months of implementation effort, only 40 of the 600 have managed to successfully run this gauntlet. For the 608 class members who indicated an interest in supported housing at in-reach, and have not dropped out of the process or been placed, the median length of time they have been waiting is 227 days as of March 13, 2015.

In a progress report to the parties on July 31, 2014, the Independent Reviewer

acknowledged the hard work and effort by the DOH and OMH to implement the Settlement Agreement. Both OMH and DOH have conducted several training sessions for Housing Contractors, Health Homes and MLTCPs and have issued regular updates to Frequently Asked Questions. DOH conducts regular conference calls with Health Homes and MLTCPs to address emerging issues, and OMH convenes regular meetings of all of its Housing Contractors to discuss their progress and troubleshoot issues that arise. The staff of both agencies are in regular contact with their contractors to monitor progress with individual cases, and especially the transition planning process. Notwithstanding these efforts, the Independent Reviewer raised concerns about the inherent complexity, fragmentation of responsibility and cumbersomeness of the implementation process, and the small results achieved, and suggested a re-examination of the workability of the process with a view to consideration of simpler alternatives. That observation is equally current today.

Most of the work of implementing the Settlement Agreement at the class member level has been delegated to private contractors –Housing Contractors, Health Homes and MLTCS –and the latter two have further delegated the work to downstream providers and ***their*** contractors. But there are no apparent benchmarks or performance measures for these contractors that are related to the specific requirements and timelines of the Settlement Agreement. For the nurse assessors, after the initial 15 day timeframe in the State's work plan for completing an assessment proved to be unrealistic, there has been no revised timeline expectation for completing this essential task. The level of activity among the Housing Contractor agencies varies widely, and there is a sizable proportion of the class members who have not yet been enrolled in a Health Home or MLTCP or assigned a care manager to begin the person centered care planning process with them. The two state agencies that bear the oversight responsibility for these contractors do not have ready access to information about how the contractors have elected to staff their efforts, or caseloads or workloads of the staff upon whose efforts the success of this entire enterprise is dependent and are therefore ill-equipped to determine whether adequate resources are being committed to the implementation effort.

Recommendations

Consistent with the requirement in the Settlement Agreement that the Independent Reviewer take a "problem-solving approach" (¶ L [7]), the Independent Reviewer has considered how the assessment and transitioning process might be speeded up, and the rate of initial declines at in-reach and later dropouts might be reduced, and offered several ideas for a different approach.

1. The linear approach to the multi-step process of in-reach, assessment, personal care planning, and locating and moving to an apartment should be reconsidered, with several of these steps and tasks occurring while the assessment process is going on. Specifically:

a) There is a need for a more robust in-reach process where, instead of a brief conversation that typically occurs at the adult home itself, the housing contractors arrange for groups of residents to visit a model apartment and/or meet with class members who have already transitioned, as part of the in-reach process that would help class members make an informed decision about supported housing.[15] We believe such an approach is more likely to engage the class members in a way that a conversation alone does not and is also consistent with the presumption in the Settlement Agreement that most class members would be found eligible for supported housing when the assessment process is complete.

b) Priority should be given to immediately enrolling in Health Homes those class members who indicate an interest in supported housing, and assigning them care managers to begin the personal care planning process. Virtually all class members are likely to require behavioral health services in the community which the Health Homes are most suited to provide. Although the Department of Health has recommended the early assignment of care managers to class members, according to the weekly report for Week 52, of the 758 people who have said yes to moving, only 341 (45%) have a care manager listed on the spreadsheet. (207 have a Health Home care manager only; 113 have an MLTCP care manager only; and 21 have a care manager from both a Health Home and MLTCP).

c) We believe that involving class members ***immediately*** in the care planning process, perhaps using the Guide prepared by the Nathan Kline researchers, will keep them more engaged and informed about the process while the assessment tasks and collection of required documents for the HRA application proceeds. One of the most consistent complaints that we have heard over the course of the past year from class members is that weeks and months can elapse following in-reach or an interview with an assessor with nothing more happening to indicate that work is proceeding on their expressed interest in moving to supported housing. The early assignment of a care manager can also get a head start on preparation for the eventual transition by ensuring that the class members have the required IDs, obtain Access-a-Ride and Half-Fare Metro cards, are prepared to apply for SNAP benefits at the earliest opportunity, and that their financial benefits are transferred in a more timely fashion. Some of these tasks are current responsibilities of the adult homes, which the care manager could ensure are timely performed. Beyond these essential transitional steps, care managers could also begin the

[15] As the Court noted in its opinion approving the Settlement Agreement:

> With the goal of enabling residents to make an "informed choice' about moving, the proposed settlement requires housing contractors to "discuss any concerns" about supported housing and requires the State to use its best efforts to locate persons living in supported housing to speak with adult home residents. (Settlement, Sec. E (2) (a)-(b).)" (ECF. No. 59, filed 3/17/14, p. 20)

process of assisting class members develop connections with community organizations such as senior citizens centers, peer drop-in centers, churches and the like to enable them to create social networks to ease their transition to community living and counter the risk of loneliness that people experience when they leave institutional settings.

d) In addition to the training that has already been provided by the DOH, we believe it would be beneficial to provide more targeted training for care managers on the specific tasks and techniques involved in transitioning residents from adult homes to supported housing. (Obtaining IDs, assembling the documents required to apply for financial entitlements and SNAP benefits, obtaining recent psychiatric evaluations and psychosocial histories, etc.) These are skills that care managers typically have not had the opportunity to develop previously, and could probably best be taught by individuals who have successfully worked with adult home residents to transition them to community housing.

e) We also recommend developing a detailed how-to manual that addresses the key tasks involved in the transition process, as a resource for the care managers. We think this is especially necessary given the large number of individuals and organizations[16] involved in performing this work, as well as the turnover that is occurring in care managers assigned to adult home residents whether due to disenrollments, reassignments or resignations.

f) As we have recommended previously, we believe that Health Homes and MLTCPs should be required to certify to DOH that the care managers assigned to class members have completed the required training prior to being deployed.

We believe that implementing these recommendations will help class members be better informed about the choice that is available to them, keep them informed and engaged throughout the process, speed up the assessment process and the HRA application, and provide for earlier collaboration on the development of a personal care plan and smoother implementation of the transition to supported housing.

As discussed in this report, the Independent Reviewer has shared a number of recommendations with the State toward improving the Settlement Agreement implementation process. Many of these have been acted on. For example, in response to the Independent Reviewer's recommendations:

[16] In addition to the six housing contractors, there are six Health Homes which directly and/or through 13 downstream providers provide care management. It should be noted that some of these downstream providers work for more than one Health Home and some are even part of Housing Contractor agencies, like FOO, FEGS and JBFCS. There are 25 MLTCPs and seven managed care plans also involved in providing care management to class members.

- A fast track approach to in-reach efforts has been adopted to target class members who are known to desire transition as a priority in the initial stages of in-reach.
- In-reach materials have been developed to ensure that class members receive consistent information about the Agreement and transition process.
- Quality assurance reviews by DOH of information pertaining to the assessment process have been expanded.
- Additional training for Housing Contractors, care managers and assessors has been offered and includes the use of case studies as learning tools.
- Suggested revisions to data systems employed by the State in monitoring class members' progress from in-reach through transition out of adult homes have been made. Additionally, weekly data reports are shared with Housing Contractors and Plaintiffs.

Other recommendations, however, have not been implemented or implemented only partially. The Independent Reviewer believes these warrant reiteration in order to improve the pace at which implementation is progressing and to achieve the goals of the Settlement Agreement.

2. It is recommended that the State facilitate the creation of a dedicated pool of nurse assessors with experience in psychiatric nursing and who have received training on the Settlement Agreement, mental health housing options and the array of community services available to individuals moving to Supported Housing. Performance standards should be developed for workload size and timeframes for completion of the various assessment related tasks (e.g., completion of the UAS-NY, securing and reviewing Comprehensive Psychiatric Evaluations, completing and submitting AHRARs, etc.). These should serve as benchmarks for monitoring performance; and actual completion of these various tasks should be included in weekly data reports.

3. Considering that many class members may not be good reporters of their medical and mental health care histories, it is again recommended that the assessment and care planning process could be aided greatly by conducting a review of Medicaid data to identify class members' current medical and mental health providers and to develop a snapshot of the services provided in the past 6-12 months which would serve as a tool in identifying their needs.

4. It has been reported that the timely receipt of comprehensive and up-to-date (within six months) Psychiatric Evaluations has been a significant factor in delays in the assessment process. Despite requests, the Independent Reviewer has not received information on the scope of this problem and the psychiatric providers involved. Thus, it is recommended that the State identify the psychiatrists responsible. To the extent that they are private practitioners outside the jurisdiction of OMH's licensed programs and working under contract with adult homes, the State should consider arranging for an independent Comprehensive Psychiatric Evaluation to be conducted by the individuals' HH/MLTCP or a mental health clinic. If the psychiatrists involved are affiliated with OMH licensed

programs, OMH should exercise its regulatory authority over the program to ensure compliance with the request.

5. Where assessments result in housing recommendations for something other than supported apartments, thus curtailing the individual's access to supported housing under the Settlement Agreement, notice should be given to Plaintiff's counsel for appropriate action.

6. Given the reportedly high caseloads of HH/MLTCP care managers, reports of care managers not arranging for needed services (e.g., Food Stamps) by the time of a person's transition and the ongoing problems of care managers maintaining regular contact with class members, the Independent Reviewer recommends that the State should establish reasonable thresholds for care managers' caseload size and performance expectations.

7. In response to an earlier recommendation, the State has developed a template for care/transition planning for use by care managers. This template identifies key items that need to be addressed to ensure a ***safe*** discharge from the adult home, such as the availability of food, utilities, financial support, ADL assistance, appointments with health and mental health providers, etc. But it does not address other major domains in an individual's life that could ensure not just a safe, but a successful and fruitful transition and quality of life in the community – issues including the individual's interests, desires and needs in such areas as continuing/adult education, employment/volunteer activities, inclusion in culturally relevant social opportunities and faith communities, civic/community activities, etc. The Independent Reviewer again recommends the creation of a care planning template that ensures the wide range of dimensions of an individual's life are discussed and plans put in place to address his/her needs and preferences.

8. The Independent Reviewer is impressed with the State's initiative of convening 21-day, pre-transition telephone calls involving Housing Contractors and HH/MLTCPs to ensure that elements of a safe transition are in place prior to an individual's move. In January, the Independent Reviewer recommended that the State consider implementing post transition calls to determine if what had been planned in anticipation of the move actually worked out, arrange for remedial action if needed and learn from the experience. As noted in the report, the State has begun implementation of this recommendation.

9. The Independent Reviewer recommends that when a class member declines assessment/transition after having expressed an interest in moving at the time of in-reach, the Housing Contractor and care manager should be immediately informed of the declination and the reason so they can take timely and appropriate follow-up action.

10. The Independent Reviewer regards it as an urgent matter to resolve access issues to all records and documents that are needed to adequately monitor the implementation of the

Settlement Agreement. The parties are currently working on drafting a proposed court order to address this concern.

List of Acronyms/Abbreviations

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

Appendix A Discharge Planning Tool