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

JOINT NOTICE OF FILING OF THE REPORT OF THE INDEPENDENT REVIEWER

On October 29, 2010, the Court adopted the parties' Settlement Agreement and retained jurisdiction to enforce it. *See* Order, ECF No. 115. On May 27, 2016, the Court entered the parties' Settlement 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 behalf of the Independent Reviewer, the parties hereby file the attached *Interim Report of the Independent Reviewer*, dated August 19, 2019.

Respectfully submitted, this 19th day of August, 2019.

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CERTIFICATE OF SERVICE

I hereby certify that on August 19, 2019, a copy of the foregoing document, *Joint Notice of Filing of the Report of the Independent Reviewer*, was filed electronically with the Clerk of Court and served on all parties of record by operation of the Court's CM/ECF system.

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INTERIM REPORT OF THE INDEPENDENT REVIEWER

In The Matter Of

United States v. Georgia

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

August 19, 2019

Introductory Comments

This is the fifteenth report submitted to the Court in this case. It is written at a critical juncture.

In a letter dated January 8, 2019, the State requested that the U.S. Department of Justice terminate the Settlement Agreement (SA) and the Extension Agreement (EA), citing "remarkable progress, and given the substantial compliance that Georgia has achieved."[1] A second letter, dated March 11, 2019, reiterated that request and provided additional detail about the State's assessment of its compliance.[2] The Independent Reviewer makes reference to the State's assertions in these letters throughout this report.

The Independent Reviewer understands that the Parties have agreed that they will continue to work together collaboratively going forward to address any outstanding issues where there is dispute about substantial compliance with the Agreements. If this is true, the Independent Reviewer pledges to work with the Parties to help with next steps.

As documented in the Independent Reviewer's previous reports, since the execution of the SA in late 2010, the State has indeed implemented many important structural and programmatic reforms in its system of supports for individuals with a developmental disability (DD) or a Serious and Persistent Mental Illness (SPMI). Admissions to State facilities for individuals with DD have effectively ended. The State reports that there have been 640 individuals with DD transitioned from one of the State Hospitals to community-based settings. Community-based services, such as support coordination/case management, crisis teams and crisis beds, small group residences and independent apartments with supports, and assertive community treatment teams, are now established throughout the State. In addition, the framework for monitoring these community-based services has been developed and numerous policies have been revised; the investigation process and quality assurance projects are maturing. The Governor and the General Assembly have ensured a substantial investment of resources and have appointed well-qualified leadership to manage the reforms. The continuity of the present leadership at the Commissioner level has been particularly important; the systemic reform compelled by the SA and EA requires a clear commitment to the values inherent in community-based services, strategic thinking and an openness to explore and implement evidence-based practices. The current Commissioner has continued to demonstrate these strengths. It is equally important that the resources essential for systemic reform remain available for use; a significant reduction in the funding for the obligations contained in the SA and EA will jeopardize the progress and sustainability of important initiatives.

The State's accomplishments to date are commendable; they have provided the opportunity for integration into typical community-based experiences rather than indefinite, prolonged, and unjustified segregation.

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[1] Governor Nathan Deal to Assistant Attorney General Eric S. Dreiband, January 8, 2019.
[2] Attorney Josh Belinfante to Assistant Attorney General Eric S. Dreiband, March 11, 2019.

Nonetheless, in the Independent Reviewer's professional judgment, there remain numerous specific obligations in the Agreements that have not been fulfilled, as required, for a recommended finding of Substantial Compliance. The reasoning and basis for this conclusion is set out in this report. Unfortunately, the State's assertions do not always reflect current facts and are sometimes inconsistent with the legal requirements in this case.

The SA and EA, still under Court supervision, require the Independent Reviewer to issue compliance reports; the EA increased the reporting to semi-annually (EA 42). As always, the Independent Reviewer tries to determine if the State is in Substantial Compliance with the SA and EA provisions, including the overarching stated intent of the Parties:

> 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.).

Given the current posture of the case, fieldwork had been delayed until recently. In light of the assertions in the State's letters and with the intent to provide substantive information for the Parties' future discussions, this Interim Report is focused primarily on provisions with a recommended finding of Non-compliance in the last comprehensive Report to the Court, filed on September 19, 2018, and in the Supplemental Report on Supported Housing, filed on December 21, 2018.

As always, the guidance provided by the Attorneys for the United States and the State of Georgia is greatly appreciated. The Department of Behavioral Health and Developmental Disabilities (DBHDD) has continued to provide information; the Director of Settlement Coordination and her Administrative Assistant have been notably responsive to multiple requests. Stakeholders throughout Georgia have continued to offer valuable insight and to serve as a reliable resource. Their collaboration continues to be essential.

The Parties were given an opportunity to comment on the draft version of this report. All comments were considered carefully and revisions were made as needed to ensure accuracy.

Methodology

The discussion in this report builds on a foundation of nine years of fact-finding in Georgia and the completion of fourteen previous reports to the Court, filed each year since October 2011. In each of these reports, there has been analysis of the State's compliance with the provisions of the SA and then the EA. The Independent Reviewer's work has been, and continues to be, informed by information and data provided by the State; conversations and extended discussions with myriad stakeholders; direct observation in both community-based and institutional settings throughout the entire state, including State Hospitals, public hospitals, jails and shelters for homeless people; and the expertise of subject matter consultants.

Since execution of the SA in late 2010, the Independent Reviewer and her consultants have completed reviews of at least 292 individuals with DD; at least 52 individuals were reviewed more than once.

Because of the current posture of this case, recent site visits to Georgia have been limited. Nonetheless, fact-finding has been continuous and ongoing but, since January 2019, has relied more heavily on information gathered through document review and telephone communication with various stakeholders.

The State has worked hard to reply to requests for documents and information. Nonetheless, the data provided by DBHDD have not always been entirely reliable; inconsistencies and conflicting information have been noted in multiple submissions. As a result, some of the State's numbers included in this report must be considered approximate. The Independent Reviewer confirmed numbers as much as possible by such methods, for example, as counting by hand and cross-referencing with previous documents.

The Independent Reviewer completed site visits in June 2019; they were focused on community residences for individuals with DD and included meetings with stakeholders in DBHDD Regions 2, 4 and 5. (These Regions include the greater metropolitan Macon area, southwestern and southeastern Georgia.) Numerous documents were examined, including critical incident reports and investigations, both in preparation for the site visits and after they had been completed. The Independent Reviewer had requested documents related to individuals in the Target Population who were both randomly selected and chosen because of the nature of particular recent incidents. The community residences were selected for review based on the details of critical incidents and on investigations with findings of deficient practices. The Independent Reviewer met and/or interviewed a total of 50 staff, family members, individuals with DD or SPMI, and advocates during the work conducted for and from the site visits.

The Independent Reviewer conducted an in-depth review of death investigations based on the documents provided for 59 individuals with DD. The deceased individuals were selected for review as follows:

- 39 individuals, who died between March 1 and June 30, 2018;
- Of the 292 individuals reviewed by the Independent Reviewer, 51 individuals have since died; 10 of these individuals (20%) were included in the review of deaths;
- Ten additional deaths were included based on the deficient practices cited in the Clinical Mortality Reviews completed by DBHDD.

In order to gain a clearer understanding of the more recent reports, 16 additional deaths were selected from investigations completed between April and June 2019. These investigations were analyzed for timeliness only.

The Independent Reviewer's specific findings for each of the 59 death investigations have been forwarded to the Parties in a separate document.

Provisions Related to Individuals with DD

Since the execution of the SA in late 2010, the State reports that 640 individuals with DD have been transferred from State Hospitals to community-based residences; the vast majority of these transitions were to typical houses in ordinary neighborhoods. DBHDD has substantially complied with the SA obligation to limit the number of individuals placed into group residences to four or fewer and to place no more than two individuals in Host Home settings. Adherence to this specific standard about size is important; the State's efforts to maintain smaller residential settings have been and continue to be recognized and applauded.

It became evident, however, even in the early years of the SA, that serious deficiencies were present in certain residences under the responsibility of certain provider agencies. These deficient practices presented a clear risk to individuals' health and safety. As a result, the Commissioner of DBHDD at the time wisely halted transitions on two separate occasions in order to bring about remedial actions and reduce the potential for risk to vulnerable individuals.

The language in the EA seeks to address concerns about individual risk. In fact, additional obligations were included in the EA to prompt DBHDD to better recognize the factors that lead to serious risk; to identify individuals with DD at heightened risk due to medical or behavioral concerns; to require the design and implementation of effective strategies to address individual risk; and to monitor and deter deficient practices before harm could occur in any community-based setting.

As documented in previous reports, the State's efforts to date have been only partially successful. Although DBHDD has added new resources, strengthened policies, offered training to staff, and attempted to more closely scrutinize adverse circumstances, there remain major gaps in processes, practices, and oversight that continue to contribute to the potential for harm. The State has struggled to implement its reforms on the ground and on a systemic basis; in fact, there are little data available about its systemic efforts. Unfortunately, as the State's own investigations into critical incidents and deaths continue to demonstrate, deficient practices, including substantiated neglect, still occur. The State has concluded that there are preventable deaths occurring in the State system, often the product of confirmed neglect by community provider staff. These deaths reveal that the system is too often unable to meet the needs of people with heightened support requirements. There are recent examples where the State's own Clinical Mortality Reviews found serious concerns with the ability of certain provider agencies to provide adequate services to people with DD; these investigations concluded that many deaths were "unexpected" and often identified substantiated neglect and other deficient practices. Since all investigations are completed by the State's own certified investigators, many of who are clinical professionals like registered nurses, the reliability of these negative findings is underscored. To be clear, not all deaths have been determined preventable; many reviews conclude that care was appropriate. But even one preventable death is too many. The State needs to do more to minimize or eliminate preventable causes of illness and death in this group.

Identifying and Safeguarding High Risk Individuals

In the EA, the State agreed to provide needed services and supports to individuals with DD in the community (EA 13). The State is to identify, assess and monitor them, per EA criteria. This obligation applies to people with DD regardless of whether they once lived in a State Hospital and regardless of whether they have a complex condition with heightened health and/or behavioral risks (EA 13). If an individual has been identified as having heightened health and/or behavioral risks, more is required.

The EA divides the DD population into two groups – those who transitioned to the community from a State Hospital and those who never lived in a State Hospital but nonetheless receive community-based Waiver services in the State's system. The latter group is much larger than the former group: the State reports that it has transitioned 640 people from State Hospitals to the community since the execution of the SA in 2010, and that there are over 12,000 people getting community-based Waiver services in the State's system.

For the former group, the EA requires the State to "maintain a High Risk Surveillance List" (HRSL) that includes all individuals with DD who have transitioned from the State Hospitals to the community during the term of the Settlement Agreement and this Extension Agreement" (EA 14). The State has complied with the EA obligation to maintain the HRSL but, as discussed below, cannot provide sufficient assurances that its system addresses individual risk, especially when someone is in decline or active crisis, according to the time parameters of the EA.

In addition, according to the EA, the State is to provide technical assistance and mobile response to help providers and Support Coordinators meet the needs of the latter/larger group who are at high risk; the interventions are termed Statewide Clinical Oversight (SCO) and are to be done in a timely manner, as required by agreed-upon EA criteria (EA 15).

Regardless of HRSL or SCO category, the EA requires the State system to respond, in certain defined ways within certain time parameters, to individuals with high risks who may be in decline or crisis. For example, the State system is to respond "immediately" when the situation is an emergency or is life threatening; the system is to respond "within 24 hours" when health is deteriorating.

The State has provided some limited data and information on the HRSL group, but very little information with regard to the larger SCO group. The State has never been able to provide sufficient SCO data and information for the Independent Reviewer to assess whether or not the State is in substantial compliance with the EA. The State has informed the Independent Reviewer, for well over a year now, that it is in the process of creating an operational SCO database, but it is clear that the database is still a work in progress, not yet fully operational, and not yet producing system-wide SCO data. In June 2019, the State responded to several Independent Reviewer queries about the database. The State

reported that the database could perform some limited functions right now, but that it was not fully operational. The State admitted, "DBHDD does not have the capacity to complete a hand validation for deliverable [EA] 15. Deliverable [EA] 15 can only be completed by an IT solution; IT projects to link data systems are currently being pursued."

Because the State's database is not fully operational, the State cannot provide the Independent Reviewer with accurate data on the timeliness of the State system's response to someone with high risk, who is in decline or crisis. Therefore, it is not possible to know whether the EA's specific timelines for response to an emergency/life threatening situation or a deteriorating health situation are actually met.

In the State's letters to the United States, the State provided no hard data and no specifics regarding the agreed-upon EA criteria related to DD services. The letters do not include any information on the timeliness of the State system's response at the different levels of severity; there are no summary data documenting the responders to each of the listed situations. The Independent Reviewer has repeatedly asked the State for such data, but the State has never been able to provide it, simply because DBHDD does not have it. The State needs to have these data in order to be able to operate and evaluate a successful and effective system that meets the needs of vulnerable people.

Furthermore, the EA requires the State to provide those on the HRSL or those receiving SCO, who have unresolved issues, with in-person assessments and/or consultations by registered nurses or other clinical professionals in order to help address the identified problems (EA 14, 15). The State has failed to provide sufficient data and information for the Independent Reviewer to assess whether or not the State is in compliance with the EA in this regard.

Given the extreme lack of systemic data and information about people in the Target Population on the HRSL or SCO list, the Independent Reviewer is left with little other than site visits to try to gain an understanding of how the State system is operating. For example, during the Independent Reviewer's most recent visits, the Independent Reviewer found:

- In a residence with medically complicated individuals, J.P. showed signs of serious weight loss due to bulimia. In January 2018, his weight dropped from 117 to 84 pounds. Despite repeated requests, it took over two months to obtain a clinical consultation. Since the consultation, this man's weight has stabilized at 100 pounds but he still requires close monitoring. In this area of the State, there is a serious shortage of nutritionists and dieticians, according to the Registered Nurse working in this residence.

- In four separate residences for individuals with significant medical or behavioral needs, direct support staff persons were asked if they were aware of the SCO protocol and its specific timeline requirements. None of the staff knew of these requirements. Support Coordinators for these four residences were also asked this

question. Only one of the Support Coordinators had heard of and read the SCO protocol.

The clinical work conducted by the State's Integrated Clinical Support Team (ICST) -- CRA Consulting -- has been well received by provider agencies responsible for individuals with either identified or potential risks. However, these resources are limited and, by report, are focused primarily on individuals with DD who are transitioning from State Hospitals or who have recently moved to a community residence. Its impact has been limited, as the ICST waits for referrals and does not move proactively to find individuals who are at risk and showing signs of impending decline. During the fieldwork completed for this report, providers who support individuals at high risk stated that there were insufficient clinical resources in Region 4; occupational and physical therapy practitioners, nutritionists and speech/language therapists are not available, as needed.

- Ongoing unresolved staffing problems, including turnover and the lack of requisite skills, contribute to an unstable and potentially unsafe environment for four gentlemen with significant medical and behavioral needs living in a community residence. This residence has been open for just over a year; there have been problems documented since the beginning. It has been substantiated for neglect. Despite the ongoing attention and diligence of the regional office and the continuation of periodic visits by the ICST, significant gaps remain in the implementation of behavioral supports for B.J., who is at risk of pica, food stealing and elopement. The local agency responsible for the oversight of behavioral programming for B.J. has failed to provide adequate monitoring of his Behavior Support Plan. Despite the assignment of one-to-one staffing, B.J. has experienced several adverse circumstances that placed him at risk of injury. There continues to be serious concern about this residence and the potential for harm that persists.

Despite the development and maintenance of the HRSL and SCO lists, the issuance of a statewide protocol, and the existence of the ICST, there remain serious impediments to protection from harm for individuals with DD in community settings throughout the State. These impediments have been described in previous reports filed with the Court. In addition, consultants retained by DBHDD have identified gaps in resources and strategies. For example, DBHDD has contracted with the Center for START Services, a well-regarded consulting group. In 2017, it conducted a gap analysis of Georgia's mental health and developmental disability services. Its 2018 report identified a list of concerns generated through conversations with stakeholders and an examination of available supports. The report concluded:

- Georgia may currently lack the capacity to fully address the mental health needs of people with IDD;
- There may be a need to improve the effectiveness of crisis response resources and services;

- IDD services may need improvement to better serve individuals who have co-occurring mental health conditions; this includes information and collaboration to improve access to available services.

The concerns raised in the START report remain largely unresolved. In its June 2019 response to the Independent Reviewer's requests, the State listed a number of internal initiatives, such as team meetings for information sharing and collaboration, but nothing about implementation in community settings, where members of the Target Population live. The State acknowledged that the "work is ongoing." The State reports that it entered into a new contract with START, on April 1, 2019, for START to provide training, consultation, and technical assistance. Regional CEU (Continuing Education Unit) training either has not yet begun or may have just started. According to the State's June 2019 response, other training and activities have not yet been scheduled--"[t]imelines for these next steps are to be determined."

Although this response to the gap analysis is positive, the work is only in its early stages. Collaborative teams were formed in September 2018 to address workforce development/training, service/program development and policy/practice/organizational structure, but implementation of critical remedial measures has not yet occurred.

Examination of existing problem areas confirms that substantial effort is still required statewide. For example, the most recent State report reveals that more than two-dozen individuals with DD have remained in crisis respite homes for greater than 30 days; there has not been a provider identified for 15 of these individuals. This has been a recurring problem for the last several years. Individuals with DD and a mental health diagnosis also too often remain in State Hospitals due to a lack of community-based options. The most recent SCO list documents that 257 individuals with DD had at least one "Behavioral Crisis involving Law Enforcement."

The lack of readily available resources is problematic, but so is the lack of expertise in certain provider agencies. For example:

- T.C. has a history of falls. Since January 27, 2018, there have been seven falls documented in critical incident reports. Visits to the Emergency Room were required in at least six falls; staples and sutures were required to repair lacerations in two incidents. The HRST score for Mr. C. is 6. There is no evidence of a fall prevention protocol. Mr. C. is assigned one-to-one staffing within line of sight. However, given the repeated history of falls, there has not been any consultation requested for a review of antecedents to the falls, the need for environmental adaptations, or the need to adjust staffing at certain times. When queried, the agency staff responsible for his health and safety could not identify anything more that should be done to ameliorate his risks.

In November 2018, DBHDD completed an analysis of "Elevated HRST Risk and Incidence Rates of Negative or Adverse Outcomes for DBHDD IDD Individuals." This

thoughtful report is an example of information that could useful in evaluating performance.

Based on the facts cited above, a finding of Non-compliance continues to be recommended for EA 13, EA 14 and EA 15.

Support Coordination

For this section on Support Coordination, the State's implementation of two provisions from the EA were reviewed:

- No later than June 30, 2017, the State shall provide Support Coordinators with access to incident reports, investigation reports, and corrective action plans regarding any individual to whom they are assigned. Support Coordinators shall be responsible for reviewing this documentation and addressing any findings or gaps in services or supports to minimize the health and safety risks to the individual. (Support Coordinators are not responsible for regulatory oversight of providers or enforcing providers' compliance with corrective action plans.) (EA 16.d).
- The caseload size for Support Coordinators shall be a maximum of 40 individuals. The caseload for Intensive Support Coordinators shall be a maximum of 20 individuals (EA 16.e).

Information about the performance of Support Coordinators was gathered through: the review of documents and data provided from DBHDD, including the "Support Coordination Services Performance Report, CY 2018," published in June 2019; interviews with Support Coordination agency staff, including Support Coordinators; and the findings of critical incident reports and investigations.

Support Coordinators are notified of a critical incident by the provider agency. The date and time of notification are found on the Critical Incident Report (CIR) form. Investigation reports and Corrective Action Plans (CAPs) for a person on their caseload are sent to the Support Coordinator by his/her supervisor, if one is received. Support Coordinators attempt to remedy any cited deficiencies by coaching provider staff and, if necessary, referring more serious risks to DBHDD or to clinical staff. DBHDD has reported, "Support Coordinators initiated and followed up on 25,591 coachings and referrals to improve the services, supports, and outcomes of individuals they serve."[3]

The EA and SCO protocol require a Support Coordinator to adhere to response time expectations, depending on the severity of the individual concern. The State provided the Independent Reviewer with no data to indicate whether there is compliance with these expected timeframes. Based on the Independent Reviewer's interviews related to the recent site visits, it is not clear that Support Coordinators are actually knowledgeable about the timeframe expectations.

[3] Performance Report, page 20.

The Independent Reviewer's review of investigations also revealed that some Support Coordinators might not perform their duties as expected in identifying and addressing risks in a timely manner. Deficient practices related to the duties of the Support Coordinator were cited in certain investigations. However, Corrective Action Plans (CAPs) were not consistently required of the Support Coordination agencies. This finding requires further examination by DBHDD.

Additional review of the facts related to EA 16.d. is required in order to determine a current recommended finding for 16.d. It does appear that access to incident and investigation reports has been improved and that coaching/referrals do occur. It is not as clear that the Support Coordinator's actions are timely and thorough without the systemic data and information that the State has failed to provide and/or examining in depth a representative sample of individuals with identified health and safety risks.

DBHDD provided a list of Support Coordinators by agency and included the number of individuals with DD on each caseload. It is undisputed that there has been a substantial investment in Support Coordination. At the time of this report, there were 420 Support Coordinators employed statewide.

The Independent Reviewer hand counted the State-supplied caseloads, analyzed the data, and determined compliance as follows:

Support Coordination Agency	Number of SCs	In Compliance	Percent Compliance
Agency 1	33	32	97%
Agency 2	11	11	100%
Agency 3	131	121	92%
Agency 4	12	10	83%
Agency 5	109	93	85%
Agency 6	49	49	100%
Agency 7	75	63	84%

There are no allowances in the EA for averaging caseload size. Based on the above data, there are three of seven agencies (43%) that do not achieve at least 90% compliance. In these instances, the caseloads exceeded the required limits by one to eight assigned individuals.

A finding of Non-compliance is again recommended for EA16.

Crisis Respite Homes

Provision 17 of the EA states that "crisis respite homes provide short-term crisis services in a residential setting of no more than four people." The State is required to track the length of stay in each crisis respite home and to report monthly on the list of individuals

who are in a crisis respite home for 30 days or longer (EA 17.c). The State has complied with this reporting requirement; the last monthly report was received on June 11, 2019 and provides information for the prior month, May 2019.

As reiterated in the Independent Reviewer's last report to the Court and as referenced above, the lengths of stay in the 12 crisis respite homes have been an ongoing concern. Lengths of stay greater than 30 days continue to reflect an inadequate array of providers with the expertise and the willingness to work with individuals with challenging behaviors.

In May 2019, there were 28 individuals whose stays exceeded 30 days; three of these individuals were discharged to family or provider residences during that month.

DBHDD recently reported that there are potential providers who have agreed to support 10 of the remaining individuals. Placement planning is in progress.

At this time, there are no providers who have been confirmed to support the remaining 15 individuals, including:

- M.W. was admitted from a jail in August 2014; although three providers have been contacted, none has expressed any willingness to support him;
- C.G. was first admitted in August 2015, after being removed from the residence of an abusive provider; she had one brief placement that was unsuccessful; she returned to the same crisis respite home in October 2017;
- D.F. was admitted in October 2016; no interested providers have been identified;
- W.R., W. H. and H.G were returned from out-of-state facilities with no identified residential provider.

Some of the individuals who have not been placed to date have histories of self-injury, aggression, and criminal charges. These individuals will require experienced providers with a proven track record of effective behavioral intervention. Despite the State's compliance with numerical and reporting requirements, until there is more evidence of increased statewide capacity to support individuals with challenging behaviors, a recommendation of Non-compliance for EA 17 remains.

Provider Recruitment

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). For both the DD and the SPMI populations within the Target Population, the SA requires the State to identify qualified providers throughout the state to meet the needs of the individuals covered by the SA (SA III.C.3.a.ii).

The State initially developed its DD Provider Recruitment Plan on November 28, 2016; the State issued a revised version of the plan on June 30, 2017, and a further revision on November 15, 2017.

In its plan, the State asserts that it is trying to recruit two types of DD community providers: residential providers, especially for those with complex health care or behavioral needs; and clinical service providers, such as occupational, physical, and speech/language therapists.

The State plan focuses on six sub-groups of the DD population: those who are transitioning or have transitioned from a hospital; those on the planning list who are waiting for community-based Waiver services; those on forensic status; those who are being served by providers who are exiting the system for whatever reason; individuals in crisis services; and aging individuals.

The State acknowledges that it needs to do more for people with DD and intensive behavioral needs; internal and external quality reviews point to unmet needs among this group. After doing outreach to stakeholders, including the providers themselves, the State learned that the DD providers want a partnership with the State, especially for individuals who have been more challenging to support, and/or when things go wrong; many providers expressed an interest in the State sending out a support team to the residence to assist.

Although there is no doubt that the State has *developed* a DD provider recruitment plan, it has yet to fully *implement* it. In spite of the written plan and recently increased Waiver rates, with one exception, the State has failed to recruit new residential providers. This failure impacts the State system's ability to meet the needs of those with complex health and/or behavioral needs, and it impacts its ability to transition people out of temporary crisis respite houses and into permanent, stable community homes. The State reports that, since March 1, 2018, it has enrolled 22 new non-residential providers to offer COMP and/or NOW Waiver services, including supported employment, transportation, nursing, respite, behavioral supports, specialized medical equipment, occupational and physical therapy and speech/language therapy, but this does not address the unmet need for additional residential providers.

Investigations and Mortality Reviews

According to the EA, the State is to implement an effective process for reporting, investigating, and addressing critical incidents involving alleged criminal acts, abuse or neglect, negligent or deficient conduct by a community provider, or serious injuries to an individual (EA 20).

There are a number of provisions in the EA that require the State to implement an effective process for investigating and addressing deaths and ensuring the implementation of corrective actions to address any deficiencies, all with the goal of reducing mortality rates.[4] The investigation process and the investigation reports themselves have improved, but the Independent Reviewer continues to have concerns about the extent to which remedial actions are being implemented to correct identified deficiencies.

In its June 2019 response to the Independent Reviewer's requests, the State admitted that "DBHDD does not currently have the capacity to summarize system-wide incident, investigation, and CAP data in an aggregate manner … DBHDD is working on an IT solution to allow for analysis of critical incident report data on a provider specific and aggregate basis." The State further admitted that DBHDD "does not hold any contracts to perform summation and/or analysis of the above referenced incident, investigation, and CAP data."

The State issues an annual report on mortality; the most recent report covered FY17 and was issued on August 16, 2018. The reports are well written and include thoughtful analysis that seeks to gain insight from broad data to improve the system. Unfortunately, the mortality rates in Georgia have not decreased since 2015 and, in fact, have slightly increased from 12.5 in FY15, to 14.0 in FY16, to 16.4 in FY17. Perhaps most significantly, the latest report reveals that for people with elevated HRST scores of 4, 5, or 6, their respective crude mortality rates in 2017 were 31.9, 45.9 and 70.1. These findings only reinforce the emphasis in the EA that the State's system needs to be able to respond promptly and well to anyone with elevated risks; the consequence for not doing so may be preventable illness and even death. The State agrees, stressing in its 2017 mortality review report: "The odds of dying increase significantly with increasing health care level scores."[5]

Unfortunately, there are still preventable deaths occurring in the State's system, often the product of substantiated neglect by community provider staff. These deaths reveal that the system is too often unable to meet the needs of people with high-risk conditions. DBHDD's own internal mortality investigations, completed primarily by registered

[4] EA 20-24 require that the State shall "implement an effective process for reporting, investigating, and addressing deaths … [t]he State shall require providers to take corrective actions in response to deficiency findings … [and] the State shall develop and implement quality improvement initiatives, including those to reduce mortality rates for individuals with DD in the community."

[5] 2017 Annual Mortality Report, page 19.

nurses, have found serious concerns with the State system's ability to deliver adequate and appropriate services to people with DD.

A finding of Substantial Compliance has been recommended previously for certain EA requirements regarding reporting, access to relevant records, the credentials of investigators, the development of an autopsy protocol and the issuance of an Annual Mortality Report (EA 23, 25, 26, and 27).

The central question now remaining is whether the State has implemented an **effective process** for addressing deaths and critical incidents.

The deaths of 59 individuals with DD were examined in preparation for this report. (Thirty-nine of these deaths were referenced in the Independent Reviewer's last report to the Court but there was insufficient information available at that time to evaluate the entire process for addressing deaths.) A detailed summary of each death with the findings of DBHDD's investigations has been submitted to the Parties.

Overall conclusions about the investigation process, reached through the analysis of these 59 deaths, include:

- DBHDD's policies regarding the reporting and investigating of deaths are clearly written and provide explicit direction to providers about their responsibility;
- The protocol now used to determine which deaths receive a full investigation, termed a Clinical Mortality Review (CMR), after an initial screening, termed a Health and Safety Risk Review (HSRR), by a clinician is reasonable. The timeline for the completion of an investigation, 30 days, is consistent with the EA.
- The majority of the HSRRs reviewed were timely; they were completed within seven days after the receipt of a Critical Incident Report (CIR). The HSRRs were primarily and appropriately completed by RNs.
- Credentialed investigators, typically RNs, complete the CMRs.
- Completion of the investigations continues to lag behind the 30-day requirement and, except for four cases, requests for an extension were not referenced in the investigation. Only 10 of 43 investigations (23%) contained all required signatures/approvals within the expected timeframe. Delays were especially noted in the final supervisory review.[6]
- The process for issuing the Corrective Action Plan, commonly termed a CAP, is quite prolonged and raises concerns about the timeliness of remedial actions. After the completion of the investigation, if negative findings or deficient practices are identified, the investigation may be sent to the Community Mortality Review Committee (CMRC) for review and the directive to issue a CAP. DBHDD staff then outline the concerns to be addressed and forward them to the provider agency for the completion of the corrective action steps to be taken. The

[6] In order to determine whether timeliness has improved for more recent investigations, the dates of the last 16 CMRs, completed between April and June 2019, were examined. The percentage of timely investigations in this sample increased to 56%, but this number is still unsatisfactory.

> proposed CAP is then reviewed again by DBHDD and, if no further changes are warranted, it is then approved. This process has resulted in CAPS pending for months after the completion of the investigation itself. This is problematic because, in cases that confirm preventable causes of illness or death or find substantiated neglect, needed remedial action to fix identified deficiencies are not being developed or implemented for months. This creates a scenario where similarly situated people in the State system may suffer neglect or preventable illness/death simply because of unresolved deficiencies.

DBHDD has contracted with the Columbus Organization to review the investigations completed for individuals who were placed from State Hospitals under the terms of the Agreements. Columbus also conducts the first review of any deaths occurring during the initial transition period from a State Hospital. Given the timeframes for the State's own investigations and the need to transfer records and other background information, the Columbus investigations might not be started until at least a month after the death; in fact, the Columbus investigations usually begin later. This delay can contribute to the delay in developing an effective CAP, if needed, because Columbus may offer recommendations for corrective actions.

In the review of the death investigations conducted by DBHDD, it was noted that deficient practices related to the duties of the Support Coordinator were not always identified as such. As a result, it is not possible to determine whether remedial action was implemented by the Support Coordination agency. (Exceptions to this finding are the DBHDD investigations into the deaths of E.D. and J.W., where the deficient practices of the Support Coordinators were clearly stated.) In fact, Support Coordinators are not always interviewed during the DBHDD investigation process. It was noted, however, that Columbus does document deficient practices that are the responsibility of the Support Coordinator and will recommend appropriate corrective actions.

Other than the Annual Mortality Report, DBHDD does not issue findings from analyzing and summarizing system-wide data from incidents, investigations and/or CAPs. It does not have this current capacity. Reportedly, DBHDD can and does analyze for trends with specific providers, if the circumstances indicate that additional scrutiny is warranted. As noted earlier, DBHDD is working on an IT solution to allow for the analysis of critical incident data on a provider specific and aggregate basis. The capacity to perform these analyses will be extremely useful in identifying and terminating provider agencies that fail to meet their obligations to prevent any harm to vulnerable individuals. Over the years, the Independent Reviewer and her clinical consultants have brought serious concerns about the poor performance of certain providers to the attention of DBHDD; information about terminated providers has been shared as requested. The issuance of periodic reports based on the analysis of critical incident data certainly would strengthen DBHDD's monitoring of provider agencies and would assist in timely remedial actions, such as the termination of contracts and licenses to practice.

On June 28, 2018, the State provided the Independent Reviewer with a document, "IDD Quality Improvement Projects," that addressed the steps the State was taking to comply

with EA 24, which requires the State to "collect and review its data regarding deaths of individuals with DD in the community to identify systemic, regional, and provider-level trends, if any. The State shall consider its mortality data, publicly available national mortality data, and recommendations from the CMRC. The State shall develop and implement quality improvement initiatives, including those to reduce mortality rates for individuals with DD in the community, as determined by the State from its assessment of mortality data and trends."

This Quality Improvement document includes a number of important elements that would address not only the causes of preventable deaths, but also the larger issues impacting people with high risk conditions in the State's community system, including issues related to: data collection, incident management, Intensive Support Coordination, expanded therapy services, improved nursing services, nutrition services, additional residential staffing, special medical care needs, key performance indicators, crisis home discharges, best practices, standardization of nursing assessments and health care plans, the clinical oversight database, a risk mitigation policy, and additional training needs. The overall approach taken by the State is laudable and holds the promise of aiding the State's compliance with EA criteria.

Nonetheless, in spite of the State's representations to the contrary, the Independent Reviewer believes that this Quality Improvement initiative is largely unimplemented; at the very least, few if any projects have been fully implemented. This was reinforced during the Independent Reviewer's recent site visits. There was little knowledge of these initiatives reflected in the interviews conducted with staff in the field. For example, when queried, community residential staff persons, including registered nurses, were not aware of the 18 web-based healthcare plan templates designed to standardize protocols related to health risks, such as constipation or aspiration. Although the Developmental Disabilities Clinical Oversight (DDCO) database was described as functional and utilized to improve processes, DBHDD also reported that, to date, the DDCO can only generate reports regarding "the number of open and closed entries and entries contrasted by population."[7] It is possible that the Projects have been completed at a higher administrative level and that the results may not be widely disseminated at this time.

Clearly, considerable progress has been made in organizing the framework for the investigation processes. This work is recognized and commended. However, until the timeliness of investigations improves further, especially at the supervisory level, and there is evidence of the timely implementation and completion of meaningful corrective actions to address deficiencies, the system cannot be considered effective. Due to the lack of timeliness and other factors, the State's assertion[8] that "providers are subject to robust inspection and, when necessary, corrective action plans and termination of contracts" cannot be confirmed. As a result, the recommendation for a finding of Non-compliance for EA 20 remains.

[7] Response to the Independent Reviewer, June 7, 2019.
[8] Letter dated January 8, 2019, page 2.

Provisions Related to Individuals with SPMI – Supported Housing

The value of stable housing with individualized supports for people with SPMI cannot be overemphasized. At this time, based on extensive experience nationwide, there is absolutely no doubt that permanent housing in an integrated setting contributes to recovery from serious mental illness. Inclusion of obligations related to Supported Housing in the SA, and again, in the EA underscores the Parties' recognition of this important intervention.

As defined in the SA and EA, Supported Housing is "assistance, including psychosocial supports, provided to persons with SPMI to assist them in attaining and maintaining safe and affordable housing and support their integration into the community."[9]

Both the SA and the EA require the State to have the *current* capacity to provide Supported Housing to approximately 9,000 people in the Target Population who need Supported Housing.[10] The Target Population includes people "with SPMI who are currently being served in the State Hospitals, who are frequently admitted to the State Hospitals, who are frequently seen in Emergency Rooms, who are chronically homeless and/or are being released from jails or prisons." [11]

As in all previous reports, Martha Knisley, subject matter consultant to the Independent Reviewer, assisted in the review of the State's progress in complying with the Supported Housing provisions in the SA and EA. Ms. Knisley examined documents[12] and other information provided by DBHDD. This information was supplemented by telephone conversations with Housing Outreach Coordinators, providers, advocates, and site visits in Region 5 completed by the Independent Reviewer.

At the outset, as discussed further below, it must be noted that DBHDD did not provide all of the data requested for this section of the report. In addition, the State numbers in the submitted data were not always consistent. As a result, the State numbers included in this report must be considered approximate; information could not be referenced for some members of the Target Population.

In its second letter to the Department of Justice, the State asserted "As of February 15, 2019, DBHDD has placed 4,616 members of the Target Population in Supported Housing through the Georgia Housing Voucher Program (GHVP)."[13] The most recent data provided by DBHDD states that 4,424 individuals have been placed in Supported

[9] See SA III.B.2.c.i. and EA 36.
[10] See SA III.B.2.c.ii(A) and EA 30, 38.
[11] See SA III.B.1.a. and EA 30.
[12] The State documents included DBHDD's "Georgia Housing and Bridge Funding Program Summary," which has been a significant source of information since the execution of the Settlement Agreement. The document relied on for this Interim Report covered the period July 1, 2018 through March 31, 2019.
[13] Letter dated March 11, 2019, page 3.

Housing through the GHVP at some point since 2010.[14] Regardless of the precise number, this is not the correct measure for a finding of Substantial Compliance with the SA and EA.

First, the numbers in the State's letter are historical or cumulative totals that do not reflect *current* capacity, as is required in both the SA and the EA.

Second, this is an important distinction because not everyone who once received a GHV remains in Supported Housing; some left the system for negative reasons, for example, becoming homeless or incarcerated. DBHDD reports a negative separation rate of 23% since FY17. (An expected rate after 2 years would be 10-15%, based on Ms. Knisley's experience.) Applying the negative separation percentage to the number of people linked since 2010 reveals that hundreds of people are no longer getting Supported Housing through the GHVP, thereby undercutting the State's implication that all of these individuals are still getting the service.

Third, after upward progress before 2018, the number of individuals with active authorizations for a GHV has been steadily decreasing throughout 2018 and 2019:

TABLE 1
State-Reported Number with Active Authorizations for GHVP

July 2015	1,623
July 2016	1,924
July 2017	2,432
January 2018	2,628
February 2018	2,582
March 2018	2,534
April 2018	2,511
May 2018	2,482
June 2018	2,453
July 2018	2,405
November 2018	2,224
March 2019	2,147
May 2019	2,039
June 2019	1,973

The June 2019 figure is a 25 percent drop from the January 2018 figure. This is a significant reduction; it is even more notable given that the legislature has been providing additional funding for Supported Housing during this period. Needless to say, the current number of 1,973 undercuts the State's implied conclusion that over 4,000 people are getting Supported Housing. When conducting an analysis of compliance with the SA and EA criteria, the number 1,973 is a more accurate reflection of who is getting a GHV right now.

[14] Program Summary cited in FN above.

Fourth, the State has summarily asserted that 3,999 individuals with SPMI have been placed in federally funded Supported Housing between October 29, 2010 and June 30, 2018.[15] The parties have agreed that it is appropriate to include people in the Target Population who are receiving Supported Housing through federal sources; but again, they must be receiving it *now* in order to be included in any analysis of *current* Supported Housing capacity as required by the SA and EA. The State provided this 3,999 number without more details. Although the State was asked to provide a list of the 3,999 individuals, with the date of linkage to federal funding and confirmation that the person is still getting federal Supported Housing, it has not done so. As a result, this number is not verifiable. Furthermore, like the GHVP numbers referenced above, the federal Supported Housing number of 3,999 is a cumulative or historical total, not a current number as is required in any SA/EA compliance analysis. Additionally, it may, and likely does, include people who have left federally funded Supported Housing and are no longer receiving it. It may even include people who do not have SPMI. Since the State cannot provide adequate justification, it would be improper to include the 3,999 figure in any compliance analysis.

In the Supplemental Report on Supported Housing, filed on December 21, 2018, the Independent Reviewer, based on Ms. Knisley's analysis, concluded that the current capacity for Supported Housing was about 3,100 individuals, including some allowance for federally funded Supported Housing, and that the State had the potential capacity to provide Supported Housing to about 4,700 individuals. This is only about half of the capacity anticipated by the SA and EA.

DBHDD did not respond to the request for recent data regarding the number of individuals who obtained federal Supported Housing, through the DCA unified referral system, from Shelter Plus Care, HUD Mainstream Vouchers, PHA Partnerships, VASH and 811 PRA. As a result, an updated assessment of current and projected capacity is not possible.

Utilization of Supported Housing is the problem in Georgia, not the lack of need for it. There is no doubt that the numbers of individuals who potentially might need Supported Housing are substantial when each sub-group of the Target Population is analyzed. There are hundreds of potential candidates for Supported Housing entering the State's system every year.[16] For example, DBHDD reported that from January 1, 2018 through March 31, 2019, there were 3,247 individuals with SPMI discharged from the State Hospitals and there were 76 individuals who were "frequently admitted" to the State Hospitals, using DBHDD's rather restrictive definition. In the most recent meeting with the Department of Community Affairs (DCA), the State estimated that there are about 1,658

[15] Letter dated March 11, 2019, page 6.

[16] The Independent Reviewer's ongoing efforts to obtain reliable and consistent Supported Housing data from the State have been frustrating and these data remain elusive. Much of the data are missing – either not tracked or unavailable. Some data points are inconsistent with earlier data points.

to 1,853 people with SPMI throughout Georgia who are chronically homeless at any given time.

Using other sources, including recent published reports:

- Out of a total of more than 50,000 adult inmates, there are several thousand adults with SPMI who are being released from the State's prison system each year;
- Out of a total annual jail population of more than 30,000 people, it is estimated that there are several thousand adults – about one-fourth of the total jail population – who have SPMI.

There are no data available on the number of adults with SPMI who are frequently admitted to emergency rooms. DBHDD has acknowledged that it does not track this group of people. In response to a recent document and information request from the Independent Reviewer, the State acknowledged repeatedly, "DBHDD does not have data responsive to this question."

The State's letter[17] to the Department of Justice emphasizes that the State is required only to have the capacity to provide Supported Housing to those with an *assessed* need for Supported Housing (EA 38). However, the State's letter fails to reference the still-active language at SA III.B.2.c.ii(A) that does not include the word "assessed." Furthermore, the State appears to be making a rather dispiriting argument that even inadequate assessment efforts – with limited outreach and overly restrictive eligibility criteria – are somehow good evidence that few people need Supported Housing. This argument entirely defeats the letter and the spirit of the SA where there is to be robust effort to perform outreach and linkage to the potential 9,000 members of the Target Population.

Given the State's emphasis on the word "assessed," it is important to determine whether the State is both conducting sufficient outreach and applying eligibility criteria fairly. Only then can there be confidence that those with an "assessed need" truly represent the actual need among members of the Target Population.

Based on review and analysis of all available information and data, the Independent Reviewer and her subject matter consultant conclude that the State has failed to conduct sufficient Supported Housing outreach to all pertinent individuals in defined sub-groups within the Target Population; this includes adults who are in or frequently readmitted to a State Hospital, frequently seen in emergency rooms, being released from prison or jail, or chronically homeless. In addition, even for those who are being screened for Supported Housing, it is concluded that the State is applying its eligibility criteria too narrowly so as to improperly restrict linkage to Supported Housing.

[17] Letter dated March 11, 2019, pages 3-4.

Recently, upon request, DBHDD provided the numbers of individuals reportedly assessed for Supported Housing in each of the five sub-groups within the Target Population, as well as the number of those individuals actually linked to Supported Housing.[18]

As illustrated below, the number of individuals assessed and then linked to Supported Housing is low when compared to the total size of the sub-groups:

TABLE 2
State-Reported Assessments/Linkages by Target Population Sub-Groups

Sub-group	Estimated Totals in Sub-group	Assessed	Approved	Linked
State Hospital	3,247	157	104	33[19]
Frequently Re-admitted to State Hospitals	76	12	9	Not provided
Chronically Homeless with SPMI	1,658-1,853[20]	CND	CND	75[21]
Being Released from Jail/Prison	8,800/2,500	615/57	453/38	Not provided

It is important to stress that the State does not have complete and verifiable data on the number of people actually linked to Supported Housing in the Target Population sub-groups. It is of considerable concern that the data that have been provided to date demonstrate very low numbers of assessments and actual linkage to Supported Housing.

It is clear that the number of individuals who receive Supported Housing is far fewer than those who are assessed for it. The number of individuals who meet the DBHDD criteria for one of the sub-groups listed in the Agreements, who are found "appropriate," who qualify for services and who are referred for housing, gets smaller at each step. The significant exclusions at each step raise questions and concerns about overly restrictive application of eligibility criteria in the State's survey, screening, assessment, and linkage process.

Much of this can be explained due to the fundamental flaws with the State's Supported Housing survey and methodology. The State represents in its Supported Housing Needs

[18] It should be noted that there were no data available for individuals with SPMI frequently seen in emergency rooms. The other data must be viewed with caution, given the inconsistencies in reporting.
[19] 26 of 33 names were confirmed with a GHVP active authorization.
[20] DBHDD has asserted various numbers regarding those individuals cited as chronically homeless people with SPMI. An official from DCA provided the number included here in Table 2 at a meeting attended by the Independent Reviewer.
[21] 9 of 75 names were confirmed with a GHVP active authorization. It is possible that federally funded housing was received but that information was not provided.

and Choice Survey policy (01-120) that "access to a full range of housing options is fundamental to informed choice," but it does not appear that all members of the Target Population have meaningful access to Supported Housing in practice. For example:

- The Applicability section of the above policy does not include people in emergency rooms, people in jails or prisons, people in shelters, or other homeless individuals not involved with PATH teams.
- Community providers are charged with completing certain sections of the Survey instrument, but it is not clear that the State takes consistent action to ensure that these sections are filled in properly or that the State reviews a representative sample of these survey instruments to confirm their validity. Community providers often lack the training and expertise required to conduct a meaningful Supported Housing assessment. In addition, since community providers complete the Risk Assessment questions, there also may be a disincentive or conflict of interest in accepting a person with the need for more intensive supports.

In addition, because the process is cumbersome and lengthy, individuals may drop out or move elsewhere before the process is finished. As reported by one community provider's Housing Coordinator, the application process proceeds as follows:

1. The Need for Supported Housing Survey is completed and submitted through the Unified Referral Process coordinated with DCA. This process attempts to maximize the use of federal housing resources.
2. DCA must approve the application and then provide recommendations for specific housing options.
3. Applications from the DCA recommendations, which may be several, are completed and submitted to the designated housing authority or landlord.
4. There is a waiting period for responses to the applications for housing.
5. If all applications are denied, DCA will then issue a Notice to Proceed for a GHV.

In examining the effectiveness of the Unified Referral Process, numerous complaints were heard regarding the length of time required to receive a decision. Further, the recommended housing options may not reflect the individual's preferred location for housing. For example, options in one city may be recommended while the individual wants or needs to live in another city. As one Housing Coordinator in southeastern Georgia reported, "This process began in October 2017 and there are, unfortunately, no shortcuts. The process is long and tedious but every consumer who is in need of housing has to go through it." This particular agency has had no one approved for a GHV during this entire Fiscal Year. "It is the housing of last resort."

Furthermore, the criteria used by DBHDD to determine whether an individual qualifies for Supported Housing are unnecessarily limiting. For example, as referenced above, the State's definition of "frequently readmitted to a state hospital" is unnecessarily restrictive. In addition, although the federal definition of "chronically homeless" must be applied to the federally funded housing programs, it does not need to be applied to the

State-funded GHVP. In reviewing the surveys of those deemed ineligible for Supported Housing, it was noted that many have SPMI and are homeless. Apparently, they are rejected because the stricter definition of "homeless" is used by DBHDD.

It is disturbing that the funds available for the GHVP are not being expended to provide more individuals with SPMI the opportunity to benefit from stable housing with supports, as required in the SA and EA. In its response to the Independent Reviewer, the State acknowledged that an unusually large amount of funding, initially allocated to Supported Housing in the last FY, was used instead for other mental health services, including, reportedly, for private psychiatric beds.

Based on the above information, it is clear that resources were available in FY19 to extend the option of Supported Housing to more individuals with SPMI who needed it. It is estimated that up to 1000 to 1200 individuals, who are in need of Supported Housing, could have been housed with the funds available, but not expended on Supported Housing, in FY19.

Initial discussions about this concern have begun with the State. It is clear that problems with the Supported Housing program have been identified and will be addressed. While the deficiencies are being rectified, it is critically important that the appropriated funding for Supported Housing be retained so that the terms of the SA and EA can be met. In the Independent Reviewer's professional judgment, any reduction in funding at this time will result in the inability to comply with the obligations of the Court Orders.

In its March letter, the State lauds its Housing Outreach Coordinator (HOC) and High-Utilization Management (HUM) initiatives. It is certainly clear that the HOCs can be a valuable resource. Recent telephone interviews, conducted for this report, confirmed their energy and their serious commitment to their responsibilities. However, these interviews also confirmed that four of the 12 HOC positions are vacant. (Reportedly, one vacancy has been filled recently; the staff person is being trained.) As shown by the attached map, even when all 12 positions are filled, only 90 of Georgia's 159 counties (57%) are included in their scope of work – nearly half the state is not covered.[22]

During the period from January 1, 2018 through March 31, 2019, the State reports that the HOCs completed 797 Supported Housing surveys; this is just 53 per month and about 5 per HOC per month, if all 12 HOCs were working. This is minimal outreach, especially when about half the state is not even covered by the HOCs. Moreover, it is not known how many of the individuals surveyed are linked to Supported Housing; the State reports that only 534 of the 797 adults surveyed met Target Population criteria and needed housing. At best, this could result in only 36 linkages per month; 3 linkages per HOC per month, again assuming all 12 HOCs are working. When queried about successful linkages to housing, the HOCs reported that there are only informal means to determine

[22] On July 15, 2019, the Independent Reviewer was informed that the additional six counties (Burke, Emanuel, Glascock, Jefferson, Jenkins, Screven) to be added in July 2017 would be assigned now to the HOC.

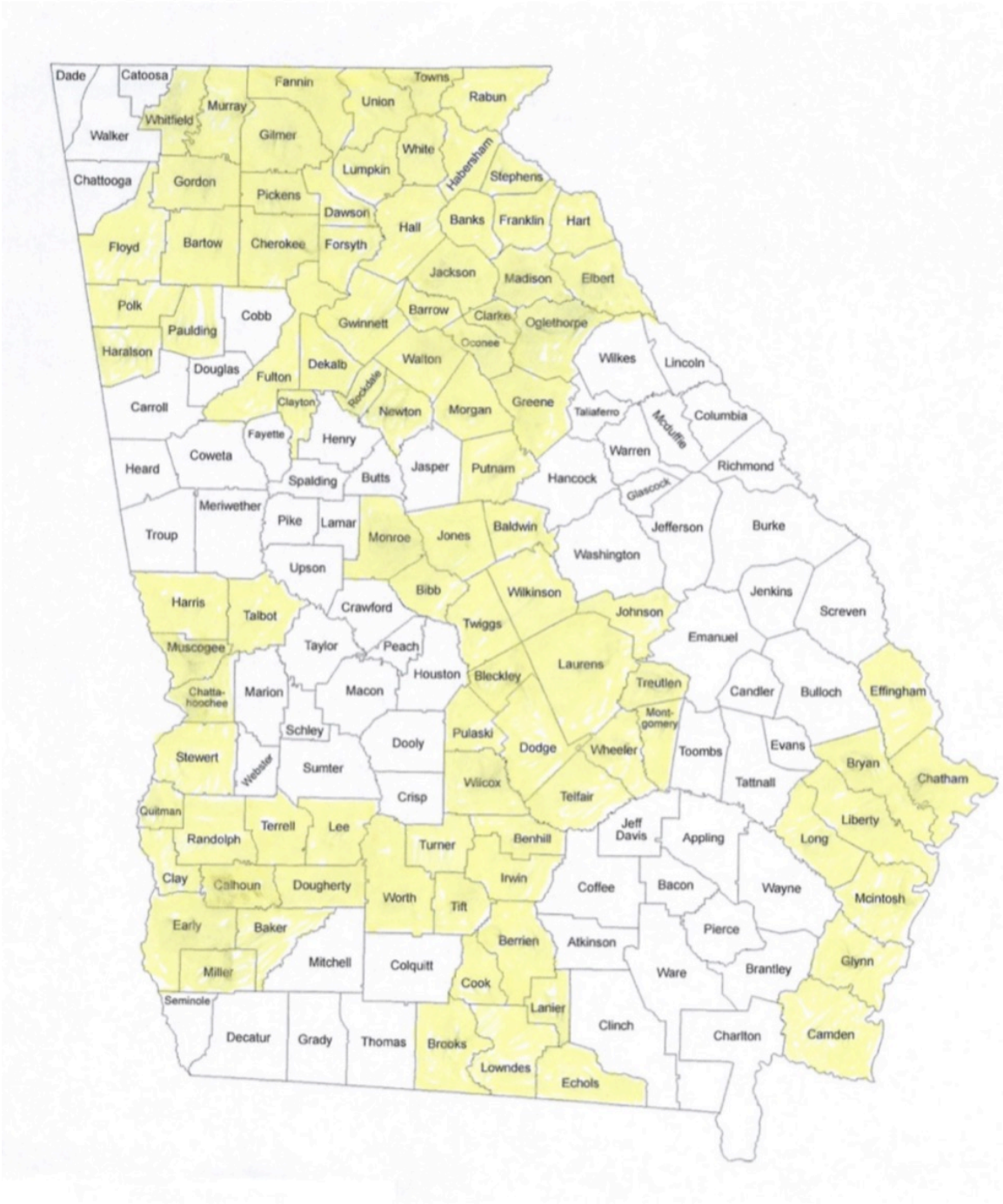
these outcomes, such as asking a supervisor or the agency's housing coordinator who actually received housing after being given a positive assessment.

In January 2019, DBHDD began an initiative called the High Utilization Management (HUM) program. Once again, in its March letter, the State cited HUM as a key element that demonstrated its substantial compliance with the Agreements. The State reports that there are nine HUM Navigators that can complete a housing needs survey, but this is not their primary responsibility. Between January and March 31, 2019, the Navigators completed only three Supported Housing assessments; the State acknowledged that none of the individuals actually received housing.

In its 2014 report, commissioned by DBHDD, the Technical Assistance Collaborative (TAC) projected that the total capacity for Supported Housing could reach 6,910 slots/units/vouchers by now, if specific agreements and practices were designed and implemented. As referenced, the actual Supported Housing totals, both current and potential are now somewhere between 3,000 and 4,700.

Based on the decreasing numbers of individuals awarded the GHV, the continuing reliance on restrictive definitions and practices, and the failure to redesign processes so that unnecessary delays are minimized, it is not possible to recommend any finding but Non-compliance for the SA and EA provisions on Supported Housing discussed in this report. Regrettably, the State's performance in the Supported Housing area appears to be slipping, rather than moving forward as expected. This is a dispiriting finding.

Counties Included in the Housing Outreach Coordinators' Scope of Work

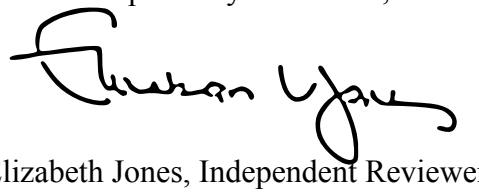


Concluding Comments

Based on the information included in the narrative above, there is still much to be done to address outstanding issues. It is encouraging that the Parties have agreed to continue to work together to help address the State's compliance with the remaining obligations of the SA and EA. The Independent Reviewer hopes this collaboration will lead to positive actions that enable the State to come into substantial compliance with the SA and EA.

In addition, the Independent Reviewer would reiterate her concern that funding allocated to date for the obligations mandated by the SA and EA remain intact. A reduction in funding will present serious obstacles to future compliance with the Court's Orders.

Respectfully Submitted,



Elizabeth Jones, Independent Reviewer