REPORT OF THE INDEPENDENT REVIEWER

In The Matter Of

United States of America v. The State of Georgia

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

Submitted By: Elizabeth Jones, Independent Reviewer

October 5, 2011

EXECUTIVE SUMMARY

The Settlement Agreement between the United States of America and the State of Georgia was approved by the Court on October 29, 2010.

By July 1, 2011, it was agreed that the Department of Behavioral Health and Developmental Disabilities would comply with thirty-five provisions. A summary of compliance findings is attached.

The Parties acknowledged the effort required for the implementation of the Settlement Agreement by establishing a timeframe through July 1, 2015. By structuring compliance requirements on an incremental basis, the Settlement Agreement recognized that change takes time; that there are lessons to be learned and unlearned about implementation; that provider capacity must be built; that stakeholder knowledge and involvement must be strengthened; and that a reliable system for monitoring, evaluation and corrective action would need to evolve at both the State and local level.

This first report recognizes that this is the baseline year of this Settlement Agreement. In fact, the State has had only eight months to complete the initial set of obligations. These obligations are critical components for the development of a system that is truly responsive to and responsible for the target population of individuals identified by the Settlement Agreement with a developmental disability or serious and persistent mental illness who are either institutionalized currently or at risk of being institutionalized in the future; who are frequently seen in Emergency Rooms; who are chronically homeless; and/or who are being released from jails or prisons.

The State has demonstrated good faith in its efforts to comply with the obligations due to be completed by July 1, 2011. The State Legislature has passed essential amendments to Chapter 4 of Title 37 and approved the funding required for the full implementation of the Settlement Agreement in the baseline year. Additional funding was authorized for the provision of supports to families. The Commissioner of the Department of Behavioral Health and Developmental Disabilities has emphasized repeatedly, and with sincerity, the importance of this commitment; his staff, at all levels of the organization, have worked diligently to implement their responsibilities; and a very capable Settlement Coordinator has been designated to assist with the requirements of the Settlement Agreement and the many requests of the Independent Reviewer.

Georgia is fortunate to have an articulate and well-informed group of stakeholders who are deeply committed to the principles and goals of the Settlement Agreement and who are energized and eager to participate in its actual implementation. This stakeholder involvement is important to the reform envisioned by the Parties to the Settlement Agreement. Meaningful integration into community life for people with disabilities is aided by the collaboration and inclusion of valued members of the community itself. Throughout the last eight months, the interest and openness to change demonstrated by those with an investment in the work of the Department of Behavioral Health and Developmental Disabilities has been highly visible and clearly expressed by their participation in and oversight of the reform efforts.

The partnership between the State's officers and its citizens should continue to evolve if the reforms initiated by legal action are to be sustained once the terms of the Settlement Agreement are concluded.

Summary of Compliance: Year One

Settlement Agreement Reference	Provision	Rating	Comments
III	**Substantive Provisions**		
III.A.1.a	By July 1, 2011, the State shall cease all admissions to the State Hospitals of all individuals for whom the reason for admission is due to a primary diagnosis of a developmental disability.	**Compliance**	The Commissioner of the Department of Behavioral Health and Developmental Disabilities has complied with this provision and has expressed his intent to develop community based alternatives to institutional care. There was no evidence to indicate that individuals with a developmental disability have been transferred between State Hospitals in contradiction of the commitment to cease admissions.
III.A.1.b	The State will make any necessary changes to administrative regulations and take best efforts to amend any statutes that may require such admissions.	**Compliance**	In House Bill 324, the State Legislature amended Chapter 4 of Title 37 of the Official Code of Georgia Annotated.
III.A.2.b.i(A)	By July 1, 2011, the State shall move 150 individuals with developmental disabilities from the State Hospitals to the community and the State shall create 150 waivers to accomplish this transition. In addition, the State shall move from the State Hospitals to the community all individuals with an existing and active waiver as of the Effective Date of this Agreement, provided such placement is consistent with the individual's informed choice. The State shall provide family supports to a minimum of 400 families of people with developmental disabilities.	**Compliance**	The Department placed more than 150 individuals with a developmental disability into community residential settings supported by the Home and Community-Based Waiver. A sample of 48 individuals was reviewed. Identified concerns were referred to the Department and corrective actions were initiated. Nine of the 11 individuals hospitalized with an existing Waiver were discharged to community settings. Two individuals remained hospitalized. Delays in placement were attributed to family objections or to provider-related issues. The Department continued to pursue appropriate community placements for these two individuals. More than 400 individuals were provided with family supports. Because there was substantial compliance with this provision, a positive rating was given.
III.A.2.b.ii(B)	Individuals in the target population shall not be served in a host home or a congregate community living setting unless such placement is consistent with the individual's informed choice. For individuals in the target population not served in their own home or their family's home, the number of individuals served in a host home as defined by Georgia law shall not exceed two, and the number of individuals served in any congregate community living setting shall not exceed four.	**Compliance**	Of the 48 individuals reviewed in the sample, none were placed in host homes with more than two individuals or in congregate community living settings with more than four individuals.

Settlement Agreement Reference	Provision	Rating	Comments
III.A.2.b.iii(A)	Assembling professionals and non-professionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Service Plans, as required by the State's HCBS Waiver Program, that are individualized and person centered.	**Compliance**	Individual Service Plans were reviewed for the 48 individuals in the sample. The format used by the Department focused on the needs and preferences of each individual.
III.A.2.b.iii(B)	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, and other services identified in the Individual Service Plan.	**Non-compliance**	The review of 48 individuals found that needed supports were lacking. For example, 14 individuals (30%) lacked consistent day program activities; weight fluctuations were not tracked and addressed in 35% of individuals reviewed; unsafe practices were observed with individuals being presented as "self-medicating with staff assistance;" informed consent to psychotropic medication was found to be lacking.
III.A.2.b.iii(C)	Monitoring the Individual Service Plan to make additional referrals, service changes, and amendments to the plans as identified as needed.	**Non-compliance**	Although there were Support Coordinators assigned to each individual in the sample, as noted above, needed supports were found to be lacking.
III.A.4.b	By the Effective Date of this Agreement, the State shall use a CMS approved Quality Improvement Organization ("QIO") or QIO-like organization to assess the quality of services by community providers.	**Compliance**	The Department utilized the services of the Delmarva Foundation to design and implement a quality assurance review process.
III.A.4.d	The State shall assess compliance on an annual basis and shall take appropriate action based on each assessment.	**Compliance**	The Delmarva Foundation issued an annual report assessing the quality of services by community providers for individuals with a developmental disability.

Settlement Agreement Reference	Provision	Rating	Comments
III.B.1.c	Pursuant to the Volntary Compliance Agreement with Health and Human Services, the State established a Mental Health Olmstead List. The State shall ensure that all individuals on the Mental Health Olmstead List as of the Effective Date of this Agreement will, if eligible for services, receive services in the community in accordance with this Settlement Agreement by July 1, 2011. The Parties acknowledge that some individuals on the Mental Health Olmstead List are required to register as sex offenders pursuant to O.C.G.A. § 42-1-12 et seq. The Parties further acknowledge that such registration makes placement in the community more difficult. The Parties may by written consent extend the application of the date set forth in this paragraph as it applies to such individuals. The written consent described in this paragraph will not require Court approval.	**Compliance**	At the time the Settlement Agreement was signed, there were 27 individuals on the Olmstead List. All of these individuals were discharged from the State Hospitals and were provided community services.
III.B.2.a.i(A)	ACT is a service that delivers comprehensive, individualized, and flexible treatment, support, and rehabilitation to individuals where they live and work. ACT is provided through a multidisciplinary team that shall include a psychiatrist, nurse, psychologist, social worker, substance abuse specialist, vocational rehabilitation specialist, and peer specialist. Services are highly individualized and customized, and address the constantly changing needs of the individual over time. Among the services that ACT teams provide are: case management, initial and ongoing assessments, psychiatric services, assistance with employment and housing, family support and education, substance abuse services, crisis services, and other services and supports critical to an individual's ability to live successfully in the community.	**Compliance**	The Assertive Community Treatment (ACT) teams funded by the Department were designed to provide the services stipulated by the Settlement Agreement.
III.B.2.a.i(B)	ACT teams shall provide crisis services, including helping individuals increase their ability to recognize and deal with situations that may otherwise result in hospitalization, increase and improve their network of community and natural supports, and increase and improve their use of those supports for crisis prevention.	**Compliance**	The Assertive Community Treatment (ACT) teams funded by the Department were designed to provide crisis services.

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.a.i(C)	ACT teams shall provide services to promote the successful retention of housing, including peer support, and services designed to improve daily living skills, socialization, and illness self-management.	**Compliance**	The Assertive Community Treatment (ACT) teams funded by the Department were designed to provide these services and supports.
III.B.2.a.i(D)	ACT teams who serve individuals with co-occurring substance abuse disorders shall provide substance abuse treatment and referral services to those individuals. Such ACT teams shall include on their staff a clinician with substance abuse expertise.	**Compliance**	The Assertive Community Treatment (ACT) teams funded by the Department were designed to provide these services and supports.
III.B.2.a.i(E)	ACT services shall be available 24 hours per day, 7 days per week.	**Compliance**	The Assertive Community Treatment (ACT) teams funded by the Department were available 24 hours per day, 7 days per week.
III.B.2.a.i(F)	The number of individuals served by an ACT team shall be no more than 10 individuals per ACT team member. ACT teams shall be comprised of 7 to 10 team members, with at least one member being a peer specialist.	**Compliance**	The Assertive Community Treatment (ACT) teams funded by the Department comply with this requirement.
III.B.2.a.i(G)	All ACT teams will operate with fidelity to the Dartmouth Assertive Community Treatment model.	**Compliance**	The Assertive Community Treatment (ACT) teams funded by the Department are expected to operate with fidelity to the Dartmouth Assertive Community Treatment model. Since the teams were established in April, 2011, their adherence to the fidelity standards will be assessed next year.
III.B.2.a.i(H)(1)	By July 1, 2011, the State shall have 18 ACT teams.	**Compliance**	The Department has funded 18 Assertive Community Treatment teams.
III.B.2.a.iii(D)(1)	By July 1, 2011, the State will have one ICM team.	**Compliance**	The Department has established two Intensive Case Management teams.
III.B.2.b.iii(A)	Beginning on July 1, 2011, the State shall retain funding for 35 beds in non-State community hospitals without regard as to whether such hospitals are freestanding psychiatric hospitals or general, acute care hospitals.	**Compliance**	The Department has funded hospital bed days in five community hospitals.
III.B.2.b.iv(A)	The State shall operate a toll-free statewide telephone system for persons to access information about resources in the community to assist with a crisis ("Crisis Call Center"). Such assistance includes providing advice and facilitating the delivery of mental health services.	**Compliance**	The Georgia Crisis and Access Line operated by Behavioral Health Link provided these services.

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.b.iv(B)	The Crisis Call Center shall be staffed by skilled professionals 24 hours per day, 7 days per week, to assess, make referrals, and dispatch available mobile services. The Crisis Call Center shall promptly answer and respond to all crisis calls.	**Compliance**	The Georgia Crisis and Access Line complied with these requirements.
III.B.2.c.ii(B)(1)	By July 1, 2011, the State will provide a total of 100 supported housing beds.	**Compliance**	Although the Department provided the requisite housing vouchers, concern was noted about the review of eligibility and access for hospitalized individuals.
III.B.2.c.ii(C)(1)	By July 1, 2011, the State will provide Bridge Funding for 90 individuals with SPMI. The State will also commence taking reasonable efforts to assist persons with SPMI to qualify in a timely manner for eligible supplemental income.	**Compliance**	The Department provided Bridge Funding as required.
III.B.2.d.i	Supported Employment will be operated according to an evidence-based supported employment model, and it will be assessed by an established fidelity scale such as the scale included in the Substance Abuse and Mental Health Administration ("SAMHSA") supported employment tool kit.	**Non-compliance**	Fidelity scale assessments were not completed. According to the State, fidelity scale assessments will be completed next year.
III.B.2.d.ii	Enrollment in congregate programs shall not constitute Supported Employment.	**Compliance**	Enrollment in congregate programs was not considered to be Supported Employment.
III.B.2.d.iii(A)	By July 1, 2011, the State shall provide Supported Employment services to 70 individuals with SPMI.	**Compliance**	The Department provided Supported Employment services to more than 70 individuals with SPMI. Since individuals were assigned to the Supported Employment providers in May, only eight were employed by July, 2011. A higher rate of employment will be expected next year.
III.C.1	Individuals under the age of 18 shall not be admitted to, or otherwise served, in the State Hospitals or on State Hospital grounds, unless the individual meets the criteria for emancipated minor, as set forth in Article 6 of Title 15, Chapter 11 of the Georgia Code, O.C.G.A. §§ 15-11-200 et seq.	**Non-compliance**	The Department is working to accomplish the appropriate placement of two minors currently placed in State Hospitals.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.2	Individuals in the target population with developmental disabilities and/or serious and persistent mental illness shall not be transferred from one institutional setting to another or from a State Hospital to a skilled nursing facility, intermediate care facility, or assisted living facility unless consistent with the individual's informed choice or is warranted by the individual's medical condition. Provided, however, if the State is in the process of closing all units of a certain clinical service category at a State Hospital, the State may transfer an individual from one institutional setting to another if appropriate to that individual's needs. Further provided that the State may transfer individuals in State Hospitals with developmental disabilities who are on forensic status to another State Hospital if appropriate to that individual's needs. The State may not transfer an individual from one institutional setting to another more than once.	**Compliance**	There was no evidence of inappropriate transfers from one institution to another.
III.D.1	By July 1, 2011, the State shall have at least one case manager and by July 1, 2012, at least one transition specialist per State Hospital to review transition planning for individuals who have challenging behaviors or medical conditions that impede their transition to the community, including individuals whose transition planning team cannot agree on a transition plan or does not recommend that the individual be discharged. The transition specialists will also review all transition plans for individuals who have been in a State Hospital for more than 45 days.	**Compliance**	Case Managers were assigned at each State Hospital.
III.D.3.a	For persons identified in the developmental disability and mental illness target populations of this Settlement Agreement, planning for transition to the community shall be the responsibility of the appropriate regional office and shall be carried out through collaborative engagement with the discharge planning process of the State Hospitals and provider(s) chosen by the individual or the individual's guardian where required.	**Compliance**	There was evidence of coordination between the Regional Office and State Hospital.

Settlement Agreement Reference	Provision	Rating	Comments
III.D.3.b	The regional office shall maintain and provide to the State Hospital a detailed list of all community providers, including all services offered by each provider, to be utilized to identify providers capable of meeting the needs of the individual in the community, and to provide each individual with a choice of providers when possible.	**Compliance**	The Regional Offices provided a list to the State Hospitals of all community providers.
III.D.3.c	The regional office shall assure that, once identified and selected by the individual, community service boards and/other community providers shall actively participate in the transition plan (to include the implementation of the plan for transition to the community).	**Compliance**	In the sample reviewed, there was evidence of participation by community providers. The transition of people with mental illness from State Hospitals will be examined more closely next year.
III.D.3.d	The community service boards and/or community providers shall be held accountable for the implementation of that portion of the transition plan for which they are responsible to support transition of the individual to the community.	**Compliance**	In the sample reviewed, there was evidence of accountability by community providers.
IV	**Quality Management**		
IV.E	The State shall notify the Independent Reviewer(s) promptly upon the death of any individual actively receiving services pursuant to this Agreement. The State shall, via email, forward to the United States and the Independent Reviewer(s) electronic copies of all completed incident reports and final reports of investigations related to such incidents as well as any autopsies and death summaries in the State's possession.	**Compliance**	The Independent Reviewer and the United States were notified of deaths and other critical incidents.

DISCUSSION OF COMPLIANCE FINDINGS

Methodology

The information for this report was gathered through multiple means. During the thirty-seven days spent on-site in Georgia, site visits were made to the State Hospitals primarily involved in this evaluation period (Georgia Regional Hospital at Atlanta, Central State Hospital, Southwestern State Hospital, Northwest Georgia Regional Hospital, and East Central Regional Hospital). These site visits included discussions with Hospital and Regional staff, document review and meetings with/observation of hospitalized individuals. (Not all of these individuals were scheduled for discharge.) Meetings were held with community providers linked to the service areas near the above-referenced State Hospitals. The meetings with providers were supplemented with site visits to community residential and day programs. Meetings were held and telephone calls/emails were exchanged with members of the stakeholder group including peers, advocates, family members, local sheriffs, and professionals engaged in the field of mental disability.

These site visits and discussions provided useful information about the community services currently available in Georgia as well as plans for future development. Six of the community providers interviewed by the Independent Reviewer provided residential supports to individuals included in the sample discussed below.

For each compliance requirement, the Department of Behavioral Health and Developmental Disabilities was asked to provide documentation of its work. This information was considered in the preparation of this report.

Expert consultants were retained to assist with the review of a random sample of forty-eight individuals with a developmental disability who were placed from a State Hospital into the community. The review was guided by a monitoring tool provided to the Parties well in advance. This monitoring tool was adapted from similar tools used to assess community placements in other States (New Mexico, Massachusetts and the District of Columbia.) The tool was not tested for inter-rater reliability specifically for its use in Georgia; however, it was tested prior to its use in the District of Columbia.

The random sample of 48 individuals had a confidence level of 90%. A proportional random sampling method was used to ensure representation across all Regions. Because of the small number of individuals placed in Region 6, that Region was oversampled to ensure representation in the survey.

The reports issued from the reviews of the individuals in the sample have been distributed to the Parties. The Department of Behavioral Health and Developmental Disabilities is in the process of analyzing these reports and has instructed its Regional staff to take corrective actions, as appropriate.

In addition to the review of the forty-eight individuals, two expert consultants were retained to evaluate the adherence of initiatives in supported employment and Assertive Community Treatment (ACT) to the well established principles for these Evidence-Based Practices in the field of mental health. The State

Health Authority Yardstick (SHAY), a tool developed at Dartmouth University, was used for these evaluations. The evaluation instrument was provided to the Parties in advance. Information was gathered through interviews and document review.

Also, two experts in the field of supported housing for adults with serious and persistent mental illness were retained to review the Department's efforts regarding the provision of housing vouchers and Bridge Funding. They met with staff from the Department of Behavioral Health and Developmental Disabilities and with a group of stakeholders.

The reports regarding supported employment, supported housing and Assertive Community Treatment have been provided to the Parties.

This year's review of the mental health initiatives focused primarily on the structure of those initiatives. Next year's report will include a review of services to a discrete sample of adults with a serious and persistent mental illness.

Additionally, a nurse who is highly experienced and expert in the field of developmental disabilities was asked to assist in the review of the three minors who were hospitalized at the time of the Settlement Agreement. Her analysis of each individual's support needs has been shared with the Parties.

Finally, as stipulated in the Settlement Agreement, this report was provided in draft form to the Parties for review and comment prior to submission to the Court. A meeting to discuss the draft report was held on August 25, 2011. Subsequently, written comments from the State were received and reviewed. On September 6, 2011, the Commissioner of the Department of Behavioral Health and Developmental Disabilities met with the Independent Reviewer for a most helpful discussion of the draft report. His suggestions for the report and for collaborative efforts in Year Two were greatly appreciated.

Review of Obligations for Year One

A. <u>Serving People with Developmental Disabilities in the Community</u>

1. Cessation of Admissions to State Hospitals

By July 1, 2011, the State agreed to cease all admissions to the State Hospitals of all individuals for whom the reason for admission is due to a primary diagnosis of a developmental disability. The State also agreed to make any necessary changes to administrative regulations and take best efforts to amend any statutes that may require such admissions.

The Department of Behavioral Health and Developmental Disabilities developed and implemented the Georgia Crisis Response System for individuals who need access to alternate care rather than State Hospitals with the cessation of Temporary and Immediate Care admissions (TIC).

Therefore, as required, the Department of Behavioral Health and Developmental Disabilities has stopped admissions of individuals to a State Hospital due to a primary diagnosis of a developmental

disability. In House Bill 324, passed by both the House and the Senate, the State Legislature amended Chapter 4 of Title 37 of the Official Code of Georgia Annotated.

The cessation of admissions is a landmark accomplishment for the State. On a number of occasions, the Commissioner of the Department of Behavioral Health and Developmental Disabilities has expressed his intent to develop community-based alternatives to institutional care in the State Hospitals. No individuals with a developmental disability have been transferred between State Hospitals in contradiction of the commitment to cease admissions.

2. Enhancement of Community Services

The State agreed to move 150 individuals with developmental disabilities from the State Hospitals to the community and to create 150 Home and Community-Based Services Waivers to accomplish this transition. In addition, the State agreed to move from the State Hospitals to the community all individuals with an existing and active Waiver as of the effective date of this Agreement, provided such placement is consistent with the individual's informed choice. The State agreed to provide family supports to a minimum of 400 families of people with developmental disabilities.

The State provided a final list of 192 individuals placed into community residential settings supported by the Home and Community-Based Services Waiver approved by the Centers for Medicare and Medicaid Services. The numerical target under the Settlement Agreement was met.

However, the Settlement Agreement also requires that the community placements be appropriately supported by services that are individualized according to the person's strengths and needs.

In order to evaluate the individualization, community integration and appropriate supports of the community placements accomplished under the terms of the Settlement Agreement, a sample of forty-eight individuals was selected from the Department's list; a proportional random sampling method was used to ensure representation across the six Regions of the Department of Behavioral Health and Developmental Disabilities.

The monitoring tool used to review the community placements focused on the potential for community integration; the presence of individualized supports; and the provision of basic health care and behavioral interventions. Interviews with the individual (in some cases, with assistance from staff) afforded insight into the exercise of choice and the accessibility to community resources and activities with individuals without a disability. Six individuals in the sample also were evaluated by a psychologist due to their needs for intensive behavioral supports.

The individuals in the random sample were predominately male (69%); between the ages of 31-40 (23%); and ambulatory without support (60%). Although eighteen individuals could speak without assistance, even if spoken language might be limited, support staff participated in the majority of interviews conducted during the reviews. However, most of the staff (84%) had known the individual less than a year.

The majority of residential settings were located near community resources, in typical neighborhoods (98%). Most of the individuals (87%) had their own bedrooms; private space was accessible for 98% of the individuals, if so desired. Site visits indicated that the majority, but not all, of the residences were clean (83%); free of safety concerns (94%); and had adequate food and supplies (96%). There were no more than four individuals in any of the residences reviewed for this report. (All placements reviewed met this requirement of the Settlement Agreement.) Overall, given the location, size and available resources, the residences provided a reasonable foundation for integration into the community. However, physical integration is not the same as social integration; that is, active, meaningful participation in typically valued community experiences.

For example, within the last three months, although almost all (92%) of the individuals participated in community outings on a consistent weekly basis, most (61%) went out with their housemates as a group. Participation in religious activities was experienced by the majority of individuals (83%) but participation in community clubs or organizations, also considered opportunities for friendships and natural supports, was enjoyed by only a quarter (25%) of the individuals. Neighbors had not been met by over a third (37%) of the individuals, despite the close proximity of their residences in neighborhood settings.

The choices made available to the individuals in the sample appeared to be limited. Nearly 11% of the individuals reviewed wanted to be registered to vote; over half of the individuals did not open their own mail; and over a third (35%) did not participate in buying or selecting their own clothes. Choices about day programs were documented to be limited, as well. Although 31% of the individuals interviewed chose their own day programs, 18% of those asked this question responded that they would rather be doing something else during the day. Most often, the preferred activity was employment.

For example, A.A., who was interviewed at his day program, refused to participate in the class room activities. He adamantly fashioned his own schedule as a janitor's helper and expressed his interest in being able to find a janitorial position and to have his own apartment. B.B. and C.C. both stated that they would rather have a job than attend a day program in a congregate setting.

Individual Support Plans were documented for each of the forty-eight individuals in the sample. However, there were notable gaps in the provision of identified supports. For example, habilitation for an individual with a developmental disability requires that there be continuous, individualized opportunities for the acquisition and exercise of skills, regardless of their complexity. At the time of the review, it was documented that fourteen individuals (30%) lacked consistent day program activities. An inordinate amount of time in bed during the day was noted for D.D. and E.E. The Individual Support Plan documentation reviewed for F.F. stated that approval for his day program "will be a while due to working on the remaining individuals in the State Hospital and getting them out in the community." G.G. was incarcerated and lost his day program; the lack of day program activities or supported employment places him at risk.

In addition to the above referenced issues about habilitation, the reviews surfaced a number of concerns about the provision of adequate health care. In reporting these concerns, it is recognized that

host homes will not have the level of documentation or nursing presence found in institutional settings. Nonetheless, it is important that reliable systems be in place to monitor health and to initiate interventions in a timely manner. For example, in 35% of the individuals reviewed, weight fluctuations were not tracked and addressed. It was documented that H.H., who has a history of fecal impaction, did not have a bowel movement for eight days and there was no attention paid to that; I.I. did not receive her dietary supplement as ordered and, consequently, lost fourteen pounds between September 9, 2010 and March 24, 2011; the management of J.J.'s nutritional status was of concern due to the failure to implement the nutritionist's recommendation.

Medications and medication administration were reviewed during the site visits. Unsafe practices were observed with at least five individuals being presented as "self-medicating with staff assistance." It was obvious to the reviewers that certain individuals were not capable of self-administering their medications and that unlicensed staff were actually completing all the steps of the medication administration. For example, unlicensed/untrained staff were actually crushing the medications and administering them in applesauce or pudding under the guise of self-administration. These practices appeared to be in violation of the Georgia Nurse Practice Act.

The use of psychotropic medications was documented for 57% of the individuals reviewed in the sample. The available documentation indicated that consent to psychotropic medication was present in thirteen (48%) of the applicable individual cases. However, the person providing consent in seven of these cases was the individual with a developmental disability and, in two cases, the provider. Given the potential side effects of psychotropic medication, this was a matter of grave concern. It is critical that the State take the necessary actions to ensure that proper consent is obtained for psychotropic medication (and any other medical procedure or Behavior Support Plan) prior to discharge from the State Hospital.

The Department of Behavioral Health and Developmental Disabilities was informed promptly of the most critical issues documented during the individual reviews. Although not specifically required under the Settlement Agreement, procedures have been instituted to investigate concerns and develop corrective action plans. For example, in the case of one individual who was re-hospitalized after his community placement, the Department conducted a root cause analysis and documented the following "lessons learned": inadequate support during transition; the need for a better working relationship between the advocacy system and hospital staff; the need for providers to meet with local law enforcement officers as appropriate; delays in obtaining provider licensure impact negatively on transitions; pressure to transition individuals out into the community can result in inadequate support and readmission; and training efforts should include both the hospital and the community.

Further more, after reviewing the draft report, the Commissioner of the Department of Behavioral Health and Developmental Disabilities reiterated his commitment to the principle of community integration. He asked the Independent Reviewer to work with him and his staff to discuss and develop specific outcome measures for use in Year Two to determine the extent of community integration for individuals placed from the State Hospitals.

At the time that the Settlement Agreement was signed by the Court, there were eleven individuals in the State Hospitals with an existing Waiver. As of this date, nine of those individuals have been discharged to community placements; two individuals remain hospitalized. Delays in placement were due to the need to address provider-related issues and family concerns. The Department of Behavioral Health and Developmental Disabilities continues to pursue appropriate community residential supports for both of these individuals.

The Department of Behavioral Health and Developmental Disabilities submitted a list of over 2000 individuals (2291) to whom family supports were provided under the Waiver. An extensive interview, including the review of supporting documentation, with a major provider of family support services confirmed that the Department has met this provision of the Settlement Agreement.

3. Assessing Quality

By the effective date of this Agreement, the State agreed to use a Centers for Medicare and Medicaid Services approved Quality Improvement Organization ("QIO") or QIO-like organization to assess the quality of services by community providers.

The Department of Behavioral Health and Developmental Disabilities has selected the Delmarva Foundation to design and implement a quality assurance review process. Delmarva is a Federally Designated External Quality Review Organization (EQRO) as designated by the Centers for Medicare and Medicaid Services. Under its contract, it is responsible for assessing the quality of services by community providers for individuals with a developmental disability. The last available report was dated August 31, 2010. The forthcoming annual report will be reviewed and discussed in the evaluation of the Quality Management System to be instituted by the State no later than January 1, 2012.

B. Serving Persons with Mental Illness in the Community

In reviewing the actions taken to comply with this Section of the Settlement Agreement, four expert consultants were retained by the Independent Reviewer to assess and evaluate the implementation of supported employment, supported housing and Assertive Community Treatment (ACT). This approach was taken, in contrast to the reviews of individuals with a developmental disability, in order to determine whether the appropriate foundation was being constructed to support and sustain the adherence to fidelity required by the Settlement Agreement. (Next year's report will include a review of a discrete sample of individuals with a serious and persistent mental illness.)

The reports from the four experts have been provided to the Parties. Discussions about supported housing, supported employment and Assertive Community Treatment were continuing with the Department of Behavioral Health and Developmental Disabilities at the time this report was being finalized.

1. Target Population

By July 1, 2011, the State is to ensure that all individuals on the Mental Health Olmstead List as of the Effective Date of this Agreement, if eligible for services, will receive services in the community in accordance with this Settlement Agreement.

When the Settlement Agreement was approved by the Court, there were twenty-seven individuals on the Olmstead List. According to the Department of Behavioral Health and Developmental Disabilities, all have been discharged from the State Hospital and receive services in the community. These individuals will be reviewed next year.

2. Intensive Services for Individuals with Severe and Persistent Mental Illness

a. Assertive Community Treatment (ACT):

The Settlement Agreement requires that all eighteen ACT teams will operate with fidelity to the Dartmouth Assertive Community Treatment model.

On July 18, 2011, as required by the provisions of the Settlement Agreement, the Department of Behavioral Health and Developmental Disabilities reported that it has established eighteen ACT teams. The teams are operated by Anka Behavioral Health (8 teams); Fulton-Dekalb Hospital Authority (2 teams); GRN Community Services Board (1 team); American Work (2 teams); RiverEdge Behavioral Health Systems (1) team; Advantage Behavioral Health Systems (1 team); and Southwestern State Hospital (3 teams).

A "Program Operations Manual for Assertive Community Treatment (ACT) Teams" was issued on February 10, 2011. The requirements outlined in this Manual are consistent with the requirements of the Settlement Agreement, including the expectations that ACT services shall be available 24 hours per day, seven days a week and that all ACT teams will operate with fidelity to the Dartmouth Assertive Community Treatment model.

In order to assess the effectiveness of ACT teams and to determine whether they were consistent with the standards reflected in the Dartmouth Assertive Community Treatment model, an expert consultant from the ACT Center of Indiana reviewed documentation and met with relevant staff from the Department of Behavioral Health and Developmental Disabilities, providers of ACT services and interested stakeholders.

In conducting her review, with agreement from the Parties, the expert consultant utilized the State Health Authority Yardstick (SHAY). This instrument was designed by a group of mental health researchers and implementers who were interested in assessing the facilitating conditions for the adoption of Evidence-Based Practices created by a state's health or mental health authority. The State Health Authority Yardstick evaluates planning; the adequacy of funding; training initiatives; leadership; the presence and effectiveness of policies and regulations; and the presence of quality improvement strategies.

The Commissioner of the Department of Behavioral Health and Developmental Disabilities has agreed that the State Health Authority Yardstick is a useful measure but that inter-rater reliability needs to be

established. The Independent Reviewer has agreed with this observation and will work with the Department and the expert consultants to resolve any such questions prior to its future use.

The expert consultant's report recognizes the prioritization of ACT services by the leadership of the Department of Behavioral Health Services; the presence of experienced team members in the State; the funding made available as a result of the Settlement Agreement; and the initial attempts to establish fidelity monitoring functions, although they are still in rudimentary stages.

The report does provide recommendations for consideration by the State including enhanced training and technical assistance to the ACT teams; adjusting the requirements for prior authorization; and providing clarification on the fidelity measures that the ACT teams are expected to meet for continued funding.

In its response to the draft report, the Department of Behavioral Health and Developmental Disabilities stated that all ACT teams have had at least one review with technical assistance during and following the review. These reviews lasted one to three days and included chart reviews, interviews with individuals, focus groups, reviews of policies and attendance at team meetings.

Based on discussions with providers, this statement could not be confirmed in its entirety. Therefore, in Year Two, the Independent Reviewer's experts will evaluate the process of fidelity monitoring, fidelity score results, and the technical assistance provided based on fidelity monitoring from both the State and provider perspective.

The Department also emphasized its provision of training to the ACT teams. This training is acknowledged by the Independent Reviewer's consultant.

3. Intensive Case Management

By July 1, 2011, the State agreed to have one Intensive Case Management Team to provide coordination of treatment and support services for individuals in the target population.

In fact, the State has established two Intensive Case Management Teams. One team is located in the Cobb/Douglas Counties area; the second team is located in the metro Atlanta region. The caseload size and staffing for the Intensive Case Management Team comply with the provision of the Settlement Agreement.

4. Crisis Services for Individuals with Severe and Persistent Mental Illness

a. Community Hospital Beds

The State agreed to retain funding for 35 beds in non-State community hospitals without regard as to whether such hospitals are freestanding psychiatric hospitals or general, acute care hospitals. These beds were established beginning in April 2011. There are now five community hospitals (Cobb, Northeast Georgia Medical Center, Tanner Medical Center, Summitridge and Peachford Hospital) with contracts to provide inpatient psychiatric care to individuals referred through the Department of

Behavioral Health and Developmental Disabilities. In part, these community hospitals replace the State Hospital beds no longer available at the Northwest Regional Hospital in Rome.

b. Crisis Line

The Georgia Crisis and Access Line is operated by Behavioral Health Link. As required by the Settlement Agreement, the crisis line is staffed twenty-four hours a day, seven days a week with professional social workers and counselors to assist in urgent and emergency needs. Callers who need more routine services are directly connected to an agency of their choice and given an appointment. Data on crisis utilization can be obtained through its website.

c. Housing Supports

As of July 1, 2011, the State was to provide a total of 100 supported housing beds for individuals with serious and persistent mental illness who are in the target population. In order to evaluate the State's planning, development and sustainability of supported housing, two consultants with expertise in both housing and community mental health were retained by the Independent Consultant to conduct site visits and interviews with the relevant housing specialists in the Department of Behavioral Health and Developmental Disabilities. Providers of supported housing and stakeholders with an interest in this issue were also invited to meet with the expert consultants.

The State's development of the 100 supported housing beds targeted for Year One and its provision of Bridge funding to at least 90 individuals with a serious and persistent mental illness were commended by the consultants. They recognized the expertise and experience of the Director of Housing Development; the adherence to quality standards; and the plan to develop a prioritization process. At the same time, the State was urged to be very intentional in its efforts to ensure the population targeted in the Settlement Agreement gets access to affordable housing. Also, it was recommended that the Department of Behavioral Health and Developmental Disabilities collaborate regularly with state and local housing organizations to ensure that individuals with disabilities get their fair share of the limited availability of affordable housing and to make certain that the housing organizations who qualify for state and federal resources actively seek that funding.

The expert consultants cautioned that there must be attention to infrastructure, capacity building, and collaborative action with housing agency partners and community agencies, if future housing targets are to be achieved. In addition, the expert consultants suggested that the Department augment its Recovery Planning processes with Critical Time intervention (CTI) or Community Support Planning (CSP) tools to help staff and hospitalized individuals consider direct placement into supported housing as an option.

d. Supported Employment

As required in this phase of the Settlement Agreement, there were at least seventy individuals provided with opportunities in Year One. In fact, the State exceeded the expectation by submitting the names of 105 individuals who were enrolled in Supported Employment Programs. Three Supported Employment providers enrolled the majority of these individuals between May 1 and June 30, 2011. Of these

individuals, eight (8%) were competitively employed at different businesses by June 30, 2011. Of those not yet employed, fourteen individuals had first contacts with potential employers; all but two of those contacts were within one month of enrollment in Supported Employment services. Since individuals were assigned to the Supported Employment providers in May, only eight were employed by July 1, 2011. A higher rate of employment will be expected next year.

The structure and substance of Georgia's Supported Employment programs were reviewed by a consultant to the Independent Reviewer. The consultant is on the staff of the Dartmouth Psychiatric Research Center and is expert in the field of Supported Employment for individuals with a serious and persistent mental illness.

The report on Georgia's programs stressed the valuable expertise of certain provider agencies with a long history of involvement with Supported Employment as an Evidence-Based Practice. The enthusiasm of stakeholders for employment as a means towards recovery was also highlighted as very positive.

The consultant utilized the State Health Authority Yardstick (SHAY), described in the above section regarding Assertive Community Treatment, to measure the State's commitment to Supported Employment, its training and technical assistance efforts, and its quality assurance efforts.

The report offers several recommendations for consideration, including the development of a plan for this Evidence-Based Practice; input from stakeholders in the planning process was encouraged. Other recommendations include investing in workforce training and consultation; identifying a qualified staff person with sufficient time to lead the improvement process and collaborate with stakeholders; and addressing the lack of outcomes related to Supported Employment on a system-wide basis.

C. Services in the Community

The Settlement Agreement states that individuals under the age of 18 shall not be admitted to, or otherwise served, in the State Hospitals or on State Hospital grounds, unless the individual meets the criteria for an emancipated minor.

At the time the Settlement Agreement was signed, there were three minors institutionalized in State Hospitals. Those individuals, two teenagers and a ten year old, remain hospitalized. This obligation was not met.

The Parties agreed that the State would work cooperatively with the Independent Reviewer and her nurse consultant to move forward on the development and implementation of appropriately designed community placements for these three individuals. Over the last three months, there have been numerous assessments and discussions; the nurse consultant conducted site visits in order to meet/observe each of the individuals, review medical records and interview relevant staff, including the Medical Directors. There is agreement that two of the individuals can be supported in the community by host families with experience and sufficient assistance. The third individual is very seriously medically compromised. There is agreement that a move to a community placement at this time would not be in

her best interest. The Independent Reviewer and her expert consultant, who has been very engaged in these ongoing discussions, concur that placement should not occur at this time.

At this time, neither of the two placements has been secured. There have been difficulties in identifying and/or retaining appropriate host home providers. In the interim, with the urging of the Department of Justice, the youngest child has begun to attend a local public school with appropriate supports for the implementation of her Individual Education Plan.

While three minors remain institutionalized, and the urgency of this provision remains, there is a good faith effort underway to develop individualized supports and relationships with qualified host families so that at least two of the young people can benefit from the experiences and relationships of a community setting without unnecessary delays.

D. Transition Planning

In the Settlement Agreement, the State agreed to have at least one case manager per State Hospital to review transition planning for individuals who have challenging behaviors or medical conditions that impede their transition to the community.

The State also agreed that planning for transition to the community will be the responsibility of the appropriate Regional Office and will be carried out through collaborative engagement with the discharge planning process of the State Hospitals and provider(s) chosen by the individual or the individual's guardian, where required. The Regional Office is required to maintain and submit to the State Hospital a detailed list of all community providers, including all services provided by each provider.

Regional Offices have assumed the primary responsibility for discharge planning from the State Hospitals. Although this obligation will be studied in more depth this year (Year Two), there was evidence of coordinated discharge planning and effective collaboration in the planning for the community placements of the two young girls referenced above. Furthermore, the State has retained two very experienced and capable consultants to assist in the assessment and discharge planning for individuals who have challenging medical conditions that might impede their transition to the community. Based on recent experience with them, they have demonstrated effective problem-solving skills and flexibility in designing individualized supports. These consultants have worked very closely with the nurse consultant retained by the Independent Reviewer.

Copies of the lists of community providers provided to the State Hospitals were obtained. These lists are updated periodically.

E. Implementation of the Agreement

The State has met its obligation to report the death of any individual actively receiving services pursuant to this Settlement Agreement. The notifications of deaths (and other critical incidents) have been followed by copies of the investigation reports and responses to queries by the Independent Reviewer.

Corrective Action Plans were requested and received following notice of the death of K.K. In that case, the allegation of neglect by the host home provider was substantiated. As a result, she no longer has responsibility for vulnerable individuals under the responsibility of the Department of Behavioral Health and Developmental Disabilities.

Based on a letter from the father of L.L., the Court has asked the Independent Reviewer to take appropriate action to review this individual's death. This matter was discussed with the Parties at the meeting held on August 25, 2011.

Conclusion

The State, through its Department of Behavioral Health and Developmental Disabilities, has demonstrated good faith and commitment in its implementation of the Year One obligations under the Settlement Agreement. The State Legislature approved the funding essential to the development of the requisite programs and, in addition, authorized an unanticipated expansion of funding for the provision of family supports.

As summarized throughout this Report, a number of important milestones have been achieved, including the cessation of admissions to the State Hospitals due to a primary diagnosis of a developmental disability and the expansion of residential placements funded by the Home and Community-Based Waiver. The mental health system in the State has been strengthened by the addition of Assertive Community Treatment teams; two Intensive Case Management teams; community hospital beds in Region 1; and the continuing operation of the Crisis Line. Significant progress has been made in the expansion of supported housing and in the opportunities for supported employment.

While recognizing the important accomplishments made through the diligent efforts of the Department of Behavioral Health and Developmental Disabilities, this independent review also highlighted critical issues requiring corrective action. The failures to provide meaningful and adequate day programming, to fully monitor health care, and to obtain informed consent for psychotropic medications and behavioral support plans were noted for some of the individuals placed from the State Hospitals into community settings under the terms of this Settlement Agreement. These concerns have been brought to the attention of the Department of Behavioral Health and Developmental Disabilities; corrective actions have been identified and implemented.

Challenges remain in the development of supported housing and supported employment; these challenges can affect compliance with the Settlement Agreement in the future. In addition, concerns were raised by some key stakeholders about the availability of crisis and other services in more rural

areas of the State. Their concerns are relevant to the development of mental health services mandated by the Settlement Agreement.

In drafting the language of the Settlement Agreement, the Parties stated their intent 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." This statement of intent is entirely consistent with the goal of the Commissioner of the Department of Behavioral Health and Developmental Disabilities that a continuum of services be reasonably accessible to every Georgian with a disability.

In this baseline year, the State has demonstrated that it can and will honor its obligation to comply with the substantive provisions of the Settlement Agreement.

Respectfully Submitted,

_______________/s/_______________

Elizabeth Jones, Independent Reviewer

October 5, 2011