IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. THE STATE OF GEORGIA, et al., Defendants.	)	CIVIL ACTION NO. 1:10-CV-249-CAP

NOTICE OF JOINT FILING OF THE REPORT OF THE INDEPENDENT REVIEWER

On October 29, 2010, the Court adopted the parties' proposed Settlement Agreement and retained jurisdiction to enforce it. *See* Order, ECF No. 115. On May 27, 2016, the Court entered the parties' proposed Extension Agreement and similarly retained jurisdiction to enforce it. *See* Order, ECF No. 259.

Both documents contain provisions requiring an Independent Reviewer to issue reports on the State's compliance efforts. *See* Settlement Agreement ¶ VI.B; Extension Agreement ¶ 42.

On September 18, 2018, the Independent Reviewer, Elizabeth Jones, submitted to the parties her semi-annual report, along with several reports from her

consultants. On behalf of the Independent Reviewer, the parties hereby file the Independent Reviewer's report and the reports of her consultants.

As stated in the parties' Joint Status Report, submitted on June 29, 2018, after the parties have an opportunity to review the Independent Reviewer's report and additional information from the State, the parties will be able to inform the Court about the State's compliance with the agreements before the end of the year.

Respectfully submitted, this 19th day of September, 2018.

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CERTIFICATE OF COMPLIANCE

I certify that the documents to which this certificate is attached have been prepared with one of the font and point selections approved by the Court in Local Rule 5.1B for documents prepared by computer.

This 19th day of September, 2018.

/s/ Aileen Bell Hughes
AILEEN BELL HUGHES
ASSISTANT UNITED STATES ATTORNEY

CERTIFICATE OF SERVICE

I hereby certify that on September 19, 2018, a copy of the foregoing document, Notice of Joint Filing of the Report of the Independent Reviewer, along with the underlying reports, were filed electronically with the Clerk of Court and served on all parties of record by operation of the Court's CM/ECF system.

/s/ Aileen Bell Hughes
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REPORT OF THE INDEPENDENT REVIEWER

In The Matter Of

United States v. Georgia

Civil Action No. 1:10-CV-249-CAP

September 19, 2018

Introductory Comments

The Settlement Agreement (SA) and Extension Agreement (EA) require the Independent Reviewer to file reports each year with the Court. This is the second of two reports for the State of Georgia's Fiscal Year 2018 (FY 2018); it covers the period from March 1, 2018 until June 30, 2018.

The State, through its Department of Behavioral Health and Developmental Disabilities (DBHDD), its Department of Community Health (DCH) and its Department of Community Affairs (DCA), has continued to demonstrate good faith in working to meet its obligations under these agreements. The Governor and the Georgia General Assembly have made a substantial investment of resources and, as a result, the community-based services and supports available to individuals with a developmental disability (DD) or a serious and persistent mental illness (SPMI) have been expanded and sustained throughout the nearly eight years since entry of the Settlement Agreement.

The availability of these resources has helped to lessen the reliance on institutional settings for many, although not all, of the individuals included under the terms of the agreements.

The shift from a system built on institutionalization to one that is built on the goal of community integration is at the core of the Settlement Agreement. In plain language, the Settlement Agreement states:

> Accordingly, throughout this document, the Parties intend that the principle of self-determination is honored and that the goals of community integration, appropriate planning and services to support individuals at risk of institutionalization are achieved. (SA, I., K.)

There are a number of strengths evident in Georgia's community-based system, including the commitment of its leadership to the systemic reform required to implement the provisions of the Court's orders. This commitment is reflected in the goals that have been established, the willingness to listen carefully to concerns and recommendations, and the continuous interest in seeking effective solutions for identified problems. Since the entry of the Settlement Agreement, the presence of stable leadership with this level of commitment has been of critical importance.

This report examines the State's performance in addressing its obligations and offers recommendations to the Court regarding findings of substantial compliance or noncompliance. The work to be completed is at a pivotal point. The Extension Agreement states, "The Parties anticipate that the State will have substantially complied with all provisions of the Extension Agreement by June 30, 2018. Substantial compliance is achieved if any violations of the Extension Agreement are minor or occasional and are not systemic." (EA 48)

In the last report to the Court, filed on March 27, 2018, it was documented that the State's progress in achieving substantial compliance with all of the Court-ordered obligations has not been uniform. The same conclusion is reached as the result of the extensive work completed for this report.

There is clear evidence that certain key obligations, such as the transition of individuals with DD from State Hospitals to more integrated community settings, have been addressed and expectations largely have been met. For example, by the end of FY 2018, the number of community placements from State Hospitals reflected a "reasonable pace," as is required per EA 7. Areas of significant concern in past years, such as the identification and prevention of health-related risks, have received focused attention and remedial actions have either been implemented or are well underway. These accomplishments are to be commended; there were many challenges that needed to be overcome.

At the same time, there is also clear evidence that other major obligations cannot receive a recommendation for a finding of substantial compliance.

For example, one of the most prominent gaps in reaching substantial compliance is access to Supported Housing, a cornerstone of the mental health system reform. Supported Housing is defined as:

> Supported Housing is: (a) integrated permanent housing with tenancy rights; (b) linked with flexible community-based services, including psycho-social supports, that are available to individuals when they need them, but are not mandated as a condition of tenancy. (SA III.B.2.c.i.; see also EA 36)

As discussed at length in the last report to the Court, and as reiterated in the narrative below, the provisions related to Supported Housing are still not implemented on a systemic basis for all of the subgroups of the Target Population, as defined in Provision 30 of the Extension Agreement, which states:

> For purposes of Paragraphs 31 to 40, the "Target Population" includes the approximately 9,000 individuals with SPMI who are currently being served in State Hospitals, who are frequently readmitted to the State Hospitals, who are frequently seen in emergency rooms, who are chronically homeless, and/or who are being released from jails and prisons. The Target Population also includes individuals with SPMI and forensic status in the care of DBHDD in the State Hospitals, if the relevant court finds that community services are appropriate, and individuals with SPMI and a co-occurring condition, such as substance abuse disorders or traumatic brain injuries.

DBHDD has initiated specific actions intended to help achieve substantial compliance with its obligations to the members of the Target Population. These actions include, within FY 2018, the award of contracts to establish 12 Regional Housing Outreach Coordinators with responsibility for "…the delivery of housing outreach case management services, specifically; community outreach targeting access to supported housing for individuals who meet the DOJ settlement criteria and are in the following settings: county jails, state prisons and community hospital emergency rooms within providers designated service area."[1] Although this is an action that has potential value, outreach efforts to date have been limited or incomplete. In addition, even when

[1] Job Description, Regional Housing Outreach Coordinator (HOC).

fully implemented, this outreach will not be available to all 159 counties in Georgia. Under the terms of the contract awards, outreach is targeted to 98 counties or 62% of the entire state.

The State has taken action to recommend a finding of substantial compliance for the obligations in EA 32 through 35 requiring the provision of Bridge Funding and Georgia Housing Voucher Program (GHVP) vouchers. However, it is important to emphasize that the State has failed to come into compliance with the Supported Housing Provisions of the SA and EA that require the State to have the capacity to provide Supported Housing to the approximately 9,000 people in the Target Population who need Supported Housing. At this time, based on these and other documented facts, it is the carefully considered judgment of the Independent Reviewer and her subject matter consultants that the State has not met the requirements for findings of substantial compliance to be recommended for EA 36, 38 and 40.

Throughout this report, there has been a conscientious attempt to obtain current facts that are reliable and that will support the recommendations made regarding substantial compliance or noncompliance. Fact-finding has benefitted greatly from ongoing access to the Commissioners of DBHDD and, as needed, DCH. Staff members from both DBHDD and DCA were instrumental in providing information relevant to the independent review of the agreements. In particular, the Director of Settlement Coordination and her Administrative Assistant were incredibly responsive to, and understanding of, the many demands placed upon them, often on short notice.

The guidance and assistance so generously provided by the attorneys for the State of Georgia and the United States Department of Justice have been especially helpful. The monthly meetings with the State and the United States have been productive and informative.

The Independent Reviewer's reporting has been facilitated by ongoing discussions with many people with an investment in the systems of support for individuals with a disability. The inclusion of the Amici, other advocates, community stakeholders and individuals with a disability and their families has been and continues to be vitally important to meaningful systemic reform. The Independent Reviewer and her subject matter consultants very much appreciate the information and thoughtful insight received from them throughout the years.

Methodology

The fact-finding for this report involved extensive fieldwork as well as multiple meetings with the Parties, the Amici and advocates for members of the Target Population, staff from community service provider agencies, clinicians and social workers in two State Hospitals, representatives of local government agencies, and other interested stakeholders, including individuals and family members who are at the crux of the Settlement Agreement and the Extension Agreement. Of particular interest were the meetings held on June 27, 2018 with agencies providing support to documented resettled refugees and adults with a primary language other than English. The clients of these agencies included individuals with SPMI who would benefit from the services implemented under the Agreement.[2]

In preparation for this specific report, the Independent Reviewer and her subject matter consultants spent 53 days on site in Georgia. Fieldwork occurred in all six DBHDD Regions.

Site visits were made to State Hospitals, community Supported Housing sites, group homes, jails, including a jail where one individual with DD was being held, crisis homes, family homes and host homes. At each residential setting, members of the Target Population were met and, if possible, interviewed. Individuals with SPMI who were homeless were interviewed on the streets.

Visits to three county jails in southern Georgia included discussions with Sheriffs and/or Jail Administrators and with correctional agency staff responsible for mental health care in the jail. A telephone call was completed with the Director of Mental Health for two jails in a metropolitan Atlanta county. One incarcerated individual with SPMI was interviewed in a Region 4 jail. Discussions were also held with Public Defenders and other attorneys who represent individuals in jails or prisons.

Reports, statistics and other essential documents were provided by DBHDD. It has not been possible to verify all of this information through independent review; any questions about accuracy or completeness are noted, if needed.

The Department of Justice requested detailed data regarding the implementation of services and supports throughout the course of the Settlement Agreement and the Extension Agreement. Data provided by DBHDD in response to those requests have been referenced throughout this report.

Subject matter consultants to the Independent Reviewer examined discrete provisions of the Settlement Agreement and its Extension. The consultants' work focused on the State's efforts to achieve compliance with its obligations. Those findings have been shared with the Parties; subsequent discussions have been held or are planned, as necessary.

Dr. Patrick Heick, a behavior analyst, and three nurse consultants, Marisa Brown, Julene Hollenbach and Shirley Roth, reviewed a targeted sample of 31 individuals with DD who were in

[2] Key staff at these three agencies either did not know about the availability of mental health services, including Supported Housing, or had limited knowledge. Outreach to agencies such as these needs to be prioritized so that they can benefit from available supports for adults with SPMI.

a crisis home, jail or had experienced encounters with law enforcement (12), transitioned to the community during FY 2018 (7), or were included for health/medical reasons on the Statewide Clinical Oversight (SCO) list (12). Each of these reviews included a site visit, document review and, with the exception of the individual in jail, the completion of a Monitoring Questionnaire. (The Independent Reviewer and DBHDD developed this Questionnaire during the early years of the Settlement Agreement.) Dr. Heick's summary report is attached. The individual reviews completed by Dr. Heick and the three nurse consultants have been provided to the Parties.

In addition, as part of the review of mortality investigations, Marisa Brown, RN conducted site visits to four locations where deaths of individuals with DD had occurred. Two of these residences were the sites of deaths that occurred during the transition period.

Laura Nuss reviewed Support Coordination by interviewing DBHDD staff, Directors of Support Coordination agencies and members of advocacy organizations. She examined all documentation provided by DBHDD related to its efforts to comply with these provisions of the Extension Agreement. She interviewed two Support Coordinators for individuals placed in a crisis respite home. Ms. Nuss's report is attached.

Dr. Angela Rollins analyzed all fidelity reviews completed in FY 2018. The report from Dr. Rollins is attached.

Dr. Beth Gouse spent time at the end of the quarter at Georgia Regional Hospital Atlanta (GRHA) and Georgia Regional Hospital Savannah (GRHS). She reviewed the hospital records of all adults discharged to shelters or hotels/motels and discussed discharge planning with hospital staff. Dr. Gouse also reviewed discharge planning for forensic clients, including those hospitalized at the Cook Building at Central State Hospital (CSH) in Milledgeville. The reports from Dr. Gouse are attached.

Martha Knisley reviewed DBHDD's efforts to comply with obligations related to Supported Housing. She met with DBHDD staff and staff from DCA. She also interviewed representatives from local agencies responsible for homeless individuals with SPMI, mental health service providers, Housing Outreach Coordinators, individuals with SPMI who had obtained or were in need of Supported Housing, and attorneys who represented adults with SPMI. She conducted site visits in Regions 2 and 3.

The consultants' work will be discussed throughout this report. Copies of reports have been provided to the Parties; certain reports will be filed with the Court. The narrative for this report relies substantially on the fieldwork conducted by the Independent Reviewer's subject matter consultants.

The Independent Reviewer and her consultants are acutely aware that we placed numerous demands on State staff and community providers who were part of our fact-finding efforts. We truly appreciate the assistance given by so many people to enable us to complete our work.

As required, the Parties were provided with a draft of this report and were given the opportunity to comment on its findings. Both the United States and the State provided detailed comments in a

timely manner. Comments were carefully considered and revisions to the report were made as appropriate. The response from the State included a considerable amount of descriptive information on the structure and processes of the system. Although that background information was useful to the Independent Reviewer, it did not significantly refute the conclusions reached in this report and, for the most part, was not included. It has been requested that DBHDD provide more outcome-driven data for any future reports.

Development of the Foundation for a Community-Based System

Over the last eight years, the State has developed the major building blocks of a community-based system of support for adults with SPMI and those with DD. These core building blocks form the foundation for more integrated services throughout Georgia. It is indisputable, and certainly highly commendable, that the State has made major strides in shifting from an institution-based system of care to one that is largely community-based.

As of June 30, 2018, the State estimated that it had devoted about 263.5 million dollars in State funds alone for the community-based services prompted by the Settlement and Extension Agreements. Looking at the larger budget that includes non-SA/EA items, in FY 2018, the State estimates that it is spending about 314.5 million dollars more on community services than in FY 2011, the beginning of the implementation efforts under the Settlement Agreement.

As a result of this investment, as reported by the State, the following core services are available throughout DBHDD's six geographical Regions:

Behavioral Health:

- Assertive Community Treatment (ACT) Teams: 22 ACT teams across the state. ACT services provided to the Target Population with SPMI must conform to the Dartmouth Assertive Community Treatment Scale (DACTS). As outlined in the attached report by Dr. Rollins, these teams continue to be monitored for their fidelity to DACTS. In general, the teams scored very well on the requisite measures with all but two teams achieving satisfactory fidelity scores (and the other two teams were close.)[3] As of June 30, 2018, 1,614 adults were enrolled in ACT services statewide. It should be noted, however, that existing ACT capacity is far greater than utilization. In essence, this means the State is paying for ACT capacity for several hundred people but not utilizing it; the State should take effective steps to close the gap so that more individuals in need will access ACT services that are already funded.
- Community Support Teams (CSTs) have been increased by two over the Settlement Agreement obligation. There are now ten CSTs. As of June 30, 2018, 343 individuals statewide were receiving CST services.
- Supported Employment continues to be available through 20 agency providers at 25 different locations throughout the state. As of June 30, 2018, there were 1,214 individuals engaged with Supported Employment services.
- Case Management is provided through 52 agencies statewide; Intensive Case Management (ICM) is available through 16 agencies. Both of these services exceed the numerical requirements in the Settlement Agreement for 45 Case Management providers and 14 ICM teams. As of June 30, 2018, there were 2,107 individuals receiving ICM supports.
- Crisis Service Centers now total 11, more than required by the Settlement Agreement.

[3] It should be noted, however, that Dr. Rollins has identified areas of concern that require oversight, including the use of remote assessment, the waiting list for ACT in metro Atlanta, the rapid turnover of ACT consumers and the scoring of the co-occurring disorders model. DBHDD is urged to review and address these identified concerns.

- DBHDD has confirmed that there are 22 Crisis Stabilization Units in operation across the state.
- Crisis teams respond to calls in all 159 counties with an average reported response time of 51 minutes; this conforms to SA parameters.
- Nineteen crisis respite apartments, with 63 beds, are available now; 18 apartments were required under the Settlement Agreement.

Developmental Disabilities:

- There are 12 mobile crisis teams currently responding to calls across the state. Six teams were required under the Settlement Agreement.
- There are 12 crisis respite homes, with four beds each, available statewide. This is the number of homes required under the Settlement Agreement.

The development and sustained implementation of the core services established under the Settlement Agreement have helped the State to achieve the intended effect of reducing reliance on institutional settings.

Background and Context for Placements from State Hospitals

As reported previously, over the course of the Settlement Agreement and its Extension, there has been a substantial reduction in inpatient beds at the State Hospitals. At the time of the entry of the Settlement Agreement on October 29, 2010, seven State Hospitals served people with a developmental disability and/or a mental illness. In October 2010, these institutions combined had a total capacity of 2,436 inpatient beds. That month, they served 2,603 unduplicated clients with either disability; the average daily census was 1,821 people.

There are now five State Hospitals. Northwest Georgia Regional Hospital and Southwestern State Hospital are closed. Adult mental health services are no longer provided at Central State Hospital. On June 30, 2018, there were a total of 1,110 adults[4] institutionalized in the State Hospitals. The majority of these adults (57%) are in secured forensic units.

On June 30, 2018, the Adult Mental Health units in the State Hospitals had a total capacity for 313 individuals. On that same date, the combined census was 307 adults with a mental illness.

On June 30, 2018, there were 628 individuals in forensic units at the State Hospitals; the maximum capacity is 641 adults. As of June 30, 2018, there were 47 adults with DD in these forensic units, an increase of nine individuals from the same timeframe in FY 2017. (Twenty-eight of these same forensic clients (60%) were hospitalized in the forensic units at this time in FY 2017.)

As of June 30, 2018, 133 adults with DD reside at Gracewood in Augusta, 12 adults with DD are in the Adult Mental Health units at ECRH (2), GRHA (6), GRHS (3) and WCGRH (1). There

[4] In the March report filed with the Court, it was documented that there were 1090 adults institutionalized and 57% were in secured units.

are 25 individuals with DD and health/medical needs in the Skilled Nursing Unit (SNF) at GRHA. There are 47 individuals with DD in forensic units at the State Hospitals.

Both Gracewood and the SNF at GRHA have adults in residence there who have a mental health diagnosis but not a DD diagnosis. There are ten individuals with this diagnosis in the SNF at Gracewood who were transferred from the Craig Center. There are three individuals with a mental health diagnosis in the SNF at GRHA.

In summary, at the initiation of the Settlement Agreement in October 2010, there were 726 individuals with DD institutionalized in State Hospitals. As of June 30, 2018, in all State Hospital units, there are a total of 217 individuals with DD who now remain. Since October 2010, there are 509 individuals with DD fewer in State Hospitals.

> **Agreement Requirement:** The SA prohibits the State from admitting or serving in State Hospitals anyone under the age of 18 (unless the person is an emancipated minor). (SA III.C.1.)

> **Agreement Requirement:** The SA requires the State to stop admitting people with DD to the State Hospitals. (SA III.A.1.)

There are no children in any of the State Hospitals. Admissions of individuals with DD have stopped except that courts still order placement of adults with DD and a forensic status into the State Hospitals.

> **Agreement Requirement:** The SA prohibits the State from transferring people with DD and SPMI from one institutional setting to another unless the individual makes an informed choice or the person's medical condition requires it. The State may transfer individuals with DD with forensic status to another State Hospital if this is appropriate to that person's needs. The State may not transfer an individual from one institutional setting to another more than once. (SA III.C.2.)

Sixty adults residing in the Craig Center at Central State Hospital were transferred to other State Hospitals when that institutional unit was closed in 2015. The Independent Reviewer has not been informed of any institutional transfers since the closure of the Craig Center.[5]

[5] There now are 28 former residents of the Craig Center still institutionalized in State Hospitals. Seventeen of these adults have DD (61%) and would be eligible for a Waiver-funded community placement. Seven of the 17 individuals with DD reside in the SNF at Gracewood and ten individuals with DD are placed in the SNF at GRHA. There are 11 former Craig Center residents (39%) who are diagnosed with a mental illness; ten individuals live in the Gracewood SNF and one former resident of the Craig Center is placed in an Adult Mental Health Unit at GRHA. Based on information to date, there are no community placement plans for ten of the individuals with a mental illness and the options for funding are seriously constrained. At this point, there appears to be scant likelihood that the majority of the remaining residents with a mental health diagnosis transferred from the Craig Center will obtain an individualized integrated residential setting outside of a State Hospital. DBHDD cites opposition to community placement in nine cases but the extent to which community-based options have been actually explored through site visits and firsthand experience was not shared with the Independent Reviewer. Meaningful informed choice would require opportunities to learn and experience community-based resources.

Agreement Requirement: The EA requires the State to notify the IR within seven days of its determination that the most integrated setting for any individual with DD is the State Hospital, a SNF, an ICF, or a psychiatric facility. (EA 10; see also EA 8). The SA allows the IR to conduct an independent assessment of any such determination. (EA 10)

The State has consistently affirmed that all individuals with DD can be served in integrated community-based settings with appropriately individualized and implemented services and supports.

Provisions Related to Individuals with DD

Status of Transitions of Individuals with DD from State Hospitals

Since the last report filed with the Court, there has continued to be strong and stable leadership assigned to the transition process obligations agreed to by the Parties. This leadership includes key staff assigned at DBHDD, its expert consultants retained to assist the State, and in certain provider agencies. In addition, the State has benefitted from proactive and forceful advocacy on behalf of the DD stakeholders throughout the state and the compelling voices of individuals with DD and their families/friends.

There have been 47 community placements from State Hospitals during this FY 2018.[6] Men and women with DD, with differing levels of required support, have moved from ECRH, including Gracewood (27), CSH forensic units (8), GRHS (6), GRHA (1) and WCRH (5). Transitions have occurred at a reasonable pace, as required by EA 7.

Of particular note is the effort made to sustain certain community placements during the post-transition adjustment period. The Independent Reviewer requested additional information about the placement of one individual, S.T., who changed community residences. There was exceptional effort made by DBHDD and provider agencies to prevent hospitalization for behavioral disturbances as well as any further interactions with law enforcement. Mr. T.'s preferences were respected. DBHDD even assigned familiar staff from Gracewood to stay with Mr. T. in a motel while a new residence was being prepared for him. As of this report, Mr. T. is stable and seems contented with his residential setting and staff.

In addition to Mr. T., seven additional individuals who transitioned in FY 2018 were reviewed for this report. A brief summary, overall very positive, for each transitioned individual is set out here:

- G.D.: Ms. D. receives one to one staffing when she is awake; this will be reassessed after six months. With careful attention to her diet and food choices, Ms. D. has lost 19 unwanted pounds. She has also reconnected to her family; they did not visit her while she

[6] There were 48 transitions reported by DBHDD. However, one individual, Z.B., was transitioned to a community placement from GRHS in July 2017 but was returned to the State Hospital after repeated elopements and medication refusals. A Dekalb County Superior Court judge ordered that ZB be returned to DBHDD custody. A case expeditor still follows ZB but he is not determined to be ready yet for discharge from GRHS.

was hospitalized at ECRH. Despite these positive findings, concern was noted about the number of individuals being supervised by the agency RN. Reportedly, she is responsible for the supervision of health care to 160 individuals. (This concern was discussed with the Director of the Office of Health and Wellness.)

- P.H.: There were no environmental issues cited in the report. The post-transition support from the Integrated Clinical Support Team (ICST) was noted; the ICST has recommended assistive technology devices and will conduct training when they are received. The Independent Reviewer's nurse consultant expressed concern about the RN's level of oversight of medication documentation.
- A.J.: Mr. J.'s undesirable behavior has been decreased post-placement through staff guidance and many opportunities for community exploration. Progress notes are very detailed and reflect a wide variety of community outings where Mr. J. is encouraged to make choices.
- K.S.: Mr. S. attends a day program and appears to have settled into a positive routine. He experienced sleep disturbance after the move from Gracewood and is now prescribed medication to help him sleep. It is advised that this medication be monitored and discontinued as soon as feasible.
- W.S.: One of the most positive benefits for Mr. S. since his transition has been the close proximity to his brother's residence. They visit frequently and Mr. S. has now been baptized and joined his brother's church. Staff at his home planned a Sunday dinner celebration for this accomplishment.
- R.W.: The nurse consultant who completed the review described this as one of the most gratifying visits she has made in Georgia. Mr. W. came to this residence with a history of serious behavioral disturbances. These undesirable behaviors have been diminished significantly through relationship building and the use of preferred activities/interests. His staff are skilled and attentive.
- G.W.: There were no issues of concern. Mr. W. experienced a 14 pound weight loss after his move from Gracewood but this was monitored and a nutritional plan was implemented with success. Mr. W.'s weight has been stabilized.

The transition process, while considerably strengthened, will continue to require diligent oversight. Although there is clear evidence of pre-transition planning and the early assignment of Support Coordination, three deaths (W.B., W.E., and E.N.,) occurred during the six months following community placement. As a result, these three deaths, in addition to the death of B.B., in FY 2017, have received additional scrutiny by DBHDD, the Columbus Organization and the Independent Reviewer.

Agreement Requirement: The EA requires the State to develop and regularly update a transition-planning list for prioritizing transitions of the remaining people with DD in the State Hospitals. The EA requires the State to move people to the community at a reasonable pace. (EA 7)

Agreement Requirement: The SA requires that individuals with forensic status be included in the DD target population. (SA III.A.3.b.)

> **Agreement Requirement:** The SA requires that the number of individuals served in a host home shall not exceed two, and the number of individuals served in any congregate living setting shall not exceed four. (SA III.A.2.b.ii(B).

DBHDD has complied with the requirement to develop and update transition-planning lists for all individuals with DD who are institutionalized in State Hospitals.

Individuals with a forensic status have been included consistently in the transition to community residential settings. These efforts are commended because they frequently require more intensive planning and are subject to Court approval.

Throughout the course of this case, the State has substantially complied with the requirement that no more than two individuals be placed in host homes and that the number of individuals placed in any group home not exceed four individuals.

Recommended Finding: It is recommended that the State be found in substantial compliance with these three provisions.

> **Agreement Requirement:** For each individual with DD transitioning from a State Hospital, a support coordinator shall be assigned and engaged in transition planning at least 60 days prior to discharge. (EA 16.g.)

Once again, in interviews completed by Ms. Nuss, all Support Coordination agencies reported that this provision remained in compliance. DBHDD also reported substantial compliance in the documentation provided to the United States and to the Independent Reviewer.

Recommended Finding: It is recommended that the State be found in substantial compliance with this obligation.

> **Agreement Requirement:** The EA requires the State to have a properly constituted team conduct effective transition planning, specifying needed supports and services that will promote successful transition for each person with DD. The EA requires the State to involve community providers in the transition planning process and to ensure that all needed supports and services are arranged and in place at the time of discharge from the State Hospital. (EA 11)

Based on information provided to the Independent Reviewer by DBHDD, a properly constituted team had been assembled for each individual transitioned from the State Hospital. Members of the team included State Hospital staff, the community provider and clinicians working as part of the ICST, an extended arm of DBHDD's Integrated Clinical Support Services. The individual and the family, if known, are an integral part of the team process to the extent possible. There is excellent oversight of the transition process by the Director of DBHDD's Office of Transitions, Division of Developmental Disabilities.

Recommended Finding: It is recommended that the State be found in substantial compliance with EA 11. Staff should be commended for the work that has been accomplished to strengthen the transition process.

> **Agreement Requirement:** The EA requires the State to provide effective monitoring post-discharge and to identify and address any gaps or issues so as to reduce risks of injury, death, or institutionalization. The EA requires the State to conduct in-person monitoring visits within 24 hours of discharge, at least once a week for the first month after discharge, and at least monthly for the next three months. (EA 12)
>
> **Agreement Requirement:** The EA requires the State to provide "needed" services and supports to individuals with DD in the community. (EA 13)

Data on post-discharge monitoring were submitted by the State for the report period ending May 31, 2018. In terms of the requisite visits by Support Coordinators, the State reported a compliance rate of 91%, a two percent increase. The compliance rate for visits by the Regional Quality Review staff was documented at 89% of the time, an increase of three percent over the last report.

Current Information provided about the work of the ICST confirmed that post-move monitoring has occurred but there were no details included as to the identity of the individual or the results of the monitoring visits.

There were three deaths of individuals with DD who died within six months of their transition in FY 2018. The Columbus Organization conducts an external qualitative review of DBHDD's investigations of post-transition deaths. The Independent Reviewer has received DBHDD's investigations for W.E. and E.N. The Columbus reports have not yet been finalized.

Both of these gentlemen were placed in the same community residence in Macon, GA.

E.N. was transitioned from Gracewood to the group home in Macon, GA. on August 15, 2017. He died on December 13, 2017. The DBHDD investigation of his death identified concerns about the continuity of his medical care in the community but did not find neglect.

Mr. E. was placed on September 20, 2017 from Gracewood. He died on May 17, 2018. The investigation of Mr. E.'s death documented deficient practices, including the agency's failure to train nursing staff on his healthcare needs. Furthermore, the Intensive Support Coordinator and the Regional Quality Review staff from Region 6 did not complete all of the visits mandated by DBHDD's own protocols and EA 12.

DBHDD's investigation substantiated neglect in the death of W.E.

In addition, a third individual also died at this address. On November 8, 2016, J.Mc. was placed in this residence from a nursing home. He died unexpectedly on March 5, 2018 as a result of aspiration pneumonia. The DBHDD investigation substantiated neglect and identified a number of deficient practices, including the failure to train temporary agency nurses in the specific

protocols for the individuals and the failure to provide proper medical assistance and treatment to Mr. Mc. in a medical emergency.

On July 18, 2018, the Independent Reviewer's nurse consultant, Marisa Brown, conducted a site visit to this group home. The purpose of her visit was to determine if the risks identified in the DBHDD investigations had been addressed. (Ms. Brown did not conduct an independent investigation of the individual deaths.) These findings will be discussed with the Parties but include the conclusions that there is currently adequate RN coverage in the home to provide appropriate assessment, plan development, staff instruction and monitoring for changes in health conditions. Protocols for dental, primary care and specialty consultation appear adequate, despite one instance in which follow-up to the oncologist's recommendation for re-evaluation did not occur in a timely manner. (The RN present during the site visit took action to correct this omission.)

On May 24, 2018, Ms. Brown made an announced site visit to the group home where B.B. died in FY 2017, within six months of her transition from Gracewood. Neglect was substantiated in her death. Ms. Brown found that the two individuals still residing in this residence are in a good state of health; their immediate health issues are being addressed. However, she noted that management issues, specifically stable staffing, continue to be problematic for this site. New managers were hired but were not expected to be at work until July 2018, over a month after this visit was completed.

A Statewide Clinical Oversight (SCO) database was initiated on March 23, 2018. Data derived from analysis of the database should be useful in identifying areas of risk that require remedial actions. However, that analytical capacity is still in its formative stages and the analysis was not available for this report. A report issued in June 2018 by the Division of Performance Management and Quality Improvement's Office of Performance Analysis has investigated the positive impact of receiving SCO for at least six months on reducing the number of hospital and emergency department admissions, in light of significant increases in health risk and co-morbidity indicators. This report is a very good effort to begin the systematic analysis of information available to DBHDD.

In addition, in order to assist in the reduction of potential health-related risk, DBHDD has issued a standardized form for nursing assessments and templates for health plans. At the request of the Independent Reviewer, Ms. Brown has reviewed these documents. Her comments will be shared with the Parties.

In order to further assess whether individuals with DD are receiving "needed services and supports to individuals in the community through a network of contracted community providers overseen by the State or its agents," the Independent Reviewer's consultant in behavior analysis and three Registered Nurses conducted site visits throughout the six Regions.

As documented in his summary and in his individual reviews, Dr. Patrick Heick, Board-Certified Behavior Analyst, examined the behavioral supports provided to 12 individuals; he conducted site visits for 11 of the 12 individuals in community settings in Regions 5 and 6. Ten of these individuals were identified in the SCO List as having had encounters with law enforcement. One

individual, C.G., returned to a Region 5 Crisis Home after another unsuccessful community placement. One gentleman was incarcerated in a jail in metropolitan Atlanta.

Dr. Heick's summary of his findings clearly documents the failure to provide adequate behavioral supports to individuals with that identified need. Interestingly, Ms. Nuss drew this same conclusion after speaking with the Executive Directors of six Support Coordination agencies. Ms. Nuss reported that Support Coordination agencies and the Georgia Advocacy Office confirm that there is an insufficient number of behavioral health providers in the system, people remain in crisis homes or psychiatric settings for long periods of time while waiting for a new provider to provide residential services, and existing residential providers are quick to discharge individuals who present behavioral health challenges.[7]

Based on his review, Dr. Heick has reported that:

- Despite evidence of significant maladaptive behaviors that negatively impacted their quality of life and greater independence, only seven of the individuals (64%) were receiving formal behavioral programming through Behavior Support Plans (BSPs) at the time of the site visit.
- Of the seven individuals with BSPs, prescribed behavioral programming appeared inadequate. Evidence of adequate ongoing collection, summary and regular review of both target and replacement behaviors was not found for any BSPs (0%).
- Only four of the seven BSPs (57%) were developed with the involvement of a Board Certified Behavior Analyst (BCBA). The BCBA is the nationally accepted certification for practitioners of applied behavior analysis.

Dr. Heick's report is attached.

The Independent Reviewer's nurse consultants conducted site visits in all six Regions. The individuals were selected from the SCO List because they had been identified with a life threatening health-related incident.

The Support Coordinators interviewed about these individuals were notified of the incidents, with the exception of Support Coordinators who work with individuals living in family homes. Generally, they learned about the incident on their next visit.

Significant identified issues included:

- B.W.'s agency does not provide any licensed nurses to conduct nursing oversight and supports to the three individuals in his home. Mr. W. has complex behavioral and health care needs that must be addressed by a licensed RN. In addition, it was observed that all staff that support Mr. W. need to be re-trained in interacting with him and should be clearly and consistently documenting his behaviors.
- J.B. lives with his family. His mother has been attempting to obtain physical therapy services for him but has not been able to do so.

[7] Report by Laura Nuss, page 11.

- J.H. has significant psychiatric and behavioral challenges. He requires the services of a Behavior Specialist for evaluation and the development of a BSP, followed by at least quarterly monitoring and analysis of behavioral data.
- V.R. lives with his family. His mother has significant health issues herself and urgently requires assistance with his care. (A conference call was held with DBHDD staff regarding this situation.)
- C.N. lives in a group home. The nursing staff does not have a reliable system in place to track the results of significant medical tests and the need for follow-up. There is no documentation regarding psychiatry visits, yet he receives three psychotropic medications.

The Independent Reviewer and her clinical consultants would be very responsive to any request from DBHDD for further discussion about these observations.

Recommended Findings: At this time, based on the information received from DBHDD regarding post-move monitoring percentages related to the Regional Quality Review staff, a finding of noncompliance is recommended for EA 12.

In addition, based on the information received for this report from Support Coordination agencies (discussed below), investigations prepared by DBHDD, independent reviews completed by experienced clinicians and DBHDD's own acknowledgement in the IQOMR data (also discussed below) that behavioral supports are not yet adequate, there is insufficient evidence to confirm that essential clinical supports, especially in the domain of behavioral programming, are in place on a systemic basis. Therefore, a finding of noncompliance is recommended for EA 13.

Support Coordination

It has been repeatedly emphasized in these reports to the Court that Support Coordination is a critical linchpin in the design, provision and monitoring of an individual with DD's supports. It is recognized as one of the most important safeguards that can be provided, especially to someone who is at higher risk because of challenging behavior or complex health/medical needs. As a result, the Extension Agreement contains detailed requirements for fulfilling this essential function.

In order to review performance in this area, the Independent Reviewer's subject matter consultant, Laura Nuss, again reviewed all documentation that was provided by DBHDD and discussed the specific issues with DBHDD leadership staff. She also spoke with six of the Directors of the seven agencies responsible for the provision of Support Coordination throughout Georgia. [8] She reviewed two individuals currently placed in a crisis respite home by meeting with staff and the Support Coordinators.

In her review, Ms. Nuss identified the strengths currently evident in the systemic application of Support Coordination:

[8] One Executive Director did not respond to Ms. Nuss's request for a conversation.

- DBHDD has developed and implemented comprehensive policies and procedures governing the delivery of support coordination and intensive support coordination services. Georgia also benefits from stable and strong leadership in both state and support coordination agency positions. Support Coordination Agencies report that regular meetings with the state leadership have been positive and beneficial to their shared mission.
- DBHDD also benefits from its organizational capacity in data analysis and reporting. Performance reporting continues to expand to include additional performance measures and adds additional elements to standard performance analysis to refine the significance of those measures.
- Individual Support Coordination Agency performance is strong in meeting policy expectations for face-to-face visits and increases as individual's needs and age increase. The availability of clinical supervision in intensive support coordination has been evident during all site visits.
- DBHDD also benefits from a robust Administrative Service Organization (ASO) that carries out regular Person-Centered Reviews and Quality Enhancement Provider Reviews. The ASO provides comprehensive reports on its findings that can inform DBHDD about support system strengths and areas in need of improvement.

> **Agreement Requirement:** The SA requires the State to provide Support Coordination to all Waiver participants. Support Coordination involves developing ISPs that are individualized and person-centered, helping the person gain access to all needed services identified in the ISP, and monitoring the ISP and making changes to it as needed. (SA III.A.2.b.iii.)

The State has complied with the requirement to establish Support Coordination and assign these resources to Waiver participants. The role of the Support Coordinator, as described in policy, is consistent with the expectations described above.

Recommended Finding: Substantial compliance is recommended for the obligation to establish Support Coordination and assign these resources to Waiver participants. However, as is discussed further below, there are outstanding issues associated with ISP development and implementation, so there is non-compliance with the second SA sentence above.

> **Agreement Requirement:** The EA requires the State to revise and implement the roles and responsibilities of Support Coordinators. The EA requires the State to oversee and monitor that Support Coordinators develop ISPs, monitor the implementation of the ISPs, recognize each individual's needs and risks, promote community integration, and help the individual gain access to needed services and supports. (EA 16.a.)
> Support Coordination involves developing ISPs that are individualized and person-centered, helping the person gain access to all needed services identified in the ISP, and monitoring the ISP and making changes to it as needed. (SA III.A.2.b.iii.)

The State has revised the role of the Support Coordinator in order to ensure that there is involvement in the development of the ISP and access to needed services/supports. The Support Coordinator is expected to monitor the ISP and make changes, as necessary. For the first time,

the DBHDD Performance Report, dated June 30, 2018, reports on performance metrics about ISP development. The report evaluates performance findings for Support Coordination agencies. However, as is referenced in Ms. Nuss's report, there are outstanding issues associated with ISP development and implementation. There are also concerns with regard to delivering needed behavioral supports, a critical part of an ISP for certain individuals displaying undesirable behavior.

Delays in the Service Change/Technical Assistance Requests (STAR) process continue to hamper the performance of Support Coordinators in helping an individual gain access to needed services and supports. DBHDD did not provide data regarding its performance in processing STAR requests in a timely manner, even though it reported that it collects that data as of February 2018.

Six out of seven Support Coordination agency Executive Directors again reported that the STAR process continues to be problematic, and that performance varied by Region. The Support Coordination agencies reported that some requests may be reviewed in a timely manner where others may languish for several months; some requests when denied are not accompanied by an Adverse Action notice so the individual/guardian can appeal the decision; and there is no mechanism in the system to notify the Support Coordinator when there has been a decision on the STAR submission. Support Coordinators report that the speed at which a decision is rendered does not always align with the urgency of the circumstances driving the request. This issue can have serious consequences for individuals and providers. Delays in receiving additional staffing or nursing services place individuals at risk for hospitalization or increased injury, abuse or neglect. If a provider puts in place the additional staffing or nursing prior to receiving an approved STAR and the STAR is subsequently denied, the provider must absorb the cost of those services. This can have a chilling effect on the service delivery system; interviews with the Support Coordination agencies have confirmed this. Support Coordinators report that this is especially true when trying to identify providers who will accept individuals with more complex and/or intense medical or behavioral health needs. It was noted that some of the delay is in part due to a shortage of nursing staff within DBHDD, that DBHDD has hired a staff person to coordinate the STAR process and that DBHDD is aware of the challenges. DBHDD is also preparing to roll out a new consumer information system that is anticipated to improve this process.

Recommended Finding: Due to the continuing problems with the ISPs, delivering behavioral supports, and the STAR process, a finding of noncompliance is recommended for EA 16.a. and the latter part of SA III.A.2.b.iii.

> **Agreement Requirement:** The State is to have the Support Coordinators use a uniform tool and guidelines for implementation that include criteria, responsibilities, and timeframes for referrals and actions to address risks to the individual and obtain needed services and supports for the individual. The tool is to, at least, address: accessibility, privacy, adequate food and clothing, cleanliness, safety, changes in health status, recent ER/hospital visits, delivery of services with respect and fidelity to the ISP, implementation of the BSP, recent crisis calls, existence of natural supports, services in the most integrated setting, participation in community activities, employment

> opportunities, access to transportation, control of personal finances, and the individual's satisfaction with current supports and services. (EA 16.b.)

As noted in previous reports, DBHDD has implemented the use of a uniform tool and has published guidelines for the implementation of the tool as required. In her August 2017 report, Ms. Nuss recommended reviewing this tool and splitting some multi-part questions apart to improve data analysis. DBHDD completed review of the tool and has implemented a revised tool, effective January 1, 2018, that addressed that recommendation.

Recommended Finding: It is recommended that DBHDD be found in substantial compliance with EA 16.b.

> **Agreement Requirement:** The EA requires the State to provide Support Coordinators with access to CIRs, investigation reports, and CAPs for all individuals on their caseloads. Support Coordinators are responsible for reviewing the documentation and for addressing any findings of gaps in services or supports so as to minimize the health and safety risks to the individual. (EA 16.d.)

DBHDD corrected the technical error in the Reporting of Critical Incidents (ROCI) information management system in this reporting period that had prevented critical incident investigative reports from being transmitted to Support Coordination agencies. The ROCI system is designed to send "same-day alerts" to the assigned Support Coordination agency when an incident or investigative report has been uploaded into the system. DBHDD provided data for the period January 1, 2018 2018 through June 15, 2018.

For Critical Incident Reports (CIRs), the average number of days to notify the Support Coordination agency was 10.3 days for the first quarter of calender year 2018, and 18.1 days for the second quarter of calendar year 2018. For investigative reports, only one month of data was reported, without indicating the total number of reports represented. In this month (May 2018), the average time for notification was 9 days.

To achieve substanital compliance with this measure, DBHDD must ensure that Support Coordination agencies are timely notified of submitted critical incident reports so that Support Coordinators can respond in a timely manner to address potential gaps in services and supports

At this time, based on the above, a finding of noncompliance with EA 16.d. continues to be recommended. However, in its response to the draft of this report, DBHDD stated that the timeliness of its notification to Support Coordinators had improved. Reportedly, in the month of June, notifications were sent an average of 2.7 days after approval of the CIR. In July, notifications were sent an average of 1.9 days after approval of the CIR, and from August 1-15, notifications were sent an average of 1.3 days after approval of the CIR. This information was provided only recently and, therefore, has not yet been verified by independent review. If these facts are confirmed and if this trend continues, a recommended finding of substantial compliance with EA 16.d. may be indicated in the future.

> **Agreement Requirement:** The State is to ensure that Support Coordinators have no more than 40 individuals on their caseloads and that Intensive Support Coordinators have no more than 20 individuals on their caseloads. (EA 16.e.)

DBHDD provided caseload data for Support Coordination as of June 30, 2018. The data document the following performance:

Support Coordination Agency	Number of SCs	In Compliance	Percent Compliance
Agency #1	29	21	72%
Agency #2	9	4	44%
Agency #3	132	126	95%
Agency #4	11	11	100%
Agency #5	109	86	79%
Agency #6	51	51	100%
Agency #7	80	74	93%

Support Coordination agencies acknowledge the challenges with maintaining caseload compliance, especially if the agency accepts all referrals. Balancing funding, hiring, short-term absences and the geographic distribution of referrals is an ongoing management challenge. Support Coordination agencies also noted the increasing demands of individuals who are assigned to general Support Coordination caseloads yet have significant service coordination needs.

Recommended Finding: In light of the data submitted by DBHDD, a recommendation is made for a finding of noncompliance with 16.e.

> **Agreement Requirement:** The EA requires the State to ensure that Support Coordinators visit each individual at least once per month (or once per quarter for individuals who only receive SE or day services). Intensive Support Coordinators are to visit each individual based on the individual's needs, but at least once per month; for individuals who are not stable, visits are to be at least once per week. Visits can take place at the person's home or other places where the individual is during the day; some visits are to be unannounced. (EA 16.f.)

The most recent DBHDD Support Coordination Performance Report continued to state that there was substantial compliance in face-to-face visits per DBHDD policy. For the period from January through March 2018, face-to-face visit compliance for Support Coordinators by agency reportedly ranged from 90% to 100%. For intensive support coordination, face-to-face visits are required at least one time per month. Here again, compliance was reported as significantly above 90% except for one month for one agency for this same time period.[9] In addition, DBHDD has analyzed the number of face-to-face visits based on need using age and health care levels as measures of need in the February and June 2018 Support Coordination Performance reports. In

[9] DBHDD Support Coordination Performance Report, June 30, 2018, pp. 19 and 21.

both instances, the results substantiate "that as health risk (represented by HCL and increasing age) rises, the number of face-to-face visits also generally rises."[10]

Although the Independent Reviewer wishes to acknowledge the work of DBHDD in tracking this requirement from the EA, she has not been able to confirm this information. The findings from the work completed by Dr. Heick, in particular, have raised questions about the number of visits to individuals who are not stable and, according to EA 16.f., should be visited at least once per week. In addition, the lack of compliance with caseload size may result in fewer visits than needed to resolve outstanding concerns. As a result, the Independent Reviewer has decided to defer a recommendation on compliance until she can complete additional fact-finding on this obligation.

> **Agreement Requirement:** By June 30, 2017, the State shall require all of its support coordination agencies and contracted providers serving individuals with DD in the community to develop internal risk management and quality improvement programs in the following areas: incidents and accidents; healthcare standards and welfare; complaints and grievances; individual rights violations; practices that limit freedom of choice or movement; medication management; infection control; positive behavior support plan tracking and monitoring; breaches of confidentiality; protection of health and human rights; implementation of ISPs; and community integration. (EA 28)

DBHDD revised its Provider Manual for Community Developmental Disability Providers to include this requirement. The revision was posted on June 1, 2017 with an effective date of July 1, 2017.

DBHDD provided letters of attestation from all Support Coordination agencies indicating that each agency had in place a risk and quality management and improvement plan, as required by Provision 28. DBHDD also indicated it is working with its ASO to include an evaluation of this requirement into future Support Coordination agency provider reviews.

The Support Coordination agencies provided evidence of their respective risk and quality management and improvement plans to Ms. Nuss at her request. The plans varied in detail; no agency provided evidence of implementation of the plan. One agency executive indicated that it was still not clear, at least to this agency, what was expected by DBHDD in this area. Four agencies submitted plans found to be sufficient; one agency provided a policy that indicated it should have a plan but it was not provided; one agency submitted a plan that was incomplete; and one agency submitted a plan still under development.

Recommended Finding: Based on the information submitted directly by the Support Coordination agencies, a finding of noncompliance is recommended for EA 28.

[10] DBHDD Support Coordination Performance Report, June 30, 2018, p. 22.

Individuals with Complex Needs

As reported previously, the Extension Agreement requires the State to implement a number of actions in order to protect the health and safety of individuals with DD who live in community-based settings and may require heightened scrutiny because of their complex medical or behavioral needs. There are two lists that summarize the issues and supports required for individuals who are at risk. The High Risk Surveillance List (HRSL) addresses individuals with DD who transferred from State Hospitals to community-based settings under the terms of the Settlement Agreement and its Extension. The Statewide Clinical Oversight List (SCO) includes individuals who live in community-based settings but were not previously transferred from a State Hospital. DBHDD's Office of Health and Wellness (OHW) enters the information for both lists. The Office of Health and Wellness is responsible for the maintenance of both lists and has the primary responsibility for monitoring that appropriate actions are taken to ensure that any adverse situations are addressed and remedied.

> **Agreement Requirement:** The EA requires the State to maintain a High Risk Surveillance List of individuals with DD in the community, who transitioned from a State Hospital since the entry of the SA, who face a heightened level of risk due to the complexity of their medical or behavioral needs and/or their community providers' inability to meet those needs. (EA 13, 14) The State is to identify, assess, monitor, and stabilize them, provide them with Statewide Clinical Oversight and Support Coordination per EA criteria. (EA 13) The HRSL shall include identifying data, as well as HRST score and a summary of CIRs and clinical findings that indicate heightened risk due to complex medical or behavioral needs. For all individuals on the HRSL, the State is to monitor CIRs, Support Coordination notes, and clinical assessments. The State is to update the HRSL at least once a month. (EA 14.a.)

DBHDD has complied with the obligation to develop and maintain a High Risk Surveillance List (HRSL). The list is updated on a monthly basis and shared with the United States Department of Justice and the Independent Reviewer. Support Coordinators have this information. Residential providers have stated repeatedly, however, that they are not aware of an individual's placement on the HRSL. The HRSL is organized with each individual's name, current provider and address; the HRST risk level is noted as well. A summary of CIRs and clinical findings are not included in the most recent list reviewed. However, as of the July 2018 list, a summary of DBHDD's processes and the summary data for individuals assessed during that time period was provided.

> **Agreement Requirement:** The EA requires the State to place individuals on the HRSL based on the following escalation criteria:
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> > Health - increase in HRST score; ER visit; hospitalization; recurring serious illness without resolution; or episode of aspiration, seizures, bowel obstruction, dehydration, GERD, or unmet need for medical equipment or healthcare consultation;
> >
> > Behavioral – material change in behavior; behavioral incident with intervention by law enforcement; or functional/cognitive decline;

> Environmental – threat or actual discharge from a residential provider; change in residence; staff training or suitability concern; accessibility issues; loss of family or natural supports; discharge from a day provider;
>
> Other – confirmed identification of any factor above by a provider, Support Coordinator, family member, or advocate. (EA 14.b.)

Based on a review of the structure of the HRSL and the information provided monthly, individuals are placed on the HRSL based on these criteria. However, it is not known independently whether the HRSL is complete and that it includes all individuals who meet these criteria. The Independent Reviewer must rely on DBHDD to confirm the thoroughness of the HRSL.

> **Agreement Requirement:** The EA requires the State to conduct the following oversight and intervention activities for each individual on the HRSL until the State determines the individual is stable and no longer designated as high risk:
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> > OHW is to oversee that the initial responses to the identified risks are completed and documented until the risks are resolved.
> >
> > For an emergency, the provider is to call 911 or crisis services, and notify the Support Coordinator (SC), Field Office (FO), and OHW.
> >
> > For deteriorating health (not imminently life threatening), the provider is to respond and notify the SC within 24 hours; if the risk is not resolved within 72 hours, the provider or SC is to notify the FO and OHW.
> >
> > For a risk that does not destabilize the health or safety of the individual, the provider is to respond, inform the SC, and verify completion of the response with the SC before the next SC visit or 30 days (whichever is sooner).
> >
> > If the risk is not resolved through the steps above, the State is to conduct an in-person assessment of the individual within seven days of the initial response.
> >
> > The State assessment is to be conducted by an RN/medical professional with advanced medical degree in the area of risk.
> >
> > The assessment is to include direct observation of staff to verify staff knowledge and competency to implement the risk reduction interventions, and the assessment is to identify any concerns/issues regarding individualized needs and identify necessary follow-up activities with a schedule for completion to address the concerns/issues.

The assessment and follow-up activities are to be noted on the HRSL and recorded in the individual's electronic record with access by the provider, SC, FO, OHW, and ICST.

If the State assessment finds service-delivery deficiencies that jeopardize the health of the individual, the State is to require all pertinent provider staff to receive competency-based training in that deficient service-delivery area.

The State is to oversee that the follow-up activities identified in the State assessment are completed/repeated and documented/revised until the risk is resolved. (EA 14.c.)

Recommended Finding: For the reasons discussed earlier in this report, a finding of noncompliance is recommended for EA 13. The State is supposed to be operating a system that provides needed services and supports to people with DD in the community. This is not occurring to the extent required, especially for people with challenging behaviors. A finding of substantial compliance is recommended for EA 14.a. and 14.b. because the HRSL is structured and updated as required. A finding of substantial compliance for EA 14.c. cannot be recommended at this time. This decision is reached for the following reasons: 1) There was conflicting information received by the Independent Reviewer and her consultant regarding the timeliness of notifications about critical incidents/risks. Although DBHDD has since submitted more recent notification data, for the first time and after receipt of the initial draft of this report, that information could not be independently verified in time for this report; 2) data provided by DBHDD regarding the requirements of EA 14.c. are limited solely to the month of July 2018 and are, therefore, insufficient to determine compliance on a systemic basis over a reasonable period of time; and 3) reviews of individuals with challenging high-risk behaviors documented the failure to train staff in the consistent competency-based application of individualized interventions. There was also insufficient data and information to enable the Independent Reviewer to determine if the system's intervention is adequate and appropriate to ensure that the individuals are stable and the outstanding risks are resolved as required by EA 14.c. In order to recommend a finding of substantial compliance for EA 14.c., the Independent Reviewer would expect to see data, similar to that provided for July 2018, for a longer period of time and in reference to individuals residing in all six Regions of the state. There were no data provided for individuals on the Statewide Clinical Oversight list, a significantly longer list of individuals.

Agreement Requirement: The EA requires the State to implement a Statewide Clinical Oversight program in all regions of the state to minimize risks to individuals with DD in the community who face heightened risk due to complex needs. SCO includes multi-disciplinary assessment, monitoring, training, TA, and mobile response to providers and SCs. (EA 15.a.) SCO is provided through a team of experienced RNs, Masters-level behavioral experts, OTs/PTs/SLTs, who may be from the OHW or FO. (EA 15.b.)

The State is to develop a protocol that states the responsibility and timeframes for providers and SCs to engage the SCO team to address individuals with heightened risk per the three risk criteria set forth in the previous Agreement Requirement until the risk is resolved. The protocol is to set forth the circumstances when and the mechanisms

through which the SCO team receives electronic notification of a heightened risk, as well as the timeframes for State review and response which are to be based on the imminence and severity of the risk. (EA 15.c.)

The State is to train its providers and SCs on the protocol, how to recognize issues that place a person at heightened risk, and how to request consultation/TA from OHW and FO. (EA 15.d.)

The State is to facilitate consults/TA to providers/SCs to address heightened risks. (EA 15.e.) The State is to provide a centralized and continuously monitored hotline and email address to receive consultation/TA requests. The State shall assess, assign for response, and respond to such requests consistent with the nature, imminence, and severity of the need. (EA 15.e.)

Recommended Findings: The State has substantially met the terms of EA 15.b., c., d. and one aspect of 15.e. (the hotline and email address). DBHDD has complied with the obligations to establish a Statewide Clinical Oversight program in all areas of the State. Both a hotline and an email address have been implemented. A protocol was developed and provider agencies were trained in the requirements of the protocol. Although, provider agencies continue to state that they do not know if a certain individual is included on the Statewide Clinical Oversight list.

As cited earlier in this report, the serious and widespread inadequacy of behavioral supports has continued to place individuals with seriously maladaptive behaviors at risk. It is not possible at this time to recommend a finding of substantial compliance for EA 15.a. and the other requirements for 15.e. Until the State can demonstrate that sufficient clinical resources are available for behavioral supports, these obligations must be recommended as in noncompliance. There were no data provided for individuals on the Statewide Clinical Oversight list.

The State is to have medical and clinical staff available to consult with community health care practitioners (primary care doctors, dentists, hospitals/ERs, specialists) to provide assistance to providers and SCs who report difficulty accessing or receiving needed services from community health care practitioners. (EA 15.f.)

In addition to clinical resources available through the Regional Field Offices, DBHDD has retained the services of a consultant, CRA Consulting, to act as an ICST. The ICST exists to provide professional clinical support services to individuals with DD when authorized by the OHW and in the absence of timely, available community clinical services and supports. ICST services are provided in collaboration with the individual's primary care provider, residential provider and Support Coordinator.

Monthly reports from CRA describe the clinical activities that have occurred, including technical assistance/training and face-to-face visits. Specific information is not provided about the individual cases so it is not possible to determine the level of acuity or the degree of clinical support that was provided in each situation.

DBHDD has reported that it has established relationships with a variety of organizations, such as the Dentistry for the Developmentally Disabled Foundation and Emory University, where a 12-week nursing curriculum addressing the clinical challenges faced by many individuals with DD is being offered. However, there continues to be widespread concern expressed by Support Coordinators, providers, attorneys and family members about the lack of available resources for individuals with complex behavioral needs.

Although DBHDD has taken the administrative and structural actions required, such as establishing the HRSL and SCO, to implement its obligations under the provisions related to individuals with complex needs, it is not evident that sufficient resources are available or deployed to meet the needs of individuals with seriously maladaptive behavioral issues.

Recommended Finding: Although the expertise of the currently available clinical supports is recognized and respected, it is still premature to recommend a finding of substantial compliance. At this time, 15.f. is recommended for a finding of noncompliance.

Crisis Services

Crisis Respite Homes (CRHs) were developed as required by the Settlement Agreement.

> **Agreement Requirement:** The State is to provide 12 Crisis Respite Homes, each with four beds, to provide respite services for people with DD and their families. (SA III.A.2.c.ii.)

The 12 Crisis Respite Homes have remained operational. There is a 48 bed capacity overall. As of June 30, 2018, there were 34 individuals in residence. Subsequently, in July 2018, there were three discharges. Thirty-one individuals remain in the crisis homes as of this date.

Recommended Finding: DBHDD remains in substantial compliance with the specific requirements for number and size.

> **Agreement Requirement:** The EA requires the State to provide individuals living in the CRHs with additional clinical oversight and intervention per the EA's Statewide Clinical Oversight provisions. (EA 17.b.) The EA requires the State to create a monthly list of individuals in the CRHs for 30 days or longer with data on lengths of stay, reasons for entry to the CRH, and barriers to discharge. (EA 17.c.)

DBHDD has complied with the requirements to issue a monthly list regarding individuals with a stay of 30 days or more. Unfortunately, the barriers to discharge continue to be very challenging for many of the individuals on the monthly list. These barriers include behavioral management issues and the lack of qualified providers with the skills and resources for alternative settings. There is one individual, C.B., who has been placed in a crisis home since June 2013; after eloping from the crisis home and damaging a neighbor's vehicle, he is currently in jail. Another individual, M.W., who was placed in a crisis home in August 2014, is still there. DBHDD is waiting for his probation officer to approve a residential placement. Four of the current residents of crisis homes were admitted in 2016. Fourteen individuals have lived in crisis respite homes

since 2017. At this time, 31 of the 31 individuals (100%) currently residing in a CRH have been there for more than 30 days. This number/percentage exceeds that reported in the March report to the Court.

There is widespread acknowledgement among Support Coordinators, clinical professionals and advocates that the resources for behavioral interventions are inadequate.

Based on these facts, despite the creation of a monthly list, the Independent Reviewer recommends a finding of noncompliance with this provision. There has been inadequate progress on resolving the well-documented systemic inadequacy of qualified provider agencies that will accept responsibility for individuals with very challenging behavioral issues.

> **Agreement Requirement:** The EA requires the State to assess its crisis response system and then meet with the IR and the United States to discuss plans for restructuring the crisis system so as to minimize individuals having to leave their homes during a crisis and to limit lengths of stay at the CRHs. (EA 17.d.)

The State assessed its crisis response system and issued a Crisis Respite Plan on June 30, 2017. Comments provided by the Independent Reviewer included concerns about the timelines for implementation into FY 2018.

Recently, DBHDD provided the Independent Reviewer with an update about its plans for the restructuring of the crisis system. The RFP was issued on June 4, 2018 and the six responses are now being reviewed. Approval has been sought from the Department of Administrative Services to proceed with a cost proposal review. DBHDD continues to work towards the goal of awarding the contract for a blended mobile crisis response system by October 1, 2018.

Recommended Finding: Until the contract for the restructuring of the crisis response system is awarded and the actual terms are reviewed and compared to the original plan, it is not possible to recommend a finding for this provision. The finding will remain deferred.

Investigations and Mortality Reviews

Since the beginning of the Settlement Agreement, there has been extensive work undertaken by DBHDD to strengthen its investigation and mortality review processes. DBHDD has reissued its policies, restructured its staffing and its protocols, redesigned its oversight capacity and consulted external, independent consultants with expertise in this area of responsibility. The direction that DBHDD has taken to strengthen its investigation and mortality review processes is consistent with standard practice in the field and is to be commended.

> **Agreement Requirement:** The EA requires the State to implement an effective process for reporting, investigating, and addressing deaths and Critical Incident Reports (CIRs) involving alleged criminal acts, abuse or neglect, negligent or deficient conduct by a provider, or serious injuries to an individual. (EA 20)

The State has implemented a number of carefully considered changes in its process for reporting, investigating and addressing deaths and Critical Incident Reports. After extensive analysis and thought, DBHDD has redesigned its investigation process. It has taken the excellent step of removing the responsibility for the investigations of abuse, neglect and death from the provider agency and assigning it to trained staff at DBHDD. This is a very important change. The incident reporting system is being revised and, when implemented, will better inform the Corrective Action Plan (CAP) process. At this time, the remaining issue that prevents a recommended finding of substantial compliance is the length of time taken to discuss an investigation with identified deficient practices with the Community Mortality Review Committee (CMRC), so that a CAP can be required, developed, implemented and monitored. Until the issue of timeliness is addressed, the system cannot be described as "effective." Until CAPS are precisely detailed and rigorously monitored to ensure full implementation, there will be unchecked vulnerabilities in the State's system of community-based supports.

Recommended Finding: Although the changes to the investigation process are very positive, a finding of noncompliance is recommended for EA 20 until DBHDD can demonstrate a more expeditious referral to the appropriate CMRC, timely implementation of any necessary CAP and confirmation that any deficient practice has been ameliorated.

> **Agreement Requirement:** The State is to conduct a mortality review of deaths of individuals with DD who are receiving Waiver services from community providers. (EA 21) The investigation is to be completed by a trained and certified investigator, and an investigation report is to be submitted to the State's OIMI within 30 days after the death is reported. The report is to address any known health conditions at the time of death. The investigation is to include review of pertinent medical and other records, CIRs for the three months prior to death, any autopsy, and the most recent ISP, and may include an interview with direct care staff in the community. The State is to require the providers to take corrective action to address any deficiency findings in any mortality investigation report. (EA 21.a.)

The redesign of the investigation process includes these requirements. Changes to the investigation format and protocols have assisted in meeting the requisite 30-day timeframe.

After review of the facts contained in the CIR, if the individual was receiving DBHDD services at the time of the death and the death was related to the services being received, DBHDD is to complete a thorough clinical records review during a Clinical Mortality Review (CMR). If the CMR yields findings other than potential abuse or neglect, a determination is made regarding the need for corrective action. If there is a finding of potential abuse or neglect by the provider entity or staff, including Support Coordination, the case proceeds through the steps of an investigation.

In addition, the Columbus Organization has been retained to review the deaths of individuals with DD who transitioned from State Hospitals under the terms of the Agreements, including any individuals who died within six months of the transition itself.

The Columbus Organization, based on its review of records and the initial investigation completed by DBHDD, issues an opinion as to whether a death was preventable or not. It also

cites areas of deficiency in provider and/or DBHDD performance. Recommendations to correct cited deficiencies are included at the end of each Columbus report. The CMRC for individuals with DD reviews the findings and recommendations of the Columbus Organization.

There were 39 deaths of DD individuals and 10 deaths of individuals with a DD/MH diagnosis reported from March 1, 2018 until June 30, 2018. The Independent Reviewer has read the investigations associated with these deaths; this set of investigations complies with the requirements of EA 21.a. However, the investigations have not been completely reviewed by the CMRC so that CAPs can be ordered to correct the deficient practices. As a result, it is unclear if the providers have taken necessary corrective actions to address any concerns cited in the investigations.

Recommended Finding: The State is likely to be found in substantial compliance with the investigation process aspects of EA 21. The work that has been undertaken to strengthen the investigation process is commendable. It is recommended that the State move as expeditiously as possible to streamline the process for CMRC review so that CAPs can be instituted and deficient practices removed. Only when that is accomplished can a finding of substantial compliance be recommended for EA 21.a.

> **Agreement Requirement:** The EA requires the State to have a Community Mortality Review Committee (CMRC) conduct a mortality review of certain deaths within 30 days of completion of the investigation and receipt of relevant documentation. The CMRC is to issue minutes of its meetings with deficiency findings and recommendations. (EA 21.b.) The State is to require the providers to take corrective actions to address any deficiency findings from the CMRC. (EA 22)

DBHDD's Policy 04-108, revised on February 5, 2018, established three Committees to review deaths of individuals who receive services/supports from DBHDD. The membership of these Committees appears to be properly constituted and their function is clearly described. Changes have been made in the review process so that the CMRCs are informed of the implementation of its recommendations for corrective actions. Semi-annual meetings will be held to discuss system implications, review recommendations and progress toward implementation and to discuss cross-functional interventions.

Recommended Finding: Although the foundation is in place for the work of the CMRCs, the timeline for their review of certain deaths is not yet timely. As a result, there are delayed instructions to providers who have deficient practices. As referenced above, the extent to which providers are adequately implementing the CAPs is also unclear. A finding of noncompliance must be recommended until the timeliness of the process is improved and there is clear demonstration that all CAPs are implemented to remedy outstanding concerns cited in the investigations.

> **Agreement Requirement:** The State is to implement a system that tracks deficiencies, CAPs, and implementation of CAP requirements for both the mortality investigation reports and the CMRC minutes. (EA 22) The State is to generate a monthly report that includes each death, CAPs, provider implementation of CAP requirements, and any

disciplinary action taken against the provider for failure to implement CAP requirements. (EA 23) The State is to analyze the death data to identify systemic, regional, and provider-level trends and compare it to national data. Based on a review of the data, the State is to develop and implement quality improvement initiatives to reduce mortality rates for individuals with DD in the community. (EA 24) The State is to publish a report on aggregate mortality data. (EA 25)

DBHDD has implemented a system to track deficiencies, CAPS, and the implementation of CAP requirements for both the mortality investigation reports and CMRC minutes. Monthly reports are generated.

Recommended Finding: Compliance here is mixed**.** The State has made good progress with tracking and reporting. However, because implementation of CAP and Quality Improvement requirements has not yet been sufficiently established, it is premature to conclude that there is substantial compliance with EA 22 and EA 23.

As required by EA 24, based on the data about deaths, DBHDD has begun to develop and implement a number of quality improvement initiatives designed to reduce mortality rates for individuals with DD in community settings. Although it will be important to watch the progress of these initiatives over time in order to gauge their impact, the projects certainly appear to be appropriate and carefully considered.

As required by EA 25, the State thus far has published four annual reports on aggregate mortality data. The Independent Reviewer has commented on those reports in either memorandum and/or discussion formats. The reports are carefully prepared and the data appear reliable.

The FY 2017 report was issued on August 16, 2018. The Independent Reviewer offered comments on this report at the Parties' meeting held on September 12, 2018. It was recommended that there be training offered to medical examiners and coroners on disability-related issues and that there be documentation in the next report of the actions taken by DBHDD to address the leading causes of death, including aspiration pneumonia and sepsis. Although the rate of increase was reported as not statistically significant, the "crude mortality rate" increased from 12.5 deaths per 1000 individuals in 2015 to 14.0 deaths per 1000 in 2016 to 16.4 deaths per 1000 individuals in 2017.

Recommended Finding: Based on the information provided by DBHDD, including the facts documented in the most recent mortality report, it is recommended that the Quality Improvement initiatives implemented to reduce mortality rates for individuals with DD be monitored further before a compliance finding is recommended for EA 24. It is recommended that the State be found in compliance with EA 25 since it has consistently published annual mortality reports.

Other Provisions Related to Individuals with DD:

Agreement Requirement: To benefit those individuals with DD who are at risk of admission to a State Hospital, the SA also requires the State to create 400 HCBS Waivers to prevent institutionalization. (SA III.A.2.b.i.) The EA requires the State to create an

additional 375 COMP Waivers and an additional 300 NOW Waivers for people with DD on the waitlist to prevent their admission to an institutional facility. (EA 19) This results in a grand total of 1,075 Waivers to be used to support people with DD in the community to prevent institutionalization.

The State submitted the following accounting of its awarding of HCBS Waivers:

Fiscal Year	Required NOW	Awarded NOW	Required COMP	Awarded COMP
FY16	100	242	100	324
FY17	100	264	125	292
FY18	100	358	150	352

Recommended Finding: Based on the above information, it is recommended that the State be found in substantial compliance with EA 19. The State has awarded 1,832 HCBS Waivers since FY 2016.

Agreement Requirement: The SA requires the State to evaluate the adequacy of Waiver services annually, which may include conducting interviews with DD service recipients, assessing services, collecting program recipient feedback via surveys, and collecting provider performance data. The State is to assess compliance annually and is to take appropriate action based on each assessment. (SA III.A.4.)

Agreement Requirement: The EA requires the State to provide to the United States copies of the Waiver assurances it provides to CMS. The State is to conduct quality reviews to be able to provide these assurances; the quality reviews are to be conducted on a data-informed sample of individuals in each region and are to include face-to-face interviews with individuals and staff, review of assessments and clinical records. As a result of these reviews, the State is to develop and implement quality improvement initiatives or continue implementing existing quality improvement initiatives. (EA 29)

The most recent Waiver application with performance measures was approved by the Centers for Medicare and Medicaid Services (CMS) on February 24, 2017 with an effective date of March 1, 2016.

DBHDD reported the following information in response to the Independent Reviewer's request:

Quality Reviews (known to the Centers for Medicare and Medicaid Services ("CMS") as Evidence Reports) are due to CMS from the Department of Community Health ("DCH") prior to every Waiver renewal, which occurs every five years. DBHDD submitted a copy of the Quality Review provided to CMS for the COMP Waiver on August 29, 2017. This Quality Review included sampling by DBHDD and the ASO and was informed by DBHDD incident management, mortality reviews, and indicators overseen by the DBHDD Office of Health and Wellness.

DBHDD's quality improvement initiatives are developed to address common findings that span the entire system, including the Quality Review submitted to CMS, but not solely from that document. Some quality improvement initiatives that are linked to the findings in the Quality Review include:

1. The development and implementation of Intensive Support Coordination roles – the purpose of this initiative is to provide additional and more comprehensive support for individuals identified as having complex needs. This quality improvement initiative was designed in response to Appendix G findings related to care provision for Waiver participants with a higher level of need.
2. Expansion of the NOW and COMP Waivers to include reimbursement for nutrition services in order to address complex dietary requirements and its resulting health risks. DBHDD received CMS approval for the addition of a Nutrition service under the 2017 NOW and COMP Waiver renewals. DBHDD is working to monitor the impact of this new service for at risk individuals. This quality improvement initiative was developed in response to Appendix C findings regarding an adequate network of qualified providers and Appendix G findings related to care provision for Waiver participants with a higher level of need.
3. Expansion of Waiver therapy services to provide increased maximum allocation to support individuals with complex needs – DBHDD received CMS approval for the expansion of therapy services, which include occupational, physical, and speech/language therapies, under the 2017 NOW and COMP Waiver renewals. This quality improvement initiative was developed in response to Appendix C findings regarding an adequate network of qualified providers and Appendix G findings related to care provision for Waiver participants with a higher level of need.
4. Support and engagement of community physicians – DBHDD recognized a need for physician-to-physician discussion involving the intricacies of treating individuals with I/DD, along with the need to address barriers community providers face in serving I/DD consumers. To address this issue, DBHDD administered a survey to community physicians regarding treatment of individuals with DD. This survey was first administered at the Health and Wellness Physicians' Summit in November 2017. This survey, which will be administered at future events, works to gather information about the community physicians' perspective on treating individuals with I/DD. Although results of the survey are still being analyzed, DBHDD will utilize the findings to identify and mitigate barriers to service delivery for I/DD individuals in the community. This quality improvement initiative was designed in response to Appendix G findings related to care provision for Waiver participants with a higher level of need.
5. The development and implementation of a stratified residential rate structure designed to provide compensation commensurate with the assessed need of the individual was approved through the 2017 NOW and COMP Waiver renewals. Each reimbursement tier is linked to a recommended number of direct support hours determined by level of need. The graduated reimbursement model was designed in response to Appendix C findings regarding an adequate network of

qualified providers and Appendix G findings related to care provision for Waiver participants with a higher level of need.

Recommended Finding: As demonstrated above, DBHDD utilizes the Quality Reviews submitted to CMS to develop and implement quality improvement initiatives throughout the I/DD system. It is recommended that DBHDD be found in substantial compliance with the requirements outlined in provision EA 29.

> **Agreement Requirement**: The EA requires the State to develop and implement a strategic plan for provider recruitment and development based on the needs of the DD population in the community and in the State Hospitals. The State is to use the plan to identify and recruit community providers who can support individuals with DD and complex needs. (EA 18)

DBHDD's strategic plan for provider recruitment was completed on November 28, 2016 and shared with the United States, the Amici and the Independent Reviewer for comment. The plan was revised on March 31, 2017, June 30, 2017 and November 15, 2017. The plan is based on an analysis of needed capacity. Six sub-populations of individuals either currently receiving services or anticipated to require services within a three to five year period were identified. For example, it was identified that 24 individuals (at that time) have been in a crisis home placement for more than 30 days and need residential services; the situation still exists today.

DBHDD has identified two categories of providers to address in the provider recruitment plan: residential service providers for individuals with complex medical or behavioral needs, and community clinical services, such as occupational, speech and physical therapy, and other critical services needed to support individuals in the community.[11] Interviews with Support Coordination agencies and the Georgia Advocacy Office, conducted by Ms. Nuss, corroborated those needs and described the negative impacts these needs are having on individuals in the community and for those waiting to transition into the community.

Thus far, the State has been unsuccessful in attracting new residential providers to its DD system. With regard to existing providers, on August 3, 2018, the Georgia Collaborative ASO website revealed the following numbers of existing clinical providers accepting new referrals:

- Behavioral support consultation = 56,
- CRA = 2,
- Nursing services = 17,
- Occupational therapy = 4,
- Physical therapy = 5, and
- Speech therapy = 6.

These figures appear to be inadequate to address existing residential needs, especially for people with complex behavioral problems who are living in crisis homes. Moreover, a review of the provider enrollment process available through the ASO website describes a process that requires,

[11] ADA Settlement Extension Agreement Parties Meeting Presentation by DBHDD, 4/13/18, p. 135.

at a minimum, seven months to successfully enroll in one of the Home and Community-Based Services Waiver programs.

The provider plan indicates that an Enterprise workgroup has been established to evaluate individual support profiles and work to address gaps in reimbursable services with final recommendations from the workgroup due in May 2018. The Independent Reviewer has not yet received a copy of these recommendations.

Recommended Finding: The critical shortage of new residential providers, as well as qualified clinicians, including those with expertise in behavioral supports, has not been addressed through implementation of the Provider Recruitment Plan. A finding of noncompliance is recommended. DBHDD needs to fully develop and implement a robust and enterprise-wide provider recruitment plan in the identified provider categories. If substantial compliance is to be recommended, this recruitment plan should result in a demonstrable increase in clinical provider enrollment, relative to the service population numbers and identified needs.

> **Agreement Requirement:** The SA requires the State to create a program to educate judges and law enforcement officials about community services and supports available to people with DD and forensic status. (SA III.A.3.a.) The State is to include individuals with DD and forensic status in the Target Population if a court finds that community placement is appropriate. (SA III.A.3.b.)

Education of the Courts has continued. DBHDD provided a list of educational sessions conducted to date in FY 2018.

There has been the continuous inclusion of individuals with DD and forensic status in the planning and implementation of transitions from State Hospitals.

Recommended Finding: It is recommended that the State be found in substantial compliance with these obligations and that these important educational and transition efforts continue.

Provisions Related to Individuals with Mental Illness

Throughout the course of the Settlement Agreement and its Extension, there have been significant reforms in the scope and accessibility of community-based supports for individuals with SPMI. During the fact-finding period for this report, numerous sources, particularly attorneys for indigent clients with SPMI, commented on the availability and importance of community-based supports. The Independent Reviewer and her consultants recognize and applaud the substantial commitment of time, energy and financial resources invested by the State. Undoubtedly, there have been important accomplishments.

At this stage of the Settlement Agreement, it is critical to build on the accomplishments to date and to continue to strengthen the opportunities for stability and independence for **all** members of the Target Population, most especially those who are confined to institutions or at risk of being so. As discussed below, the outreach to certain members of the Target Population is not uniform,

consistent or complete. As a result, key requirements remain with recommendations for findings of noncompliance.

It must be emphasized that the requirement that the State have the capacity to provide Supported Housing to any of the 9,000 people in the Target Population with an assessed need for such support has not been met. DBHDD has discussed its plans for complying with this obligation but it has not yet done so. The delays in outreach to members of the Target Population and the restrictive definitions employed to determine eligibility for an assessed need for housing must be addressed if compliance is to be recommended.

Substantial compliance with these agreed-upon provisions is attainable, if the measures set out at the end of this report were implemented.

It must also be noted that the data provided for this report were often contradictory and, thus, confusing. Since FY 2012, the Georgia Housing Voucher and Bridge Funding Program Summary has been the primary source document for the Independent Reviewer's report. Statistical information provided outside of that Program Summary has not been verified.

Supported Housing and Bridge Funding

The strength of Georgia's implementation of the Settlement Agreement obligations pertaining to Supported Housing is the continued availability of resources in the Georgia Housing Voucher Program (GHVP) and in Bridge Funding for recipients of Supported Housing. The State has relied on an annual appropriation as well as funds from turnover (funding for vouchers that becomes available when someone vacates their unit). The State has had the opportunity to use other subsidies and vouchers for new referrals.

DCA and DBHDD have formed a working partnership vital to maximizing and expanding resources for individuals in the Target Population. DBHDD Regional Office staff, selected service providers and Community Service Boards (CSBs) have demonstrated a willingness to conduct housing outreach and make housing referrals.

During the course of the Agreement, DCA secured a Housing Choice Voucher (HCV) preference for individuals in the Target Population for their Public Housing Authority "balance of state" rental assistance program. DCA also sought HUD 811 funds for program rental assistance (PRA) for individuals with disabilities, including individuals in the Target Population in 2012 and sought HUD Mainstream Voucher rental assistance resources through a HUD competition in 2018[12]. DBHDD sought an agreement with the Atlanta Housing Authority in 2015 that became effective in 2017.

> **Agreement Requirement:** The SA and EA require the State to have the capacity to provide Supported Housing to any of the approximately 9,000 persons with SPMI in the Target Population who need such support. (SA III.B.2.c.ii. (A); see also EA 30. Supported Housing may be funded by the State; for example, through DBHDD and its Georgia Housing Voucher Program (GHVP) or through the Georgia Department of

[12] It was recently announced that Georgia has received 135 Mainstream vouchers.

Community Affairs (DCA)) or by the federal government; for example, through the U.S. Department of Housing and Urban Development and its Section 8 program. (SA III.B.2.c.ii.(A)

Agreement Requirement: The SA requires the State to provide Bridge Funding for up to 1,800 individuals with SPMI in the Target Population. (SA III.B.2.c.ii.(C). Bridge Funding includes money for security deposits, household necessities, living expenses, and other supports during the time the person is becoming eligible for federal disability or other supplemental income. (SA III. B.2.c.i.(C); see also EA 31.) Funding for this program would come exclusively from the State. The EA requires the State to provide Bridge Funding for an additional 600 individuals, for a grand total of 2,400 individuals with SPMI in the Target Population (EA 32, 33)

The State continues to fund and administer the GHVP, including allocating Bridge Funding.

Bridge Funding was provided to 1,461 participants in FY 2018, a 25 percent increase over FY 2017 and well above the Extension Agreement's requirement. However, the total expenditure for Bridge Funding was $2,150,600, approximately 30% less than FY 2016 and 40% lower than FY 2017. The average "bridge" cost per participant is $1,211, a reduction of 50% from the previous year. Spending patterns remained the same, with lower amounts attributed to each category. Furnishings and first and second month rent account for 24% of this cost and provider fees account for 16% of the expenditures. The remaining funds were allocated for household items, food, transportation, medication, moving expenses, utility and security deposits and other expenses.

Agreement Requirement: By June 30, 2016, the State shall provide GHVP vouchers for an additional 358 individuals in the Target Population. (EA 34)

By June 30, 2017, the State shall provide GHVP vouchers for at least an additional 275 individuals in the Target Population. (EA 35)

At the end of June 2018, there were 2,405 individuals living in Supported Housing with a GHV. An additional 469 individuals had a Notice to Proceed.

GHVP Assistance	6/30/15	6/30/16	6/30/17	6/30/18
Individuals with a Notice to Proceed	236	321	360	469
Individuals with a signed lease	1,623	1,924	2,432	2,405

Recommended Finding: It is very clear that the State has not yet achieved the capacity to serve the approximately 9,000 people in the Target Population who need Supported Housing. Current capacity, even with generous assumptions, is at about half of the 9,000 figure set out in both the SA and EA. A finding of substantial compliance is recommended for the narrower obligations regarding Georgia Housing Vouchers and Bridge Funding required by EA 31 through 35.

Agreement Requirement: Per the SA, Supported Housing is: (a) integrated permanent housing with tenancy rights; (b) linked with flexible community-based services,

> including psycho-social supports, that are available to individuals when they need them, but are not mandated as a condition of tenancy. (SA III.B.2.c.i.; see also EA 36)

The State is challenged with linkage to flexible services. Based on DBHDD's most recent report, approximately 28% (669/2405) of the individuals living in Supported Housing units were not engaged in services. A review of other states suggests the number is generally in the 10% range. The high number of individuals living in housing but not receiving services may be an indication that staff are either not applying well tested strategies, including assertive outreach techniques and interventions for engaging individuals, and/or staff are not skilled in those techniques. It also could be related to DBHDD not monitoring and holding providers accountable or incentivizing providers for housing stability. Effective linkage requires effective engagement, monitoring and provision of incentives. Reportedly, DBHDD has revised its policy to require a "health and safety check-in" once a month, a widely used method to engage individuals and ensure their safety and wellbeing. This policy was not in effect during the Settlement Agreement period to date and would require monitoring to determine if it is being carried out as a linkage to flexible services.

Recommended Finding: A finding of compliance with Provision 36 cannot be recommended because of clear evidence of ineffective linkage and, as discussed further below, because Supported Housing is not yet being made available to anyone in the Target Population.

> **Agreement Requirement:** To satisfy the "integrated" requirement, the SA requires that at least half of the Supported Housing units be either scattered-site housing or apartments clustered in a single building with no more than 20 percent of the units in one building occupied by people in the Target Population. (SA III.B.2.c.i.(A).; see also EA 37) The SA requires that 60 percent of Supported Housing be two-bedroom units and the other 40 percent be one-bedroom units. (SA III.B.2.c.i.(B).)

The State has consistently complied with the requirements regarding scattered-site locations. DBHDD reported that, in FY 2018, 78% of housing was scattered site (1864/2405), 22% above the minimum standard; this is a 13% decrease from FY 2017 when 2,029 individuals were living in scattered site housing. A review of a report on locations and on rental payments confirms earlier reports that housing is generally scattered site. However, it should be noted, there are large disbursements to three different rental companies that raise the question of DBHDD staff and their contractors utilizing these rental properties in excess of this requirement.

Recommended Finding: The State is in substantial compliance with the scattered site requirements in EA 37.

> **Agreement Requirement:** Per the SA and the EA, there are five sub-groups of people with SPMI within the Target Population: (1) those currently being served in the State Hospitals; (2) those who are frequently readmitted to the State Hospitals; (3) those who are frequently seen in Emergency Rooms; (4) those who are chronically homeless; and (5) those who are being released from jails or prisons. (SA III.B.1.a.; see also, EA 30) Individuals in the Target Population need not be currently receiving services from DBHDD in order to be eligible to receive Supported Housing. (EA 36) The Target

> Population includes individuals in these five sub-groups who have a co-occurring condition such as a substance use disorder or a traumatic brain injury. (SA III.B.1.d; see also EA 30) The Target Population also includes individuals with SPMI and forensic status in the care of DBHDD in a State Hospital where a court has determined that community services are appropriate. (SA III.B.1.b.; see also EA 30) The EA requires the State to implement procedures to refer individuals with SPMI in the Target Population to Supported Housing if the need is identified at the time of discharge from a State Hospital, jail, prison, Emergency Room, or homeless shelter. (EA 40)

The State's provision of housing with supports has enabled individuals with SPMI, and a smaller subset of individuals with a MH/DD diagnosis, to experience stabilization and membership in their communities. The importance of Supported Housing cannot be overstated on either an individual or systemic level. However, as discussed further below, not every subgroup in the Target Population has reliable access to these resources.

DBHDD has not successfully provided assistance to individuals in the Target Population who are being discharged from institutions or who are frequently seen in emergency rooms. DBHDD does not employ all the necessary strategies[13] that can be applied for this purpose with this Target Population. For example, individuals often get released from prison or jail with few resources and no place to live or individuals return frequently to emergency rooms when they are homeless or unstably housed. Three years ago, there was an attempt to provide such assistance in Atlanta with PATH taking referrals of individuals who were homeless and hospitalized at Georgia Regional Hospital Atlanta (GRHA). As discussed in previous reports, this process only worked for approximately 10% of the individuals referred because the steps needed to ensure this was done were not added into the process. Other states have shown remarkable success when the process was fully understood and carried out; transitional or bridge support is considered standard practice today. For example, a recent review of a similar program in North Carolina demonstrated a success rate of 94% for individuals accessing permanent housing over a two-year period. DBHDD has reported that it is making plans to provide such assistance. However, these efforts are in the early stages and have not progressed sufficiently for the purposes of the present review.

It is also of concern to report that the State has not been making much progress in actually linking people to Supported Housing in recent months. For example, the State has been reporting that the net number of GHVP slots utilized has been declining each month in 2018: January-2,628; February-2,582; March-2,534; April-2,511; May-2,482; June-2,453 and July-2,405. This is a steady decline each month and does not reflect the kind of positive movement one would expect as the Parties approached the anticipated compliance date set out in the Extension Agreement.

Recommended Finding: Based on the above information, the State cannot be recommended for substantial compliance with EA 40 because implementation of procedures to refer individuals

[13] It is standard practice today to use *critical time intervention* or other strategies to provide intensive assistance to individuals during transition from jails, prisons, homelessness and hospital discharge.

with SPMI to Supported Housing at the time of discharge from jails, prison, emergency rooms is not systemic and aspects of the procedures are seriously flawed.

> **Agreement Requirement:** The EA requires the State to implement a Memorandum of Agreement between DBHDD and DCA, with the following six elements: (a) a unified referral strategy regarding housing options at the point of referral; (b) a statewide determination of need, with a tool, an advisory committee, a training curriculum, training and certifying of assessors, and analyzing and reporting statewide data; (c) maximizing GHVP; (d) housing choice voucher tenant selection preferences granted by HUD; (e) effective utilization of available housing resources; and (f) coordination of state resources and agencies. (EA 39)

The implementation of the GHVP has highlighted the strong and productive relationship between DBHDD and its sister agency, the Department of Community Affairs (DCA). A Memorandum of Agreement and the establishment of a liaison position between the two agencies have underscored this collaboration. DCA has continued to be an active partner in the discussions about the Settlement and Extension Agreements' obligations and has been receptive to recommendations for streamlining and expediting processes. The working relationship between these two agencies is a major strength.

The Memorandum of Agreement between the two agencies addressed the obligations included in the Extension Agreement, but as discussed below, it has not yet been fully implemented as required by the EA.

As reported in February 2018, the unified referral strategy it is not yet fully implemented for "anyone in the Target Population" to have access to the (unified) referral process and then access to housing (39.a.). DCA and DBHDD are making a concerted effort to explore other resources beyond the GHVP so that the GHVP can be the last resort for individuals not eligible for other resources. Their performance falls short related both to capacity and to the ability to have reached stakeholders and individuals in the Target Population.

The statewide determination of need process (39.b.) is underway but the determination of need process which is now the gateway into Supported Housing for most individuals is still not available to "anyone" in the Target Population. To be available to "anyone," individuals in all the sub-populations at least would have to have the potential to ask for and/or have someone ask them to complete the survey. This is not yet possible.

DBHDD recently changed the required focus of the advisory committee to oversee the needs assessment (39.b.). Based on interviews with advisory committee members, it is unclear as to whether the advisory committee serves this purpose.

Housing Outreach Coordinators (HOCs) have begun completing the tool to assess need in "select" jails and prisons and in emergency rooms. Based on information obtained through interviews with eleven Housing Outreach Coordinators (the twelfth person resigned and did not keep the scheduled interview appointment), they have made attempts primarily by going to the front desk, asking to speak to staff (and often leaving their business card), in a subset of the facilities, asking for meetings and trying to establish contact through other mental health

representatives who work closely with law enforcement or with hospital staff. The success to date using these methods is mixed. Housing Outreach Coordinators report not getting any response from some of the facilities. In some situations, they have been able to arrange meetings to discuss benefits of the programs or to be invited to come to the facility to interview someone about to be discharged.

These methods of contact are quite laborious and often not fruitful in establishing the level and type of relationship that will result in referrals. Because the HOCs are disconnected from the processes that lead to someone getting housing, it is likely the referrals will decline overtime, if facility personnel do not see rapid results or any results at all.

Eleven of the twelve funded HOC positions were filled by April 2018 and one position was filled in June 2018. Two Housing Outreach Coordinators have already resigned and supervisors were required to fill in. One replacement since has been hired. Finally, and very significantly, the target areas served by these 12 HOCs don't cover the entire state. Although this is an action that has potential value, outreach efforts to date have been limited or incomplete. As referenced earlier, even when fully implemented, this outreach will not be available to all 159 counties in Georgia. Under the terms of the contract awards, outreach is targeted to 98 counties or 62% of the entire state.

Provision (39.c.) of the EA requires that the GHVP be maximized. Through a review process developed at DCA, if an individual meets requirements for another funding source for Supported Housing, such as a HCV, HUD Shelter Plus Care (rental assistance for individuals who are homeless), VASH, 811, etc., they are referred to the other program, thus freeing up GHVs for individuals not eligible for the other resources. Even though this is occurring, the process for this review is not automated, requiring an extra review step for staff to determine eligibility. As a result, potential placements are slowed down. To the extent that other funding sources are utilized before approving the use of the GHV, the State has complied with the intent of this provision. However, it must be noted that over 430 GHVs from FY 2018 remain unused at the time of this report so, in that sense, they have not been maximized.

Regarding 39.d., the housing choice tenant selection preference obtained through the efforts of the United States Department of Justice in 2012 and renewed in 2015 is set to expire at the end of the Settlement Agreement. While this initiative held great promise, the total number of individuals transitioned to the Housing Choice Voucher Program was 319 as of April 2018. (The reporting of this number has been inconsistent over time but, after review of all the data provided by DBHDD for this reviewer, it appears to be the most accurate number.) In 2012, DCA committed to allocating 100 vouchers in FY 2012 and 500 vouchers in each of FY 2013, 2014 and 2015 for persons covered by the Settlement Agreement. DCA obtained approval from HUD on May 3, 2012 to set these specific preferences.

Effective utilization of available housing resources (such as Section 811 and public housing authorities) is required (39.e.) as part of the Memorandum of Agreement between DCA and DBHDD. This provision is key to the State's ability to expand capacity and meet demands for new housing. The HUD Project Rental Assistance was first funded in 2012. Georgia was one of the first thirteen states in the country to receive an award for this new program. DCA received

$4.27 million to cover the costs for the extended use agreements for rental assistance for 134 units. Georgia listed two target populations in their application, individuals who qualify in this Settlement Agreement's Target Population and individuals who qualify under the State's Money Follows the Person program. DBHDD reports 100 of these units are to be utilized by the Target Population. To date, 44 individuals in the Target Population have been approved for rental assistance in this program. The program is challenging to administer and Georgia and other states have made some adjustments, with HUD approval, for how funds will be used. However, the plain fact is that the program is under-utilized.

As referenced earlier, the data provided about capacity have been contradictory and, therefore, the actual capacity is unclear. It is estimated that there is roughly a current capacity for approximately 4500-4600 individuals. This is approximately half of what is required by the SA and EA. Furthermore, this estimated capacity falls far short of the numbers of units/ vouchers that could be utilized as projected by the Technical Assistance Collaborative[14] in their 2014 report on potential resources for expanding capacity. TAC projected the total capacity could reach 6,984 slots/units/vouchers, if agreements were in place for utilization of current and projected vouchers and subsidies for the Target Population across a range of state and local programs and funding sources. While it is highly unlikely every housing program will meet its potential, the lack of state and local agreements for utilization of resources limits the potential capacity for the Target Population.

As stated above, the coordination of available state resources and state agencies is important. It is also required as an action step in the Memorandum of Agreement (39.f.).

Recommended Findings: There has only been minimal progress since the requirements for the Memorandum of Agreement were reviewed and reported on in March 2018. As such, the State is not yet recommended as in compliance with this obligation. Specifically, the unified referral strategy (39.a.) is not available for "anyone" in the Target Population and the determination of need is not statewide (39.b.). There is also not yet an effective utilization of housing resources as listed in the Settlement Agreement (39.e.) and coordination with available state resources and state agencies, while in progress, is not yielding sufficient benefits (39.f.). There has been substantial compliance with the requirement to use the GHVP only after other funding sources are explored (39.c.) and the Housing Choice Voucher Tenant Selection preferences are in effect through the life of the Settlement Agreement. (39.d.)

> **Agreement Requirement:** The SA and EA require the State to have the capacity to provide Supported Housing to any of the approximately 9,000 persons with SPMI in the Target Population who need such support. (SA III.B.2.c.ii. (A); see also EA 30. The EA modified this to be "an *assessed* need for such support." EA 38) Supported Housing may be funded by the State; for example, through DBHDD and its Georgia Housing Voucher Program (GHVP) or through the Georgia Department of Community Affairs (DCA)) or by the federal government; for example, through the U.S. Department of Housing and Urban Development and its Section 8 program. (SA III.B.2.c.ii.(A)

[14] K. Martone, M. Herb and P. Holland. *Georgia Housing Capacity Report submitted to the Georgia Department of Behavioral Health and Developmental Disabilities,* June 2014.

> **Agreement Requirement:** The State shall implement procedures that enable individuals with SPMI in the Target Population to be referred to Supported Housing if the need is identified at the time of discharge from a State Hospital, jail, prison, emergency room, or homeless shelter. (EA 40). For purposes of Paragraphs 31 to 40, the "Target Population" includes the approximately 9,000 individuals with SPMI who are currently being served in State Hospitals, who are frequently readmitted to the State Hospitals, who are frequently seen in emergency rooms, who are chronically homeless, and/or who are being released from jails or prisons. The Target Population also includes individuals with SPMI and forensic status in the care of DBHDD in the State Hospitals, if the relevant court finds that community services are appropriate, and individuals with SPMI and a co-occurring condition, such as substance abuse disorders or traumatic brain injuries. (EA 30)

At this point in time, there are certain obligations, referenced above, where implementation continues to fall significantly short of the language embodied in the Settlement Agreement and its Extension Agreement.

First, it is recognized that the State has worked continuously over the past four years to identify individuals in need of Supported Housing-- first through Phase I, a pilot to test the process, then following development of new policies and processes, Phase II, which is ongoing. However, as reported consistently in the annual reviews completed by the Independent Reviewer and her housing consultant, this process has failed to identify individuals in need across all the sub-populations in the Target Population. DBHDD defined the criteria used for identifying each sub-population. Likewise, the protocols developed by DBHDD do not provide timely and complete action steps for standard referral processes for this Target Population. This is a huge undertaking and, as stated by DBHDD staff, "change takes time."

Over the course of the Agreement, most individuals receiving Supported Housing were previously homeless (54%). The number of individuals moving from the State Hospital has remained in the range of 11%; individuals exiting jails or prison average around 5% of the total number of individuals placed in Supported Housing.

As illustrated in the recent analysis completed by Dr. Gouse in her review of discharges from the forensic units of State Hospitals, Supported Housing was provided to only four individuals in 2017 and two individuals through June 30 in 2018. Most individuals discharged from forensic units are recommended by the Hospital for Community Integration Homes (CIHs); that is the option thus approved by the courts. While this is certainly appropriate for many individuals from a risk perspective, there are a number of individuals who could live in a less supervised setting with additional wrap around services and supports, but this is typically not viewed as a viable option as an initial placement from the Hospital. As a result, the overreliance upon CIHs results in unnecessarily long extended Hospital stays for some individuals because of the lengthy wait list. In addition, even when the Court approves release, there are challenges with finding providers willing to accept some individuals and the lack of specific timeframes for completion of referral packets, interviews with providers, and provider response to referrals adds to the longer length of stay.

In terms of referrals from state prisons, DBHDD has stated, and the HOCs have confirmed, that referrals from prisons have been limited to those inmates being released after incarceration for sex offenses. DBHDD has documented that only two individuals released from prison have received Supported Housing.

There has been no reliable data provided regarding referrals of individuals frequently seen in emergency rooms.

Furthermore, as documented in the reports by Dr. Gouse, adults leaving the State Hospitals are rarely discharged to Supported Housing. Although discharges to shelters have decreased significantly since February 2016, when a policy change was issued, the quarterly review of hospital discharges indicated that Supported Housing is not a principal option for individuals who lack families, friends or their own residential resources.

DBHDD has issued plans and timelines for increasing referrals to Supported Housing for individuals leaving jails, prisons and State Hospitals. However, the timeliness for implementation of these plans largely extends beyond the anticipated date for the completion of the Agreements.

Second, with a single exception, the advocates and staff who work in the field have cited the lack of available affordable rental housing as a major challenge. Housing must be available if capacity is to be realized. Building capacity begins with determining what affordable stock is available and making a plan to increase it. DBHDD recently reported they had no problems with capacity.

In Georgia, there are only 38 available rental homes/apartment units per 100 renter households whose income is at 30% of area median income. There are only 55 affordable and available homes per 100 renter households for individuals at 50% of the area median income[15]. Even with a rental subsidy, individuals whose income is only approximately $750 per month (SSI) will have difficulty finding housing in most Georgia rental markets. SSI is only 21% of the area median income in Georgia[16]. DBHDD reports DCA acknowledges this need as well as the scarcity of available decent affordable rental units for the Target Population, which in turn affects capacity.

Most affordable housing in Georgia is already occupied and/or available to a wider population of individuals and families with low incomes that qualify them for the HCV program and the LIHTC program or to individuals who qualify for support from categorical programs such as VASH, HOPWA, ESG and re-entry programs. Occupancy rates run very high. The state cannot simply count the number of slots/ subsidies for these groups and report this as capacity.

[15] *The Georgia Housing Profile.* The Gap Report: National Low income Housing Coalition, Washington D.C. (June 26, 2018)

[16] *Priced Out: The Housing Crisis for People with Disabilities.* . The Technical Assistance Collaborative, Boston Massachusetts. (2017)

Capacity in programs that don't typically expand significantly will also rely on turnover for new referrals.

Beyond the broader question of increasing availability, there is a need to develop a pipeline of affordable housing, where possible, dedicated in whole or part to the Target Population. In Georgia, this includes the GHVP, 811 and the HCV units available through the time limited preference. It also includes the HUD McKinney Shelter Plus Care and HUD (disability) Mainstream Vouchers. There are written agreements and eligibility criteria for the target populations for these programs. DBHDD and DCA have made limited progress with affordable housing slots/vouchers under DCA control and even less progress accessing resources identified as needed for Supported Housing through the unified referral process.

These two areas of inadequate implementation must be addressed before there can be a recommendation of substantial compliance made to the Court.

Provisions Applicable to Individuals with DD and/or SPMI

Quality Management

There is continuing, very promising, evidence that DBHDD has made significant strides in establishing a reliable and responsive Quality Management system.

In preparation for this report, there were discussions with the staff working on Quality Management strategies for DBHDD. Reports and details about current initiatives were examined through the documentation made available for review. Of particular merit are the reports being prepared to analyze performance outcomes, especially in the areas for health-related risks, and the tools being designed for use by practitioners in community-based settings.

The strength of DBHDD's Quality Management system continues to emerge. Its evaluative strategies are invaluable as a safeguard to the many accomplishments being designed and implemented as part of the systemic reform underway in Georgia.

Concluding Comments

In preparing this report, it has been strikingly evident that a number of significant reforms have either been accomplished or initiated in the restructuring of Georgia's systems of support for individuals with DD and SPMI. Across the span of nearly eight years, there has been a substantial investment of resources, both human and financial, in developing and sustaining community-based alternatives to institutionalization. The Independent Reviewer and her subject matter consultants acknowledge and appreciate the scope of these efforts.

Systemic reforms always present challenges. At this time, the challenges remaining under the provisions of the Settlement Agreement and its Extension appear to fall into a discrete number of categories: Supported Housing, supports for individuals at higher risk due to maladaptive behaviors or health conditions, and completing the strength of the safeguards that will help protect individuals from harm and maximize opportunities for meaningful community integration.

There is additional evidence that would be very instrumental towards reaching substantial compliance in areas that have been recommended for noncompliance. This supplemental documentation includes:

Supported Housing

- Evidence that **all** jails, prisons and emergency rooms statewide have knowledge of the availability of Supported Housing and how to access it. There should be documentation of contacts with all jails, prisons and emergency rooms statewide. The number of individuals referred to Supported Housing from each subset of the Target Population should demonstrate that access to Supported Housing is available statewide.
- Evidence of the re-examination and redefinition of the Housing Outreach Coordinators' role to ensure seamless referrals to Supported Housing.
- Evidence of verification that the monthly wellness case management checks have been completed for those individuals with SPMI who have a Housing Voucher but are without services.
- Evidence of the re-examination and any corrective action of the current processes that constrain referral, by definition or otherwise, to Supported Housing.
- Evidence of the implementation of strategic planning to increase the housing stock available for Supported Housing.
- Evidence that DBHDD and DCA are working with PHAs to apply for additional HUD Mainstream Vouchers in 2018 and will work with PHAs and agencies with VASH and HOPWA vouchers to provide greater access to housing with support.

Programmatic Supports for Individuals with DD

- Evidence that the STAR requests are reviewed and acted upon within a maximum of 30 days from receipt,
- Evidence that the availability of providers and provider agencies with expertise is increased statewide.

- Evidence that the crisis-restructuring plan is implemented and that changes are effective in managing crises and avoiding institutionalization.

Systemic Safeguards

- Evidence that training in the principles of community integration continues to occur.
- Evidence that the caseloads for Support Coordinators meet the requirements of the Extension Agreement.
- Evidence that the CRMCs review all investigations with deficient practices within 30 days of completion of the investigation.
- Evidence that notices of CAPS are issued within five business days of CMRC review.
- Evidence of sanctions against providers that do not comply with timelines and mandated corrective actions.
- Evidence of a moratorium on providers with recurrent or notably deficient practices.

The opportunity to discuss these recommendations would be welcomed.

_____/s/_____
Elizabeth Jones, Independent Reviewer

September 19, 2018

Independent Review: Support Coordination, Provider Recruitment and Quality Improvement

Submitted by Laura Nuss
August 4, 2018

Purpose
To assess the state of Georgia's compliance with the Extension Agreement dated May 16, 2016; specifically, the obligations related to the provision of support coordination (16 a.-g.), provider recruitment efforts (18) and quality improvement initiatives (24) as of August 4, 2018.

Methodology
The following activities and document reviews were part of the evaluation of support coordination for this report:

- July 19, 2018: Meeting with DBHDD officials to discuss specific support coordination provisions found in the Settlement Agreement. Present for this meeting included: Ronald Wakefield, DD Division Director; Amy Howell, Assistant Commissioner and General Counsel; Catherine Ivy, Office of Waiver Services; Robert Bell, Director of Community Support; Joelle Butler, Support Coordination Manager; and Evelyn Harris, Settlement Agreement Coordinator.
- July 19, 2018: Meeting with DBHDD officials to discuss quality improvement initiatives. Present for this meeting included: Ron Wakefield; Amy Howell; Catherine Ivy; Melissa Sperbeck, Director, Division of Performance Management and Quality Improvement; J. R. Gravitt, Office of Performance Analysis; and Virginia Sizemore, Office of Quality Improvement.
- July 20, 2018: Site Visit at a GCSS crisis respite home and interviews with Intensive Support Coordinators representing two individuals who reside at this home.
- July 23, 2018: Phone call with Georgia Advocacy Office staff Devon Orland, Renee Pruitt and Joe Sarra.
- July 26 – 30, 2018: Individual phone calls with the Executive Directors of six of the seven Support Coordination Agencies (SCAs): Twana King, GA Support Services; Chianti Davis, The Columbus Organization; Tammy Carroll, Benchmark Human Services; Sharon Higgins, CareStar; Randy Moore, Compass Coordination, Inc.; and, Michelle Schwartz, Creative Consulting Services.

The following documents were reviewed:

- ADA Settlement Extension Agreement Parties Meeting PowerPoint, DBHDD, dated April 13, 2018.
- DBHDD Support Coordination Performance Report, DBHDD, June 30, 2018.
- Orientation to PMQI, Division of Performance Management and Quality Improvement Presentation, DBHDD, July 19, 2018.
- Notification of Support Coordination Agencies (CIRs), data provided by DBHDD dated June 28, 2018 for the period of March 16, 2018 – June 15, 2018.
- Support Coordination Record Review (SCRR) Tool, The Georgia Collaborative ASO.
- ISP QA Checklist Findings Tool, The Georgia Collaborative ASO, 05/05/2015.
- DBHDD Individual Service Plan Quality Assurance Tool, January 1, 2018.
- Support Coordination Interview Tool, The Georgia Collaborative ASO, 07/01/2018.
- Georgia Collaborative ASO Quality Enhancement Provider Review Final Assessment Report, Professional Case Management, Review Period 6/18/2017 – 6/17/2018.

- Georgia Collaborative ASO Quality Enhancement Provider Review Final Assessment Report, CareStar Inc., Review Period 12/04/2016 – 12/03/2017.
- Untitled and undated statement asserting compliance with provision 16(d) citing ASO performance review results of 98% in FY 18 without supporting documentation provided as an attachment via email on July 23, 2018.
- Copy of SC-ISC Caseload Report by Agency, dated 06/30/2018.
- Deliverable 24 DBHDD evidence dated June 28, 2018.
- Attachment A: IDD Quality Improvement Projects, Department of Justice deliverable 24 update 06/27/2018.
- DBHDD Response to Item #2 re: FY 18 Community Quality Improvement Plan, page 9.
- DD Quality Improvement Quarterly Meeting Minutes, 06/27/2018.
- The Georgia Collaborative ASO, Quality Management Annual Report FY 2017. https://s18637.pcdn.co/wp-content/uploads/sites/15/FY-2017-Quality-Management-Annual-Report-Final.pdf
- Outcome Evaluation: "Recognize, Refer, and Act" Model, 02-435, dated January 19, 2018.
- Service Change/Technical Assistance Requests (STARs), Division of Developmental Disabilities presentation, March 2018 https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/imported/DBHDD/Providers/Toolkit/Understanding%20the%20STAR%20Process-march2018.pdf.
- 2016 Annual Mortality Report, NOW and COMP Waiver, GA DBHDD, August 22, 2017 https://dbhdd.georgia.gov/documents/mortality-reports.
- Georgia Collaborative ASO Provider Enrollment. https://www.georgiacollaborative.com/providers/intellectual-developmental-disabilities-services/.

Systemic Strengths

DBHDD has developed and implemented comprehensive policies and procedures governing the delivery of support coordination and intensive support coordination services. Georgia also benefits from stable and strong leadership in both state and support coordination agency positions. Support Coordination Agencies report that regular meetings with the state leadership have been positive and beneficial to their shared mission.

DBHDD also benefits from its organizational capacity in data analysis and reporting. Performance reporting continues to expand to include additional performance measures and adds additional elements to standard performance analysis to refine the significance of those measures.

Individual Support Coordination Agency performance is strong in meeting policy expectations for face-to-face visits and increases as individual's needs and age increase. The availability of clinical supervision in intensive support coordination has been evident during all site visits.

DBHDD also benefits from a robust Administrative Service Organization (ASO) that carries out regular Person-Centered Reviews and Quality Enhancement Provider Reviews. The ASO provides comprehensive reports on its findings that can inform DBHDD about support

coordination, provider and systemic performance and that can guide on-going quality improvement efforts.

16.a.: Noncompliance

DBHDD revised and implemented the roles and responsibilities of support coordination beginning in 2016 and has continued to evolve its methods of state monitoring and performance oversight. DBHDD utilizes several methods to routinely monitor the performance of support coordination services.

DBHDD Policy, Reporting Requirements for Support Coordination, 02-437, requires that Support Coordination agencies submit performance reports to DBHDD on a monthly basis. The policy requires that the report include:

1. Caseload size by Support Coordinator;
2. Number of ISPs approved by the DBHDD Field Office within the past month;
3. Participant Face-to-Face Visit Requirements Performance;
4. Number of Quality Outcome Measures Reviews Completed/ number due per policy requirements.

These same performance metrics can be independently pulled from the Consumer Information System by DBHDD.

DBHDD also utilizes its Administrative Service Organization (ASO), The Georgia Collaborative ASO, to conduct quarterly Person-Centered Reviews (PCRs) on a random sample of HCBS waiver recipients. "The purpose of the PCR is to assess the individual's quality of life as well as the effectiveness of and satisfaction individuals have with the service delivery system."[1] The PCR includes, but is not limited to, the completion of the Individual Service Plan Quality Assurance Checklist (ISP QA), the Support Coordinator Record Review (SCRR) and Support Coordinator Interview (SCI). The ASO also conducts Quality Enhancement Provider Reviews (QEPRs) on a sample of HCBS providers each year, a review of the provider agency's systems and practices. Two Support Coordination Agencies are subject to QEPRs. DBHDD provided two QEPR reports completed in FY 18 for CareStar Inc. and Professional Case Management as evidence of these reviews.

Utilizing these monitoring methods, findings for each of the elements prescribed in 16 a. are provided below.

ISP Development

The DBHDD Support Coordination Performance Report, dated June 30, 2018, reports on ISP performance metrics for the first time, drawing from data reported from the ASO ISP QA Checklist completed between January 1, 2018 and March 31, 2018 (n = 231). The ISP QA Checklist evaluates the ISP on 12 different sections of the ISP and each section is divided by

[1] The Georgia Collaborative ASO FY 17 Quality Management Annual Report, p. 70.

four expectations. Each section is then evaluated on whether each expectation is addressed on a scale of zero to four. DBHDD considers a rating of three or four expectations met in each section as a positive result. Using this methodology, all Support Coordination Agencies had at least 80 percent overall for combined scores of three or four as indicated below[2]:

State overall	**89%**
Benchmark	95%
CareStar	80%
Columbus	88%
Compass	100%
Creative	89%
Georgia Support	95%
PCSA	92%

The statewide average for ISPs that met all expectations for all 12 sections for the first quarter of 2018 was 67%.[3] This represents a slight increase over the FY 17 statewide average of 58.7% as reported in the ASO FY 17 Quality Management Annual Report.[4] The section of the ISP receiving the lowest performance rating for the first quarter of 2018 was "Goals are Person-centered", with 28% of all ISPs addressing 4 of 4 expectations and an additional 18% of ISPs addressing 3 of 4 expectations (combined 48% of all ISPs). This represents a decrease over the FY 17 results where 43.9% of ISPs met 4 of 4 expectations and an additional 21.4% addressed 3 of 4 expectations (65.3%). The sections of the ISP receiving the highest ratings in both ratings periods (over 90%) were in "Rights, Psychotropic Medications, Behavior Supports" and "Health and Safety Review."

According to the DBHDD FY 18 Community Quality Improvement Plan, the Department utilizes data collected from the ASO to identify where the system could benefit from some type of performance improvement initiative.[5] The Department provided a listing of "trainings that have been recommended and provided and that address area items noted in the QMAR."[6] Included in this list of training were four topics addressing person-centered documentation and language, an appropriate quality improvement initiative in response to the weak performances identified in the ISP QA Checklist findings.

DBHDD does not report on the timely development of ISPs in the Support Coordination Performance Report, and it is not reported in the ASO Quality Management Report. This performance metric is an HCBS waiver quality measure but was not made available for this report. DBHDD does not report on the number of ISPs approved by the DBHDD Field Office each month although this is reported by the support coordination agencies on a monthly basis. DBHDD also does not report on the timely approval of ISPs by the DBHDD Field Offices. These latter metrics would reflect performance in the submission of quality ISPs not requiring

[2] DBHDD Support Coordination Performance Report, June 30, 2018, p. 41.
[3] DBHDD Support Coordination Performance Report, June 30, 2018, p. 42.
[4] Georgia Collaborative ASO FY 17 Quality Management Report, p. 90.
[5] DBHDD FY 18 Community Quality Improvement Plan, p. 9.
[6] DBHDD response document re: FY 18 Community QI Plan provided to the Independent Monitor, July 5, 2018

subsequent corrections for approval, and the performance of the DBHDD field office in the timely review and approval of ISPs.

Implementation of Plan

This element of provision 16. (a) includes that support coordinators monitor the implementation of the plan, recognize the individual's needs and risks if any, promote community integration, and respond by referring, directly linking and advocating for resources to assist the person in accessing necessary services and supports. This overlaps in part with 16. (b) which will address the use of the Individual Quality Outcome Measures Review (IQMR) and implementation of the coaching and referral policy. This section will address implementation of the ISP as monitored by face-to-face visits and the ASO Person-centered Reviews.

The most recent DBHDD Support Coordination Performance Report illustrates continued substantial compliance in face-to-face visits per DBHDD policy. For the period January through March 2018, face-to-face visit compliance for support coordinators by agency ranged from 90% to 100%. For intensive support coordination, face-to-face visits are required at least one time per month. Here again, compliance remained significantly above 90% except for one month for one agency for this same time period.[7] DBHDD has gone further and analyzed the number of face-to-face visits based on need using age and health care levels as measures of need in the February and June 2018 Support Coordination Performance reports. In both instances, the results substantiate "that as health risk (represented by HCL and increasing age) rises, the number of face-to-face visits also generally rises."[8]

During these face-to-face visits, the support coordinator is expected, in part, to evaluate the implementation of the ISP utilizing the Individual Quality Outcome Measures Review Tool (IQOMR). The IQOMR is divided into seven focus areas: Environment; Appearance/Health; Supports and Services; Behavioral and Emotional; Home/Community Opportunities; Financial; and Satisfaction. This report will discuss the support coordinators' findings as recorded in the IQOMR under provision 16. (b). The Person-Centered Review (PCR) completed by the Georgia Collaborative ASO also assesses the individual's quality of life and the effectiveness of the service delivery system. The PCR includes a Provider and Support Coordinator Record Review and Support Coordinator Interview and is organized into six Focused Outcome Areas: Whole Health; Safety; Person Centered Practices; Community Life; Choice; and, Rights.[9]

In FY 17, the ASO identified as Areas for Growth key indicators specific to this provision. In Person-Centered Practices, providers were found to regularly review, with the individual, progress toward and benefit of goals 40.4% of the time, and for support coordinators 56.1% of the time.[10] The Community Life Focus Area, the degree to which individuals were interacting with and integrated in their surrounding community, showed the lowest average score among all focus areas at 71.1%, a 10% decrease over FY 16. Drilling down further in the Choice Focus

[7] DBHDD Support Coordination Performance Report, June 30, 2018, pp. 19 and 21.
[8] DBHDD Support Coordination Performance Report, June 30, 2018, p. 22.
[9] Georgia Collaborative ASO FY 17 Quality Management Annual Report, pp. 70 and 76.
[10] *Ibid*, p. 81

Area to investigate support coordinator performance in this area (as opposed to results from individual and staff interviews) illustrates substandard results as illustrated below[11]:

- Documentation demonstrates how the individuals is supported to learn about, explore and experience the community = 39%
- Documentation demonstrates how the individual is supported to/able to participate in the community activities and employment the same as individuals without disabilities = 62.2%
- Documentation demonstrates how there is development of social roles and natural supports that reflect the individual's interests = 46.4%

As noted earlier in this report, DBHDD should be utilizing this type of data to craft quality improvement initiatives. The Department-provided listing of "trainings that have been recommended and provided and that address area items noted in the QMAR" included one training topic relevant to these performance findings, Networking in the Community to Build Relationships and Natural Supports.

An important element in monitoring the implementation of the ISP is the requirement to amend the ISP when there is a change in the individual's condition or circumstances necessitating a change in services and supports. This is accomplished through an ISP amendment, and in certain circumstances under the Comprehensive and NOW HCBS waivers, the submission of Service Change/Technical Assistance Requests (STARs). A support coordinator is required to submit a STAR to[12]:

- Reallocate funds from one service to another between service categories where the need for the other service has not been assessed and approved;
- Specialized Medical Supplies exceeding $3,800;
- Additional Residential Staffing;
- Extraordinary Staffing for CAG;
- Need for Nursing services or increased nursing hours; and,
- Requests for clinical assessments or technical assistance from DBHDD.

The STAR request is submitted by a support coordinator to the DBHDD Regional Office to obtain approval for a new service, an increase in the amount of a service or obtain an assessment to determine the need for a service. If the STAR is approved, the support coordinator must then submit an ISP amendment to the regional office for approval and funding authorization.

In this reviewer's August 2017 and February 2018 reports, it was identified that the STAR process was not timely leading to significant delays in receipt of new or increased levels of services. In the DBHDD document, Ongoing Quality and Performance Improvement Based on the June 2017 Support Coordination Performance Report, dated February 8, 2018, under Audit and Review Results, the document lists:

[11] *Ibid*, p. 84

[12] Service Change/Technical Assistance Requests (STARs), Division of Developmental Disabilities presentation, March 2018

- *Increasing efficiency of STAR processing*
    - *Field Offices are maintaining data regarding the timeliness of decisions for STAR requests and maintaining categories of requests by type;*
    - *Standardized STAR Process for Field Offices written and distributed for February 1, 2018* implementation.

Five out of six SCA Executive Directors again reported that the STAR process continues to be problematic, and that performance varied by region. The support coordination agencies reported that some requests may be reviewed in a timely manner where others may languish for several months, some requests when denied are not accompanied by an Adverse Action notice so the individual/guardian can appeal the decision, and there is no mechanism in the system to notify the support coordinator when there has been a decision on the STAR submission. Support coordinators report that the speed at which a decision is rendered does not always align with the urgency of the circumstances driving the request. This issue can have serious consequences for individuals and providers. Delays in receiving additional staffing or nursing services places individuals at risk for hospitalization or increased injury, abuse or neglect. If a provider puts in place the additional staffing or nursing prior to receiving an approved STAR and the STAR is subsequently denied, the provider must absorb the cost of those services. This can have a chilling affect on the service delivery system, and interviews with the service coordination agencies has confirmed this. Support coordinators report that this is especially true when trying to identify providers who will accept individuals with more complex and/or intense medical or behavioral health needs. It was noted that some of the delay is in part due to a shortage of nursing staff within DBHDD, that DBHDD has hired a staff person to coordinate the STAR process and that the Department is aware of the challenges. DBHDD is also preparing to roll out a new consumer information system that is anticipated will improve this process.

DBHDD did not provide data regarding its performance in processing STAR requests in a timely manner even though it reported that it collects that data as of February 2018.

Finally, DBHDD has used the National Core Indicators (NCI) as a method to cross-validate its performance and outcome findings. In the June 30, 2018 Support Coordination Report, DBHDD assessed support coordination using seven indicators related to familiarity with the support coordinator, support coordinator responsiveness, and Individual Service Plan development, allowing for 24 points of comparison. (One item does not have a national average reported; therefore, it was not used in the comparison, but reported.) Support Coordination Agencies performed within or significantly above the national average 96 percent of the time on all NCI support coordination-specific items. All agencies performed significantly above the national averages for the indicators of individuals having the people they wanted at their service planning meeting; and for persons being able to choose the services they want in their service plan. Georgia Supports Services was the only agency scoring significantly below the national average for the indicator related to individuals being able to contact their support coordinator when they want to. [13]

[13] DBHDD Support Coordination Performance Report, June 30, 2018, p. 49.

DBHDD can demonstrate full compliance with this provision by:

- Demonstrating statistically significant improving performance in the section of the ISP receiving the lowest performance rating by the ASO using the ISP QA Checklist for the first quarter of 2018: Goals are Person-centered", with 28% of all ISPs addressing 4 of 4 expectations and an additional 18% of ISPs addressing 3 of 4 expectations (combined 48% of all ISPs).
- Demonstrating statistically improving performance in the Focus Outcome Area Community Life support coordination measures in the FY 18 Georgia Collaborative ASO Quality Management Annual Report.
- Providing data regarding the timeliness of STAR decisions for evaluation.

16.b.: Compliance

As noted in previous reports, DBHDD has implemented the use of a uniform tool, the IQOMR, and published guidelines for implementation of the tool as required. In her August 2017 report, this reviewer recommended reviewing this tool and splitting some multipart questions apart to improve data analysis. DBHDD completed a review of the tool and has implemented a revised tool effective January 1, 2018 that addressed that recommendation.

To complete the IQOMR, the support coordinator is to use observation of the setting, staff and the individual, record review and discussion with the individual and staff. Based on the support coordinator's completion of those steps, each focus area question is evaluated as "acceptable" or "coaching" when a concern, issue or deficit is discovered in an element of a focus area question.[14] The DBHDD policy and procedure, Outcome Evaluation: "Recognize, Refer, and Act" Model, 02-435, last reviewed January 19, 2018, is what DBHDD refers to as "coaching and referral" in its data and performance reports.

DBHDD reports this system continues to be effective as evidenced by continued positive data gathered from the Consumer Information System (CIS). For the period October 2016 to October 2017, DBHDD reports that Support Coordinators opened 14,838 coaching records, provided 3,712 referrals in response to individuals' needs in order to facilitate positive outcomes, that 90% of identified issues were resolved through coaching without requiring elevation to referral status, and, that less than 1% of issues remain unresolved and required follow-up by the Division of Accountability and Compliance.[15] This exactly mirrors the performance reported in the Fiscal Year 2017 Annual Support Coordination Performance Report.

In the February 16, 2018, FY 17 Support Coordination Performance Report, DBHDD evaluated the number of coaching and referrals per person for each Support Coordination Agency. This represented the first time this analysis was completed, and DBHDD indicated that "one should exercise great caution before proceeding to draw conclusions on the number and frequency comparisons for several reasons." Those reasons being that it is a new metric that requires

[14] DBHDD Support Coordination Performance Report, June 30, 2018, p. 24

[15] ADA Settlement Extension Agreement Parties Meeting Materials, PowerPoint Presentation, January 12, 2018

additional analysis, that there are other positive outcomes occurring for individuals in the system regardless of the rate of coaching and referrals made, or some support coordinators may simply not be documenting coaching efforts.[16] DBHDD published a second report on June 30, 2018 and updated its findings for the period July 2017 through March 2018 (partial year of FY 18). The resulting discussion below was identical in both reports except where noted:

> *"Coaching and referral activities (combined) are ordered from highest to lowest as listed below, and the order of the tables below follow this order. As can be seen, appearance/health and supports/services, not surprisingly, are the areas where support coordinators have focused the highest volume of coaching and referral activities.*
>
> *1. Appearance/health,*
> *2. Supports/services,*
> *3. Environment,*
> *4. Home and community options,*
> *5. Financial,*
> *6. Behavioral and emotional,*
> *7. Satisfaction.*
>
> *As with the overall system performance perspective, Compass most frequently delivered the largest number of coaching and referral activities per individual across most areas; conversely, Columbus most frequently delivered the fewest coaching and referral activities per individual across most areas.*
>
> *Appearance/health is the busiest area of activity for support coordinators, and appearance/health has over half of all open referrals beyond the expected close date. This indicates that support coordinators are experiencing barriers to resolving appearance/health issues for individuals, and support coordinators may need additional support to facilitate improved appearance/health outcomes.*
>
> *Support coordinators also dedicated substantial resources towards producing positive outcomes for supports/services areas by delivering coaching and referral activities second most frequently in this area. Almost 25 percent (12.5 percent in the June 30, 2018 report) of all open referrals beyond the expected close date are also in this area, which suggests that support coordinators may need additional support to facilitate improved supports and services outcomes."*
>
> *"DBHDD is still investigating ways to determine how support coordination activities (e.g., face-to-face visits, coaching sessions, referrals, ancillary activities, etc.) as well as the combination of other services and supports are related to outcomes."*

The coaching and referral statistics reported for the period July 2017 through March 2018 (9-month period) are trending higher over FY 17 (14,227 coachings and 4,486 referrals). Despite this, the average number of coachings per person remains low if the support coordinator in fact

[16] GA DBHDD Support Coordination Performance Report, February 16, 2018, p. 21

records a coaching each time an element of the IQOMR is found to be less than acceptable. In this 9-month period, two Support Coordination Agencies averaged less than 1 coaching per person, five agencies averaged less than 2 coachings per person and one agency averaged 3.22 coachings per person. The IQOMR between July and December 2017 contained 25 items, and between December and March 2018 contained 55 items, and IQOMR Tools are to be completed every quarter for individuals receiving support coordination services and monthly for those receiving intensive support coordination. Rough calculations result in over one million assessed elements in this time period, so the low frequency of coachings per person would suggest that the DBHDD provider system is performing extremely well.

DBHDD reported the IQOMR findings for the first quarter of calendar year 2018 to act as a baseline of performance in the June 2018 Support Coordination Performance Report in the table below[17].

Baseline March 2018	
SC	
Environmental	92.8%
Appearance/Health	93.3%
Supports and Services	95.6%
Behavioral and Emotional	73.5%
Home/Community Opportunities	91.0%
ISC	
Environmental	97.3%
Appearance/Health	90.9%
Supports and Services	91.5%
Behavioral and Emotional	58.1%
Home/Community Opportunities	85.5%

The June report established baselines for each Support Coordination Agency in each area. These findings generally align with the ASO PCR findings in the health and behavior areas and are higher than those reported in the ASO findings in Supports and Services and Home/Community Opportunities. The challenges identified in the Behavioral and Emotional focus area are reflected across the system. Interviews with Support Coordination Agencies and the Georgia Advocacy Office confirm that there is an insufficient number of behavioral health providers in the system, people remain in crisis homes or psychiatric settings for long periods of time while waiting for a new provider to provide residential services, and existing residential providers are quick to discharge individuals who present behavioral health challenges.

The Support Coordination Agency Executive Directors expressed less satisfaction with the coaching process than previously reported. Discussions revealed a number of changing dynamics in the field in this area. Support Coordination Agencies reported that there continues to be some tension expressed by provider agencies that view coachings as punitive and it can poison relationships. Support coordinators also reported concerns that increasingly providers are

[17] Ibid, p. 37

pressuring individuals to change Support Coordination Agencies if subject to unwanted oversight. There continues to be little confidence that DBHDD has a system in place to affect provider performance effectively.

16.c.: Substantial Compliance

DBHDD produced a second report, DBHDD Support Coordination Performance Report, February 16, 2018, evaluating data for the period October 2016 to October 2017, and a third report dated June 30, 2018 with updated data through March 2018. These reports evaluated performance findings for Support Coordination Agencies in the following areas:

1. Caseload Size,
2. Face-to-Face Visits,
3. Coaching and Referrals,
4. Outcomes,
5. Critical Incident Reports (June 30, 2018),
6. ISP Quality Results (June 30, 2018).

16.d.: Noncompliance

DBHDD corrected the technical error in Reporting of Critical Incidents (ROCI) information management system in this reporting period that prevented critical incident investigative reports from being transmitted to Support Coordination Agencies. The ROCI system is to designed to send "same-day alerts" to the assigned Support Coordination Agency when an incident or investigative report has been uploaded into the system. DBHDD provided data for the period January 1, 2018 2018 through June 15, 2018.

For Critical Incident Reports, the average number of days to notify the Support Coordination Agency was 10.3 days for the first quarter of calender year 2018, and 18.1 days for the second quarter of calendar year 2018. For investigative reports, only one month of data was reported without indicating the total number of reports represented. In this month (May 2018), the average time for notification was 9 days.

These findings were supported through interviews with Support Coordination Agency Executive Directors who confirmed that notifications for critical incidents continue to come into the support coordinaiton agency in about two weeks, and that when critical incident investigation reports are received, it is likely nine months to a year since the critical incident occurred and it is no longer relevant.

To achieve substanital compliance with this measure, DBHDD must ensure that Support Coordination Agencies are timely notified of submitted critical incident reports so that support coordinators can respond in a timely manner to address potential gaps in services and supports.

16.e.: Non-compliance

DBHDD Support Coordination Performance Report dated February 16, 2018 reported on caseload compliance using a standard of 85% for substantial compliance. As of October 1, 2017, five (5) SCAs maintained caseloads above 85% and two were below 85%. One of those agencies, CareStar, was at 100% compliance for four consecutive months and then dropped to 70 and 75% for August and September of 2017. In the June 30, 2018 DBHDD Performance Report, as of March 2018, the "proportion of support coordinators in compliance with caseload requirements is above 85% for six of seven Support Coordination Agencies, and the overall caseload compliance for the population is 91 percent as well."[18]

DBHDD provided caseload data for support coordination as of January 7, 2018 to the Independent Reviewer for the February report documenting the following performance:

- One agency at 100% compliance;
- Four agencies at 90% or above compliance;
- Two agencies between 85-89% compliance; and,
- One agency at 75% compliance.

DBHDD provided caseload data for support coordination as of June 30, 2018 to the Independent Reviewer for this report documenting the following performance:

- Two agencies at 100% compliance;
- Two agencies above 90% compliance;
- Two agencies between 70 – 80% compliance; and,
- One agency at 44% complaince.

Support Coordination Agencies acknowledge the challenges with maintaining caseload compliance, especially if the agency accepts all referrals. Balancing funding, hiring and on-boarding, short-term absences and the geographic distribution of referrals is an ongoing management challenge. Support Coordination Agencies also noted the increasing demands of individuals who are assigned to general support coordination caseloads yet have significant service coordination needs.

16.f.: Substantial Compliance

Please see data reported under 16.a. of this report.

16.g.: Substantial Compliance

Data provided by DBHDD indicates that support coordinators are assigned more than 60 days prior to discharge from State Hospitals.

[18] DBHDD Support Coordination Performance Report, June 30, 2018, p. 17

18.: Noncompliance

DBHDD has identified two categories of providers to address in the provider recruitment plan; residential service providers for individuals with complex medical or behavioral needs, and community clinical services, such as occupational, speech and physical therapy, and other critical services needed to support individuals in the community[19]. Interviews with Support Coordination Agencies and the Georgia Advocacy Office corroborate those needs and described the negative impacts these needs are having on individuals in the community and for those waiting to transition into the community.

This reviewer accessed the Georgia Collaborative ASO website, Find a Provider tool at https://www.valueoptions.com/referralconnect/facilitySearch.do?nextpage=nextpage on August 3, 2018 to search for clinical providers accepting new referrals. The following results were provided:

- Behavioral support consultation = 56,
- CRA = 2,
- Nursing services = 17,
- Occupational therapy = 4,
- Physical therapy = 5,
- Speech therapy = 6.

A review of the provider enrollment process available through the ASO website describes a process that requires at minimum seven months to successfully enroll in one of the DD HCBS waiver programs.

The plan described in the Parties Meeting indicates that an Enterprise workgroup has been established to evaluate individual support profiles and work to address gaps in reimbursable services with final recommendations from the workgroup due in May 2018.

DBHDD needs to fully develop and implement a robust and enterprise-wide provider recruitment plan in the identified provider categories resulting in significant increases in clinical provider enrollment relative to the service population numbers and needs to demonstrate compliance.

24: Compliance

The FY 2016 Annual Mortality Report, the third such report, was published on August 22, 2017. The report is in compliance with this provision. The FY 17 report is expected in August 2018. DBHDD provided a listing of IDD Quality Improvement Projects submitted as an attachment to the Department of Justice Deliverable 24, dated June 27, 2018, specific to initiatives including those to reduce mortality rates for individuals with DD in the community. The list certainly reflects appropriate quality improvement initiatives in support of health and wellness for individuals with intellectual and developmental disabilities.

[19] ADA Settlement Extension Agreement Parties Meeting Presentation by DBHDD, 4/13/18, p. 135.

Notably absent were efforts directed toward addressing the most frequently cited deficient practices (deficient response to change in condition, an emergency or medical needs) and to one of the leading causes of death, aspiration. The Quality Improvement list ends with a status update on additional training needs:

> "Training on Preventive Healthcare and Specific Conditions Common in Individuals with I/DD has been provided. Additional training being developed includes topics such as Health/Wellness, Medical Risks, Responding to Medical Care Needs, Documentation of Care, especially clinical progress notes and medical notes."

Responding to medical needs was among the most frequently cited deficient practice that has yet to be addressed via a quality improvement effort now almost one year later. The Mortality Report also pointed out that individuals with intellectual and developmental disabilities shared six of the top ten leading causes of death with the U.S. and Georgia general populations. This supports that general public health recommendations must also be implemented for those supported by DBHDD. The FY 17 ASO Quality Management Annual Report identified as an area for growth that less than 50% of an individual's records contained the person's preventative health care report for male and female preventative screenings compliance.[20] It is not clear if this is among the quality improvement efforts.

28: Noncompliance

DBHDD provided letters of attestation from all Support Coordination Agencies indicating that each agency had in place a risk and quality management and improvement plan as required by Provision 28. DBHDD also indicated it is working with its Administrative Service Organization to include an evaluation of this requirement into future support coordination agency provider reviews.

The Support Coordination Agencies provided evidence of their respective risk and quality management and improvement plans to this reviewer upon request. The plans varied in detail, none provided evidence of implementation of the plan, and one agency executive indicated that it was still not clear at least to this agency what was expected by DBHDD in this area. Four agencies submitted plans found to be sufficient, one agency provided a policy that indicated it should have a plan but it was not provided, one agency submitted a plan that was incomplete, and one agency submitted a plan still under development.

Conclusion

DBHDD has established a strong system of Support Coordination Agencies and supporting policies and procedures. DBHDD has strong data collection, analysis and reporting capabilities and an organizational structure to support the development of quality improvement initiatives. There are some discrepancies apparent when reviewing the ASO independent findings and those reported by the support coordinators. Interviews with Support Coordination Agencies suggest

[20] Georgia Collaborative FY 17 Quality Management Annual Report, p. 81.

there are remaining challenges for DBHDD. The reform intended to move support coordination and other waiver services into complementary roles that would better reflect collaborative partnerships in service delivery, with a shared emphasis on producing quality outcomes for waiver participants, has certainly experienced success. But tension does remain, especially in cases of poorly performing waiver service providers. While DBHDD continues to develop increasing monitoring and surveillance data collection and analysis capabilities, this must be paired with consistent support and interventions on the part of DBHDD to ensure continued improvements in the system at large.

Independent Review: Compliance with ACT following DACTS Standards

Angela L. Rollins, Ph.D.
August 8, 2018

Purpose

The purpose of this report is to assess compliance with the Settlement Agreement provision requiring that ACT services follow the Dartmouth Assertive Community Treatment Scale (DACTS) standards. This obligation was carried forward from the original Settlement Agreement.

III.B.2.a.i.(G).

All ACT teams will operate with fidelity to the Dartmouth Assertive Community Treatment model.

Methodology

To assess compliance with this provision, numerous FY18 documents were reviewed: State-provided ACT fidelity assessments for each team; State-contracted ACT census tables (monthly census reports by team); DACTS item scoring table by team; ACT quality improvement plan summaries; monthly team discharge tables (i.e., raw discharge numbers including duplicates); ACT effectiveness study (dated January 2018); ACT person-time discharge analysis (dated January 2018); and similar reports from previous years. Previous reports were used for comparison on progress. Also, a brief phone conversation with an ACT program administrator took place. A report written by Norquist Grayson was also reviewed, particularly the sections regarding ACT services.

Findings

System strengths

State fidelity monitoring. The State continues to implement ACT in 22 State-contracted teams and uses the DACTS as the fidelity standard. Teams receive an annual assessment of their fidelity according to the DACTS with written reports, including feedback on items where the team scores below 5 (the highest possible score). Teams are expected to score a mean of 4.0 or higher across all 28 DACTS items, as well as expecting teams to score a 3 or higher on each individual DACTS item. When either of these standards is not met, the State and the team implement a corrective action plan to remedy weak areas.

DACTS fidelity scores. Over all 28 DACTS items, the 22 State-contracted teams are scoring well, with an overall statewide DACTS average of 4.34. Only two teams had a mean DACTS score below 4.0 (both scored a 3.9, also very high). Some concerns about specific items are detailed below.

Active DBHDD regional Field Office staff. The corrective action plans showed evidence of active involvement from DBHDD Field Offices in supporting ACT services. This involvement is consistent with previous observations over the years. With a larger State, the ability to have in-person, hands-on technical assistance from knowledgeable staff nearby is essential. Examples noted included both team-level trainings offered onsite at the agency and monthly or quarterly monitoring of fidelity metrics to improve compliance with DACTS standards.

Areas for further consideration

Low frequency of ACT services. Some concerns remain regarding teams' struggling with maintaining a high frequency of contact between ACT teams and their consumers. Although the DACTS criteria to achieve a "5" on frequency of contact is perhaps stringent (four or more per consumer per week), a score of "2" denotes less than two contacts per consumer per week. Seven of 22 teams scored a "2" on this item in FY18, indicating this aspect of ACT service is becoming a problem for more teams again, although the statewide average on the items remains relatively steady around 2.9 or 3.0. A "3" on this item indicates less than three contacts per consumer per week.

Table 1. S4 and S5 scores over time.

	S4 Service intensity		S5 Service frequency	
	State Average	# Teams scoring 1 or 2	State Average	# Teams scoring 1 or 2
FY18	4.0	2/22	2.9	7/22
FY17	4.0	0/22	3.0	4/22
FY16	3.9	2/22	3.0	3/22
FY15	3.7	0/22	2.9	5/22
FY14	3.9	0/22	2.8	8/22
FY13	3.8	2/21	3.0	3/21

Co-occurring disorders model scoring. One concern with fidelity scoring is that all 22 teams were rated a 5 on the co-occurring disorders model item, one of the more difficult DACTS items to rate. It would be exceedingly rare for all 22 teams to score this high, particularly given that some teams were without a substance abuse specialist and did not offer substance abuse groups. Without additional details, I view these scores with some skepticism. A DACTS score of 4 on this item, for instance, still requires a stage-based approach to group offerings (i.e., both persuasion-oriented and action-oriented groups). An inflated score on this item by one point (e.g., scoring a team as a 5 instead of a 4), inflates the overall DACTS mean by .0357. Inflating this item score by 2 points (e.g., scoring a team as a 5 instead of a 3), inflates the overall DACTS mean by .071. Inflating this item score by even 4 points (i.e., scoring teams as a 5 instead of a 1, which is unlikely given my knowledge of the teams), would inflate the overall DACTS mean by .143. Therefore the overall impact of scoring errors would not be terribly large on the statewide DACTS overall average, even in the unlikely event that every team was given a score of 5 instead of 1 on this single item. For example, in the worst case scenario of inflating by 4 full points (which is unlikely), the state average would be corrected to 4.20 from 4.34 (the current statewide average as reported). Given the current DACTS overall means of the 3 lowest scoring teams in the state (3.89, 3.93, and 4.04), a two-point error would put the lowest scoring teams to 3.82, 3.86, and 3.96, respectively. Any actual scoring error cannot be quantified without additional information.

Even if scoring errors for this item are minimal, it remains important to examine scoring methods for this item to reinforce critical elements of integrated dual disorders treatment that produce the

best results for consumers on ACT teams with co-occurring mental health and substance use disorders.

Consumer tenure on ACT. Another concern is the rapid turnover of consumers on the ACT teams, either due to rapid graduation and/or high dropouts. The reports on the rate of discharge are concerning because the State indicates that there is no way to reliably mark enrollment in ACT in their systems. As a proxy, the State assumes ACT enrollment at the first instance of ACT billing with no prior billing in the previous 45 days. This is a reasonable method in the absence of a distinct enrollment date, but the data presented still do not allow us to measure ACT tenure for consumers, a critical point of consideration as to whether the State is using ACT as a time-limited service. As mentioned in the report, observing length of stay only for those consumers who have left the team can be problematic when observations are over short periods. Over longer periods, these issues are less problematic (e.g., over five years, a greater percentage of consumers have time to graduate, even after a long length of stay). Within a shorter timeframe, there also may be other methods to assess the current tenure of ACT consumers who remain with the team in addition to length of stay for ACT discharges to provide a fuller description of how long consumers enrolled are receiving ACT services.

Remote fidelity assessment. Seven of the 22 State-contracted teams received a remote fidelity assessment in FY18. As noted in my February 2018 report to the Independent Reviewer, there are some concerns about how teams were selected for the remote assessment and how some of the more difficult elements of remote fidelity assessments (e.g., chart reviews to score numerous items) were conducted. This report also emphasized the developmental quality of onsite assessments noted in my own research on these methods. I can say that some teams scored via a remote assessment still scored low on a few items, indicating that these methods used in Georgia were able to capture lower scoring ACT procedures.

ACT Effectiveness. The State also changed its method of evaluating ACT effectiveness. It is now comparing the number of admissions and hospital days during and after ACT. Previous years' reports compared the metrics before and during ACT. Changes in all three phases is important for comparison (pre, during, and post ACT). Adding an "after ACT" phase in the comparison could help illuminate any loss in the benefits of ACT if ACT services are terminated too early, so this addition is worthwhile. However, it would be beneficial to examine hospitalization patterns with respect to all three phases and to include descriptive data on number and length of hospitalizations for each group of consumers in the comparison. The main findings of the report were that hospital admissions were more common during an ACT episode than after that ACT episode. However, days hospitalized were higher for those who were hospitalized after ACT, compared to those hospitalized during ACT. The report indicates these analyses only include one year of data, so it is perhaps early to draw many conclusions.

Access to ACT in Region 3. A report co-authored by Norquist mentioned waiting lists for ACT teams in metro Atlanta. An administrator for one large agency anecdotally reported that their wait list can grow to around 40 (roughly half an ACT team) each month. Many of those on the waiting list are reported to be very likely to meet ACT criteria because the referral sources are now knowledgeable about ACT admission criteria and rarely attempt to refer consumers who

would not be accepted for ACT. Increasingly monthly intake maximums would likely decrease wait lists but also would be likely to negatively impact the quality of services offered because ACT consumers often need assistance in numerous domains at enrollment (e.g., mental health, housing needs, insurance, legal problems) and ample time for engagement with the providers.

Conclusions

Georgia is in compliance with the provision that ACT teams operate with fidelity to the DACTS, with an overall DACTS statewide average of 4.34. However, concerns remain regarding certain elements of ACT services; these may require further monitoring and improvements, as noted above.

Independent Review: Behavioral Programming for Eleven Individuals with a Developmental Disability

Submitted by:
Patrick F. Heick, Ph. D., BCBA-D
August 8, 2018

The following *Summary* was prepared and submitted in response to the Independent Reviewer's request to summarize a sample of reviews completed as part of her analysis of supports provided to individuals with challenging behaviors, including those with encounters with law enforcement. The following summary is based upon the reviews of the behavioral support and services for eleven individuals[1]. These reviews compared the behavioral programming and supports that are currently reported to be in place with generally accepted standards and practice recommendations with regard to components of effective behavioral programming and supports – these components included: (1) level of need (i.e., based on behaviors that are dangerous to self or others, disrupt the environment, and negatively impact his/her quality of life and ability to learn new skills and gain independence); (2) Functional Behavior Assessment (FBA); (3) Behavioral Support Plan (BSP); (4) ongoing data collection, including regular summary and analysis; and (5) care provider and staff training. It should be noted this reviewer does not intend to offer these as reflective of an exhaustive listing of essential elements of behavioral programming and supports. Furthermore, these reviews were based on the understanding that all existing documents were available onsite and/or provided in response to the Independent Reviewer's initial request. However, as noted within submitted individual reviews, requested documentation was found to be inconsistently available onsite. It should be noted that an informal review of a twelfth individual was also completed as requested; however, a Monitoring Questionnaire was not completed as directed – information related to this individual review is not summarized here.

This Summary is submitted in addition to Monitoring Questionnaires completed for each of the eleven individuals sampled, as well as Data Summaries. It should be noted that the following Summary and data summaries are based upon the Monitoring Questionnaires, which were completed using information obtained during on-site observations and interviews with care givers, as well as documentation provided in response to the Independent Reviewer's document request including documents obtained while onsite or received electronically from the Independent Reviewer or designee.

Summary

Findings

- Based on a review of the completed individuals' service records and other provided documentation, as well as the completed Monitoring Questionnaires, most of the individuals sampled demonstrated significant maladaptive behaviors. These behaviors had dangerous and disruptive consequences to these individuals and their households, including negative impacts on the quality of these individuals' lives and their ability to become more independent. More specifically, of those sampled, ten (91%) engaged in behaviors that could result in injury to self or others, ten (91%) engaged in behaviors that disrupt the environment and six (55%) engaged in behaviors that impeded his/her ability to access a wide range of environments. In addition, of those sampled, nine (82%)

[1] A twelfth individual (A.D.) was visited while incarcerated at the DeKalb County Jail. He had a history of failed community placements and was awaiting the identification of a residential provider. As noted above, given that a Monitoring Questionnaire was not completed by the reviewer, he was not included within the current sample.

engaged in behaviors that impeded their abilities to learn new skills or generalize already learned skills. Overall, eleven (100%) of the individuals sampled appeared to demonstrate significant maladaptive behaviors that negatively impacted their quality of life and greater independence. The current review also revealed that most of the individuals sampled experienced negative outcomes or required more intensive supports. More specifically, of those sampled, ten (91%) individuals[2] experienced one or more incidents with law enforcement and eight (73%) individuals accessed crisis services, including calling mobile crisis supports and/or admission to one or more Crisis Support Homes. Of those sampled, nine (82%) individuals experienced at least one transfer between settings and nine (82%) individuals experienced an emergency room visit or unexpected hospitalization. Lastly, of those sampled, nine (82%) individuals have displayed one or more incidents of elopement (see Figure 1).

Closer examination of obtained information revealed the following findings:

- Ten (91%) of the individuals sampled experienced one or more incidents with law enforcement. Of these ten, three (30%) and seven (70%) individuals had a single or multiple encounter(s) with police, respectively, and five (50%) individuals were reportedly arrested one or more times (see Figure 2).
- Eight (73%) of the individuals sampled had accessed crisis services, including calling mobile crisis support and/or admission to one or more Crisis Support Homes. Of these eight, all (100%) of the individuals had experienced multiple incidents of crisis support, with six (75%) and three (38%) individuals experiencing previous or current admissions, respectively, to Crisis Support Homes (see Figure 3).
- Nine (82%) of the individuals sampled experienced a transfer between settings. Of these nine, four (44%) and five (56%) individuals experienced single or multiple transfers, respectively, with at least four (44%) individuals transitioning due to their unsafe behavior (see Figure 4).
- Nine (82%) of the individuals sampled experienced an emergency room visit or unexpected hospitalization. Of these nine, four (44%) and five (56%) individuals experienced a single or multiple emergency room visits, respectively, including eight (89%) individuals who were transported at least once to the ER due to their unsafe behavior (see Figure 5).
- Nine (82%) of the individuals sampled displayed incidents of elopement, with two (22%) and seven (78%) individuals demonstrating single or multiple incidents, respectively. Fortunately, only one (11%) individual was reported missing during an elopement incident (see Figure 5).

Overall, of the eleven individuals sampled, only seven (64%) individuals were receiving formal behavioral programming through Behavior Support Plans (BSPs) at the time of the on-site visit. Based on the data provided above, it appeared that all of the individuals would likely benefit from positive behavioral programming and supports implemented within their homes or residential programs (see Figure 1).

[2] One of the individuals reviewed (C.G.) did not have an encounter with law enforcement. She was included in the current sample based on her re-admission to a Crisis Support Home following another community-based placement and because she had previously been reviewed by the reviewer.

- As noted above, of the eleven individuals sampled, seven (64%) individuals had BSPs implemented at the time of the onsite visits. Of these seven, seven (100%) individuals had BSPs that were considered current (i.e., updated or implemented within the last 12 months); however, only six (86%) individuals had BSPs that were actually designed for the setting in which it was currently implemented. Evidence that sampled staff had received training on the BSP was only identified for four (57%) individuals. Lastly, BCBA involvement in the development of the BSP was noted only for four (57%) individuals (see Figure 6).

- As noted above, of the eleven individuals sampled, seven (64%) individuals had BSPs. Of these seven, six (86%) individuals had BSPs that suggested that a Functional Behavior Assessment (FBA) had been completed. However, when closely examined, of the six FBAs described, only four (67%) appeared to utilize descriptive methods of assessment and only four (67%) were completed in the current setting. Overall, only three (50%) FBAs were considered current and complete – this indicated that only three (43%) BSPs were developed using current and complete FBAs. Generally accepted practice recommendations include developing a BSP based on results of a comprehensive FBA completed within the natural environment (current setting), including an emphasis on the use of descriptive (e.g., systematic direct observation) methods, in addition to indirect methods, when identifying and supporting potential hypotheses regarding underlying function(s) of target behavior (see Figure 7).

- As noted above, seven (64%) individuals had BSPs and, in general, individuals with a BSP typically have a corresponding Crisis Safety Plan (CSP). Of these seven individuals with BSPs, seven (100%) were found to have CSPs either as independent documents or crisis strategies integrated within the BSP. In addition, it was noted that one individual (Q.C.) who did not have a BSP, actually had a CSP currently in place. When closely examined, of the eight CSPs, eight (100%) were considered current (i.e., updated or implemented within the last 12 months) and seven (88%) appeared designed for the setting in which it was currently implemented. However, evidence that sampled staff had received training on the CSP was only identified for the plans of three (38%) individuals (see Figure 8).

- As noted above, seven (78%) of the individuals had BSPs. Upon closer examination of these BSPs, it was noted that prescribed behavioral programming appeared inadequate (see Individual Summary of Findings for specific information). For example, as illustrated in Figure 9, of the seven BSPs reviewed, only three (43%) BSPs adequately identified and operationally defined target behaviors. And, evidence of adequate ongoing data collection on these target behaviors was found for only one (14%) BSP. In addition, no (0%) BSPs adequately identified and operationally defined functionally equivalent replacement behaviors (FERBS). And, evidence of adequate ongoing data collection of FERBS was not found for any (0%) BSPs. Overall, evidence of adequate ongoing collection, summary, and regular review of both target and replacement behaviors was not found for any (0%) of the BSPs. And, although seven (100%) and seven (100%) BSPs included antecedent- and consequence-based interventions, respectively, only four

(57%) included strategies to promote replacement behaviors. Lastly, only two (29%) and one (14%) of the BSPs, based on verbal report and direct observation, respectively, appeared to be implemented with a high degree of integrity. Overall, this reviewer noted significant inadequacies in behavioral programming for all of the individuals with BSPs (see Figure 9). It should be noted that, although several sampled FBAs and/or BSPs (e.g., S.S., C.G., D.N., & D.H.) appeared of higher quality than other sampled FBAs and/or BSPs, behavioral programming associated with these plans was limited due to inadequate definitions of target and/or replacement behaviors, inadequate ongoing data collection and/or monitoring of target and replacement behaviors, and inadequate training and/or treatment integrity. Generally accepted practice recommendations include identifying and operationally defining target behaviors and FERBs as well as ongoing data collection and regular review to promote data-based decision making and facilitate revisions, when necessary.

- As noted above, seven (64%) individuals had BSPs. Upon closer examination of these BSPs, it was revealed that only four (57%) were developed with the involvement of a Board Certified Behavior Analyst (BCBA). The BCBA is the nationally accepted certification for practitioners of applied behavior analysis. This certification is granted by the Behavior Analyst Certification Board (BACB), a nonprofit corporation established to develop, promote, and implement a national and international certification program for behavior analyst practitioners.

Note: In the Figures below, 1 means Yes and 0 means No. The item numbers at the top of each column in Figures 1-5, and 9 refer to that question in the Monitoring Questionnaire.

162. Does the individual engage in any behaviors (e.g., self-injury, aggression, property destruction, pica, elopement, etc.) that could result in injury to self or others?

163. Does the individual engage in behaviors (e.g., screaming, tantrums, etc.) that disrupt the environment?

164. Does the individual engage in behaviors that impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, libraries, etc.)?

165. Does the individual engage in behaviors that impede his/her ability to learn new skills or generalize already learned skills?

166. Does the individual engage in behaviors that negatively impact his/her quality of life and greater independence?

189. Has there been police contact?

191. Has there been an emergency room visit or unexpected medical hospitalization?

192. Has there been an unauthorized departure?

194. Has there been a transfer to a different setting from which he/she originally transitioned?

197. Have crisis services been contacted?

Figure 1

Name	BSP	item 162	item 163	item 164	item 165	item 166	item 189	item 191	item 192	item 194	item 197
A.H.	1	1	1	1	1	1	1	1	1	1	1
W.F.	1	1	1	1	1	1	1	1	1	1	1
Z.C.	0	1	1	1	1	1	1	1	1	1	1
S.S.	1	1	1	1	1	1	1	1	1	0	0
C.G.	1	1	1	1	1	1	0	0	1	1	1
D.N.	1	1	1	0	1	1	1	1	1	1	1
J.J.	0	1	0	1	0	1	1	1	0	1	0
Q.B.	1	1	1	0	0	1	1	0	1	1	1
Q.C.	0	0	1	0	1	1	1	1	0	1	1
D.H.	1	1	1	0	1	1	1	1	1	1	1
R.H.	0	1	1	0	1	1	1	1	1	0	0
total (N=11)	7	10	10	6	9	11	10	9	9	9	8
percentage	64%	91%	91%	55%	82%	100%	91%	82%	82%	82%	73%

189. Has there been police contact?

Figure 2

Name	item 189	single event	1+ events	arrest
A.H.	1	0	1	1
W.F.	1	0	1	1
Z.C.	1	0	1	0
S.S.	1	1	0	0
C.G.	0	0	0	0
D.N.	1	0	1	1
J.J.	1	0	1	1
Q.B.	1	1	0	0
Q.C.	1	1	0	0
D.H.	1	0	1	1
R.H.	1	0	1	0
total (N=11)	10	3	7	5
percentage	91%	30%	70%	50%

197. Have crisis services been contacted?

Figure 3

Name	**item 197**	single event	1+ events	previous admission	current admission
A.H.	1	0	1	0	0
W.F.	1	0	1	1	0
Z.C.	1	0	1	1	0
S.S.	0	0	0	0	0
C.G.	1	0	1	1	1
D.N.	1	0	1	1	1
J.J.	0	0	0	0	0
Q.B.	1	0	1	1	1
Q.C.	1	0	1	0	0
D.H.	1	0	1	1	0
R.H.	0	0	0	0	0
total (N=11)	8	0	8	6	3
percentage	73%	0%	100%	75%	38%

194. Has there been a transfer to a different setting from which he/she originally transitioned?

Figure 4

Name	**item 194**	single event	1+ events	due to unsafe behavior?
A.H.	1	1	0	cnd
W.F.	1	0	1	1
Z.C.	1	1	0	0
S.S.	0	0	0	0
C.G.	1	0	1	1
D.N.	1	0	1	1
J.J.	1	1	0	0
Q.B.	1	0	1	0
Q.C.	1	1	0	0
D.H.	1	0	1	1
R.H.	0	0	0	0
total (N=11)	9	4	5	4
percentage	82%	44%	56%	44%

191. Has there been an emergency room visit or unexpected medical hospitalization?

Figure 5

Name	item 191	single event	1+ events	due to unsafe behavior?	item 192	single event	1+ events	missing
A.H.	1	1	cnd	1	1	0	1	0
W.F.	1	0	1	1	1	0	1	0
Z.C.	1	0	1	1	1	0	1	0
S.S.	1	1	0	1	1	0	1	0
C.G.	0	0	0	0	1	0	1	0
D.N.	1	0	1	1	1	0	1	0
J.J.	1	1	0	0	0	0	0	0
Q.B.	0	0	0	0	1	1	0	0
Q.C.	1	0	1	1	0	0	0	0
D.H.	1	0	1	1	1	0	1	0
R.H.	1	1	0	1	1	1	0	1
total (N=11)	9	4	5	8	9	2	7	1
percentage	82%	44%	56%	89%	82%	22%	78%	11%

Figure 6

Name	BSP	BSP is Current	BSP Designed for current setting	Staff were trained on the BSP	A BCBA was involved
A.H.	1	1	1	cnd	0
W.F.	1	1	1	cnd	0
Z.C.	0				
S.S.	1	1	1	1	0
C.G.	1	1	1	1	1
D.N.	1	1	1	1	1
J.J.	0				
Q.B.	1	1	0	1	1
Q.C.	0				
D.H.	1	1	1	0	1
R.H.	0				
total (N=11)	7	7	6	4	4
percentage	64%	100%	86%	57%	57%

Figure 7

Name	BSP	FBA	FBA is current & complete	FBA used descriptive methods	FBA completed in current setting
A.H.	1	1	cnd	cnd	cnd
W.F.	1	1	cnd	cnd	cnd
Z.C.	0	0			
S.S.	1	1	0	1	1
C.G.	1	1	1	1	1
D.N.	1	1	1	1	1
J.J.	0	0			
Q.B.	1	0			
Q.C.	0	0			
D.H.	1	1	1	1	1
R.H.	0	0			
total (N=11)	7	6	3	4	4
percentage	64%	86%	50%	67%	67%

Figure 8

Name	BSP	CSP	CSP is current	CSP designed for current setting	Staff were trained on the CSP
A.H.	1	1	1	1	cnd
W.F.	1	in BSP	1	1	cnd
Z.C.	0	0			
S.S.	1	1	1	1	cnd
C.G.	1	1	1	1	1
D.N.	1	1	1	1	1
J.J.	0	0			
Q.B.	1	1	1	0	1
Q.C.	0	1	1	1	0
D.H.	1	1	1	1	0
R.H.	0	0			
total (N=11)	7	8	8	7	3
percentage	64%	73%	100%	88%	38%

122. Was the proposed hypothesis of function(s) of behavior identified?

124. Were all target behavior(s) adequately defined (e.g., objective, measureable, etc)?

127. Was there ongoing and adequate data collection for all target behaviors?

128. Were replacement behavior(s) based upon the FBA (i.e., functionally equivalent)?

129. Were replacement behavior(s) adequately defined (e.g., objective, measureable, etc)?

132. Was there ongoing and adequate data collection for all replacement behaviors?

133. Were strategies to promote replacement behavior(s) identified?

134. Were preventative, proactive and/or antecedent-based strategies identified?

135. Were consequence-based strategies identified?

146. Did verbal reports from current staff member(s) indicate that the BSP was implemented with a high degree of integrity?

147. Did direct observation of current staff member(s) indicate that the BSP is implemented with a high degree of integrity?

149. Was there evidence (documentation) that target and replacement behavior data had been collected, summarized, and regularly reviewed (at least monthly) by the clinician?

Figure 9

Name	BSP	item 122	item 124	item 127	item 128	item 129	item 132	item 133	item 134	item 135	item 146	item 147	item 149
A.H.	1	1	0	0	0	0	0	0	1	1	0	0	0
W.F.	1	1	0	0	0	0	0	0	1	1	0	0	0
Z.C.	0												
S.S.	1	1	1	0	1	0	0	1	1	1	0	0	0
C.G.	1	1	0	0	1	0	0	1	1	1	1	1	0
D.N.	1	1	1	0	1	0	0	1	1	1	0	0	0
J.J.	0												
Q.B.	1	0	1	1	0	0	0	0	1	1	0	0	0
Q.C.	0												
D.H.	1	1	0	0	1	0	0	1	1	1	1	0	0
R.H.	0												
total (N=11)	7	6	3	1	4	0	0	4	7	7	2	1	0
percentage	64%	86%	43%	14%	57%	0%	0%	57%	100%	100%	29%	14%	0%

Independent Review:
Discharge of Individuals to Shelters and Hotels/Motels

Submitted by Beth Gouse, Ph.D.
August 12, 2018

Purpose: Assess whether individuals being discharged from State Hospitals receive assessment for and consideration of supported housing prior to discharge to a shelter or hotel/motel

Methodology:

- Interviews with individuals in care;
- Interviews with clinical leadership at GRHA and GRHS, including Mr. Coleman, Chief of Social Work-GRHA, Christie Lastinger, Chief of Social Work-GHRS, and Dr. Bashera, Medical Director-GRHS;
- Record review (records of all individuals discharged from GRHA and GRHS to shelters and hotels/motels between January 1 and June 30, 2018;
- Readmission data for individuals discharged to shelters and hotels/motels from GRHA for last two quarters of FY17 and first two quarters of FY18;
- Readmission data for individuals discharged from GRHS for the last two quarters of FY17;
- Review of document titled: Overview: *Strategies for Outreach to State Hospitals, Community Hospital EDs, Jails/Prisons & Homeless Populations;*
- DBHDD shelter discharge reports FY2018.

Findings:

1. **Discharges from GRHA and GRHS to shelters and hotels/motels.**
    a. Compared to the first two quarters of FY18, at GRHA, discharges to shelters in the last two quarters of FY 2018 increased 20% (from 10 to 12) and discharges to hotels/motels increased 30% (from 10 to 13). At GRHS, discharges to shelters increased 112.5% (from 8 to 17) and discharges to hotels/motels remained the same (6). While this reflects an overall improvement relative to the higher percentage of individuals discharged to shelters prior to the policy change that went into effect in FY16, 3rd quarter, requiring review by the DBHDD Medical Director prior to discharge to a shelter, discharge to shelters and hotels/motels has not decreased significantly since the first quarter of FY 18 and, in fact, has increased somewhat. The significant increase in discharges to shelters from GRHS was due to the following factors: lacking a severe and persistent mental illness (SPMI) diagnosis or having a primary diagnosis of substance use and residential substance use treatment beds were not available. In addition, there were a few individuals who were not from the Savannah area and requested to return to their home areas out of state. Unlike at GRHS, individuals discharged from GRHA primarily had SPMI diagnoses and were less likely to have a primary substance use diagnosis.
    b. While significantly more individuals completed the Supported Housing Need and Choice Evaluation Screening Checklist while at GRHS as compared to GRHA, there was evidence of only one of these individuals receiving a voucher following his hospitalization in the last 2 quarters of FY18.
    c. The practice of the shelter committee at GRHS reviewing each request for discharge to a shelter and meeting with the individual continues, yet this process of interviewing with the individual has not yet been instituted at GRHA. Of note is that on at least two occasions, the shelter committee denied the request as the

individual was either not deemed ready for discharge or was willing to wait for an alternative placement.

2. **Readmission data.**
   a. GRHA: As of 7/11/18, 44% of those discharged to shelters **in the last two quarters of FY17** had some type of contact at GRHA (either a brief assessment, a temporary observation unit stay, or an inpatient stay in adult mental health or forensic inpatient unit). Of the 44%, 24% were either readmitted to the adult mental health unit or forensic inpatient unit. Of those discharged to hotels/motels, 20% had some type of contact at GRHA (either a brief assessment, a temporary observation unit stay, or an inpatient stay in adult mental health or forensic inpatient unit.) Of the 20%, 13% were readmitted to the adult mental health unit.
   b. GRHA: As of 7/11/18, 41% of those discharged to shelters **in FY18** had some type of contact at GRHA (either a brief assessment, a temporary observation unit stay, or an inpatient stay in adult mental health or forensic inpatient unit.) Of the 41%, 36% were either readmitted to the adult mental health unit, forensic unit, or to the temporary observation unit. Of those discharged to hotels/motels, 9% had some type of contact at GRHA (either a brief assessment, a temporary observation unit stay, or an inpatient stay in adult mental health or forensic inpatient unit). One of these individuals was discharged to a hotel on 4/19/18 with ACT services. The ACT team began pursuing civil commitment due to noncompliance with treatment in the community due to potential dangerousness to children. The client was placed in a crisis stabilization unit 13 days after his discharge from GRHA to the hotel after he allegedly attempted to lure a child into his room with candy. The hotel supervisor reportedly contacted the ACT team within one hour of his discharge from GRHA due to this incident. The client was readmitted to GRHA on 7/2/18 where he remained as of 7/11/18.
   c. Of note is that stays of 3 days or less in the temporary observation unit are not counted as inpatient admissions, despite being on the grounds of GRHA. In addition, of particular concern is that some of the stays in the temporary observation unit lasted more than 3 days. For practical purposes, these individuals were experiencing significant psychiatric symptoms warranting hospital level of care. Furthermore, of the individuals who had stays on the temporary observation unit, approximately 15% were discharged to a shelter. These discharges are not reflected on the DBHDD Shelter Discharge Report. Please note that this readmission data is only based on readmissions to GRHA and does not include admissions to private hospitals.
   d. GRHS: As of 8/10/18, 33% of individuals discharged to shelters and hotels/motels in the last two quarters of FY17 have been readmitted to GRHS and 20% of those discharged to hotels/motels were readmitted.

3. **Length of stay.**
   a. Average length of stay (ALOS) was also examined to ascertain how length of stay impacts discharges to shelters and hotel/motels. The data in this regard differ significantly between GRHA and GRHS. At GRHA, the ALOS has continued to increase from FY17 to FY18 for those discharged to shelters (FY17-19.25 days,

FY18-36.25 days, reflecting an 88% increase) and to hotels/motels (FY17-21.25 days, FY18-27.25 days, reflecting a 28% increase). Meanwhile at GRHS, the ALOS for those discharged to shelters decreased 26% (from 20 days in FY17 to 14.75 days in FY18). In contrast, for those discharged to hotels/motels from GRHS, the ALOS increased 65% (from 10.3 days in FY17 to 17 days in FY18) (Note that data for GRHS in FY17, quarter 2 was excluded from the calculation because there appeared to be an outlier with a significantly lengthier LOS relative to individuals in any other quarter).

4. **Aftercare follow-up.**
    a. According to the aftercare report, completed by Hospital social workers after discharge, that attempts to determine whether the individual followed up with scheduled aftercare appointment, for those discharged to shelters in the 3rd and 4th quarters of FY18, consistent with data from the first 2 quarters of FY18, the report was completed most of the time. This continues to be an improvement over FY17. However, the overwhelming majority of individuals discharged to shelters and hotel/motels do not follow-up with scheduled aftercare appointments. Furthermore, contrary to what one might expect, having an ACT team or ICM does not result in improved connection to services after discharge, if the placement is a shelter or hotel/motel.

5. **ACT/ICM.**
    a. The number of individuals referred or already receiving ACT and ICM services in the 3rd and 4th quarters of FY18 was similar to those referred or already receiving these services in the first two quarters of FY18. This reflects a continued positive trend as individuals appropriate for these services are receiving or being referred more than in FY16. However, record review does not reveal linkage with these providers, prior to discharge, for new referrals, especially at GRHA. Furthermore, without this support in the community, transition to permanent housing is extremely unlikely as is evident based on the data previously noted about poor rates of aftercare follow-up and high readmission rates.
6. **PATH.**
    a. The review of records clearly reflects efforts by social workers to offer a variety of resources (e.g., PATH, placement in PCH, transitional housing, residential substance abuse treatment, BOSU assistance, ACT, ICM, etc.) during the discharge planning process. However, record review reveals that though these services are offered at both GRHA and GRHS, they are routinely offered earlier in admission at GRHS, resulting in actual linkage with the provider prior to discharge. When the referral is not made, it is typically because the individual refuses the service. Even if the individual refuses, the practice at GRHS is that staff request that the PATH team come to meet with the individual regardless and an effort to engage is at least attempted.

7. **Unit-based discharge planning interventions.**
    a. There continue to be limited unit-based treatment interventions focused on discharge planning and building knowledge of community resources. Numerous

transition planning groups and related skills-based interventions are available in the treatment malls at both GRHA and GRHS; however, the majority of individuals do not attend the treatment mall during the initial weeks of admission. Aside from the Peer Mentor project at GRHA, the writer is unaware of any additional initiatives focused on improving linkage to community providers.

8. **Recovery Treatment Plan.**
   - **a.** The recovery plan form was revised and rolled out in AVATAR in October 2017. Training on the revised IRP manual and clinical chart audit tool was held on May 21, 2018. It is unclear whether the revised form will assist with developing more focused, individualized objectives and interventions geared towards transition and successful community placement. Recovery plans reviewed for this report did not reveal significant differences in either the individualized goals and objectives or changes from one treatment plan to the next. However, there was evidence that the present status section of the treatment plan was updated. This training was attended by a host of multidisciplinary staff. It is unclear whether data from the clinical chart audit tool are available yet.

9. **Benefits/Entitlements.**
   - **a.** The benefits application process continues to be a challenge. While the record review revealed some progress with the procurement of IDs, there was evidence that some individuals still do not have IDs despite the longer lengths of stay. Some of this is due to the difficulties associated with procuring birth certificates for individuals from out-of-state. According to documentation provided by this reviewer, DBHDD and the GRHA Collaborative identified this issue as a focus of attention; however, it is unclear what procedures have been developed as a result.

10. **Communication**.
    - a. Communication between Hospital staff and community providers is variable. GRHA has more challenges in this regard due to the larger number of providers and the increased turnover of social work staff and the reliance upon contract staff. Documentation provided to this reviewer identifies collaboration between DBHDD regional staff and GRHA staff focused on, among other things, improving community provider involvement. Scheduling joint training and "meet and greet" opportunities were identified as action steps. It is unclear how these initiatives are being implemented or how the progress is being monitored/measured. At GRHS, the record review revealed evidence of communication between social work staff and DBHDD regional staff around the Supported Housing Need and Choice Evaluation Screening. In addition, PATH staff and Crisis Respite Apartment program staff have weekly standing appointments at GRHS, making it more likely that linkage to these programs occurs.

Concluding Comments:
The number of individuals discharged to shelters and hotels/motels has remained stagnant or slightly increased since the first quarter of FY18. This occurs even though the length of stay has significantly increased from FY17 to FY18.

At GRHA, although referrals to PATH have increased over time, linkage to PATH does not routinely occur prior to discharge because referral is often made just prior to discharge as opposed to early in the admission. At GRHS, referral to PATH occurs earlier in admission, allowing for linkage to happen prior to discharge more routinely.

Staff at both GRHA and GRHS consistently offer a wide variety of services to individuals but many refuse. Increasing use of peer mentors and on–unit programming focused on community resources should help in this regard. While there are more peer mentors, on-unit programming has not significantly changed.

The document titled: Overview: *Strategies for Outreach to State Hospitals, Community Hospital EDs, Jails/Prisons & Homeless Populations* identifies a number of strategies to improve discharge planning and coordination between hospitals and community providers. The document details three goals and nine objectives with the first review to be completed in July 2018. It is unclear whether this review was completed and/or what progress has been made towards implementation.

Based on the record review of all individuals discharged to shelters and hotel/motels in FY18, this writer is aware of only two individuals who transitioned to supported housing with a GHVP. Given the high readmission rates and that individuals referred to shelters, hotels and motels rarely follow-up with treatment following discharge, even those with ACT and ICM, this resource will continue to be underutilized unless current practices are substantially changed.

Independent Review:
Discharge Planning for Forensic Clients In State Hospitals

Submitted by Beth Gouse, Ph.D.
August 12, 2018

Purpose: Assess whether individuals being discharged from State Hospitals with a legal status of IST/CC (Incompetent to Stand Trial/Civilly Committed) and NGRI (Not Guilty by Reason of Insanity) receive assessment for and consideration of supported housing prior to recommendation for discharge.

Methodology: This review included interviews with individuals in care, clinicians, as well as interviews with clinical leadership and data provided by Dr. Karen Bailey, the Director, Office of Forensic Services (e.g., list of individuals with DD who remain hospitalized, census data). For the current report, limited records were reviewed for individuals with a legal status of IST/CC and a legal status of NGRI at CSH. Specific forms reviewed included multidisciplinary assessments, recovery plan documents, risk assessments, annual Court letters, and Forensic Review Committee (FRC) documentation.

Findings:

1. **Discharge Planning.**
    - **a.** The discharge planning process for forensic individuals requires additional requirements (e.g., more comprehensive risk assessments, presentation to Forensic Review Committee (FRC) and FRC approval, etc.) in order to determine readiness for increased privileges and graduated release, subject to Court-required approval. Since the prior report in February 2018, documentation reflects continued efforts by staff to move individuals towards discharge. Individuals reviewed at CSH in 2017 were reviewed on July 13, 2018 and a number of these individuals have since been discharged. Furthermore, data provided by DBHDD indicate that the majority of time, the Court agrees with the Hospital's recommendation for release. For example, currently, there are reportedly only eight individuals whom the Hospital recommended for release and the Court disagreed.
    - **b.** Discharge planning reflected in recovery plans does not always reflect individualized goals and interventions that change when the individual is not progressing towards discharge or that the interventions actually focus on the skills necessary for successful outplacement. The recovery plan form was revised and rolled out in AVATAR in October 2017. Training on the revised IRP manual and clinical chart audit tool was held on May 21, 2018. It is unclear whether the revised form will assist with developing more focused, individualized objectives and interventions geared towards transition and successful community placement. Recovery plans reviewed for this report did not reveal significant differences in the individualized goals and objectives identified in one treatment plan to the next. However, there was evidence that the present status section of the treatment plan was routinely updated. A clinical chart audit tool has been developed but aggregate data about findings regarding quality of discharge planning has not been provided.
    - **c.** DBHDD provided data about the current individuals with DD who remain hospitalized: 20/35 (57%) of DD individuals with a legal status of IST/CC are being recommended for discharge. This is essentially the same number of individuals being recommended for discharge as indicated in the prior report. Of

the five NGRI individuals still hospitalized, four (80%) are being recommended for discharge. In the last report, there were eight NGRI individuals being recommended for discharge. DBHDD did not provide data about whether the Court was in agreement with discharge recommendations, as had been previously provided. In addition, data provided indicated that providers were only identified in 13 of the 24 individuals being recommended for discharge, suggesting that finding providers willing to accept some of these individuals is a challenge. This was evident in a few of the records reviewed. For example, one individual with moderate ID has been meeting with various providers for the past six months.

2. **Timeliness of documentation.**
    a. Consistent with this evaluator's prior report, completion of recovery plans, risk assessments, Forensic Review Committee (FRC) meetings, and annual Court letters are generally occurring in a timely manner and, therefore, not contributing to delays in discharge planning. There are monthly meetings between the DBHDD Forensic Director and specific Hospital Forensic Directors, as well as consultation on an as needed basis. There continue to be some documentation-related delays associated with the Court, as evidenced by delays in scheduling court dates for hearings, delays in receiving correspondence (e.g., Court order allowing expansion of privileges, conditional release, etc.), as well as occasional instances when the Court disagrees with the Hospital's recommendation for conditional release. For example, according to data provided by DBHDD, there are currently 65 individuals whom the hospital has recommended for release whom are awaiting a court date.

3. **Civil Commitment.**
    a. Inpatient civil commitment remains the more commonly recommended type of commitment. Though this decision is ultimately the Court's, efforts to educate the Court about available community resources for monitoring and support does not appear to be increasing the use of outpatient commitment. According to Dr. Bailey, the number of individuals recommended for outpatient commitment remains approximately the same in FY18 as in FY17.

4. **Court Interface/Education**.
    a. The assignment of forensic community coordinators in 2016 continues to have a positive effect on increasing the Court's willingness to order release into the community, in large part due to the increased awareness of the Court on monitoring capabilities in the community. However, there is an overreliance upon use of Community Integration Homes (CIHs) due to the 24 hour supervision when less intensive supervision options may be appropriate. Continuing to educate the Courts is critical to increasing awareness of other community-based resources.
    b. Efforts to educate the Court regarding community resources continue and are discussed below. Since the last Independent Reviewer's report, the following trainings have been provided to Court-related personnel:

Gwinnett criminal defense section on March 16, 2018;
Rockdale Circuit Public Defenders on April 26, 2018;
Southwestern Judicial Circuit Prosecutors on May 17, 2018;
Flint Circuit Public Defenders on May 18, 2018;
Rockdale Circuit Bar Association (CR and civil commitment) on June 8, 2018;
Griffin Judicial Circuit Prosecutors on July 10, 2018;
Peace Officer Association of GA –scheduled for week of August 13, 2018.

5. **Housing Resources.**

a. Forensic legal status data indicate that while the overall census has remained relatively stable, the number of individuals with a NGRI legal status continues to decrease, while the number of IST restoration individuals continues to increase. See table below: As of 2/23/17-As of 1/1/18-As of 8/1/18:

Legal Status	CSH	ECRH	GRHA	GRHS	WCGRH	Total
Pretrial	4/7/4	2/3/0	5/1/3	3/4/4	2/1/2	16/16/13
IST restoration	54/56/67	20/17/26	83/86/82	29/33/38	41/51/53	227/243/266
IST/CC	68/63/65	28/31/28	17/18/19	50/51/50	59/54/49	222/217/212
NGRI	54/47/37	14/15/13	14/13/11	27/20/16	42/42/44	151/137/121
Total	180/173/173	64/66/67	119/118/115	109/108/108	144/148/148	616/612/611

Though not reflected in this table, Dr. Bashera also reported that the percentage of individuals transferred from jails for treatment at GRHS has increased from about 3% to 12% in the past four years. This is consistent with the national trend of the increasing number of individuals with mental health issues currently housed in jails and the importance of linking these individuals to services in the community.

b. Availability of supported and supervised housing remains a factor delaying discharges. According to Dr. Bailey, there continues to be a waiting list for Community Integration Homes (CIH), likely due to an overreliance on this resource by judges because of the 24-hour supervision in this setting. As of June 30, 2018, 4 of the 61 slots were unfilled so this is a significant improvement in the 80% operating capacity noted in the prior report. In addition, there are currently 30 individuals on the waiting list for a CIH, including those making transition visits. This is a significant increase over the seven identified as being on the waiting list at the time of my last report. The overreliance on CIHs for outplacement and the associated wait list result in increased lengths of stay in the hospital setting. For example, one individual has been successfully using community privileges since October 2017. He went to court on May 23, 2018 and the Court agreed he is ready to reside in the community. However, as of July 13, 2018, his application for a CIH had not yet been submitted.

c. With respect to the forensic apartment slots, there are 51 slots, up from 48. As of June 30, 2018, the apartments in Athens and Albany were operating at close to capacity each month between January 2018 and June 2018. In contrast, the

apartments in Valdosta and Savannah were operating between 60% and 87% capacity between January 2018 and June 2018. Six individuals are in the process of making transition visits and there is not a waiting list for this type of residential placement. While still somewhat underutilized, these capacity ratios are an improvement over the data provided for the last report indicating an increase in discharges to this setting. Also of note is that both of these types of residential placement options are serving individuals with a legal status of NGRI or IST/CC.

d. According to data provided by DBHDD, out of 125 individuals (67 IST/CC and 58 NGRI) discharged in Calendar Year 2017, **4** (1 individual with IST/CC legal status and 3 individuals with NGRI legal status) were discharged to a housing program (defined in policy as GHVP). (See table below).

CY Discharge	2017				
	legal category				
D/C location	cc-IST	IST - rest	NGRI	pretrial	Grand Total
Community Residence	2	4	5		11
FAMILY HOME - WITH RELATIVES	5	17	3	4	29
GROUP HOME	24	16	32	1	73
HOME - WITHOUT RELATIVES			2	1	3
Hospice	1				1
Housing Program	1		3		4
JAIL	8	321	5	47	381
Medical Inpatient Facility	3				3
Nursing Home	9	3	4		16
PCH	14	2	4		20
SHELTER		2			2
Grand Total	**67**	**365**	**58**	**53**	**543**

In the table below, only two individuals are reported as receiving a GHV.

Forensic Discharges by Location. January 1. 2018 through June 30, 2018

	Legal Status				
Discharge to:	**cc-IST**	**IST- rest**	**NGRI**	**pretrial**	**Total**
Crisis Apartment		1			**1**
FAMILY HOME – WITH RELATIVES	1	11	1		**13**
GROUP HOME	18	4	17		**39**
Housing Program			2		**2**
JAIL	3	190	1	26	**220**
LICENSED PERSONAL CARE HOME	7		3		**10**
Medical Inpatient Facility	1		1		**2**
RESIDENTIAL TREATMENT PROGRAM	2		7		**9**
Nursing Home	5	6	3		**14**
Total	**37**	**212**	**35**	**26**	**310**

Clearly, this is a significantly underutilized option. In addition, while DBHDD has reported that individuals step down from CIHs and forensic apartments to live with family, GHVP apartments, and nursing homes, the numbers that step down to these settings are still not being tracked. As a result, individuals are discharged

primarily to supervised settings as opposed to more independent living settings with wraparound services.

6. Concluding Comments

The timeliness of recommendations for discharge for individuals with a forensic legal status have improved over the past few years. However, there continue to be some Court-related delays as far as timely response to recommendations.

The use of peer mentors has increased and there was evidence in the record review of the positive impact these staff have on helping individuals move towards discharge.

Though Hospitals are routinely completing thorough risk assessments that inform discharge planning, development of specific risk-reduction strategies and related skill development are not always evident in the recovery plans.

Use of community integration homes (CIHs) is most commonly the discharge setting recommended by Hospitals. While this is certainly appropriate for many individuals from a risk perspective, there are a number of individuals who could live in a less supervised setting with additional wrap around services and supports, but this is typically not viewed as a viable option as an initial placement from the Hospital. As a result, the overreliance upon CIHs results in unnecessarily long extended Hospital stays for some individuals because of the lengthy wait list. In addition, even when the Court approves release, there are challenges with finding providers willing to accept some individuals and the lack of specific timeframes for completion of referral packets, interviews with providers, and provider response to referrals adds to the longer length of stay.