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

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

NOTICE OF JOINT FILING OF THE REPORT OF THE INDEPENDENT REVIEWER

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

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

On March 26, 2018, the Independent Reviewer, Elizabeth Jones, submitted to the parties her semi-annual report, along with several reports from her consultants. On behalf of the Independent Reviewer, the parties hereby file the Independent Reviewer's report and the reports of her consultants.

Respectfully submitted, this 27th day of March, 2018.

FOR PLAINTIFF:

BYUNG J. PAK
United States Attorney
Northern District of Georgia

/s/ Aileen Bell Hughes
(with express permission)
AILEEN BELL HUGHES
Georgia Bar No. 375505
Assistant United States Attorney
Northern District of Georgia
600 United States Courthouse
75 Ted Turner Drive, SW
Atlanta, GA 30303
Telephone: (404) 581-6000
Fax: (404) 581-4667
Email: aileen.bell.hughes@usdoj.gov

JOHN M. GORE
Acting Assistant Attorney General
Civil Rights Division

ALBERTO RUISANCHEZ
Acting Deputy Assistant Attorney General
Civil Rights Division

STEVEN H. ROSENBAUM
Chief
Special Litigation Section

MARY R. BOHAN
Deputy Chief
Special Litigation Section

/s/ Richard J. Farano
(with express permission)
RICHARD J. FARANO
District of Columbia Bar No. 424225
Senior Trial Attorney

United States Department of Justice
Civil Rights Division
Special Litigation Section
950 Pennsylvania Avenue, NW
Washington, DC 20530
Telephone: (202) 307-3116
Fax: (202) 514-0212
Email: richard.farano@usdoj.gov

FOR DEFENDANTS:

CHRISTOPHER M. CARR
Attorney General
Georgia Bar No. 112505

ANNETTE M. COWART
Deputy Attorney General
Georgia Bar No. 191199

SHALEN S. NELSON
Senior Assistant Attorney General
Georgia Bar No. 636575

State Law Department
40 Capitol Square, SW
Atlanta, GA 30334
Telephone: (404) 656-3357
Fax: (404) 463-1062

/s/ Jaime Theriot
JAIME THERIOT
Special Assistant Attorney General
Georgia Bar No. 497652

Troutman Sanders LLP
3000 Bank of America Plaza
600 Peachtree Street, NE
Atlanta, GA 30308
Telephone: (404) 885-3534
Fax: (404) 962-6748
Email: jaime.theriot@troutman.com

JOSH BELINFANTE
Special Assistant Attorney General
Georgia Bar No. 047399

Robbins Ross Alloy Belinfante
Littlefield LLC
999 Peachtree Street, NE
Atlanta, GA 30309
Telephone: (678) 701-9381
Fax: (404) 601-6733
Email:
josh.belinfante@robbinsfirm.com

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2018, a copy of the foregoing document, Notice of Joint Filing of the Report of the Independent Reviewer, along with the underlying reports, were filed electronically with the Clerk of Court and served on all parties of record by operation of the Court's CM/ECF system.

/s/ Jaime Theriot
JAIME THERIOT
Georgia Bar No. 497652

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

March 26, 2018

Introductory Comments

The Settlement Agreement (SA) and the Extension Agreement (EA) require the Independent Reviewer to file reports each year with the Court. This is the first of two reports for the State of Georgia's Fiscal Year 2018 (FY18); it covers the period from July 1, 2017 until February 28, 2018.

As with each previous report, the Independent Reviewer and her subject matter consultants have focused on the State's compliance with the provisions of the Settlement Agreement and the Extension Agreement. Fact-finding has been completed through extensive fieldwork, interviews, discussions, document review and analysis. The Parties held quarterly meetings with the Amici as stipulated in the Extension Agreement.

The State's efforts to restructure and reform the systems of support for individuals with a developmental disability (DD) or with a serious and persistent mental illness (SPMI) have reached a critical point in this case. The Extension Agreement states, "The Parties anticipate that the State will have substantially complied with all provisions of the Extension Agreement by June 30, 2018. Substantial compliance is achieved if any violations of the Extension Agreement are minor or occasional and are not systemic." (EA 48).

As documented in this report, the State, through its Department of Behavioral Health and Developmental Disabilities (DBHDD) and its Department of Community Health (DCH), has shown good faith in working to meet its obligations under the Settlement Agreement and its Extension. Since FY11, there has been a substantial investment of resources by the Governor and by the Georgia General Assembly. There is clear evidence of diligence in examining responsibilities under the Court Orders; there has been commendable openness in listening to concerns and recommendations.

Nonetheless, progress in achieving compliance with all of the Court-ordered obligations has not been uniform.

Although there will be discussion of the State's efforts and outcomes throughout this report, two findings are highlighted now to underscore the conclusion above. Both of these findings stem from the specific actions required to implement the overarching goals of the Settlement Agreement and its Extension. As stated in the Settlement Agreement:

> 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.)

For the first finding, at this time, there is clear evidence of significant positive change in the obligations related to EA 6, 7, 9 and 11. These EA provisions focus on individuals with DD who are institutionalized in the State Hospitals; they require specific actions in order to implement carefully planned and person-centered transitions from a segregated, congregate setting to the most integrated setting appropriate to the individual's needs.

The process of transitioning individuals with a developmental disability from State Hospitals to community-based residences and supports has been strengthened. Forensic clients are included in the transitions, as well as individuals who are medically fragile. Support Coordinators are assigned while the person is still institutionalized and there is evidence of continuity in this assignment. Clinical consultations are part of the transition process. Although there were delays this winter due to the flu epidemic, it appears that a reasonable pace of transitions may be accomplished by the end of June 2018. The number of community placements in FY18 to date (29) has exceeded the number of individuals (28) placed in all of the last Fiscal Year.

However, in this second finding, there remains substantial work to be completed to ensure that compliance will be achieved. The SA and EA provisions related to Supported Housing are currently not implemented on a systemic basis for all of the subgroups of the Target Population, as defined in Paragraph 30 of the Extension Agreement, which states:

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

This EA provision is substantially similar to language in the SA at III.B.1. Both the SA and the EA require the State to have the capacity to provide Supported Housing to any of these individuals (SA III.B.2.c.ii.A and EA 38). As this report documents, despite recently shared plans for the future, Supported Housing is not available in a systemic manner to anyone in the Target Population who is included in the above-referenced definition. Outreach to and opportunities for assessment of the need for housing with supports is not found on a systemic or statewide basis for individuals with SPMI who are being released from jails or prisons or for those who are frequently seen in emergency rooms. Furthermore, the number of individuals assessed for and linked to Supported Housing upon discharge from State Hospitals has remained relatively low throughout the existence of the Settlement Agreement and its Extension.

The importance of these Provisions was recently brought to the attention of the Independent Reviewer in the circumstances surrounding the release from prison of Mr. D., a man with SPMI and a member of the Target Population. Information about Mr. D. was obtained in an interview with him; he gave his permission for his experiences to be described in this report.

> Mr. D. spent 22 years of his life in prison. During his incarceration, he witnessed one cellmate commit suicide and another prisoner stabbed to death. He participated in a work program and was praised for his skills as a short-order cook. While in a class at the prison, he heard about an agency that would provide support for someone with a serious mental illness but no referral or other connection to this potential resource was made for him.

> Mr. D. was given two-days notice of his release from prison. He was asked where he would like to go when he received his bus ticket. He chose to return to Columbus, GA, the only place he knew. He had no plans for housing, no money of his own and was not given any assistance in planning what would happen following his release. The debit card he was given when leaving the prison did not even have the 25 dollars it was supposed to include. As a result, after arriving in Columbus, he spent two or three days without food until a homeless man told him that the Salvation Army could give him a meal.
>
> Mr. D. lived on the streets and in shelters. Other homeless men and women shared their few belongings with him. He searched and found a job as a cook but did not have the resources to obtain stable housing. He experienced nightmares about the deaths he witnessed in prison. He began to worry that he would regress and return to the "old ways" that had led him to prison in the first place.
>
> While struggling, Mr. D. remembered the name of the agency that could help him with his mental illness. Fortunately, that agency had services in Columbus and he was promptly accepted into its program. He was assigned a therapist who is helping him recover from trauma. He was assisted in finding an apartment, although it is not located near his employment. Since his transportation allowance has run out, he leaves his apartment at 3:30 each morning and walks 45 minutes to his morning shift. Mr. D. is adamant that his employment is very important to him. He also expressed deep appreciation for the support he receives from the mental health agency staff.

Mr. D.'s experiences are recounted at some length because they illustrate the importance of complying with the obligations of the Settlement Agreement and its Extension. If the requirements articulated in the Extension Agreement had been implemented for Mr. D., his release from prison would have been planned with him and would have included an assessment for housing with supports, including mental health services and employment. He would not have endured hunger, homelessness and emotional distress without treatment.

This report is supplemented by the work completed by the Independent Reviewer's subject matter consultants in nursing, psychology, discharge planning and evidence-based practices in Assertive Community Treatment (ACT) and Supported Housing. The attached reports contain additional detail and analysis about the provisions examined in the narrative below.

A draft of this report was shared with the Parties for their comments. All comments that were received were carefully considered; changes and/or additions were made as needed. The frequent discussions, always cordial, candid and productive, held with the Commissioners of DBHDD and DCH are greatly appreciated and have contributed to a better understanding of the challenges involved in systemic reform. DBHDD staff members, in many capacities, have continued to be accessible and responsive. The Director of Settlement Coordination and her Administrative Assistant have been unfailingly helpful and patient with the multiple demands placed upon them in the course of the Independent Reviewer's work. The attorneys for the Department of Justice and the State of Georgia have responded to many questions and requests with insight and thoughtfulness. Their guidance and assistance have been invaluable. The Amici, advocates, community stakeholders and individuals with a disability and their families clearly demonstrated

their investment in Georgia's efforts and expressed a deep commitment to the reforms underway or hoped for in the near future.

Methodology

The fact-finding for this report involved extensive fieldwork as well as multiple meetings with the Parties, the Amici, staff from service provider agencies, peer mentors, representatives of local government agencies, and other interested stakeholders, including individuals and family members who are at the core of the Settlement Agreement and its Extension.

In preparation for this report, the Independent Reviewer spent 34 days on site in Georgia. Fieldwork occurred in all DBHDD Regions.

Site visits were made to State Hospitals, Supported Housing, group homes, crisis homes and host homes. At each residential setting, members of the Target Population were met and, if possible, interviewed.

Visits to seven County Jails included discussions with Sheriffs and/or their deputies and with correctional agency staff responsible for mental health care in the jail. Two incarcerated individuals with SPMI were interviewed in their cells. Discussions were also held with Public Defenders and other attorneys who represent individuals in jails or prisons.

Two attempts were made to visit a prison operated by the Department of Corrections in order to learn more about the planning for the release of any offender with SPMI. However, the Independent Reviewer was instructed that these visits were not possible without a court order. In order to assist with this situation, DBHDD leadership arranged a conference call. On February 27, 2018, the Independent Reviewer spoke about discharge planning with the Mental Health Unit Director of a state prison in north Georgia. Discharge planning and the connection to community supports were also discussed with Mr. D., the man released from prison after incarceration sentences of a total of 22 years.

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

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

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

Dr. Patrick Heick and Julene Hollenbach reviewed a targeted sample of 21 individuals with DD who either experienced encounters with law enforcement or were included for health/medical reasons on the Statewide Clinical Oversight (SCO) list or the High Risk Surveillance List (HRSL). Each of these reviews included a site visit, document review and the completion of a Monitoring Questionnaire. (The Independent Reviewer and DBHDD developed this

Questionnaire during the early years of the Settlement Agreement.) Dr. Heick's summary report is attached. The individual reviews completed by Dr. Heick and Ms. Hollenbach have been provided to the Parties.

Laura Nuss reviewed Support Coordination by interviewing DBHDD staff, Directors of Support Coordination agencies and members of advocacy organizations. She examined all documentation provided by DBHDD related to its efforts to comply with these provisions of the Extension Agreement. Ms. Nuss's report is attached.

Dr. Angela Rollins analyzed the five DACTS Fidelity Reviews completed thus far in FY18. The report from Dr. Rollins is attached.

Dr. Beth Gouse spent time at the end of each quarter at Georgia Regional Hospital Atlanta (GRHA) and Georgia Regional Hospital Savannah (GRHS). She reviewed the Hospital records of all adults discharged to shelters and discussed discharge planning with Hospital staff. Dr. Gouse also reviewed discharge planning for forensic clients, including those hospitalized at the Cook Building at Central State Hospital (CSH) in Milledgeville, West Central Georgia Regional Hospital (WCGRH) in Columbus, and East Central Regional Hospital (ECRH) in Augusta. The report from Dr. Gouse is attached.

Martha Knisley reviewed DBHDD's efforts to comply with obligations related to Supported Housing. She met with DBHDD staff and staff from the Department of Community Affairs (DCA) several times in person and through conference calls. She also interviewed representatives from local agencies responsible for homeless individuals with SPMI, mental health service providers, individuals with SPMI who had obtained or were in need of Supported Housing, and attorneys who represented adults with SPMI. Ms. Knisley visited two jails with the Independent Reviewer in order to learn about discharge planning for offenders with SPMI. Ms. Knisley's report is attached.

The Independent Reviewer's subject matter consultants spent a combined total of 20 days on site in Georgia in preparation for their written reports.

The consultants' work will be discussed throughout this report. Copies of all reports have been provided to the Parties; certain reports will be filed with the Court.

The Independent Reviewer and her consultants greatly appreciate the assistance they were given by so many people in order to complete our work.

Discussion of the Provisions

This report focuses primarily on the provisions included in the Extension Agreement. Unless they have been released, provisions from the first Settlement Agreement are carried over; they are generally evaluated for the report completed at the end of the Fiscal Year. (The annual report is filed with the Court in September.) At that time, data for the entire year will be available from DBHDD.

Background and Context for Placements from State Hospitals

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

There are now five State Hospitals. Northwest Georgia Regional Hospital and Southwestern State Hospital are closed. Adult mental health services are no longer provided at Central State Hospital. On February 28, 2018, there were a total of 1,090 adults institutionalized in the State Hospitals. The majority of these adults (57%) are in secured forensic units.

As of February 28, 2018, 146 adults with DD reside at ECRH/Gracewood in Augusta and there are 30 individuals with DD and health/medical needs in the Skilled Nursing Unit at GRHA.

In December 2017, the Adult Mental Health units in the State Hospitals had a total capacity for 313 individuals. On February 28, 2018, the combined census was 289 adults with a mental illness.

On February 28, 2018, there were 625 individuals in forensic units at the State Hospitals; the maximum capacity is 641 adults. As of February 28, 2018, there were 35 adults with DD in forensic units.

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

There are no children in any of the State Hospitals. Admissions of individuals with DD have stopped except that courts still order placement of adults with DD and a forensic status into the State Hospitals. In FY17, the courts ordered nine individuals with a primary diagnosis of DD into forensic units in the State Hospitals.

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

Sixty adults residing in the Craig Center at Central State Hospital were transferred to other State Hospitals when that institutional unit was closed in 2015. There now are 20 former residents of the Craig Center at Gracewood; 12 individuals have a mental illness and 8 of those individuals have DD. There are 13 former residents of the Craig Center at GRHA; 2 adults have a mental illness and 11 individuals have DD. The Independent Reviewer has not been informed of any institutional transfers since the closure of the Craig Center.

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

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

Provisions Related to Individuals with DD

Status of Transitions of Individuals with DD from State Hospitals

The responsible and timely transition of institutionalized individuals with DD to individualized and integrated community-based residential settings with the necessary services and supports, as documented in the Individual Support Plan (ISP), is central to the Settlement Agreement and its Extension. The State has worked diligently to address earlier systemic problems found with these transitions; it has initiated processes and protocols to protect health and safety. Leadership staff with experience, skill and knowledge have been assigned to the transition process and there has been an allocation of resources through State funding and the federal Home and Community-Based Services Waiver.

As of February 28, 2018, there are 175 individuals with DD institutionalized at Gracewood and GRHA. An additional 35 individuals with DD and a forensic status remain in State psychiatric hospitals.

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

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

As of the date of this report, since July 1, 2017, there have been 29 transitions from the State Hospitals to community placements, primarily in small group homes of four or fewer individuals. There were five placements in July, three placements in August, six placements in September, ten placements in October and a total of three more placements in November, December and January, one in each month. (The flu epidemic and the resulting quarantine at Gracewood impacted the schedule for transitions.) In late February, there were two additional placements.

In the first eight months of this FY, the overall number of placements has already exceeded the number of DD placements made in FY17. Assuming that the pace of transitions that occurred in the earlier months of FY18 continues through the next four months of March, April, May and June, it will be possible to make a determination of whether the State has moved people at a "reasonable pace"; this determination will be included in the next report to the Court.

In addition, when the placements for this FY are completed, a representative sample of transitioned individuals will be reviewed using the Monitoring Questionnaire to determine whether the services and supports included in each ISP are in place and are sufficient to address an individual's assessed needs for health, skill development and community integration.

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

All Support Coordination agencies reported that this provision remained in compliance. DBHDD also reported compliance in the materials presented to the Parties. The Independent Reviewer examined compliance with this requirement of the Extension Agreement by discussing the processes and protocols with DBHDD staff and reviewing the discharges of certain individuals with DD from Gracewood.

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

Based on information provided to the Independent Reviewer by DBHDD, a properly constituted team, including participation by the community provider, has been assembled for each individual transitioned from the State Hospital. The Independent Reviewer has confirmed this through several discussions with Hospital staff and community providers. This provision will be examined again when the review of the representative sample is completed for the next report. A finding of Compliance is anticipated.

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

Agreement Requirement: The EA requires the State to provide "needed" services and supports to individuals with DD in the community. (EA 13)

The last data on post-discharge monitoring were submitted by the State for the quarter ending December 31, 2017. It showed a compliance rate of 89%, the same percentage as for the previous quarter, ending on September 30, 2017.

Information provided about the work of the Integrated Clinical Services Team (ICST) indicated that post-move monitoring has occurred but there were no details included as to the identity of the individual or the results of the monitoring visits.

There were four deaths of individuals with DD who died within six months of their transition in FY18. The Columbus Organization conducts an external qualitative review of DBHDD's investigations of post-transition deaths. The Independent Reviewer recently received two of those Columbus investigations. Two investigations remain outstanding.

In the deaths of B.B. and R.E., Columbus found the DBHDD investigations to be timely, thorough and complete.

There was sufficient evidence to substantiate neglect by the provider who assumed responsibility for B.B. The agency failed to provide adequate staffing in the home; failed to track skin integrity, weight and bowel movements; and failed to report her hospitalization. The Columbus report stated that "when problems regarding Ms. B.'s care were identified, it should be noted that there appeared to be consistent and regular follow up of Ms. B.'s care and it should be positively noted that when serious threats such as seriously inadequate staffing were discovered, those monitoring the transition stayed at the home until the problem was corrected."

In the case of R.E., there was no evidence of neglect. The Columbus report stated that "Mr. E. received follow-up transition visits according to policy and that concerns regarding his nutrition were addressed in the transition follow-up visits and with his primary care physician."

The Columbus Organization made several recommendations regarding the transition process, including the inclusion of direct support staff and the timing/intensity of training about an individual's needs. The Independent Reviewer was assured that these Columbus reports would be discussed with Gracewood staff responsible for the transition process.

Systemic data regarding the number of hospitalizations and the occurrence of serious incidents/injuries were not provided to the Independent Reviewer. Such data, if available, would be very useful in evaluating compliance with these provisions. As indicated in work completed for this report by Dr. Heick and Ms. Hollenbach, there remain substantial gaps in the provision

of behavioral supports and proactive clinical assessments for individuals with DD who live in community settings, including family homes. The lack of essential supports contributes to risk of harm, diminishes the development of skills and detracts from the individual's overall quality of life.

Both of these provisions will be evaluated in the review of a representative sample of individuals with DD who have transitioned by the end of June 2018.

At this time, based on the information received for this report, it is clear that systemic change in the transition and placement process is underway. There are positive indications that the careful planning for transitions is being implemented and that the pace of transitions will continue. At the same time, there is continuing evidence that essential clinical supports are not in place on a systemic basis.

There are four months remaining in this FY; it is premature to recommend a compliance finding to the Court. After all transitions are completed at the end of June 2018 and there is an updated transition planning list for the next FY, a recommendation by the Independent Reviewer will be made to the Parties and then to the Court.

Support Coordination

Support Coordination is a critical linchpin in the design, provision and monitoring of an individual with DD's supports. It is one of the most important safeguards that can be provided, especially to someone who is at higher risk because of challenging behavior or complex health/medical needs. The Extension Agreement contains detailed requirements for the implementation of this essential role.

In order to review performance in this area, the Independent Reviewer's subject matter consultant, Laura Nuss, reviewed all documentation that was provided by DBHDD and discussed the specific issues with DBHDD leadership staff. She also spoke with each of the Directors of the seven agencies responsible for the provision of Support Coordination throughout Georgia. She reviewed one individual's case with a Support Coordination agency; this individual was found to have experienced neglect in the review conducted by the Independent Reviewer's consulting nurse.

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

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

However, the work of the Support Coordinator is impeded by the limitations in the access to and availability of certain essential services and supports, including behavioral supports. Support Coordinators interviewed for this report were in agreement that behavioral supports are inadequate at this time.

> **Agreement Requirement:** The EA requires the State to revise and implement the roles and responsibilities of Support Coordinators. The EA requires the State to oversee and monitor that Support Coordinators develop ISPs, monitor the implementation of the ISPs, recognize each individual's needs and risks, promote community integration, and help the individual gain access to needed services and supports. (EA 16.a.)

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

As discussed in the attached report by Ms. Nuss, DBHDD does not report on Support Coordination performance in the area of ISP development. It was confirmed that the Regional Field Offices were timely in their review of ISPs. However, a significant problem was identified by four out of seven (57%) Directors of Support Coordination agencies. According to their reports, the STAR process is the means to obtain approval for a new service or an increase in the amount of an existing service. As described in the Independent Reviewer's last report to the Court, the STAR process experienced delays in processing these requests. These problems have not been resolved. As a result, there have been significant delays in the receipt of new or increased levels of essential services.

At this time, no data have been provided or made available on the extent of this problem. Since this is a significant finding, it will be monitored by the Independent Reviewer and discussed in her next report.

Since the continuing delays in processing STAR requests is a serious impediment to both the delivery of necessary supports and the implementation of the Support Coordinators' responsibilities, there cannot be a recommendation for a finding of Compliance until this problem is fully corrected.

> **Agreement Requirement:** The State is to have the Support Coordinators use a uniform tool and guidelines for implementation that include criteria, responsibilities, and timeframes for referrals and actions to address risks to the individual and obtain needed services and supports for the individual. The tool is to, at least, address: accessibility, privacy, adequate food and clothing, cleanliness, safety, changes in health status, recent ER/hospital visits, delivery of services with respect and fidelity to the ISP, implementation of the BSP, recent crisis calls, existence of natural supports, services in the most integrated setting, participation in community activities, employment opportunities, access to transportation, control of personal finances, and the individual's satisfaction with current supports and services. (EA 16.b.) The EA requires the State to annually collect data on the tool and assess the performance of the Support Coordination agencies in helping individuals gain access to needed services and supports. (EA 16.c.)

DBHDD has implemented the use of a uniform tool and has published guidelines for the implementation of the tool as required. A revised tool was issued addressing recommendations made by the Independent Reviewer's consultant. Therefore, DBHDD should be found in Compliance with EA 16. b.

DBHDD produced a report that evaluated data for the period from October 2016 to October 2017. This report evaluated findings on caseload size, face-to-face visits, coaching and referrals and outcomes. The report did not address ISP development. Importantly, given the concerns raised in this report regarding behavioral supports, the lowest scoring performance area was noted to be achievement of positive behavioral and emotional outcomes. All Support Coordination agencies reported that additional behavioral support service providers were needed.

The lack of adequate behavioral supports was confirmed in the reviews completed by Dr. Heick. As discussed below, it appeared that at least eight out of nine individuals (89%) with encounters with law enforcement would likely benefit from positive behavioral programming and supports implemented within their homes or residential programs.

Once the report issued by DBHDD includes data regarding the development of ISPs and there is evidence that outcomes meet acceptable levels of performance, there could be a recommendation for a finding of Compliance with EA 16.c.

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

DBHDD is not in compliance with this provision at this time. DBHDD provided access to the Reporting of Critical Incidents (ROCI) application to community residential services providers and published a User's Guide on June 7, 2017. The February 2018 *DBHDD Support Coordination Performance Report* reported on the number of Critical Incidents by a Support Coordination agency as a possible performance measure. However, during the fact-finding for this report, it was reported that Support Coordination agencies were not able to view Critical Incident Reports (CIRs) entered by provider agencies in the ROCI system. Subsequent interviews with the Support Coordination agencies' Executive Directors confirmed that, in all agencies, CIRs were not made available to them, or were significantly delayed in transmission by several months, and that the Support Coordination agency did not receive notice of a completed Incident Investigation Report or a Corrective Action Plan.

Data to confirm and evaluate the consequences of this problem on a systemic basis were not available for discussion in this report. However, the Independent Reviewer's nurse consultant reviewed two individuals who were the subject of CIRs; neither Support Coordinator was informed and only learned of the incident when she arrived for her visit. For example:

- A CIR regarding K.D. was filed on August 14, 2017 but the Support Coordinator was not notified by either the provider or DBHDD. When the Support Coordinator arrived for a routine visit on August 17, 2018, she observed that K.D. had a black eye.

- R.D.'s residential provider did not notify his Support Coordinator of the need to follow-up on a basal cell carcinoma diagnosis and an eye infection. It was only through the Support Coordinator's ongoing visitation that the status of his health was monitored. (This Support Coordinator was eventually successful in obtaining a new residential provider for this gentleman.)

DBHDD officials did not share this information with the Independent Reviewer's consultant that the Critical Incident System was not operating as described in the DBHDD policy. DBHDD did indicate that the original strategy to track Support Coordination compliance with conducting follow-up on CIRs did not work as planned.

At this time, based on the above, a finding of Compliance with EA 16.d. cannot be recommended.

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

The caseload size of each Support Coordinator was reviewed in order to assess compliance with this obligation.

Employer	Number of SC's	Number in Compliance	Percentage in Compliance	*Reviewer's Findings*	
Benchmark	22	22	100%	21/22	95.45%
CareStar	8	7	87.50%	7/8	87.5%
Compass	8	6	75%	6/8	75%
Columbus	119	104	87.39%	99/115	86.06%
Creative	103	95	92.23%	95/103	92.23%
Georgia Support	44	44	100%	44/44	100%
PCSA	73	67	91.78%	64/71	90.14%
Total	369	345	93.50%	336/371	90.56%

As indicated in the table above, the Independent Reviewer's consultant found discrepencies in the summary data provided by DBHDD for her review. For example:

- The data provided by DBHDD indicate that one Intensive Support Coordinator (ISC) who works for Benchmark carried a caseload of 16 intensive and 6 non-intensive individuals, which violates the DBHDD policy that an ISC may not carry more than 20 individuals. This results in a compliance rating of 95% rather than 100%, as reported by DBHDD.

- Lower ratings of compliance in two other agencies (Columbus and PCSA) were identified by the Independent Reviewer's consultant when discrete information for caseload size was analyzed. These three agencies received higher ratings of compliance by DBHDD.

Furthermore, DBHDD reported compliance below 90% for three out of seven agencies (43%). As discussed by the Independent Reviewer in meetings with DBHDD, caseload size must be in

compliance for each agency. Compliance is not measured by averaging caseloads across all agencies that provide Support Coordination.

As a result of the above findings, a recommendation is made for Non-Compliance with 16.e.

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

The February 2018 *DBHDD Support Coordination Performance Report* provided data on face-to-face visits for the period July through September 2017. Performance for Support Coordination ranged from 89% (Columbus) to 99% (Creative Consulting). In the same report, on page 20, DBHDD completed additional analysis to study whether people with higher health care levels (drawn from the HRST) received more frequent visits. Findings revealed that "support coordination agencies have positive performance overall not only for delivering the number of face-to-face visits, but also are visiting individuals more frequently as their health risk and age increase."

A fuller discussion of the individuals receiving more than the minimum number of visits requires more data than provided in the above report. The Independent Reviewer will request that more specific information about the individuals with increasing risk due to health and/or age be provided to her consultant. The adequacy of support coordination can then be analyzed in more detail before a compliance finding for this provision is recommended to the Court.

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

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

Performance in the areas of ISP development and approval, timely processing of STAR requests and the effective operation of the critical incident management system should be evaluated during the next review.

A recommendation of Compliance or Non-Compliance on the above requirement is deferred until the next report to the Court.

Individuals with Complex Needs

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

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

DBHDD has complied with the obligation to develop and maintain a High Risk Surveillance List (HRSL). The list is updated on a monthly basis and shared with the Department of Justice and the Independent Reviewer. Support Coordinators have this information. Residential providers have stated repeatedly, however, that they are not aware of an individual's placement on the HRSL. The HRSL is organized by the name and status of each individual. There have not been any aggregate data provided to the Independent Reviewer that summarize the actions taken to identify, assess, monitor and stabilize the individuals included on the HRSL as a whole. Reviews of performance need to be completed on a case-by-case basis.

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

Environmental – threat or actual discharge from a residential provider; change in residence; staff training or suitability concern; accessibility issues; loss of family or natural supports; discharge from a day provider;

Other – confirmed identification of any factor above by a provider, Support Coordinator, family member, or advocate. (EA 14.b.)

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

Agreement Requirement: The EA requires the State to conduct the following oversight and intervention activities for each individual on the HRSL until the State determines the individual is stable and no longer designated as high risk:

OHW is to oversee that the initial responses to the identified risks are completed and documented until the risks are resolved.

For an emergency, the provider is to call 911 or crisis services, and notify the Support Coordinator (SC), Field Office (FO), and OHW.

For deteriorating health (not imminently life threatening), the provider is to respond and notify the SC within 24 hours; if the risk is not resolved within 72 hours, the provider or SC is to notify the FO and OHW.

For a risk that does not destabilize the health or safety of the individual, the provider is to respond, inform the SC, and verify completion of the response with the SC before the next SC visit or 30 days (whichever is sooner).

If the risk is not resolved through the steps above, the State is to conduct an in-person assessment of the individual within seven days of the initial response.

The State assessment is to be conducted by an RN/medical professional with advanced medical degree in the area of risk.

The assessment is to include direct observation of staff to verify staff knowledge and competency to implement the risk reduction interventions, and the assessment is to identify any concerns/issues regarding individualized needs and identify necessary follow-up activities with a schedule for completion to address the concerns/issues.

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

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

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

The above requirements were discussed at length with each Director of a Support Coordination agency. They reported generally that performance in this area is dependent upon the relationship between the Support Coordinator or Intensive Support Coordinator and the service location as well as the relationship developed between the Support Coordination agency and the provider agency. Intensive Support Coordinators are much more likely to be informed due to the frequency of their contacts with a provider or natural support(s). One Support Coordination agency meets regularly in group meetings with providers in order to establish on-going communications and to reinforce expectations.

Aggregate data are not available to verify compliance with these Requirements.

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

The State is to develop a protocol that states the responsibility and timeframes for providers and SCs to engage the SCO team to address individuals with heightened risk per the three risk criteria set forth in the previous Agreement Requirement until the risk is resolved. The protocol is to set forth the circumstances when and the mechanisms through which the SCO team receives electronic notification of a heightened risk, as well as the timeframes for State review and response which are to be based on the imminence and severity of the risk. (EA 15.c.)

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

The State is to facilitate consults/TA to providers/SCs to address heightened risks. (EA 15.e.)

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

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

DBHDD has complied with the obligations to establish a Statewide Clinical Oversight program in all areas of the State. A hotline and email address have been implemented. A protocol was developed and provider agencies were trained in the requirements of the protocol. However, provider agencies have repeatedly stated that they do not know if a certain individual is included on the Statewide Clinical Oversight list itself.

Regional Field Office clinicians are responsible for providing current information about the individuals on the Statewide Clinical Oversight List as well as for those on the High Risk Surveillance List. Assessment of the quality of the clinicians' work must be assessed on an individual by individual basis.

The Independent Reviewer's nurse consultant found that the quality of health care, including nursing, provided to 12 individuals with complex medical/health needs met professional standards. However, there were examples of interventions that were not identified by either the Regional Field Office clinician or the provider agency itself. The Independent Reviewer received the following note from her nurse consultant:

A person's health status is extremely important for the individual to be successful. It is of even greater importance with individuals who have multiple medical issues, utilize many medications and/or have other challenges. Those individuals rely on staff to be proactive in ensuring preventative care is provided, potential health issues are identified, and medical treatment is done expediently to prevent a more serious situation. Nursing should be assessing each person and his/her environment to anticipate the person's health needs, develop and implement a plan of care, follow-up to determine if the plan is effective, then continue to do ongoing monitoring and adjusting based on that individual. It appears that nursing oversight should be more proactive in identifying issues and advocating for the health needs of individuals. Examples of health needs that had not been identified by nursing are:

- There were several people with gastrostomy tubes that required the head of their beds to be elevated. Most homes had no mechanism to identify that the head of the bed was elevated to the correct level.

- Staff must be knowledgeable of the purpose and side effects of each medication that is administered so that they can observe for both. Many medications are used for various purposes. The reason for the medication should be specific for that person; otherwise, staff are unable to determine if the medication is accomplishing its purpose. The side effects were often found on the Medication Administration Records (MARS). However, the purpose was seldom on the MARS, but the generic purpose would usually be found in a separate file or on the ISP. Neither location was easily accessible to staff and not specific to the person; however, that seemed to be an accepted practice.

- KH had a gastrostomy tube inserted due to her inability to gain weight. She eats orally and utilizes the enteral tube for supplemental feedings. During the past year, she has gained 20 pounds and is at the top of her ideal weight range. She is non-ambulatory and utilizes a wheelchair. A nutritional assessment should be done to determine if her present diet is still most appropriate or should be adjusted so that she does not become overweight. A physical therapy assessment would determine if her wheelchair still meets her needs or if pressure areas may be created due to the increased weight. She has also had a history of pulling out her enteral tube; therefore, an assessment to determine if the enteral tube is still necessary would be beneficial. Those assessments are being proactive and anticipating potential problems before they occur and/or improving her quality of life.

- A vibrating toothbrush was recommended in May 2017 to improve CT's oral care. In October 2017, CT was recommended to obtain dental care under sedation. In February 2018, neither recommendation had occurred. However, good oral hygiene is essential for a person to experience good health.

- RD has diabetes, hypertension and is overweight. Proper dietary management is critical for each of those conditions; however, a nutritional assessment had not been requested.

Nurses are in a unique position that allows them to integrate all aspects of individuals' care, advocating to ensure that concerns are addressed, standards are upheld, and positive outcomes remain the goal. To do so, the nurse's role is the ongoing assessment of the person's health status and the person's response to the plan of care with the goal of proactively meeting their physical, emotional, cognitive and social needs.

The 12 reviews completed for this report again confirmed that Informed Consent is not obtained for each individual receiving psychotropic medication. This has been a serious concern that has been reported by the Independent Reviewer since she first began to monitor community placements seven years ago. It is unacceptable to fail to obtained Informed Consent and to substitute the signature of the psychiatrist prescribing these powerful medications.

Copies of the 12 individual reviews completed by the Independent Reviewer's nurse consultant have been forwarded to the Parties. On March 22, 2018, the Independent Reviewer and her nurse consultant completed a conference call with the Director of the OHW to discuss findings of concern, such as those related to Informed Consent and the documentation of medication. The positive findings referenced below were also acknowledged:

Selected Health-Related Questions from the Monitoring Questionnaire

No.	Question:	N	Yes	No	CND	NA
85.	In your professional judgment as a Registered Nurse: Are the individual's serious physical health care needs met?	12	12			
86.	Are the health care interventions consistent with professional standards of care?	12	12			
87.	Does nursing care meet professional standards?	12	12			
96.	Is there documentation that the individual and/or a legal guardian/surrogate decision-maker has given **informed** consent for the use of psychotropic medication(s)?	12	1	7		4
100.	Does the individual's nurse or psychiatrist conduct monitoring as indicated for the potential development of tardive dyskinesia using a standardized tool (e.g. AIMS) at baseline and at least every 6 months thereafter)?	12	5	2	1	4
104.	Is there any evidence of administering excessive or unnecessary medication(s)?	12		11	1	
187.	Is there any evidence of actual or potential harm, including neglect?	12	1	11		
188.	In your professional judgment, does this individual require further review?	12	3	9		

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

The role of the ICST includes the following:

- To provide specialized services to individuals who transitioned from State Hospitals to community-based settings under the terms of the Settlement Agreement and its Extension;

- To assess and identify clinical needs and appropriate supportive clinical services for those individuals eligible for a COMP Waiver who are currently residing in a State Hospital but are preparing to transition to a community-based setting;

- To provide clinical technical assistance and training to ID/DD providers who are currently supporting or expected to support Waiver participants;

- To provide clinical supports to Waiver participants who have an HRST score of 5 or 6 and are not part of the Settlement Agreement when there is an identified clinical need and a gap in the availability of community-based clinical resources. Requests for ICST services for individuals with HRST scores below 5 are evaluated and triaged based on severity/intensity, urgency and the availability of community clinicians.

Monthly reports from CRA describe the clinical activities that have occurred, including technical assistance/training and face-to-face visits. In December 2018, there were 63 face-to-face visits but it is unclear as to the number of unduplicated individuals who were seen. Specific information is not provided about the individual cases so it is not possible to determine the level of acuity or the degree of clinical support that was provided in each situation.

DBHDD has implemented an Improving Health Outcomes Initiative to improve health outcomes for individuals with ID/DD through a collaborative learning process which builds on the strengths and insights of individuals receiving supports and services, their families, community providers and DBHDD. The Independent Reviewer did not receive information about the discrete activities in time to include discussion of this resource in this report. However, this appears to be a promising project and will be reviewed in the next report.

Despite the resources described above, the extent to which behavioral supports are still lacking is of considerable concern. The Independent Reviewer's consultant in behavioral analysis found serious shortcomings in his onsite reviews of nine individuals with DD who had experienced encounters with law enforcement. (These individuals were identified on and selected from the Statewide Clinical Oversight List.)

Based on the documentation reviewed and the onsite observations/interviews, most of these individuals demonstrated significant maladaptive behaviors:

> These behaviors had dangerous and disruptive consequences to these individuals and their households, including negative impacts on the quality of these individuals' lives and their ability to become more independent. More specifically, of those sampled, nine (100%) engaged in behaviors that could result in injury to self or others, nine (100%) engaged in behaviors that disrupt the environment and six (67%) engaged in behaviors that impeded his/her ability to access a wide range of environments. In addition, of those sampled, five (56%) engaged in behaviors that impeded their abilities to learn new skills or generalize already learned skills. Overall, eight (89%) of the individuals sampled appeared to demonstrate significant maladaptive behaviors that negatively impacted their quality of life and greater independence. Only one of the individuals sampled appeared to have isolated incidents that did not appear to reflect a longstanding and global pattern of responding. However, all (100%) of the individuals sampled experienced one or more contact with the police. And, eight (89%) individuals accessed crisis services, six (67%) experienced psychiatric hospitalizations, and six (67%) experienced transfers to different settings due to their maladaptive behavior.

Despite these maladaptive behaviors and their consequences, the extent to which behavioral supports, meeting professional standards, were implemented was deemed to be inadequate. For example:

> Of those sampled, however, only seven (78%) individuals were receiving formal behavioral programming through Behavior Support Plans (BSPs) at the time of the on-site visit. It should be noted that one individual, who did not have a BSP, appeared to this reviewer as the lone sampled individual who might continue to be successful without formal behavioral programming. And, although another individual had a BSP implemented at his day program, it was unknown if similar programming was in place at his home. Nonetheless, it appeared that at least eight individuals would likely benefit from positive behavioral programming and supports implemented within their homes or residential programs.

A conference call was held on February 23, 2018 with DBHDD leadership staff to discuss these overall findings as well as concerns related to specific individuals in the targeted sample. The Director of the Division of Developmental Disabilities expressed concern about the overall findings but was adamant that serious effort is underway to implement additional resources and clinical oversight. A new clinical/administrative position, Manager of Statewide Behavioral Supports, has been created and a clinician has been hired recently to implement these responsibilities. It was agreed that DBHDD would respond to each of the nine reviews and additional discussion would occur in the near future to evaluate progress being made on a systemic basis.

At this time, it is clear that DBHDD has taken the administrative and structural actions required, such as establishing the HRSL and SCO, to implement its obligations under the provisions related to individuals with complex needs. Additional time and effort is still needed to ensure thoroughness, sufficiency and uniformity in the provision of clinical supports to individuals with complex needs on a systemic basis.

DBHDD has informed the Independent Reviewer that data related to the health needs and interventions for individuals on the SCO are now being aggregated and analyzed. The Independent Reviewer hopes that these data will be available for her next report.

Although progress is recognized, it is premature to recommend a Compliance or Non-Compliance finding. Therefore, the rating of these provisions will be deferred until the next report.

Crisis Services

The development of Crisis Respite Homes (CRHs) was completed during the timeframe for the first Agreement.

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

As the chart below illustrates, the 12 Crisis Respite Homes have remained operational. There is a 48 bed capacity overall. As of this date, there are 39 individuals in residence.

DBHDD remains in compliance with the specific requirements for number and size.

Region 1		
Total Number of DD Crisis Support Homes = 2	**Bed Capacity**	**Number of Residents, as of March 1, 2018**
House #1	4	2
House #2	4	4

Region 2		
Total Number of DD Crisis Support Homes = 2	**Bed Capacity**	**Number of Residents, as of March 1, 2018**
House #1	4	4
House #2	4	4

Region 3		
Total Number of DD Crisis Support Homes = 1	**Bed Capacity**	**Number of Residents, as of March 1, 2018**
House #1	4	3

Region 4		
Total Number of DD Crisis Support Homes = 2	**Bed Capacity**	**Number of Residents, as of March 1, 2018**
House #1	4	3
House #2	4	2

Region 5		
Total Number of DD Crisis Support Homes = 2	**Bed Capacity**	**Number of Residents, as of March 1, 2018**
House #1	4	4
House #2	4	2

Region 6		
Total Number of DD Crisis Support Homes = 3	**Bed Capacity**	**Number of Residents, as of March 1, 2018**
House #1	4	4
House #2	4	4
House #3	4	3

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

DBHDD has complied with the requirements to issue a monthly list regarding individuals with a stay of 30 days or more. Unfortunately, the barriers to discharge have been very challenging for many of the individuals on the monthly list. These barriers include behavioral management issues and the lack of qualified providers with the skills and resources for alternative settings. There is one individual who has been in a crisis home since June 2012; one who has been in a crisis home since June 2013 and one who was placed there in August 2014. Five of the current residents of crisis homes were admitted in 2016. Twenty-two individuals have lived in crisis respite homes since 2017. At this time, 30 of the 39 individuals (77%) currently residing in a CRH have been there for more than 30 days.

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

Based on these facts, despite the creation of a monthly list, the Independent Reviewer recommends a finding of Non-Compliance with this provision.

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

The State has assessed its crisis response system and issued a Crisis Respite Plan on June 30, 2017. Comments provided by the Independent Reviewer included concerns about the timelines for implementation into FY18.

DBHDD has not provided any further detailed information about its restructuring of the crisis response system. In response to the Independent Reviewer's inquiry, it was reported that the release of the RFP for an integrated system of mobile crisis teams was expected in mid-March 2018; the system was to be operational in October 2018. However, as of March 26, 2018, the RFP has not been released.

As discussed above, there has been inadequate remedial action implemented to reduce the lengths of stay in Crisis Respite Homes.

The Independent Reviewer will examine the actions implemented by the end of June 2018, and then recommend a finding related to compliance for consideration by the Court. She has serious concern about the prolonged stays in Crisis Respite Homes and the impact of these stays on the psychological and social well being of the individuals who do not have stable housing or involved families.

Investigations and Mortality Reviews

The Independent Reviewer commends the direction that DBHDD has underway to redesign its investigation and mortality review processes. She has been briefed on the changes and will continue to follow them closely. She has also informed DBHDD leadership responsible for these systemic safeguards that a recommended finding related to compliance will be deferred until her next report. If the work that has begun is continuous and consistent, as supported by the review of death investigations and remedial actions, she anticipates a recommendation for Compliance.

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

After extensive analysis and thought, DBHDD has redesigned its investigation process. It has taken the excellent step of removing the responsibility for the investigations of abuse, neglect and death from the provider agency and assigning it to trained staff at DBHDD. This is a very important change.

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

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

After review of the facts contained in the CIR, if the individual was receiving DBHDD services at the time of the death and the death was related to the services being received, DBHDD is to complete a thorough clinical records review during a Clinical Mortality Review (CMR). If the CMR yields findings other than potential abuse or neglect, a determination is made regarding the

need for corrective action. If there is a finding of potential abuse or neglect by the provider entity or staff, including Support Coordination, the case proceeds through the steps of an investigation.

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

The Columbus Organization, based on its review of records and the initial investigation completed by DBHDD, issues an opinion as to whether a death was preventable or not. It also cites areas of deficiency in provider and/or DBHDD performance. Recommendations to correct cited deficiencies are included at the end of each Columbus report. The Community Mortality Review Committee reviews the findings and recommendations of the Columbus Organization.

As referenced earlier, two recently released Columbus reports analyzed the quality of the DBHDD investigations into the deaths of individuals with DD who transitioned to community residences. (Two Columbus reports are still outstanding.) Columbus found the two DBHDD investigations to be timely, thorough and comprehensive. Columbus also provided thoughtful recommendations to strengthen the interview process.

There were 31 deaths reported from the months of December 2017 and January 2018.

On April 12, 2018, the Independent Reviewer is scheduled to meet with the Director of the Division of Accountability and Compliance to discuss the status of the overall restructuring of the investigation process and its application to the 31 deaths referenced above.

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

A CMRC has been established. The Independent Reviewer attended its October 2017 meeting and was impressed by the depth of the discussion. Meeting minutes are issued. The State requires providers to take corrective actions to address any deficiency findings from the CMRC. At this time, completion of remedial actions are tracked but not discussed again with the CMRC. The Independent Reviewer has recommended that the CMRC be informed of the results of each recommendation on a quarterly basis. DBHDD has reported that its policy is being revised to include twice annual CMRC Quality Improvement meetings for the purpose of reviewing aggregate data.

The Independent Reviewer recommends a finding of Compliance with this Provision.

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

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

The redesign of the investigation process includes changes to the tracking of deficiencies and Corrective Action Plans (CAPS). There is a plan to aggregate data from mortality reviews in order to identify trends and implement quality improvement initiatives.

As noted above, further review of the redesign is still needed as implementation actions go forward and are established. There will be an in-depth review of this provision in the next report.

As required, the State has published annual reports on aggregate mortality data. The Independent Reviewer has commented on those reports in both memorandum and discussion formats. It is recommended that this specific requirement be found in Compliance. The reports are carefully prepared and the data appear reliable.

Other Provisions Related to Individuals with DD:

The following provisions will be updated in the next report to the Court.

Agreement Requirement: To benefit those individuals with DD who are at risk of admission to a State Hospital, the SA also requires the State to create 400 HCBS Waivers to prevent institutionalization. (SA III.A.2.b.i.) The EA requires the State to create an additional 375 COMP Waivers and an additional 300 NOW Waivers for people with DD on the waitlist to prevent their admission to an institutional facility. (EA 19) This results in a grand total of 1,075 Waivers to be used to support people with DD in the community to prevent institutionalization.

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

As documented in past reports, the State has been timely and complete in creating the Waivers required under the Agreements. However, the timeline for the provision in the Extension Agreement does not end until June 2018. Therefore, these provisions will be evaluated in the next report to the Court.

In addition, there has been information provided to the Independent Reviewer that the inability to obtain Waiver-funded services, despite the allocation of a Waiver slot, has put individuals with DD and behaviorally challenging behaviors at risk of institutionalization. The reviews completed

by Dr. Heick included at least one such individual. The Independent Reviewer wishes to examine these issues further prior to recommending a finding related to compliance. She also requires further information from the State regarding its annual assessment of the adequacy of Waiver services and any actions, including remedial actions, if necessary, it considers appropriate.

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

The most recent Waiver application with performance measures was approved by the Centers for Medicare and Medicaid Services on February 24, 2017 with an effective date of March 1, 2016. No other information has been provided regarding this provision.

On March 22, 2018, for inclusion in her next report, the Independent Reviewer requested a summary from DCH detailing its Quality Assurance procedures and findings. At this time, DCH is in discussions with CMS regarding the structure of its Quality Assurance plan.

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

The State did develop 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 plan was shared for comment with the Department of Justice, the Amici and the Independent Reviewer.

Implementation of actions for provider recruitment have been complicated by the rate system and State requirements for out-of-state providers.

The Independent Reviewer wishes to defer discussion of implementation until her next report. She will consider the available facts at that time and recommend a finding to the Court.

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

Education of the Courts has continued. DBHDD provided a list of educational sessions conducted to date in FY18 but there has not been information provided as to the geographic

regions/areas that have been reached. DBHDD will be requested to include that information for the next report.

In FY17, the Courts ordered nine individuals with a primary diagnosis of DD into forensic units in the State Hospitals. There has been the inclusion of individuals with DD and forensic status in the planning and implementation of transitions from State Hospitals.

Provisions Related to Individuals with Mental Illness

Throughout the course of the Settlement Agreement and its Extension, there have been significant reforms in the scope and accessibility of community-based supports for individuals with SPMI. The Independent Reviewer and her consultants recognize and applaud the substantial commitment of time, energy and financial resources invested by the State. There have been important accomplishments.

However, with four months remaining until the anticipated timeline for the completion of the Settlement Agreement and its Extension, the concerns addressed below require heightened attention to implementation. Full implementation of the provisions related to Supported Housing is essential for substantial compliance with the terms of the Settlement Agreement and its Extension.

Supported Housing and Bridge Funding

As exemplified by the story of Mr. D. at the beginning of this report, the value of Supported Housing for individuals with SPMI cannot be exaggerated. These provisions are of critical importance.

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

Over the years, DBHDD has been commended for the development, introduction and continuation of its Georgia Housing Voucher Program (GHVP) and its resource allocations for Bridge Funding.

> **Agreement Requirement:** The SA requires the State to provide Bridge Funding for up to 1,800 individuals with SPMI in the Target Population. (SA III.B.2.c.ii.(C). Bridge Funding includes money for security deposits, household necessities, living expenses, and other supports during the time the person is becoming eligible for federal disability or other supplemental income. (SA III. B.2.c.i.(C); see also EA 31.) Funding for this

> program would come exclusively from the State. The EA requires the State to provide Bridge Funding for an additional 600 individuals, for a grand total of 2,400 individuals with SPMI in the Target Population (EA 32, 33)

On January 12, 2018, the State reported that, since the beginning of the Settlement Agreement, 4,700 individuals have received Bridge Funding, which is well above the requirements in the SA and the EA.

Bridge Funding was provided to 1,094 participants in FY17, a 13% increase over FY16. In FY18 to December 31, 2017, Bridge Funding had been provided to 359 individuals. The average "bridge" cost per participant is now $2,603.34. Furnishings and first and second months' rent account for 50% of this cost and provider fees account for 20%. The remaining funds (30%) were allocated for household items, food, transportation, medication expenses, utility and security deposits, and other similar expenses.

At the end of December 2017, there were 2,626 individuals living in Supported Housing with a Georgia Housing Voucher (GHV). On January 12, 2018, the State reported that, since the beginning of the Settlement Agreement, 4,422 individuals have received a GHV. The State has yet to provide us with data on the number of individuals in the Target Population who moved seamlessly from the GHVP to federal funding for housing and who still receive such federal funding.

> **Agreement Requirement:** Per the SA, Supported Housing is: (a) integrated permanent housing with tenancy rights; (b) linked with flexible community-based services, including psycho-social supports, that are available to individuals when they need them, but are not mandated as a condition of tenancy. (SA III.B.2.c.i.; see also EA 36) To satisfy the "integrated" requirement, the SA requires that at least half of the Supported Housing units be either scattered-site housing or apartments clustered in a single building with no more than 20 percent of the units in one building occupied by people in the Target Population. (SA III.B.2.c.i.(A).; see also EA 37) The SA requires that 60 percent of Supported Housing be two-bedroom units and the other 40 percent be one-bedroom units. (SA III.B.2.c.i.(B).)

The State has consistently complied with the requirements regarding scattered-site locations. Site visits to apartment complexes have been made over the years by the Independent Reviewer and/or her housing consultant in order to confirm compliance with this obligation. As of June 15, 2017, data from DBHDD indicated that the percentage of scattered sites per Region ranged from 78% in Region 6 to 96% in Region 5.

In response to her request, the Independent Reviewer was informed that over 700 individuals with SPMI, who receive rental assistance from the GHVP, do not receive mental health services. Reportedly, these individuals have declined mental health services. Although this is permitted in the wording of the Settlement Agreement, it raises some concern and requires further examination. The Housing First model recognizes that some individuals with SPMI refuse services initially but come to accept them after being housed in their own apartment.

> **Agreement Requirement:** Per the SA and the EA, there are five sub-groups of people with SPMI within the Target Population: (1) those currently being served in the State Hospitals; (2) those who are frequently readmitted to the State Hospitals; (3) those who are frequently seen in Emergency Rooms; (4) those who are chronically homeless; and (5) those who are being released from jails or prisons. (SA III.B.1.a.; see also, EA 30) Individuals in the Target Population need not be currently receiving services from DBHDD in order to be eligible to receive Supported Housing. (EA 36) The Target Population includes individuals in these five sub-groups who have a co-occurring condition such as a substance use disorder or a traumatic brain injury. (SA III.B.1.d; see also EA 30) The Target Population also includes individuals with SPMI and forensic status in the care of DBHDD in a State Hospital where a court has determined that community services are appropriate. (SA III.B.1.b.; see also EA 30) The EA requires the State to implement procedures to refer individuals with SPMI in the Target Population to Supported Housing if the need is identified at the time of discharge from a State Hospital, jail, prison, Emergency Room, or homeless shelter. (EA 40)

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

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

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

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

Ms. Knisley completed a careful review of the work to date. She found that there were facts to support recommendations of Compliance or Non-Compliance as follows:

Requirement	Recommended Finding	Notes
39. Between the Effective Date of this Extension Agreement and June 30, 2018, the State shall continue to build capacity to provide Supported Housing by implementing a Memorandum of Agreement between DBHDD and the Georgia Department of Community Affairs, which includes the following components:		MOA completed but not being fully "implemented." If the State were in the process of implementing all the sub-requirements under this Provision, then consideration could be made for Compliance. However, the State has not complied with a., b., c., e. and f. of this Provision.
a. a unified referral strategy (including education and outreach to providers, stakeholders, and individuals in the Target Population) regarding housing options at the point of referral;	a. Non-Compliance	This Provision is not met because the Provisions for education and outreach to all Target Populations are not yet in place and there is no evidence yet of new staff being trained sufficiently to conduct outreach and education. There is no evidence that a referral strategy has been developed sufficient for all Target Populations—this is necessary in order to evaluate the implementation steps as being sufficient but also to assess the knowledge, preparation, practice and performance of staff being able to take these steps for all sub-Target Populations.
b. a statewide determination of need for Supported Housing, including developing a tool to assess need, forming an advisory committee to oversee the needs assessment, developing a curriculum to train assessors, training and certifying assessors, and analyzing and reporting statewide data:	b. Non-Compliance	b. Tool, advisory committee, curriculum and reporting are in place. Cannot be in compliance until all the Target Populations' need for housing is assessed, individuals are being referred, and the referral process is meeting requirements.
c. maximization of the Georgia Housing Voucher Program:	c. Non-Compliance	c. The State has not yet provided data that provide information about available resources and indicate GHVs are maximized in proportion to available resources nor has the State indicated of the individuals getting GHVs that the program was being used only for individuals not qualifying for another program. The supply of Housing Choice Vouchers (HCVs), Mainstream

		Vouchers for people with disabilities, VASH (vouchers for veterans) and Shelter Plus Care (SPC) subsidies is limited in some jurisdictions so it is not always possible to use these resources to better maximize the GHVs. However, there is no information available to determine when this is an issue.
d. housing choice voucher tenant selection preferences (granted by the U.S. Department of Housing and Urban Development);	d. Compliance	This Provision is in place but clear information as to the extent to which preferences are being made available has not been provided for the past 9 months.
e. effective utilization of available housing resources (such as Section 811 and public housing authorities); and	e. Non-Compliance	There is not sufficient information to determine if utilization is effective. The information provided more recently has been confusing and contradictory. At one time, there appears to have been outreach to PHAs but this appears to be more limited now. On the other hand, the DCA has attempted to maximize LIHTCs.
f. coordination of available state resources and state agencies.	f. Non-Compliance	No evidence of an established working relationship on a systemic basis with DOC, Parole and Probation, Jails or the Criminal Justice Coordinating Council (CJCC) by DBHDD that is resulting in individuals exiting jails and prisons sub-populations getting access to Supported Housing, although DCA has a working relationship with some of these groups. No evidence of a consistently productive relationship with CoC in Atlanta that is resulting in individuals who are in the chronically homeless sub-population getting access to Supported Housing. There is no evidence of working with Medicaid on examining hospital emergency room usage.

At this point in time, there are two major areas of serious concern that lead to the Independent Reviewer's recommendation for a finding of Non-Compliance for key provisions related to Supported Housing. Those areas of serious concern are summarized in the narrative below and are discussed in more detail in the attached report by Ms. Knisley.

The Settlement Agreement and its Extension are unequivocal in stating who is to benefit from Supported Housing and Bridge Funding:

> For purposes of Paragraphs 31 to 40, the "Target Population" includes the approximately 9,000 individuals with SPMI who are currently being served in State Hospitals, who are frequently readmitted to the State Hospitals, who are frequently seen in emergency rooms, who are chronically homeless, and/or who are being released from jails or prisons. The Target Population also includes individuals with SPMI and forensic status in the care of DBHDD in the State Hospitals, if the relevant court finds that community services are appropriate, and individuals with SPMI and a co-occurring condition, such as substance abuse disorders or traumatic brain injuries. (EA 30)
>
> 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. Supported Housing includes integrated permanent housing with tenancy rights, linked with flexible community-based services that are available to consumers when they need them, but are not mandated as a condition of tenancy. Supported Housing is available to anyone in the Target Population, even if he or she is not receiving services through DBHDD. (EA 36)
>
> The State shall implement procedures that enable individuals with SPMI in the Target Population to be referred to Supported Housing if the need is identified at the time of discharge from a State Hospital, jail, prison, emergency room, or homeless shelter. (EA 40)

There is not sufficient evidence at this time to report that members of all subgroups in the Target Population have access to Supported Housing resources through a timely basic assessment of their need for housing. Although DBHDD has issued more detailed plans very recently, these plans are plans for, rather than full implementation of, the requirements of the Settlement Agreement and its Extension.

Correctional Facilities

As verified through interviews and site visits, members of the Target Population who are incarcerated in and are being released from jails and prisons throughout Georgia do not have access on a systemic basis to housing and mental health supports through DBHDD's resources for the GHVP.

According to information supplied by DBHDD, there are 144 county jails, 24 county prisons, 34 state prisons and 4 private prisons throughout Georgia. In addition, there are transitional centers, probation centers, and residential treatment facilities. In spite of this, DBHDD has cited ongoing

relationships with just six jails and five prisons. (A site visit to one of these six jails confirmed that a staff person from a community mental health agency was assigned to the jail and was assisting with discharge planning.) However, discussions with an official at one prison, referenced above, and six other jails without a DBHDD contracted provider's involvement indicated relationships that were tangential or created relatively recently. Although all sources for this report said they welcomed more assistance in assessing and linking offenders to Supported Housing, with one exception, they reported little interaction with State or local mental health personnel on behalf of offenders with SPMI scheduled for release from incarceration.

The importance of linking an offender to housing prior to release was underscored in the telephone conversation with the Mental Health Unit Director in a north Georgia prison. She reported that release, even early release, from that prison could not be approved unless there was appropriate housing identified. If no housing were available, the offender could be held up to the last day of her mandatory sentence. The inability to release someone created an unwanted situation for both the offender and the prison staff. Mr. D.'s story, referenced above, is a compelling example of the consequences of the failure to assess and link offenders to Supported Housing in a timely manner at the time of their release.

Emergency Rooms

Individuals who are "frequently seen in" Emergency Rooms have not been included in the planning for Supported Housing until very recently. Although the partnership with Emergency Rooms in public and private hospitals may be more challenging to establish, there has been scant attention to this obligation.

State Hospitals

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

DBHDD has issued plans and timelines for increasing referrals to Supported Housing for individuals leaving jails, prisons and State Hospitals. (See, for example, Appendix A to Dr. Gouse's report, which discusses discharges from GRHA.) However, the timeliness for implementation of these plans largely extends beyond the anticipated date for the completion of the Agreements.

Housing Outreach Coordinators

Although there have been Housing Coordinators working in each Region since the inception of the GVHP, reportedly, their outreach role has been diminished. Instead there will be substantial reliance on 12 newly hired Housing Outreach Coordinators (HOCs) to expand outreach efforts related to Supported Housing.

As of the date of this report, six (50%) of the new HOC staff have been hired. Although two started their work in December 2017, four of the six staff now in place started work on February 1, 2018. As reported by one HOC, just about all of them are still being trained. When the full complement of 12 HOCs is in place, significant sections of the State—more than 25 percent of the counties--will not be included in their areas of responsibility. It is not clear what, if any, other resources will supplement them in outreach to jails, prisons and Emergency Rooms in areas with no HOC coverage.

Forensic Status

The discharge planning and implementation process for individuals with SPMI and forensic status is more complicated due to the multiple layers of clinical, legal and judicial involvement and review. For several years now, there has been concern that individuals with SPMI in the forensic units of State Hospitals do not progress towards discharge as expeditiously as non-forensic clients. This observation has been discussed at length with the Director of the Office of Forensic Services. A partial solution to this concern was to be implemented through a statewide revision of the forensic recovery planning process. Although there was a pilot of the revised format and process, there has not yet been standardization and implementation across all State Hospitals.

Forensic clients with SPMI tend to be released to Community Integration Homes. There has been a significant decrease in discharge to forensic apartments, a slight increase in discharges to Personal Care Homes and a larger increase to nursing homes (related to the opening of the Bostick Nursing Center in Milledgeville).

Of note, there were no forensic individuals discharged with a GHVP. Also, it is unclear whether the significant decrease in discharges to the forensic apartments is due to longer lengths of stay in the apartments and fewer openings.

The chart below compares the residential locations at discharge for individuals with forensic released in FY17 and FY18 to date.

	FY17	FY18 (Q1 and Q2)
Community integration homes	49%	53%
Supervised apartment	22%	3%
Personal Care Home	9%	15%
Nursing home/medical facility	6%	18%
Home (with or without family)	14%	11%

DBHDD has reported that individuals step down from the Community Integration Homes and forensic apartments to live with family, GHVP apartments and nursing homes. Following receipt of the draft version of this report, DBHDD provided information regarding the number of individuals that step down to these settings. The majority of individuals (40% in FY17) leave Community Integration Homes for forensic apartments. Length of stay data provided indicate that the average length of stay in Community Integration Homes is approximately 18 months and in forensic apartments about 8 months. This suggests that individuals are indeed stepping down, but it is important to track and monitor to ensure that psychiatric hospital readmission is not

occurring with regularity. In FY17, four individuals with a legal status of IST/CC were readmitted within three months of discharge; one person was able to be discharged after 11 days. Readmission data for individuals with NGRI legal status were not provided.

This pattern diverges from the use of supported apartments and small (four people or less) group residences for individuals with DD and a forensic status. Data from the Division of Developmental Disabilities indicate the placement of seven forensic clients with DD during the timeframe for this report. These individuals are receiving services from community-based providers who are experienced in forensic work, including the responsibility to ensure compliance with Court Orders and, in some instances, restrictive Protective Orders.

As of February 26, 2018, there were 36 individuals with DD with a forensic status remaining in State Hospitals. Of these, the respective Hospital is recommending discharge for 17 individuals (47%). The Court denied discharge or is opposed to discharge for two individuals.

A Memorandum of Agreement between DBHDD and DCA has been signed but is not fully implemented at this time. The most serious barrier to a recommendation for Compliance is the State's failure to ensure access to an assessment for Supported Housing for all sub-groups in the Target Population with the subsequent provision of housing with supports.

Other Provisions Related to Individuals with SPMI:

> **Agreement Requirement:** The SA requires the State to provide various intensive services for people with SPMI. The State is to provide at least 22 ACT teams to people in need. (SA III.B.2.a.i.(H) All of the ACT teams are to be multidisciplinary, including a peer specialist, with no more than 10 team members serving individuals at a 1:10 ratio. (SA III.B.2.a.i.(A)(F) The ACT teams are to provide comprehensive, individualized, customized, and flexible treatment, support, and rehabilitation to individuals where they live and work. (SA III.B.2.a.i.(A) The teams are to operate 24/7 and are to operate with fidelity to the Dartmouth Assertive Community Treatment model. (SA III.B.2.a.i.(E)(G)) The teams are to provide at least the following services: case management, assessments, psychiatric services, assistance with employment and housing, family support and education, substance abuse services, crisis services, services to improve daily living skills and illness self-management, and other services and supports that are critical to an individual's ability to live successfully in the community. (SA III.B.2.a.i.(A)(B)(C)(D)

There continue to be 22 ACT teams in operation across the State. Four of these teams have waiting lists for enrollment into services.

All ACT teams are required to operate with fidelity to the Dartmouth Assertive Community Treatment model. However, only five fidelity reviews had been completed by DBHDD in time for the submission of this report. Dr. Angela Rollins examined each of those fidelity reviews and her findings/observations are discussed in the attached report.

Of note is the struggling performance of two teams in providing sufficient intensity of support. Since sufficiently intense support, depending on an individual's current need for the presence of

ACT team involvement, is essential to the integrity of the implementation of the ACT model, it is strongly recommended that these two teams be reviewed further and provided with technical assistance.

In addition, Dr. Rollins has voiced caution about the practice of conducting fidelity reviews remotely rather than through onsite visits and discussions.

Since there were only five fidelity reviews available for review at this time, all of the provisions related to ACT will be fully evaluated in the next report to the Court. A recommendation regarding Compliance or Non-Compliance is deferred until then.

Provisions Applicable to Individuals with DD and/or SPMI

Quality Management

DBHDD has made significant strides in establishing a reliable and responsive Quality Management system. As described at the Parties' meeting with the Amici on January 12, 2018, the Division of Performance Management and Quality Improvement is designed to "utilize accurate and timely performance data to systematically and consistently manage a network of providers and promote improvements in performance and quality of services."

There are a number of initiatives underway to increase knowledge about risk factors, develop collaborative initiatives and analyze outcome measures. Information from these initiatives is shared and discussed at the Executive Quality Council and Behavioral Health and Intellectual/Developmental Disabilities Quality Councils.

The establishment of an effective and responsive Quality Management system is critical to safeguarding the systemic reform underway in Georgia as well as the obligations stipulated to by the Parties to the Settlement Agreement and its Extension.

The Independent Reviewer acknowledges and commends the work that is currently underway. She intends to retain a subject matter consultant in Quality Management to help her evaluate the work being done. Her recommended finding on the status of compliance will be submitted to the Court in her next report

Concluding Comments

The Independent Reviewer acknowledges and appreciates the scope of the provisions agreed to in the Settlement Agreement and its Extension. These obligations for systemic reform have presented many challenges, as well as opportunities for increasing community-based supports for individuals with DD and/or SPMI.

There is no doubt that the State is working diligently to achieve substantial compliance with its obligations. As a result, there have been important structural changes in the systems of care

relied upon by the individuals in the Target Populations. This report summarizes some of those reforms and, where available, confirms the outcomes of those initiatives through individual examples and systemic data.

At the same time, this report has attempted to provide a frank assessment of the work that is presently incomplete, or considered through independent review to be inadequate, and is at risk of leading to recommendations for findings of Non-Compliance.

The Independent Reviewer's preliminary recommendations to the Court for findings of Compliance or Non-Compliance are summarized throughout this report. Meetings about these preliminary recommendations are planned in order to facilitate discussion of any areas that are considered at risk of non-compliance.

_____/s/_____
Elizabeth Jones, Independent Reviewer

March 26, 2018

ATTACHMENT A

INDEPENDENT REVIEW: SUPPORTED HOUSING AND BRIDGE FUNDING

Submitted by:
Martha B. Knisley
February 27, 2018

Introduction

This report to the Independent Reviewer summarizes compliance of the Supported Housing, the Georgia Housing Voucher and Bridge Funding programs required by the Settlement Agreement and the Extension of the Settlement Agreement in United States of America v the State of Georgia (Civil Action No. 1:10-CV-249-CAP), referred to hereafter as the Settlement Agreement and Extension Agreement.

This report will cover information gathered and reports generated by the Department of Behavioral Health and Developmental Disabilities (DBHDD) from July 1, 2017 through February 28, 2018 to demonstrate progress towards compliance with obligations of the Settlement Agreement that are also included in the Extension of the Settlement Agreement, signed May 27, 2016.

Information analyzed for this report was obtained from five sources: (1) written documents provided by the Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Department of Community Affairs (DCA); (2) key informant interviews with the Amici and DBHDD staff, including interviews with Monica Johnson, Director of the Division of Behavioral Health, Dr. Terri Timberlake, Director, Office of Adult Mental Health, Letitia Robinson, DBHDD Housing Director, Constance Smith, Georgia Housing Voucher (GHV) Manager, Amy Howell, Deputy Director and General Counsel, Carmen Chubb, Deputy Commissioner for Housing at the DCA and David Whisnant, Director, Office of Homeless & Special Needs Housing; (3) Meetings with two Community Services Boards (CSBs) in DBHDD Region 3; (4) a follow-up discussion with Fred Coleman, Director of Social Work, Georgia Regional Hospital Atlanta, the Atlanta Continuum of Care, an individual placed in housing; and (5) jail staff in two Region 3 County jails.

This report indicates the State's progress toward compliance with each Supported Housing requirement in the Extension of the Settlement Agreement (Paragraphs #30-40) and one Settlement Agreement requirement that is carried over in Paragraph 30 of the Extension Agreement.

Extension Agreement

Bridge Funding and Georgia Housing Voucher Program

32. By June 30, 2016, the State shall provide Bridge Funding for at least an additional 300 individuals in the Target Population.

33. By June 30, 2017, the State shall provide Bridge Funding for at least an additional 300 individuals in the Target Population.

34. By June 30, 2016, the State shall provide Georgia Housing Voucher Program (GHVP) vouchers for an additional 358 individuals in the Target Population.

35. By June 30, 2017, the State shall provide Georgia Housing Voucher Program (GHVP) vouchers for an additional 275 individuals in the Target Population.

Bridge Funding

Bridge funding was provided to 1,094 participants in FY 17, which is a 13% increase over FY16 and well above the requirement in the Extension Agreement of "an additional 300 individuals in the Target Population by June 30, 2017." The average "bridge" cost per participant is $2,521.54. Furnishings and first and second month rent account for 45% of this cost and provider fees account for 21%. The remaining funds (33%) were allocated for household items, food, transportation, medication, moving expenses, utility and security deposits and other expenses. Expenses in categories in the remaining funds saw a 6% increase in the past year.

Bridge funding has been provided to 359 participants in FY 18 (July to December 31, 2017). The average "bridge" cost per participant is $2,603.34. Furnishings and first and second month rent account for 50% of this cost and provider fees account for 20%. The remaining funds (30%) were allocated for household items, food, transportation, medication, moving expenses, utility and security deposits and other expenses.

Georgia Housing Voucher Program

The State has met compliance requirements for filling units in the Georgia Housing Voucher Program; however, the number of individuals living in a Supported Housing unit with a GHV is less than the required number to be filled by six (6) individuals due to a 40% turnover during the Settlement Agreement time period. This turnover has occurred despite 18% of the individuals being re-engaged.

DBHDD was required to provide 2,000 GHVP vouchers for individuals in the Target Population by June 30, 2015; an additional 358 by July 1, 2016 and an additional 275 by June 30, 2017. Below is a chart depicting DBHDD's progress in providing GHVP vouchers since June 30, 2016:

Chart 1: Georgia Housing Voucher Program Performance[1]

GHVP Assistance	June 30, 2016	June 30, 2017	Dec. 31, 2017[2]
Individuals with a Notice to Proceed[3]	321	360	408
Individuals placed in housing with a GHV	3,193	4,054	4,422
Individuals living in SH at end of reporting period	1904	2,432	2,626

Individuals are continuously looking for and vacating housing. Housing compliance is measured by: 1.) those who had a "notice to proceed" to look for housing and are in "active search"; 2.)

[1] As reported by DBHDD
[2] 6 mos. data
[3] Notice to Proceed is defined as individual being approved to search for housing

those with signed leases living in housing; and 3.) those who moved into a rental unit. The number of individuals with a notice to proceed on December 31, 2107 was 408 and the number of individuals with a signed lease on December 31, 2017 was 2,626. The total number of units that have been filled since the inception of the program is 4,424.

The number of individuals with a "notice to proceed" continues to increase each Fiscal Year and there are always individuals in active search with a "notice to proceed" at the end of the Fiscal Year. Identifying the number of individuals with a "notice to proceed" demonstrates that DBHDD and providers are continuing to pursue Supported Housing as required in this Settlement Agreement. It also helps measure the length of time it takes for an individual to get housing, which is a performance indicator. The data suggest it takes longer to find an available unit today than in the past. DBHDD staff, including Regional Housing Coordinators, Community Services Boards and PATH providers, and the Amici representatives continue to express concern about rising rents and landlords exiting the program.

Supported Housing

36. Supported Housing is assistance, including psychosocial support, provided to persons with SPMI to assist them in attaining and maintaining safe and affordable housing and support their integration into the community. Supported Housing includes integrated permanent housing with tenancy rights, linked with flexible community-based services that are available to consumers when they need them, but are not mandated as a condition of tenancy. Supported Housing is available to anyone in the Target Population, even if he or she is not receiving services through DBHDD.

This compliance requirement is not being met at this time because the services provided to individuals are not flexible and services are not always available when individuals need them, particularly, but not solely, in the pre-tenancy phase of Supported Housing[4]*.*

Background

Flexibility in Supported Housing is largely acknowledged as: 1) making supports available when needed based on an individual's choice and circumstances, including when no other suitable, safe housing arrangements are available, when the individual is determined to need instrumental, community and personal support either because of their disability or as a result of loss of identity and functional skills; 2) supporting individuals' "integration" into the community with community support teams, starting as early as possible, not just at the time of or after they move; 3) re-balancing services requirements so individuals can get support services with the fewest number of requirements and changes in staff, including adding sensible presumptive requirements; and 4) enabling both institution based and community

[4] *The State is required to meet requirements in #36, #38, and #40 of the Extension Agreement to assess need, develop a unified referral strategy and implement procedures to make referrals of individuals in the Target Population to Supported Housing. These requirements have to be met during the critical pre-tenancy phase of Supported Housing and are closely related and overlap with the requirements in #35 of the Extension Agreement.*

based staff to jointly assist individuals while they are still institutionalized. Most individuals with long term disabling conditions in the target population can live successfully in safe affordable permanent Supported Housing so long as they have choice and flexible community based services at the level of intensity and frequency they need. Arrangements for such are made during pre-tenancy and closely reviewed thereafter to enable individuals to support their integration into the community and participate in flexible services essential to maintaining their safe affordable housing and their integration into the community.

Attaining housing refers primarily to pre-tenancy tasks being successfully implemented so individuals can gain access to Supported Housing. Pre-tenancy refers to the time period and tasks associated with individuals attaining safe affordable housing. It includes instrumental tasks, including staff assisting individuals to obtain documents, including proof of identify and verification of income. It includes assisting an individual to make the choice of moving to Supported Housing versus other places to move and, when choosing Supported Housing, making a choice of location. For individuals hospitalized, being released from prisons or jail or exiting an emergency room, the time frame for making these decisions could be very short. For individuals being released from prison, there is the added complexity of prisons not being located close to the community where they are going to reside so linkage to services and housing is more difficult. It could also mean they are not released until their full sentence ends, regardless of parole, unless they have a place to live.

Established basic practice for Supported Housing includes well defined responsibilities for pre-tenancy tasks. These include policies for access and referral. Agreements between institutions and entities assisting an individual to move such as Community Services Board staff, homeless outreach workers and services providers, are necessary so each of these tasks is well defined and responsibilities are assigned to each organization and specific staff. Obstacles such as obtaining documents (proof of identity, verification of income, etc.) must be overcome with clear measurable responsibilities assigned to staff to obtain documents or assist individuals. Staff must be able to obtain access to hospitals, emergency rooms, jails and prisons and be reimbursed for their time arrangements. The State and its partner organizations (jails, prisons, hospitals, providers and other key organizations) must establish policies to ensure this access and ensure reimbursement for providers who are required to “in-reach” to begin working with individuals who are in jail, prison, shelters and hospitals. Without explicit arrangements, this in-reach is not always possible.

There are other well-established parameters in addition to in-reach and securing documentation arrangements. For example, standard practice today is for discharge planning from hospitals to begin at admission. Information and discharge plan requirements have changed across the country as a result of the necessity to make Supported Housing arrangements and reduce recidivism. The Centers for Medicare and Medicaid Services (CMS) and many states have established performance requirements for discharge planning and recidivism reduction. State, local CSBs and hospitals across the country have established high-utilizer protocols to identify individuals who are frequently re-admitted to hospitals and emergency rooms. Federal and state correctional organizations and mental health agencies

have established linkage requirements for individuals being released from correctional agencies. CMS has issued guidance on accessing benefits; it has also issued guidance for determining access to disability benefits for individuals who have been hospitalized.

Housing denials based on criminal or credit problems frequently delay or interfere with an individual being able to access housing. State and local jurisdictions have been pro-active by assisting individuals and their staff to make reasonable accommodation requests and to improve tenant selection policies and agreements. The above referenced practices and policies are well established common practices that, when implemented successfully and monitored, can remedy the problems of lack of flexibility and integration in the most integrated community setting for the Target Populations found in Georgia today.

The recommendation for a finding of Non-Compliance for Provision 36 of the Extension Agreement is based on individuals in the Target Population not getting support to "attain" housing and is based largely on two findings:

Findings

1.) DBHDD has not "implemented" standard policies, practices and requirements for individuals in the Target Population exiting jails, prisons or (state) hospitals or for individuals using emergency rooms who may be "in need of" Supported Housing to get the pre-tenancy assistance they need for referral and linkage to Supported Housing[5]. Providers are not working on a systemic basis with individuals in jails, prisons, hospitals and emergency rooms to establish the necessary relationship and to complete pre-tenancy tasks. In most situations, providers are not informed of a referral until it is too late to conduct the tasks and no other inpatient, institutional staff or emergency room staff have been informed and are completing these tasks. State prisons and County jails have mental health unit staff, typically under contract, who could assist and are eager to assist with this process, as confirmed on recent site visits to two jails. In most situations, staff working in these facilities are trained clinicians who can assist with assessments.

Less than 5% of jails and prisons have been informed of Supported Housing options and the needs survey process or were informed earlier by Regional Housing Coordinators who developed some jail and prison relationships. The Regional Housing Coordinators did not have the capacity nor were provided direction to make referrals; they no longer have that responsibility. Almost all jail and prison staff who are in a position to assist with pre-tenancy tasks and could conduct a needs assessment have not been informed of the possibility of such an arrangement and emergency room staff have not been informed at all.

DBHDD began a Division of Behavioral Health and GA Regional Hospital Atlanta (GRHA) Collaborative quarterly meeting, beginning in December 2016 to address improving processes related to transitioning, discharges and community follow-up. In February 2018, it was

[5] Assessing need and referral practices will be discussed further below in #38, #39 and #40.

reported this work group is now conducting a more through process mapping exercise with the support of the DBHDD Office of Quality Improvement. Such a process is commonly known to be essential for any change of this nature. This process started when it was recognized that meeting about this problem for a year had not yielded results and that "meeting on a regular basis" is not the same as "solving the problem." In the case of GRHA, where hospital reports demonstrate that only 1% to 2.2% of individuals have been directly referred to Supported Housing at discharge in the past year, this process mapping can identify what steps need to take place, policies changed and new processes and responsibilities clarified. Three goals and eight objectives to begin these processes and make changes have now been identified with actions associated with these goals and objectives. One action being planned for April 1, 2018 is to change authorization language for services so services can begin with an IT interface or telephonic response rather than a face-to-face response. Other action items have either July 1 or October 1, 2018 as implementation start dates[6]. These plans include a number of important variables to the State's success in generating referrals at GRHA. But, as the Director of the Division of Behavioral Health recently stated when discussing DBHDD beginning this process now, "it's going to take time." "We don't know what we don't know." This writer agrees with this point. However, to be clear, this planning process should have begun two years ago in order for this Provision to be implemented during the anticipated timeframe of the Extension Agreement.

2.) Providers are not being reimbursed for assisting individuals residing in institutions, including jails, prisons and state psychiatric hospitals, with pre-tenancy tasks. DBHDD will need to establish state-funded service reimbursement requirements as part of their existing reimbursement arrangements for this to happen. This is a common practice in health care to ensure individuals can successfully transition to community settings. Pre-tenancy task implementation is much more difficult for individuals who are high utilizers of emergency rooms. However, there are proven methods for accomplishing this task as well.

37. Supported Housing includes scattered-site housing as well as apartments clustered in a single building. Under this Extension Agreement, the State shall continue to provide at least 50% of Supported Housing units in scattered-site housing, which requires that no more than 20% of the units in one building, or no more than two units in one building (whichever is greater), may be used to provide Supported Housing.

This provision has been met.

38. Under this Extension Agreement, by June 30, 2018, the State will have capacity to provide Supported Housing to any of the individuals in the Target Population who have an assessed need for such support.

[6] Nine Objectives are listed were listed. One has an April 1, 2017 start date, five have July 1, 2018 start dates and three have October 1 start dates

A recommended finding of Compliance or Non-Compliance cannot be determined because the State has not assessed the need for Supported Housing for individuals exiting all hospitals, jails and prisons who fall into the Target Population. Therefore, capacity to meet the individuals "with assessed need" is not possible to define.

DBHDD's most recent report of individuals being assessed for need reveals that 1,635 individuals were assessed as being in need of Supported Housing as part of the Phase II Survey process[7]. Chart 2 provides a breakdown of the individual's living situation at the time of the survey:

Chart 2: % of Individuals Living Setting at Time of Needs Survey

Clustered Housing	Crisis Stabilization / Crisis residence/ BHCC	DBHH Residential Program	Friend/ Relative	Grp/ Personal/ Boarding Home	Homeless (non-sheltered)	Homeless Shelter	Jail/ Correctional Facility	Private residence	Psychiatric Hospital
1%	3%	10%	26%	4%	25%	11%	4%	11%	5%

Since 2012, the percentage of individuals by "prior residential status" at the time of their referral for Supported Housing in each of the State's six Regions is shown in **Chart 3** below. These numbers are considered "self-reported;" however, providers make referrals and presumably know if this self-report is correct. These percentages have been fairly consistent over time across the nine "prior residential status" categories regardless of the number of referrals each year. There have been 5,130 authorized referrals to the GHVP over the past seven and a half years. Referrals are made by providers who assess an individual's need for housing and request a GHV or other subsidy and also make arrangements for bridge funding as needed.

Chart 3: Prior Residential Status by Percentage of Individuals with a Notice to Proceed to Housing

Categories	YR 1	YR 2	YR 3	YR 4	YR 5	YR 6	7 Yr.	6 Mos[8].
Homeless	61%	38%	73%	51%	42%	50%	55%	54%
Residential	6%	13%	6%	7%	8%	27%	9%	10%
PCH or GRH	2%	5%	4%	2%	4%	7%	4%	3%
Hospital	3%	26%	9%	10%	9%	4%	10%	10%
CSU or CA	1%	1%	0%	0%	3%	0%	1%	1%

[7] This number will continue to increase as Needs Surveys are being completed routinely; however the percentages of individual's living situation has remained fairly constant over time.

[8] Data provided by DBHDD for FY 18 is through December 31, 2017.

Rent Burdened	1%	2%	0%	3%	2%	1%	1%	1%
Family/friends	22%	11%	5%	19%	17%	7%	13%	13%
Jail or Prison	2%	3%	2%	7%	13%	0%	5%	5%
Incomplete	2%	1%	0%	2%	2%	4%	1%	1%
Total (by #)	704	667	1297	733	870	414	946	445

The percentage of need is likely the same regardless of where an individual is living. The data used to calculate compliance are from the specific categories in Chart 2 consistent with Settlement Agreement requirements. Prior residence is helpful though because this data has been provided for review over a seven-year period and helps identify patterns. Most importantly, neither chart depicts the actual need, just who was surveyed and where people were residing at time of referral. DBHDD must be able to demonstrate they can identify "any" individual in the Target Population in need of Supported Housing. Most striking are the low numbers of individuals with their prior residential status being jails, prisons, hospitals and CSUs and other types of crisis facilities, as well as boarding homes and personal care homes. Needs surveys are not conducted in emergency rooms.

Surveys are simply not conducted and referrals are not made routinely for a significant number of individuals across multiple sub-populations of the Target Population. Specifically, individuals exiting jails, prisons, hospitals and emergency rooms are not having a survey completed before they exit these facilities. DBHDD indicates individuals exiting hospitals often are connected to housing and are discharged from the hospital before a survey is completed. However, there are not data to support this assertion. DBHDD also indicates that, after implementing Phase II of the needs survey process, they did not formalize checking on whether a survey was completed or not (assume before discharge) until October 2017. A separate report shows Regions 1 and 5 represent 77% or 37 of the 48 discharges to Supported Housing from State Hospitals in FY18. DBHDD appears to be beginning to recognize that the needs survey and the discharge planning process to assure referrals to Supported Housing do not work effectively for individuals being discharged from state psychiatric hospitals.

There are encouraging signs that DBHDD is aware of just how cumbersome the process is now. It is also clear that DBHDD processes for completing surveys and making referrals will need to be modified for individuals in need of Supported Housing other sub-groups in the Target Population. DBHDD appears to be on the brink of starting a newly staffed outreach process to jails, prisons, CSUs and emergency rooms. One workgroup with a July 1, 2018 timeframe for implementation is working on creating a process for individual level data/information sharing and a data sharing agreement. Staff are attending meetings with staff from these systems but meetings alone won't yield results. DBHDD appears to be unaware of how the needs assessment processes can work effectively for individuals exiting jails, prisons, CSUs, other crisis facilities and emergency rooms.

Data from the Georgia Department of Corrections[9] reveal that, on December 31, 2017, there were 37,538 individuals incarcerated in Georgia's 34 state run prisons and another 18,737 individuals incarcerated in ten other types of state correctional facilities, including county prisons, private prisons and smaller boot camps and transitional facilities. The most recent data available from 2016 indicate that approximately 31,700 individuals were incarcerated in 149 county jails in Georgia[10]. The latest data available from the US Department of Justice, Bureau of Justice Statistics (BJS) estimates that 37% of prisoners and 38% of jail inmates reported being told by mental health professionals they had a mental disorder and were told the name of the disorder[11]. According to the Bureau, approximately 1 in 7 prisoners and 1 in 4 jail inmates had what the facility describes as a "serious psychological distress" (SPD) in FY 2011-12. These conditions correlate closely with the Georgia SPMI definitions with the exception that the SPD explicitly includes Post Traumatic Stress Disorder and the Georgia definition is silent on this but does not exclude this diagnosis. Approximately 73% (jail inmates) and 74% (prisoners) indicated they had had some type of mental health treatment in their lifetime and more than half (54%) of prisoners and a third (35%) of jail inmates had received mental health treatment since their admission to the facility where they were incarcerated. An estimated 30% of each group currently receiving services said they were taking prescribed medication and 37% of prisoners and 38% of jail inmates who had been told they had a disorder were receiving treatment at the time they were interviewed. These percentages also match the percentages reported by clinical staff during interviews in two Georgia county jails in FY18.

Even accounting for minor differences in categorizations between SPMI as defined by Georgia and SPD as defined by the BJS, the data demonstrate at least 7,000 individuals with SPMI in jails and prisons in Georgia may be in need of Supported Housing. The DBH process and requirements for assessing need were factored into calculating this number. Not all individuals will exit in one year. The jail population is constantly turning over so it is estimated at least 1,750 individuals exiting jails annually would meet requirements. Over 16,000 prison inmates exited a Georgia Department of Corrections facility in the last Fiscal Year so, using DBHDD needs data, nearly 2,000 individuals exiting prisons annually would meet DBHDD requirements for Supported Housing. Many individuals exiting jail or prison have limited resources and skills, could benefit from and will likely choose Supported Housing as they exit these facilities. They simply aren't being counted because they are not being assessed.

Assessing needs for individuals who are homeless is a complex engagement issue that will be addressed more fully under the section of this report specific to requirement #39 of the Extension Agreement regarding referrals.

No effort has been made to identify individuals who repeatedly use emergency rooms for behavioral health treatment fully or in part as a result of their behavioral health problems. DBHDD has not made any effort in seven years to quantify "frequent users," ensure DBHDD

[9] Georgia Department of Correction. Inmate Statistical Profile. (December 31, 2017).
[10] Prison Policy Initiative Research Clearinghouse Report on Georgia. (December 2016).
[11] *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, National Inmate Survey, 2011-12,* NCJ 250612. Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice.

staff and/or providers can secure agreements with emergency rooms and develop a pathway to Supported Housing for “frequent users” of emergency rooms. DBHDD has set forth a "safety net" policy for providers’ engagement of individuals for services. DBHDD states in its policy that providers are to "have relationships with local community hospital emergency departments.” It is not yet clear in reading the policy what expectations will be set forth to address the Settlement Agreement requirements for the referrals of frequent users of emergency rooms to gain access through a needs process and referral. The DBHDD description of this initiative appears to suggest this will happen in the future.

Assessing need for individuals exiting emergency rooms is a complicated arrangement not heretofore approached by DBHDD, as required in the Settlement Agreement and the Extension Agreement. As with other requirements, this has been identified repeatedly by this reviewer as a compliance issue. There is no paucity of data from dozens of projects and analyses of projects and approaches being taken across the country that, if analyzed, would give DBHDD information on how to approach this issue. Major cross system data exist following several national reviews. When DBHDD was asked in November 2017 about data they had on individuals “frequently seen in emergency rooms,” the answer provided three months later in February 2018 was that DBHDD could provide information for individuals seen in CSUs and BHCCs, but not emergency rooms. DBHDD indicated these numbers would be available in 2018 with the “use of Housing Outreach Coordinators.” Based on information requested in November 2017 and provided on February 21, 2018 the Housing Outreach Coordinators will facilitate outreach and community engagement specific to “targeted” hospital emergency rooms. DBHDD’s response did not provide any specifics about when this would be done and whether or not specific protocols would be put in place to identify, determine need and facilitate the necessary access to Supported Housing. As with jails, prisons and hospitals, emergency room referral processes must be tailored to best achieve results based on the facility operations and requirements. Provider and Outreach staff must be able to respond quickly and on a daily basis for any process to be effective.

39. Between the Effective Date of this Extension Agreement and June 30, 2018, the State shall continue to build capacity to provide Supported Housing by implementing a Memorandum of Agreement between DBHDD and the Georgia Department of Community Affairs, which includes the following components:

a. a unified referral strategy (including education and outreach to providers, stakeholders, and individuals in the Target Population) regarding housing options at the point of referral;

b. a statewide determination of need for Supported Housing, including developing a tool to assess need, forming an advisory committee to oversee the needs assessment, developing a curriculum to train assessors, training and certifying assessors, and analyzing and reporting statewide data;

c. maximization of the Georgia Housing Voucher Program:

d. housing choice voucher tenant selection preferences (granted by the U.S. Department of Housing and Urban Development);

e. effective utilization of available housing resources (such as Section 811 and public housing authorities);

f. coordination of available state resources and state agencies.

The DBHDD and DCA have signed an Memorandum of Agreement (MOA) and taken steps to implement it. The two agencies have planned a unified referral strategy but have not fully implemented it for all of the Target Populations. The two agencies have developed but have not fully implemented a statewide determination of need tool and have not maximized the Georgia Housing Voucher Program. The two agencies have not demonstrated effective utilization of available housing resources and have not coordinated available resources and state agencies. The only item the State can be found in compliance is 39 "d" because the DCA successfully secured a HUD preference for the balance of state HCV program for the Target Population in this Settlement Agreement. The State cannot be found in compliance with all requirements of Provision 39.

For 39(a), the unified strategy is not yet in place statewide for all sub groups in the Target Population. The same is true for 39 (b). Data are not available to demonstrate maximization of the GHVP (39(c)) although the process being implemented this year with the unified referral can lead to the State maximizing the GHVP in the future when other sources that could be made available are being made available, as discussed under 39(e) below.

The effective use of available resources as required in 39(e) appears to be a challenge not just in the use of resources but even in reporting data for review. For example, the State has not provided updates to the utilization of the balance of state HCVs. These HCVs are being made available as a result of Georgia being granted a preference for the Settlement Agreement Target Population. This Fiscal Year, the State has only referenced "capacity" for the use of these vouchers, not actual use as was reported previously. The same is true for HUD 811 PRA (Project Rental Assistance). Twenty-seven (27) individuals are reported to have moved into units with a PRA Section 811 subsidy although the number of individuals in the Target Population is unknown since individuals not in this Target Population can get 811 PRA. The State currently reports capacity of 100, which is less than the 330 PRA subsidies reported in 2017. This larger number appears to be in reference to the number of Rental Assistance Contracts (RACs) that have been signed between DCA and Low Income Housing Tax Credit (LIHTC) property owners for future availability. This program was funded in early calendar year 2015 and is greatly underutilized both in expanding to its potential capacity and in utilization.

The State also frequently references Memorandum of Understandings (MOUs) for referrals with local Public Housing Authorities (PHAs) and, in 2015, provided "model" unsigned MOUs between DBHDD and the Atlanta Housing Authority and the Columbus Housing Authority. Other PHAs were also referenced previously but model MOUs were never provided to this reviewer. The presentation of the DBHDD-Atlanta PHA MOU is most perplexing as DBHDD has indicated twice in FY18 that there was turnover in the PHA and, thus, the MOU was never

executed. (Interestingly, the Agreement was signed in 2016 but never implemented.) Meanwhile, an MOU was executed in 2017 between the Atlanta PHA and the Atlanta Continuum of Care (CoC). The turnover referenced by DBHDD did not interfere with the Atlanta CoC from executing an agreement with the PHA for essentially the same purpose; that agreement has been fully implemented.

The Veteran's Administration Supported Housing Program (VASH) and Housing Opportunities for Persons with AIDS (HOPWA) resources were cited in earlier reports as resources, as was the Re-Entry Partnership (criminal justice) Housing Program that has also been available. In 2014 and 2015, it appeared that there was momentum building for access to these available housing resources but, for whatever reason, this has subsided and today even securing accurate reports is challenging. There was one report of the potential for two promising opportunities with implementation of the Unified Referral System. One is the potential for DBHDD providers with the Homeless Management Information System (HMIS) to see vacancies (slots or units) their CoCs have for Supported Housing and, tied to that, a requirement for HOPWA agencies to be folded into that information.

HUD provides an array of resources that could be tapped for Supported Housing for the Target Population, including Special Purpose Vouchers for individuals with disabilities, in Georgia, there are 453 of those vouchers; nearly 7,000 permanent Supported Housing subsidies or units, most available to individuals in the Target Population; 2,228 households served with HOPWA funds; 2,504 VASH vouchers. While most of these units are filled or vouchers are being utilized with agreements for use on turnover, they could clearly become part of the State's capacity. These programs have been well advertised, some for a number of years; agreements for access to these programs through the DBH-DCA unified referral system could occur in the future through more systematic agreement upon referral processes and coordination between state and local organizations. Clearly, resources exist but, without agreements, are not available. The task now is that they become available as required in this Extension Agreement. Otherwise, in this reviewer's opinion, the State cannot come into compliance with this provision of the Extension Agreement.

40. The State shall implement procedures that enable individuals with SPMI in the Target Population to be referred to Supported Housing if the need is identified at the time of discharge from a State Hospital, jail, prison, emergency room, or homeless shelter.

The State is not yet in compliance with this requirement. Referral arrangements are not yet implemented although new planning steps have begun in FY18, in some situations replacing previous planning steps, are underway. With careful planning, process mapping, collaboration and other preparation, these steps could result in implementation and compliance in the future.

This provision is key to the State's overall compliance with Supported Housing. Without referrals for each of the Target Population subgroups, as identified in the Settlement Agreement and Extension Agreement, the State is not in overall compliance and needed capacity cannot be determined.

Implementing procedures that enable individuals with SPMI in the Target Population to be referred to Supported Housing encompasses procedures, tasks and action steps in Provisions 36, 38, (specifically the process for assessing need and requirements) and 39 (specifically implementing the unified referral process, determination of need, effective utilization of available housing resources and coordination of available state resources and state agencies), as well as in this Provision, 40. Reference was made to referrals in each of the aforementioned sections. Below is additional information regarding the status of referrals to Supported Housing.

Implementing a referral process consistent with Settlement requirements has been a topic of concern in the Independent Reviewer's and this reviewer's annual reports on Supported Housing, beginning in 2012 when a question was raised about the paucity of referrals from institutions to Supported Housing. In the August 2012 Report, a question was asked of the State, "…based on the underlying principles of the Settlement Agreement, are individuals currently hospitalized, frequently seen in Emergency Rooms, being frequently readmitted to state hospitals or being released from jail and prison afforded access to the housing voucher in the same manner as individuals who are currently homeless"?[12] In 2013, recommendations were made regarding this issue and included a reference to review referral practices. Likewise the 2014, 2015, 2016 and 2017 reports all cited these issues and numerous recommendations were made.

In 2017, the Report concluded with identifying "assessing need" so individuals can access housing as "the first and perhaps most immediate challenge" to compliance. The report referenced ensuring "referral arrangements are made for individuals whose need for Supported Housing can be assessed and, for individuals who choose Supported Housing supporting their integration and providing assistance to individuals to attain housing. This includes establishing the referral and needs assessment arrangements with all jails, prisons, homeless shelters, emergency rooms and for individuals frequently admitted to State Hospitals."

The FY 2017 report also referenced two additional challenges: One reference was to "making improvements in the needs assessment process to ensure the process can be done in a timely manner and making a referral from jails, prisons, emergency room or hospitals possible."

A second was a reference to "not relying on PATH to be the primary provider for referrals of individuals exiting State Hospitals, shelters and other locations. PATH is meant to be providing assertive outreach and support; early provider engagement is essential for PATH to be successful."

The DBHDD has recently begun to "plan" on how to make these arrangements and with whom. However, it appears that DBHDD has yet to fully recognize the scope of how to make

[12] Memorandum from Martha Knisley to Elizabeth Jones on August 2012 RE: Site Visit Summary and Report on Housing Supports for Individuals with SPMI.

arrangements and to implement these as required in the Settlement Agreement and Extension Agreement. DBHDD reported in February 2018, that it did not need to make changes to policy changes until it has assessed needs for such after implementation of new processes. Typically, changes of this nature are subject to process mapping and being tested ahead of time so changes after the fact are less necessary and disruptive and so implementation, as required in this Settlement Agreement, can be attained.

Service Providers must make housing referrals under Georgia's system even though inpatient, PATH and outreach coordinators can assist. As referenced in previous sections, individuals cannot get flexible services during pre-tenancy because of the requirement that an individual must be referred to a provider who is required to do a full clinical assessment and obtain authorization before providing services. There is conflicting information in the field (in Georgia) among reputable providers regarding authorization of services and when authorization can be waived. The issue here may not be whether or not authorization can be waived, the issue is what information is being made available and what can be done so providers can provide pre-tenancy services so their referrals to housing can be expedited. The outcome is that individuals in jails, prisons and hospitals are not offered services for the referral process to be completed so these individuals can actually access housing in a timely manner. There is virtually no connection between the community and prisons' mental health services so pre-tenancy assistance is not provided. There is sufficient clinical information available for individuals exiting hospitals and prisons so these delays in assessing need and making referrals are unnecessary.

The above references speak to barriers and challenges. The following examples illustrate these:

The first is the State's recent attempt to provide outreach to organizations who release or discharge individuals from institutions, including jails, prisons, state hospitals and emergency rooms. Previously, the State contended they were "demonstrating compliance" by providing outreach to "big jails" and a small number of prisons. However, some "big jails" were never included in their routine list of five jails in three different Regions and five prisons where the needs surveys were being conducted. In 2015, the Housing Coordinators in each of the Regions identified how they could expand their role to jails and prisons and what obstacles would need to be overcome to get referrals from these facilities. Regional Transition Coordinators outside Region 3 have also referenced how they could make arrangements to get referrals from prisons and jails. Recent discussions with Housing Coordinators and CSBs reveal that the Housing Coordinators' roles have diminished. There has been some turnover with these positions but, until recently, were considered valuable assets to implementing Supported Housing Settlement requirements. Today, they mostly process the GHVs and bridge funding.

In August 2017, the State announced they would contract with CSBs to hire thirteen Housing Outreach Coordinators (HOCs) for the purpose of providing onsite connections to more jails and prisons for access to the housing survey, referral to the Unified Referral Process and community advocacy, marketing and education about Supported Housing resources. (This number was later changed to twelve positions.) The HOCs are to represent DBHDD efforts to actively engage

individuals in the Target Population criteria at provider meetings, staffing and community and stakeholder meetings. They are to provide education and technical assistance. They are to report monthly to DBHDD and provide work plans updated every 90 days. The CSBs have been provided outcome expectations for the HOCs. One significant challenge to assessing need and referral from prison is that often individuals are sent to prisons that are not close to where they were living and want to return. This means cross agency referrals and significant logistical challenges. Even the recent individual (Mr. D) highlighted by DBHDD as a success coming out of prison was given a bus pass in a far eastern county to Columbus, GA, but with no money. He slept on the streets and in a shelter for weeks before he walked into a service provider agency on his own and asked for help with his symptoms. It was only then that he was referred for housing. He also got a job on his own.

Effective February 1, 2018, two CSBs had declined the offer to hire a HOC and six of the remaining eleven had been hired. Two of the HOCs had attended one training event in December and a second training event was being planned for February. One HOC interviewed in January said she had attended orientation for her job in December and was looking forward to more orientation in February so she could better understand expectations.

It's conceivable that in six months to a year, if this new process proceeds as planned with implementation to the extent that referrals are being made to Supported Housing for "any" individual in the Target Population exiting jails and prisons, the State could come into compliance with referring this sub-group. This will require HOCs being hired and fully trained, providing technical assistance, making agreements with jails and prisons and then implementing outreach to over 200 jails and prisons. It will also require service agencies being provided adequate resources for pre-tenancy tasks (including providing services in jails and prisons as necessary) and information for taking referrals, the referral process not being subjected to time consuming approvals and DBHDD making the inevitable and needed changes in procedure and policy necessary for successful implementation.

One area for further exploration for DBHDD is the "re-entry process" already established between DCA and the Department of Community Supervision (DCS). There is the potential to have DBHDD service providers included in the DCA and DCS Re-Entry Housing Partnership (RHP) program. DBHDD has explained in detail this process after being prompted by this reviewer to do so. DBHDD has also explained the role that DCS and DCA play with Accountability Courts. DBHDD has added Forensic Peer Mentors in select correctional facilities. Hopefully, DBHDD can implement a plan to actually gain referrals as a result of using the Unified Referral process and securing service provider support in the future. Funding has been provided for Forensic Peer Mentors but no details have been provided on when DBHDD will be participating in these processes with DCS and DCA so permanent housing referrals can be made through the Unified Referral Process. DBHDD indicates they are beginning to outreach to providers and these agencies now. It is likely this will occur once HOCs are in place and provider arrangements can be made. This process can be evaluated again when these arrangements are finalized and implementation begins.

Another well-documented example of the flawed referral process is lack of engaging individuals for housing referrals as they are exiting Georgia Regional Hospital Atlanta. This is necessary so referrals to Supported Housing from the GRHA can be made. With the presence of a Fulton County CSB and a strong CoC, it is possible adequate service provider involvement and, thus, more housing can be made in Fulton County and Atlanta. In past reports, detailed descriptions of problems of individuals discharged to shelters and an ineffective initiative to utilize PATH providers to make bridge arrangements for individuals referred to them by staff at GRHA have been made. The first problem seems to have subsidized with "direct" referrals to shelters decreasing.

DBHDD entered into an agreement with five PATH providers in Atlanta to engage individuals exiting GRHA. This practice was started in the spring of 2016. DBHDD expanded contracts with the five providers in Atlanta to also include transitional living for this cohort. This shift was created to engage individuals prior to discharge, to reduce direct discharges to shelters and to provide other low barrier housing options.

In FY 2016, this reviewer noted that PATH cannot compensate for the lack of a comprehensive, competent "housing first" approach; it complements it. This does not appear to have happened in Region 3. In discussions with Hospital staff, PATH teams, other service providers and the CoC in FY17 and FY18, they report difficulties with engaging individuals while they were hospitalized or after they have moved to unsafe housing in the community.

A review of the PATH six month data (January-June 2017) provided by DBHDD in July 2017, indicated that only five out of thirty-four individuals referred from GRHA moved into permanent housing and 4 of these individuals were residing with family members. The remaining individual was placed in permanent housing on May 23, 2017 and disappeared from housing by June 5, 2017. It appears that only one individual was referred for a GHV (discharged from the hospital on April 17, 2017 and PATH reports the individual is awaiting response from DBHDD).

DBHDD reports fifty-eight individuals were offered a referral to PATH from GRHA in the first two quarters of FY18. However, a review of discharge records show the actual number of PATH referrals where the individual consented and contact was made was three in the first two quarters of FY18. The difference appears to be that, while PATH is offered, it is not offered until close to discharge; thereby limiting the opportunity for the PATH provider to effectively engage with the individual and make a referral that results in linkage to Supported Housing.

There is also indication that some individuals offered PATH already have providers, either ICM or ACT, so this is a duplicate referral. Only one individual has moved into Supported Housing when their prior residence was a State Hospital in Region 3 and six individuals in Region 2 this Fiscal Year. The needs assessment and referral process is simply too cumbersome for GRHA both because the planning and implementation of the process using PATH as an interim service provider is not sufficient nor is the process for referrals when other providers, ACT or ICM are assigned to assist the individual to return to the community. The average length of stay at

GRHA is long enough to not be a barrier nor is the availability of housing vouchers or subsidies. The data are clear, referrals to Supported Housing for individuals exiting GRHA are not working. To add, Regions 1 and 5 accounted for 77% of thirty-seven out of forty-eight referrals to Supported housing this Fiscal Year. This further demonstrates that if an individual resides in a State Hospital in a Region other than 1 or 5, they do not have adequate access to Supported Housing upon discharge.

The Atlanta referral issues though aren't just confined to GRHA referrals. Recently, the Atlanta CoC was given the responsibility to close a large shelter with approximately 200 residents, Peachtree and Pine, where a significant number of individuals with SPMI were residing continuously or intermittently. The CoC solicited support from the United Way Regional Commission on Homelessness and twenty-five agencies to assist in the process. DBHDD and DCA met with the CoC in September 2017 to "introduce strategies" to identify and transition individuals in the Target Population.

DBHDD pledged assistance with the closing of this shelter similarly to an offer made to get referrals to housing there two years ago that was unsuccessful. The assistance pledged was PATH providers to engage individuals, help with stabilization and referral to housing. Of the sixty-nine individuals identified for PATH engagement, only two appeared interested. However, there was no follow through with those two because PATH providers did not come the shelter to meet them until they left in the morning. Shelter residents typically leave the shelter in the morning returning in the evening. PATH providers know this but didn't come to the shelter until after the individuals left for the day. DBHDD reports PATH providers continued to go to the shelter during the closing process. However, since closings always have to occur within a narrow window of time, the CoC simply had to move on by securing assistance and using their own limited resources to get individuals access to transitional and permanent housing with subsidies.

After the fact, DBHDD stated that since individuals were living in a shelter (they were "not the target population for the PATH team" yet DBHDD offered their assistance as their primary role in assisting with the closure. The irony is that without assistance provided by other organizations, these individuals would have been left to live on the street. Luckily the CoC and its partner agencies successfully assessed an individual's need, made the referral and successfully transitioned the individuals. The point being, the CoC has obviously developed a successful process and perhaps DBHDD could learn how they have made it work. It should also be noted that the Atlanta CoC has raised concerns with DBHDD and DCA regarding unified referral; again perhaps, lessons could be learned to streamline the unified referral process.

The irony of this problem is that the CoC is using "one time" funds from the City, the United Way and a federal grant to temporarily patch together a service and housing referral system in Atlanta. Their success masks the underlying problem of a long term solution that, by definition, DBHDD needs to be party to so the referral process to Supported Housing can actually work. Also ironically, the Atlanta PHA entered into an agreement with the CoC for housing subsidies---

all the while DBHDD said such an agreement with them could not be done because of staff problems at the Atlanta PHA.

The last example is DBHDD's approach to referrals from emergency rooms. As stated in the "assessing need" section of this report, the absence of any process for referral from frequent users of emergency rooms results in a recommended finding of Non-Compliance for this requirement. As part of DBHDD's FY18 outreach strategy, DBHDD is proposing to capture data by modifying their web portal to identify individuals "who were in a Community Hospital Emergency Department and discharged to a temporary/transitional setting prior to obtaining a voucher (GHVP, 811, Section, etc.) by July 1, 2018." This is a good plan, however it does not reference what DBHDD will do to implement a referral process. Perhaps capturing the data can provide a clearer picture of the extent to which individuals in the Target Population are utilizing emergency rooms so DBHDD and service providers can establish a threshold for frequency of visits and concentrate on "high" utilizers. DBHDD indicates the HOCs will have responsibility to outreach to emergency rooms but no information is specified about how the HOCs could manage a workload of outreach to all the jails and prisons and all the emergency rooms. After July 1, 2018 this information and DBHDD plans for implementation and implementation progress can be further assessed so the timeframe for reaching compliance can be determined.

Reference to Original Agreement Language Still in Place

B.2.c.ii.(B) The State will provide housing supports for approximately 2,000 individuals in the target population with SPMI that are deemed ineligible for any other benefits pursuant to the following schedule:

The State is now taking the step to determine who is "deemed ineligible" for any other benefits as part of their Unified Referral Process (between DBHDD-DCA). However no effort was made to determine if individuals in the GHVP were "deemed ineligible" for any other program prior to October 2017; therefore, the State is not in compliance with this requirement. This problem was first brought to the State's attention in the 2012 and 2013 Independent Reviewer's Reports.

To illustrate, individuals who meet the State's definition as having SPMI and being chronically homeless, likely qualify for HUD Shelter Plus Care subsidies. In Region 3, 72% of individuals got a GHV and statewide 54% of individuals getting a GHV met the "chronically homeless" definition. The HUD Shelter Plus Care (S + C) funding far exceeds the GHVP and is expanding each year. Total funding from HUD for homeless programs in Georgia in 2017 was $41 million and S+C was the category with the greatest resource allocation. Other resources such as HUD Non-Elderly Disabled (NED) vouchers, HUD Mainstream vouchers, PHA HCV preferences (in local jurisdictions), Veterans Supported Housing Vouchers (VASH), 811 PRA and Housing Opportunities for Persons with Aids (HOPWA) could also be tapped.

Summary

The State has demonstrated compliance with the requirements in the Bridge Funding and Georgia Housing Voucher Program as described in Provisions 31-35 of the Extension Agreement. The State has also demonstrated compliance with Provision 37 of the Supported Housing requirements. It is not possible to measure compliance with Provision 38, which refers to the State having capacity to provide Supported Housing to any of the individuals in the Target Population who have an assessed need because "any" of the individuals in the Target Population have not been given the opportunity to be assessed for such support. The State has made good faith efforts to meet Provision 39 of the Extension Agreement but falls short on sub items a., b., c., e. and f.

The State has simply not completed the basic tasks or taken action steps to implement Provisions 36, 38, and 40 in the Extension Agreement and ii B. in the original Agreement) for Supported Housing for all of the Target Populations statewide. Developing plans and creating new positions for outreach don't meet the threshold requirements as written in this Settlement Agreement. The State's own data and detailed descriptions of outreach and plans paint a picture of "new" intentions but, as DBHDD acknowledges, there simply has not been enough time and attention to achieve the requirements of this Agreement. Some projects such as the GRHA Path project and Housing Coordinators outreach have come and gone without success. Every year beginning in 2012 concerns about this lack of follow-through and attention to jail, prison, emergency room and state psychiatric hospital referrals have been reference in these reports. The same can be said for maximizing the GHVPs and ensuring these resources go to individuals "deemed ineligible" for other resources.

This compliance review bears out that DBHDD's acknowledgement that changes now being planned "take time" is correct. Compliance for almost all of these items is tied to implementation not planning alone.

Summary Analysis of Requirements for Supported Housing

Introduction to Supported Housing Provisions in the Extension Agreement
For purposes of Paragraphs 31 to 40, the "Target Population'' includes the approximately 9,000 individuals with SPMI who are currently being served in State Hospitals, who are frequently readmitted to the State Hospitals, who are frequently seen in emergency rooms, who are chronically homeless, and/or who are being released from jails or prisons. The Target Population also includes individuals with SPMI and forensic status in the care of DBHDD in the State Hospitals, if the relevant cou1i finds that community services are appropriate, and individuals with SPMI and a co-occurring condition, such as substance abuse disorders or traumatic brain injuries.

Original Agreement excerpts:

ii.

(A.) By July 1, 2015, the State will have capacity to provide Supported Housing to any of the 9,000 persons in the target population who need such support. The Supported Housing required by this provision may be in the form of assistance from the Georgia Department of Community Affairs, the federal Department of Housing and Urban Development, and from any other governmental or private source

(B) The State will provide housing supports for approximately 2,000 individuals in the target population with SPMI that are deemed ineligible for any other benefits pursuant to the following schedule

Extension Agreement:

Requirement	Recommended Finding	Notes
31. By June 30, 2016, the State shall provide Bridge Funding for at least an additional 300 individuals in the Target Population.	Compliance	
32. By June 30, 2017, the State shall provide Bridge Funding for at least an additional 300 individuals in the Target Population.	Compliance	
33. By June 30, 2016, the State shall provide GHVP vouchers for an additional 358 individuals in the Target Population.	Compliance	
34. By June 30, 2017, the State shall provide GHVP vouchers for at least an additional 275 individuals in the Target Population.	Compliance	

35. Supported Housing is assistance, including psychosocial support, provided to persons with SPMI to assist them in attaining and maintaining safe and affordable housing and support their integration into the community. Supported Housing includes integrated permanent housing with tenancy rights, linked with flexible community-based services that are available to consumers when they need them, but are not mandated as a condition of tenancy. Supported Housing is available to anyone in the Target Population, even if he or she is not receiving services through DBHDD.	Non-Compliance	This Provision is not being met because the services provided to individuals are not flexible. This determination is based on two findings. One, individuals cannot get flexible services during pre-tenancy because of the requirement that an individual must be referred to a provider who is required to do a full clinical assessment and obtain authorization before providing services. There is conflicting information regarding authorization of services and when authorization can be waived. So individuals in jails, prisons and hospitals are not offered services to move into housing in a timely manner. There is sufficient clinical information available for individuals exiting hospitals and prisons so this delay is unnecessary. Individuals cannot get services in jails and services being provided to individuals in prison are contracted out to private providers or provided in house. There is virtually no connection between the community and prisons so pre-tenancy is not provided. The Utilization Management process also constrains flexibility post tenancy.
37. Under this Extension Agreement, by June 30, 2018, the State will have capacity to provide Supported Housing to any of the individuals in the Target Population who have an assessed need for such support.	Non-Compliance	This Provision cannot be met because the State has not assessed need of individuals exiting all hospitals, jails and prisons who fall into the Target Population. The State's own data illustrate this point. Assessing need for individuals exiting emergency rooms is a complex undertaking. There is no paucity of data from dozens of

		projects and analyzes of projects and analyses being taken across the country that if analyzed would give DBHDD information on how to approach this issue. Major cross system data exists following several national reviews. No effort has been made to identify individuals who repeatedly use emergency rooms for behavioral health treatment or fully or in part as a result of their behavioral health problems. DBHDD has not made any effort to study let along tackle this issue.
38. Supported Housing includes scattered-site housing as well as apartments clustered in a single building. Under this Extension Agreement, the State shall continue to provide at least 50% of Suppo11ed Housing units in scattered-site housing, which requires that no more than 20% of the units in one building, or no more than two units in one building (whichever is greater), may be used to provide Supported Housing.	Compliance	
39. Between the Effective Date of this Extension Agreement and June 30, 2018, the State shall continue to build capacity to provide Supported Housing by implementing a Memorandum of Agreement between DBHDD and the Georgia Department of Community Affairs, which includes the following components: a. a unified referral strategy (including education and outreach to providers, stakeholders, and individuals in the Target Population) regarding housing options at the point of referral;	 a. Non-Compliance	MOA completed but not being fully "implemented." If the State was in the process of implementing all the sub-requirements under this Provision, then consideration could be made for Compliance. However, the State has complied with a., b., c., e. and f. of this Provision. This Provision is not met because the Provisions for education and outreach to all Target Populations is not yet in place and there is no evidence yet of new staff being trained sufficiently to conduct outreach and education. There is no evidence that a referral strategy has been developed sufficient for all Target Populations—this is

		necessary in order to evaluate the implementation steps as being sufficient but also to assess the knowledge, preparation, practice and performance of staff being able to take these steps for all sub-Target Populations.
b. a statewide determination of need for Supported Housing, including developing a tool to assess need, forming an advisory committee to oversee the needs assessment, developing a curriculum to train assessors, training and certifying assessors, and analyzing and reporting statewide data:	b. Non-Compliance	b. Tool, committee, curriculum and reporting In place. Cannot be met until all the Target Populations need for housing is assessed, individuals are being referred, and the referral process is meeting requirements.
c. maximization of the Georgia Housing Voucher Program:	c. Non-Compliance	c. The State has not yet provided data that provide information of available resources and indicate GHVs are maximized in proportion to available resources nor has the State indicated of the individuals getting GHVs that the program was only being used for individuals not qualifying for another program. The supply of Housing Choice Vouchers (HCVs), Mainstream Vouchers for people with disabilities, VASH (vouchers for vets) and Shelter Plus care (SPC) subsidies is limited in some jurisdictions so it is not always possible to use these resources to better maximize the GHVs. However, there is no information available to determine when this is an issue.
d. housing choice voucher tenant selection preferences (granted by the U.S. Department of Housing and Urban Development);	d. Compliance	This Provision is in place but clear information as to the extent to which preferences are being made available has not been provided for the past 9 months.
e. effective utilization of available housing resources (such as Section 811	e. Non-Compliance	There is not sufficient information to determine if utilization is

and public housing authorities); and		effective. The information provided more recently has been confusing and contradictory. At one time, there appears to have been outreach to PHAs but this appears to be more limited now. On the other hand, the DCA has attempted to maximize LIHTCs.
f. coordination of available state resources and state agencies.	f. Non-Compliance	No evidence of an established working relationship with DOC, Parole and Probation, Jails or the Criminal Justice Coordinating Council (CJCC) by DBHDD that is resulting in individuals exiting jails and prisons sub-populations getting access to Supported Housing, although DCA has working relationship with some of these groups. No evidence of a consistently productive relationship with CoC in Atlanta that is resulting in individuals who are in the chronically homeless sub-population getting access to Supported Housing. There is no evidence of working with Medicaid on examining hospital emergency room usage
40. The State shall implement procedures that enable individuals with SPMI in the Target Population to be referred to Supported Housing if the need is identified at the time of discharge from a State Hospital, jail, prison, emergency room or homeless shelter.	Non-Compliance	Very clear evidence that Target Population's need not being determined.

ATTACHMENT B

INDEPENDENT REVIEW: DISCHARGES FROM STATE HOSPITALS

Submitted by:
Beth Gouse, Ph.D.
February 22, 2018

PROGRESS REPORT FOR SHELTER DISCHARGES

Overview

This progress report summarizes the independent review of the individuals discharged to shelters and hotels/motels from Georgia Regional Hospital-Atlanta (GRHA) between July 1 and December 31, 2017. Data were reviewed and compared with data from shelter and hotel/motel discharges between January 1 and June 30, 2017. Information about readmissions of these individuals was also reviewed. In addition, implementation of recommendations from prior report were reviewed.

Methodology

This review included:

- Interviews with individuals in care;
- Interviews with clinical leadership at GRHA, including Mr. Coleman, Chief of Social Work, and Dr. Li, Hospital Administrator;
- Interviews with Christie Lastinger, Chief of Social Work, Jada Nobles, Assistant Chief of Social Work, and Dr. Bashera, Medical Director;
- Interview with PATH team members at GRHA;
- Record review (records of all individuals discharged from GRHA and GRHS to shelters and hotels/motels between July 1 and December 31, 2017);
- Readmission data for individuals discharged to shelters and hotels/motels from GRHA for last two quarters of FY17 and first two quarters of FY18;
- Readmission data for individuals discharged from GRHS for the last two quarters of FY17 and the first two quarters of FY18;
- Policy review;
- Review of document: *Overview: Strategies for Outreach to State Hospitals, Community Hospital EDs, Jails/Prisons & Homeless Populations;*
- PATH data regarding those discharged from GRHA between January 1 and June 30, 2017;
- DBHDD shelter discharge reports for quarters 1 and 2 for Fiscal Year (FY) 2018;
- Interviews with PATH teams from Region 1 and Region 3;
- Interviews with DBHDD central office staff.

Findings

1. **Discharges from GRHA and GRHS to shelters and hotels/motels.**
    a. Compared to the last two quarters of FY17, at GRHA, discharges to shelters in the first two quarters of FY18 decreased 61% (from 26 to 10), discharges to hotels/motels decreased 33% (from 15 to 10), and discharges to transitional housing increased 6% (from 49 to 52). At GRHS, discharges to shelters increased 60% (from 5 to 8) and discharges to hotels/motels decreased 40% (from 10 to 6).

Discharges to transitional housing decreased 16% (from 6 to 5). Overall, this reflects a continued positive response to the policy change that went into effect in FY16, 3rd quarter, requiring review by the DBHDD Medical Director prior to discharge to a shelter. Also, of note is that there were two individuals at GRHS who requested a discharge to a shelter and the shelter committee met with each individual and did not approve the discharge request. In one instance, the individual stayed several more months, eventually discharging to his own apartment with a GHVP. The other individual discharged to a Personal Care Home (PCH). This evaluator asked whether there were any individuals from GRHA whose request for a shelter discharge was denied and there were not. In addition, this evaluator asked staff at GRHS whether there were any other individuals in the past year discharged with a GHVP and there were not.

2. Readmission data.

a. GRHA: As of October 26, 2017, 16% of those discharged to shelters in the last two quarters of FY17 were readmitted to GRHA, 20% of those discharged to hotels/motels were readmitted to GRHA, and 25% of those discharged to transitional housing were readmitted to GRHA. As of January 18, 2018, 40 % of those discharged to shelters in the first two quarters of FY18 were readmitted and an additional individual was admitted for a forensic outpatient evaluation. Of note is that one of these individuals had an additional three stays for a brief assessment and was discharged back to a shelter each time. Another one was discharged to a shelter on December 12, 2017 after a 54-day stay, was readmitted for three days (12/24-12/26/17) and discharged again back to a shelter, returned on 1/14-1/15/18 after spending four days in a crisis stabilization unit and discharged again back to a shelter. Note that stays of three days or less in temporary observation unit are not counted as inpatient admissions, despite being at GRHA. However, for practical purposes, these individuals were experiencing significant psychiatric symptoms warranting hospital level of care. Please note that this readmission data are only available for GRHA and do not include admissions to private hospitals.

b. GRHS: As of February 1, 2018, 40% of those discharged to shelters in the last two quarters of FY17 were readmitted to GRHS and 20% of those discharged to hotels/motels were readmitted. As of February 1, 2018, 25% discharged to shelters in the first two quarters of FY18 were readmitted and 17% of those discharged to hotels/motels were readmitted.

3. Length of stay.

a. Average length of stay (ALOS) was also examined to ascertain whether there is a correlation between ALOS and discharge setting. The data in this regard differ significantly between GRHA and GRHS. At GRHA, the ALOS has continued to climb for those discharged to shelters. In the last two quarters of FY17, the ALOS was 19.5 days compared to 35.5 days during the first 2 quarters of FY18 (an 82% increase). Meanwhile at GRHS, the ALOS for those discharged to shelters

decreased 40% (from 21.5 to 13 days). In contrast, for those discharged to hotels/motels from GRHA, the ALOS decreased 35% (from 28.5 to 18.5 days) and slightly increased (12%) at GRHS (from 12 to 13.5 days). For individuals discharged to transitional housing, the ALOS at GRHA increased 24% (from 38 to 47 days) and remained essentially unchanged at GRHS (note that for the 1st quarter FY18, the ALOS was 343 days…well above the ALOS for the prior two fiscal years so this quarter was excluded for analysis purposes.) Given the readmission data reported in #2, coupled with the longer ALOS, it is concerning that placement in supported housing is not effected.

4. **Aftercare follow-up.**
    a. According to the aftercare report, completed by Hospital social workers after discharge, that attempts to determine whether the individual followed up with scheduled aftercare appointment, for those discharged to shelters in the 1st and 2nd quarters of FY18, the report was completed most of the time, which is an improvement over the last two quarters of FY17. However, the percentage that followed up with aftercare decreased to 10% from 17% in the last two quarters of FY17. The overwhelming majority of individuals discharged to shelters and hotel/motels do not follow-up with scheduled aftercare appointments.

5. **Shelter location.**
    a. In response to well-documented issues with Peachtree and Pine shelter, it finally closed during this current review period. As a result, most individuals discharged from GRHA went to Atlanta Union Mission and, to a much lesser degree, Atlanta Day Shelter.

6. **ACT/ICM.**
    a. The number of individuals referred or already receiving ACT and ICM services in the first two quarters of FY18 was similar to those referred in FY17 and more than those referred in FY16. While most recent data did not indicate new referrals to ACT/ICM, for the most part, this was due to individuals requiring this level of service already having been connected prior to admission. However, the actual number of PATH referrals, though almost always offered to individuals, decreased in the first two quarters of FY18. The referral is frequently not made because the individual refuses the service. Furthermore, this offer continues to be made towards the end of the individual's stay, especially at GRHA, thereby limiting the opportunity for linkage to this service prior to discharge. In contrast, at GRHS, this referral tends to occur earlier in the admission and even if the individual refuses, the practice is that staff request that the PATH team come to meet with the individual regardless and an effort to engage is at least attempted. This approach results in increased likelihood of linkage prior to discharge. In light of the data noted above regarding increased ALOS at GRHA, it is concerning that this linkage is not occurring prior to discharge. Without this support in the community, transition to permanent housing is extremely unlikely as is evident

based on the data previously noted about very discouraging rates of aftercare follow-up and readmission rates.

7. **PATH.**
   a. The review of records clearly reflects efforts by social workers to offer a variety of resources (e.g., PATH, placement in PCH, transitional housing, residential substance abuse treatment, BOSU assistance, ACT, ICM, housing voucher, etc.) during the discharge planning process. However, the actual number of PATH referrals, though almost always offered to individuals, decreased in the first two quarters of FY18. While there were no PATH referrals during the first quarter of FY18 (out of twelve discharged to shelters and hotels/motels, there were no PATH referrals and three individuals were not referred because they were identified as already having ACT or ICM in place). During the second quarter of FY18, out of eight discharged to shelters and hotels/motels, three were referred to PATH. The referral is frequently not made because the individual refuses the service, especially at GRHA. Furthermore, this offer continues to be made towards the end of the individual's stay, especially at GRHA, thereby limiting the opportunity for linkage to this service prior to discharge. In contrast, at GRHS, this referral tends to occur earlier in the admission and even if the individual refuses, the practice is that staff request the PATH team come to meet with the individual regardless and an effort to engage is at least attempted. This approach results in increased likelihood of linkage prior to discharge. In light of the data noted above regarding increased ALOS at GRHA, it is concerning that this linkage is not occurring prior to discharge. Without this support in the community, transition to permanent housing is extremely unlikely as is evident based on the data previously noted about very discouraging rates of aftercare follow-up coupled with readmission rates.

      However, a review of the PATH data report provided by DBHDD regarding PATH referrals for the last two quarters of FY17 indicated that only five out of thirty-four individuals are in permanent housing and four of these individuals are residing with family members. The remaining individual was placed in permanent housing on May 23, 2017 and had disappeared from housing by June 5, 2017. It appears that only one individual was referred for a GHVP (discharged on April 17, 2017 4/17/17 and report states awaiting response from DBHDD). Furthermore, despite an average of eight days between referral to PATH to date of discharge, the majority of individuals either refuse PATH services or are not seen prior to discharge. While this report appeared to be preliminary, the data highlight issues with engagement and communication.

8. **Unit-based discharge planning interventions.**
   a. Engaging individuals in discharge planning early in admission is critical. There continue to be limited unit-based treatment interventions focused on discharge planning and building knowledge of community resources. Numerous transition planning groups and related skills-based interventions are available in the

treatment malls at both GRHA and GRHS; however, the majority of individuals do not attend the treatment mall during the initial weeks of admission. Hence, the importance of on-unit programming in this regard. It is unclear whether the minimal programming is due to limited staff resources. One promising development is the additional hiring of peer mentors via the Peer Mentor Pilot Project currently in place at GRHA. The increased availability of these two staff on the admissions units is an important avenue for increasing engagement and helping individuals move towards supported housing. Their charge is to engage with individuals while hospitalized and maintain contact and provide support as they transition into the community and hopefully into supported housing.

9. Benefits/Entitlements.

a. The benefits application process, though often initiated, does not routinely come to fruition by the time of discharge. Given the increase in the average length of stay, in the most recent quarter, the record review does not demonstrate improvement in this regard. This evaluator's prior report detailed specific challenges in this process. While BOSU staff continue to make efforts to initiate this process, sometimes individuals refuse to cooperate. Engagement by mentors and unit-based programming on community resources are just a couple of options to improve cooperation. There are also continued systemic issues with local Social Security offices. According to the Overview document (Appendix A), the Division of Behavioral Health and GRHA Collaborative began meeting in December 2017 and is scheduled to meet quarterly (next meeting is in March 2018). It appears that the issue with procurement of IDs (especially from out-of-state) is identified as a focus of attention; however, there is no mention of the broader benefits application process. Without a concerted effort to address this barrier, not only is placement in supported housing very unlikely, but access to residential substance use treatment is limited (e.g., GRHS identified access to substance use treatment as a barrier for many due to the need for IDs, treatment fees, etc.)

10. Communication.

a. Communication between Hospital staff and community providers is variable. In order to address the ongoing challenges in this regard, the Overview document (Appendix A) identifies a collaboration between DBH regional staff and GRHA staff focused on, among other things, improving community provider involvement. Accomplishments include a "meet and greet" at GRHA between ACT teams from Regions 1 and 3 and hospital staff most likely involved in transition and discharge planning. A similar event with Intensive Residential Treatment providers is pending (awaiting scheduling). The addition of more transition specialists charged with facilitating transition from GRHA is identified as another strategy to improve coordination between hospital staff and community providers. Finally, this document also referenced initial informational sessions between regional staff, including the Director of

Supported Housing, and GRHA staff and ongoing, but unspecified, training opportunities. It is unclear how these initiatives are being implemented or how the progress is being monitored/measured.

11. Civil Commitment.

a. There continues to be limited consideration of civil commitment and guardianship as temporary tools to assist individuals with recovery and treatment compliance. On one request for shelter placement form, there was a note to the team requesting that the individual be evaluated for civil commitment. This evaluator was unable to find documentation that this occurred. According to Dr. Bailey, the percent of individuals recommended for inpatient versus outpatient commitment is unchanged from 2017 to the first half of 2018 (42% versus 43%).

12. Recovery Treatment Plan.

a. The recovery plan form was revised and rolled out in AVATAR in October 2017. Training to date has focused on the technical challenges associated with the form in AVATAR and has only included the treatment team facilitators (staff who write the document in AVATAR). It is unclear whether the revised form will assist with developing more focused, individualized objectives and interventions geared towards transition and successful community placement. An audit tool is under development to further assess the impact of the revised form. Training with the entire team on the recovery model and the changes to the form is also planned, though not scheduled.

DISCHARGE PLANNING FOR FORENSIC CLIENTS IN STATE HOSPITALS

Overview

This progress report summarizes the independent review of data provided to the evaluator regarding individuals with a legal status of IST/CC (Incompetent to Stand Trial/Civilly Committed) and NGRI (Not Guilty by Reason of Insanity) hospitalized in Georgia Regional Hospital Columbus, Georgia Regional Hospital Savannah (GRHS), East Central Hospital (Augusta), Central State Hospital, and Georgia Regional Hospital Atlanta (GRHA). Data were reviewed in order to gather information about the status of discharge planning and the extent to which recovery planning with individuals with a forensic legal status facilitates discharge and whether access to community supports necessary for successful outplacement is evident.

Methodology

This review included interviews with individuals in care, clinicians, as well as interviews with clinical leadership and Dr. Karen Bailey, the Director, Office of Forensic Services. For the

current report, limited records were reviewed for individuals with a legal status of IST/CC and a legal status of NGRI from GRHA and GRHS. Specific forms reviewed included multidisciplinary assessments, recovery plan documents, risk assessments, annual Court letters, and Forensic Review Committee (FRC) documentation.

Findings

1. **Discharge Planning Process.**
    a. The discharge planning process for forensic individuals is challenging because of the additional layer of Court-required approval and related Hospital-related requirements (e.g., Forensic Review Committee (FRC), interface with regional staff (e.g., Planning List Administrator (PLA) and placement on various lists (i.e., active DD list, etc.), and potential barriers to placement due to specific underlying charges. Since the prior report, documentation reflects continued efforts by staff to move individuals towards discharge. However, recovery plans do not routinely reflect that interventions change when the individual is not progressing towards discharge or that the interventions actually focus on the skills necessary for successful outplacement. It was expected that the revised recovery plan form would change this by encouraging treatment teams to adopt a more flexible, recovery-based approach. However, the plan was not rolled out until October 2017 and system-wide training to treatment teams has not yet occurred. An audit tool is being developed to assess/monitor emphasis on transition planning and the extent to which interventions are revised. Therefore, it is not clear to what extent, if any, this revised form will have an impact. It was reported prior to the last report that this information is being tracked for individuals who are recommended for recommitment. In addition, DBHDD provided data about the current individuals with DD who remain hospitalized: 21/35 (60%) of DD individuals with a legal status of IST/CC are being recommended for discharge and of the 21, the Court is disagreeing with the recommendation for 5 (24%). Of the 8 NGRI individuals still hospitalized, 3 (37%) are being recommended for discharge and the Court is not disagreeing with any of those recommendations for discharge.

2. **Timeliness of documentation.**
    a. Consistent with this evaluator's prior report, completion of recovery plans, risk assessments, Forensic Review Committee (FRC) meetings, and annual Court letters are generally occurring in a timely manner and, therefore, not contributing to delays in discharge planning. There are monthly meetings between the DBHDD Forensic Director and specific Hospital Forensic Directors, as well as consultation on an as needed basis. There continue to be some documentation-related delays associated with the Court, as evidenced by delays in scheduling court dates for hearings, delays in receiving correspondence (e.g., Court order allowing expansion of privileges,

conditional release, etc.), as well as occasional instances when the Court disagrees with the Hospital's recommendation for conditional release.

3. **Civil Commitment.**
    a. Inpatient civil commitment remains the more commonly recommended type of commitment. Though this decision is ultimately the Court's, continuing to educate the Court about available community resources for monitoring and support may increase the use of outpatient commitment. According to Dr. Bailey, the number of individuals recommended for community release is essentially unchanged in the first two quarters of FY18 relative to FY17 (43% versus 42%). Efforts to educate the Court regarding community resources continue and are discussed below.

4. **Court Interface/Education**.
    a. The assignment of forensic community coordinators in 2016 has had a positive effect on increasing the Court's willingness to order this type of commitment, in large part due to the increased awareness of the Court on monitoring capabilities in the community. For example, according to Dr. Bailey, the number of individuals monitored in the community has increased from about 100 to about 250. Initially intended to monitor individuals with a NGRI legal status, judges have ordered the monitoring of many IST/CC individuals. Because these forensic community coordinators are DBHDD staff and are community-based, it is likely that judges have more confidence in their ability to effectively monitor individuals in the community. Continuing to educate the Courts is critical to increasing awareness of other community-based resources. Overreliance upon forensic community coordinators for monitoring IST/CC individuals may have the unintended consequence of interfering with timely discharge of NGRI individuals.
    b. According to Dr. Bailey, a number of formal trainings in various jurisdictions have occurred in the past six months or are scheduled to occur, including:
        i. Municipal Court Judges Training-October 2017;
        ii. Georgia Criminal Defense Attorneys Winter Seminar, Georgia Bar Association-January 2018;
        iii. Accountability Courts Annual Conference-September 2017;
        iv. Carroll County DA's Office-December 2017;
        v. Houston County State and Superior Court Judges, DA's Office, and Public Defender's Office-January 2018;
        vi. Griffin Judicial Public Defender's Office-January 2018;
        vii. Clayton County Public Defender's Office-January 2018;
        viii. Chatham County Breaking the Cycle Meetings;
        ix. Gwinnett Bar Association Criminal Defense Lawyer's Association-Scheduled for March 2018.

5. **Housing Resources.**

a. Forensic legal status data indicate that in the past year, while the overall census has remained relatively stable, the number of individuals with a NGRI legal status and the number of individuals with an IST/CC legal status have decreased, while the number of IST restoration individuals has increased. See table below: As of 2/23/17-As of 1/1/18

Legal Status						**Total**
	CSH	**ECRH**	**GRHA**	**GRHS**	**WCGRH**	
Pretrial	4/7	2/3	5/1	3/4	2/1	16/16
IST restoration	54/56	20/17	83/86	29/33	41/51	227/243
IST/CC	68/63	28/31	17/18	50/51	59/54	222/217
NGRI	54/47	14/15	14/13	27/20	42/42	151/137
Total	180/173	64/66	119/118	109/108	144/148	616/612

This suggests a slight increase in discharges of individuals with a NGRI and IST/CC legal status; individuals who have significantly longer lengths of stay relative to pretrial and IST restoration individuals.

b. However, availability of supported and supervised housing does continue to be a factor delaying discharges. According to Dr. Bailey, there continues to be a waiting list for Community Integration Homes (CIH), likely due to an overreliance on this resource by judges because of the 24-hour supervision in this setting. As of December 31, 2017, fifty of the sixty-one slots were filled and the remaining eleven slots are reserved/"in process" for individuals from all five hospitals. Of note is that an additional six beds were opened in Savannah since the prior progress report. While increasing the bed capacity has a positive effect on discharge options, implementing processes to speed up the 'in process' placements is necessary to improve on an 80% operating capacity. For example, in the prior report, forty-eight out of fifty-five beds were filled, with seven in process; currently there are eleven "in process." In addition, there are seven individuals on the waiting list for a CIH, down from nineteen at the time of the prior progress report.

c. There has been improvement in discharging individuals with significant medical difficulties who require skilled nursing care. The opening of Bostick Nursing Center in Milledgeville has helped in this regard.

d. With respect to the forty-eight forensic apartment slots, as of June 30, 2017, twenty-nine were filled and an additional seven individuals are in the process of making transition visits. There is not a waiting list for this type of residential placement. This indicates that these apartments are not only underutilized, but that developing a strategy for increasing referrals is necessary. Also of note is that both of these types of residential placement options are serving individuals with a legal status of NGRI and IST/CC (e.g., currently in the CIHs, there are twenty-four individuals with a legal status of

NGRI and twenty individuals with a legal status of ICT/CC; in the forensic apartments there are twenty-one individuals with a legal status of NGRI and nine with a legal status of IST/CC).

e. While CIHs continue to be the most common residence at discharge, the following table indicates a significant decrease in discharge to forensic apartments and a slight decrease in discharges to residing with family. There is a slight increase in discharges to personal care homes and a larger increase to nursing homes (related to the aforementioned Bostick Nursing Center). Of note is that there were no individuals discharged with a GHVP. Also, it is unclear whether the significant decrease in discharges to the forensic apartments is due to longer lengths of stay and fewer openings.

	FY17	FY18 (Q1 and Q2)
Community integration homes	49%	53%
Supervised apartment	22%	3%
Personal Care Home	9%	15%
Nursing home/medical facility	6%	18%
Home (with or without family)	14%	11%

While DBHDD reported that individuals step down from CIHs and forensic apartments to live with family, GHVP apartments, and nursing homes, the numbers that step down to these settings are still not being tracked. In addition, length of stay data provided indicate that the average length of stay in CIHs is approximately a year and a half and in forensic apartments, about eight months; suggesting that individuals are indeed stepping down, but it is important to track and monitor to ensure that readmission to hospital is not occurring with regularity. In FY17, four individuals with a legal status of IST/CC were readmitted within three months of discharge, one was able to be discharged again after eleven days. Readmission data for individuals with NGRI legal status were not provided.

APPENDIX A

Division of Behavioral Health & Atlanta GA Regional Hospital Collaboration

I. Overview

The Division of Behavioral Health and the Atlanta GA Regional Hospital teams formed a collaboration in December of 2016 to address processes related to transitioning, discharges and community follow up. Coordination meetings take place one time per month, 2 hours per meeting. Special call meetings may also occur. Participants of this workgroup include the following:

Monica Johnson – Co-Chair	Division Director, Division of Behavioral Health
Dr. Charles Li – Co-Chair	Regional Hospital Administrator (Atlanta)
Dr. Delquis Mendoza	Clinical Director, GA Regional Hospital (Atlanta)
Fred Coleman	Social Work Chief, Ga Regional Hospital (Atlanta)
Dr. Terri Timberlake	Director, Office of Adult Mental Health
Adrian Johnson	Director, BH Field Operations
Gwen Craddieth	Regional Services Administrator (BH) – Region 3
Kimberly Briggs	Regional Services Administrator (BH) – Region 1
Letitia Robinson	Supported Housing Director
Cassandra Price	Director, Office of Addictive Diseases
Tony Sanchez	Director, Office or Recovery Transformation
Debbie Atkins	Director, Office of Crisis Coordination

II. Goals & Objectives

Goals and objectives for this group have been developed and are outlined below:

Goal 1	**People with behavioral health needs transitioning to or from the community and hospitals will have easy access to appropriate and adequate community based services.**
Objective 1.	90% of eligible individuals transitioning to the community from the hospital will have an active or in process application for entitlement benefits

Objective 2.	Reduce the length of stay between discharge readiness and actual discharge by 50%
Objective 3.	90% of individuals are scheduled to be seen by a licensed physician/psychiatrist/physician extender within 14 business days of discharge
Objective 4.	90% of individuals are scheduled to be seen by a licensed or credentialed professional within 7 business days of discharge
Objective 5.	90% of discharge planning meetings will include representation by appropriate community providers, (via face to face, conference call, skype, etc.)
Objective 6.	90% or more of individuals discharged from the hospital will go into permanent, temporary, or transitional housing
Objective 7.	Improve processes via policy related to hospital to community discharges
Goal 2	**Develop a more effective continuum of care that ensures the appropriate levels of care are in place through the continuum and access is available.**
Objective 1.	Decrease the number of inappropriate referrals to the hospital from the community by 50%
Goal 3	**Ensure that a recovery oriented system of care is in place to support treatment planning, general treatment and supports.**
Objective 1.	Increase utilization of peer workforce in the hospitals by adding 2 CPS to each state hospital

The above goals & objectives will be reviewed annually to determine progress made towards accomplishment of work. The first review will be July 2018.

III. Strategies and Action Plans

In addition to ensuring this collaborative is working towards the goals/objectives, there are priority items that have been identified to improve the system that impact the achievement of goals. These initiatives are outlined below.

1. Identification of the barriers related to hospital engagement of the community provider in community transition planning.

Action Items

A. Implement automatic alerts from the ASO/Beacon system that notifies the community provider of inpatient admission for individuals that are known. Behavioral Health Link (BHL) operates the statewide access and crisis line and serves as the dispatch for mobile crisis and coordinates access to DBHDD Hospitals and DBHDD contracted Crisis Stabilization Units and

Behavioral Health Crisis Centers. BHL can access authorization information from Beacon to identify if an individual in the inpatient setting has an existing authorization for outpatient services. Notifications will be forwarded to the community provider so there is awareness to prompt coordination efforts between the community provider and the inpatient entity. **Timeline for implementation: On or before July 1, 2018.**

B. DBHDD Hospital staff to identify staff to be trained to have access to the Beacon system to determine if the individual presenting for services in the hospital has a community provider, based on the authorization status. This offers another opportunity to prompt coordination efforts between the community provider and the inpatient entity. **Timeline for implementation: On or before July 1, 2018**

2. Develop concepts for incentivizing the Community Provider Network to engage with the transitions process.

Action Items

A. Division of Behavioral Health to develop and pilot a "High Utilizer Management" program for Tier 1 Community Providers (Community Service Boards). This program is being designed to more effectively identify individuals with high admission rates to inpatient facilities to improve coordination of care efforts and reduce admissions to inpatient care. The BH Division received consultation from MTM Consulting, an international behavioral healthcare consulting firm in the summer of 2017. The development of a "High Utilizer Management" program was an item brought forward from the consultation session that we agreed to adopt into our strategic planning for the new fiscal year that will begin on July 1, 2018. **Timeline for implementation: On or before October 1, 2018**

3. Review the Community Transition Planning (CTP) Service Guidelines to address potential barriers with low utilization of this service by community providers.

A. Revise the language in the service authorization that requires a face to face visit as the first interface to allow for telephonic or another IT interface. **Timeline for implementation: On or before April 1, 2018**

B. Review the rates for CTP to determine if it is in line with the expectations of the Department. **Timeline for implementation: On or before October 1, 2018**

4. Improve opportunity for learning from successful and complex cases.

Action Items

A. Develop mechanism to have a venue to discuss complex cases that have presented in both the hospital and community. This includes cases that did not have the outcome that was desired, or perhaps that worked well and use as learning models. The team will consider how to do this in an effective way. **Timeline for implementation: On or before July 1, 2018**

5. Engage Quality Improvement Office in the Division of Performance Management & Quality Improvement to lead a process flow for discharge planning, transitions, and follow up to community.

Action Items

A. The Office of Quality Improvement has partnered with the BH Division & Atl GA Regional Hospital Collaborative to work on a process improvement initiative. This project involves mapping the process and coordination points to support hospital discharge planning, transition planning and community follow up. This work has resulted in 1) A day long mapping work session; 2) A follow up half day work session to edit the process flow mapping; 3) A process flow chart that identifies strengths of the process and opportunities for improvement. Now 6 ongoing smaller sessions (e.g. 1-2 hrs. vs half/full days) are scheduled to complete the work. In the month of March, community providers will have an opportunity to review the draft of the process flow to provide input. Our goal is to have a completed, vetted process flow that aligns with policy (or impacts policy change where warranted), and a plan for trainings to promote alignment with the process for both hospital and community stakeholders after the start of the news fiscal year. **Timeline for implementation: On or before September 30, 2018**

IV. Community Provider Involvement

To solicit the input for this body of collaborative work, the BH Division and Atl GA Regional Hospital Collaborative has committed to a quarterly meeting that is inclusive of community behavioral health providers from regions 1 and 2. The first meeting was held in December 2017. The meetings are ongoing on a quarterly basis, the next being held in March 2018. This meeting also includes additional participation from members of the Atl Ga Regional Hospital, such as individuals from social work, admissions, and other treatment team members.

V. Accomplishments to Date

The BH Division and Atl Georgia Regional Collaborative has taken on a large set of goals and priorities as outlined throughout this document. Below is a listing of accomplishments that have occurred to date.

1. In 2017, implementation of the Peer Mentor Pilot Project at Atlanta Regional Hospital was finalized. The goal was to hire 2 Peer Mentors that can work with individuals while they are in the hospital setting and can be a mentor as they transition to the community provider. Now, both Peer Mentors are in place. We are learning what works well and what needs to be improved. The plan is to expand this initiative to all the DBHDD State Hospitals, after an adequate evaluation period has transpired.

2. In 2017, the development of the Level of Care Workgroup focused on bringing clinical leadership from the community Crisis Stabilization Units/Behavioral Health Crisis Centers and the DBHDD Hospital clinical leadership to explore many factors related to care across the continuum. This work was led by Debbie Atkins and Dr. Terri Timberlake with consultation from Dr. Emile Risby, primarily focused on: 1) Defining the correct level of care of hospital admissions as well as 2) Identification of potential barriers at the CSU/BHCCs that may impact their ability to serve individuals with higher acuity. This group was able to identify challenges as well as solutions. Many of the items that were identified have now been targeted as improvements that can be made to our bed board system managed by BHL/GCAL. This system update is currently underway and is expected to continue into the start of the fiscal year.

3. Individuals ready for hospital discharge that may not be due to lack of an ID was a topic this group took on in 2017. We considered several ways to problem solve for this as well as seeking input from our Legal Office to determine what may be appropriate or not. While this continues to be an issue for a small group of individuals, things such as hospital considering using electronic mechanisms to request birth certificates vs mailing were identified. While, this issue is not permanently resolved, much time was used to creatively think through ways to overcome this issue.

4. ACT Teams from Regions 1 & 3 participated in a “Meet and Greet” at the Atl GA Regional Hospital in 2017. This was initiated to improve coordination and communication between ACT Teams and the hospital staff most likely to be involved in transition and discharge planning. Due to the positive feedback of that event, another event will be scheduled that will focus on the ITR (Intensive Treatment Residential) providers in the community and the hospital. A date for the aforementioned is TBD.

5. Over the course of a couple of months in 2016 thru 2017, data was gathered and reviewed related to the goals and objectives outlined at the start of this document. The purpose of the initial review was to determine baseline information so we will have the ability to track progression towards achievement of the goals.

6. While the current collaborative focuses on the BH Division (including Regions 1 & 3) and the Atl GA Regional Hospital, it was understood that there was a need to hear from all Regions and the DBHDD State Hospitals as we continue to make strategic improvements across our systems. As such, a 2-part series of meetings was held in 2017. Participants included individuals from each DBHDD region office, clinical and administrative leadership from the state hospitals, BH

Division leadership, finance and budget leadership, BHL, and Beacon. The outcomes of the work informed the current crisis continuum strategic plan, the re-design to the GCAL/BHL bed board work, and the strategic initiatives identified in this document.

7. In 2017, region offices added transition specialists that are to focus on hospital to community transitions. While the positions previously existed, the duties of the positions evolved to other work that took away from the focus on the original work of hospital transitions. There was also a need to have consistency across regions related to the work and expected outcomes. Upon review of data, the decision was made to add additional positions to the applicable region offices. This additional resource capacity is a part of the ongoing strategy to improve coordination between hospitals and community. These actions also demonstrate the impact of this collaborative work on broader areas; while this workgroup mostly focuses on Atlanta Regional hospital and regions 1 & 3, the intervention of the additional resource capacity was applied in other regions as well. A total of 4 new positions were added, one each for regions 1, 2, 3 and 6.

8. In 2017, the BH Division & Atl GA Regional Hospital Collaborative expanded to invite participation of community providers leadership from regions 1 & 3 on a quarterly basis to ensure ongoing communication and input between the community and hospital. Participants from the community providers include CEOs, Clinical Directors, and other leadership roles, in addition to the collaborative members outlined at the beginning of this document, as well as extended staff from the hospital.

9. In early 2018 (Feb), the Region 3 regional field office in partnership with the Atl GA Regional Hospital and Region 1 staff facilitated an information session designed to enhance understanding across community providers, hospital staff and regions. Ongoing training opportunities will continue to be identified and implemented as warranted.

10. Starting in 2017 and on an ongoing basis, Letitia Robinson, Director of Supported Housing, has facilitated a series of meetings, information sessions/trainings for hospital staff related to access to GHVP and other housing supports through the coordinated entry process. This work is ongoing as Letitia continues to make herself available to provide technical assistance for hospital staff as needed outside of formal information sessions or trainings.

11. Through improved coordination between the community and hospitals, we have experienced a decrease in shelter discharges from the Atl Regional Hospital.

ATTACHMENT C

INDEPENDENT REVIEW: DACTS FIDELITY REVIEWS

Submitted by:
Angela L. Rollins, Ph.D.
February 22. 2018

Introductory comments

Elizabeth Jones requested a review of the five Assertive Community Treatment (ACT) fidelity reports completed by DBHDD fidelity reviewers to date in FY18, with particular attention given to team scores on S4 Service Intensity (average weekly minutes of face to face service provision from ACT team to consumers) and S5 Frequency of Contacts (average number of weekly face to face service contacts from ACT team to consumers).

Of the five fidelity reports reviewed, four were full fidelity reports that included narrative comments on items where the team's score was less than 5, while the fifth was a report of scores only (narrative report likely pending). One fidelity report was completed remotely for a team in Region 3. Another fidelity report was completed remotely for a team in Region 4. Two other reports were for fidelity assessments completed onsite for teams in Region 2. The scores-only document was completed for a team in Region 1 (unclear whether the assessment was completed onsite or remotely). I also reviewed team fidelity scores provided by DBHDD for FY13-FY17.

For context, the meaning of scores for these two items are provided below in Table 1. A score of 4 indicates a substantial frequency and amount of service: 3 or more weekly contacts and 85 minutes to almost 2 hours of weekly contact. Even a score of 3 on the DACTS (more than 2 weekly contacts and 50-84 minutes of weekly contact) is a notable increase in service frequency and intensity above other typical outpatient mental health services. The ACT model's requirements for frequent and intensive face to face services are intended to allow staff the ability to assess and support consumers with serious and persistent mental illness who have high-level needs in a variety of clinical and functional life domains. These needs increase risk for hospitalization, housing instability, and poor engagement with traditional, office-based outpatient services. The life domains targeted by these frequent and intensive visits include psychiatric symptom monitoring and management (e.g., provide cognitive behavioral therapy during times of distress to avoid crisis and/or hospitalization; the ability to adjust medications quickly to avoid relapse), supports in learning skills for community living (e.g., money management training to help obtain and keep housing, supported employment to get a competitive job in the community), and assessment and treatment for substance use disorders.

Table 1. DACTS S4 and S5 ratings.

S4	INTENSITY OF SERVICE: high total amount of service time as needed.	Average of less than 15 min/week or less of face-to-face contact per client.	15 - 49 minutes / week.	50 - 84 minutes / week.	85 - 119 minutes / week.	Average of 2 hours/week or more of face-to-face contact per client.
S5	FREQUENCY OF CONTACT: high number of service contacts as needed.	Average of .99 or less face-to-face contact / week or fewer per client.	1.00 - 1.99 / week.	2.00 - 2.99 / week.	3.00 - 3.99 / week.	Average of 4.00 or more face-to-face contacts / week per client.

Observations on Service Intensity and Frequency Items

My observations below also include comparison to Georgia statewide fidelity scores over time, going back to FY13. Georgia uses the Dartmouth Assertive Community Treatment Scale (DACTS) where 28 items are scored on a scale from 1 to 5, where 5 is the highest possible score and 1 is the lowest possible score. Georgia strives for teams to average a 4.0 or above across all 28 items, but requires corrective action plans for items where teams score a 1 or 2, even if the overall score is 4.0 or better.

1. **Two of five teams show struggle on these two services intensity and frequency items in FY18.** Of the five teams reviewed, all scored over a 4.0 on the total mean DACTS score across all 28 items, indicating generally well-functioning teams. While three of the five teams scored well on both the S4 Service Intensity and S5 Service Frequency items (i.e., scoring 5s and 4s), two teams scored low in these areas (i.e., a 1 or a 2). One team scored a 2 on both S4 Intensity (47.5 minutes/week/consumer) and S5 Frequency of contacts (1.5 contacts/week/consumer). The other team scored a 3 on S4 Intensity and 2 on Frequency of contact (this was the report with scores only at this time, so I could not review actual data underlying the fidelity score).
2. **Both of these teams are showing little improvement with these items since FY16, having more difficulty with S5 frequency.** I pulled these teams' scores since FY13 to see if these struggles are a trend. As seen in Table 2 below, one team has continually scored 3's on S4 dating back to FY13 and has scored either a 2 or a 3 dating back to FY13 on S5 (ie., never reaching a 4 on either item). The other team, after a peak year in FY16, has declined on their score of these items since FY16, starting with a 5 and 4 respectively (S4 intensity and S5 Frequency).
3. **Low service frequency has been a lower-scoring item statewide compared to other items, but has improved since FY14.** In FY16 and FY17, only three teams (14%) and four teams (18%), respectively, have scored below a 3. As noted in #2 above, at least one of these teams has consistently been a low scorer.
4. **Level of service intensity has not been a point of concern statewide over time**, with statewide average running 3.7 or above and very few, if any, teams scoring below a 3.
5. **Fidelity score analysis and recommendations could be improved.** On these two items and others, the FY18 report feedback appears to be the same (or substantially similar) for each team that has scored low on that item. The item explanation for the score does not appear to examine closely why a team is scoring low so that the team and reviewers can think about targeted solutions for the issue. For instance, teams may score low on treatment frequency in highly rural areas where multiple tasks are completed in a single visit vs multiple visits by different team members. This is different than a highly urban team where transience of consumers and no-shows for appointments might decrease the frequency of contacts. Other teams may have enrolled a high number of treatment resistant consumers who avoid staff contact attempts and for whom creative engagement strategies could be emphasized. The reports emphasize the use of motivational interventions and engagement strategies for no-shows in a mostly "canned" report language which makes me wonder if the reviewers and teams are trying to understand the challenge. Clearly, in the case of Team 2, the feedback provided over time has not been effective, since they frequently score a 2 on this item.

Table 2. S4 and S5 scores over time.

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

Other Observations

I noted that two of the four reports indicated that they were conducted remotely. One team was located in Region 3 (local to the fidelity team). Remote fidelity assessment can be useful in a large state with established teams, and I personally conducted research documenting good reliability and validity of these remote methods. However, I have several concerns. I do want to make sure that DBHDD has a plan to continue to do onsite fidelity assessment for each team at some regular interval. Even though remote fidelity can be used for assessment purposes, the on-site visits are a valuable tool for providing technical assistance and support to teams. In fact, the majority of team leaders in my research still preferred onsite assessments for the developmental coaching that takes place during the course of an onsite fidelity assessment. These visits are typically not just a function of data collection but are points of discussion with representative from the mental health authority about the challenges of providing ACT services or maintaining fidelity to certain model ideals. I am also concerned that these reports lacked additional detail regarding the methods to collect and score fidelity data remotely so that the report reader can evaluate the methods. For instance, the reports should indicate the criteria the state uses for selecting a site for remote fidelity assessment (e.g., stable high fidelity scores for 3 or more years and no team leader turnover). Also, there is great variability in how remote chart review could be conducted and those methods should be described (e.g., do teams report chart data themselves or are DBHDD staff able to directly review charts from electronic health records remotely). If teams are reporting chart review data themselves, how is this done and, most importantly, how does DBHDD make sure that consumers selected for chart review are indeed a random selection of all active consumers, regardless of level of engagement. As advantageous as remote assessments can be, teams must not be allowed to veto the chart review of particular consumers who are not well-engaged. The fidelity scoring methods primarily use medians to account for these outliers. As remote fidelity assessments are completed, it is also worth examining any substantial shifts in item scores or other inconsistencies with past scores.

ATTACHMENT D

INDEPENDENT REVIEW:
SUPPORT COORDINATION FOR INDIVIDUALS WITH DD

Submitted by:
Laura Nuss
February 24, 2018

Support Coordination Report

In the Matter of

United States of America v. The State of Georgia

Methodology

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

- February 8, 2018: Phone call with DBHDD officials to discuss specific support coordination provisions found in the Settlement Agreement. Present for this call included Ronald Wakefield, IDD Director, Amy Howell Deputy Commissioner, Robert Bell who leads Support Coordination efforts, Joelle Butler, Support Coordination Manager, and Evelyn Harris, Settlement Agreement Coordinator.
- February 9, 2018: Phone call with Georgia Advocacy Office staff Devon Orland, Renee Pruitt and Joe Sarra.
- February 13 – 19, 2018: Individual phone calls with the Executive Directors of each of the seven Support Coordination Agencies (SCAs): Twana King, GA Support Services; Chianti Davis, The Columbus Organization; Tammy Carroll, Benchmark Human Services; Sharon Higgins, Care Star; Randy Moore, Compass Coordination, Inc.; Michelle Schwartz, Creative Consulting Services; and, Toni Brandon, Professional Case Management.

The following documents were reviewed:

- ADA Settlement Extension Agreement Parties' Meeting Materials, GA DBHDD, dated January 12, 2018.
- Ongoing Quality and Performance Improvement Based on the June 2017 Support Coordination Performance Report, GA DBHDD, dated February 5, 2018.
- Outcome Evaluation: "Recognize, Refer, and Act" Model, 02-435, dated January 19, 2018.
- Support Coordination Caseloads, Participant Admission, and Discharge Standards, 02-432, dated October 23, 2017.
- Support Coordination and the Critical Incident Process, 02-440, FULL IMPLEMENTATION DATE - DECEMBER 1, 2017.
- The Service Planning Process and Individual Service Plan Development, 02-438 FULL IMPLEMENTATION DATE - DECEMBER 1, 2017.
- Support Coordinator Responsibility for Assessments, Evaluations, and Healthcare or Behavioral Plans, 02-436, dated January 19, 2018.
- Part III Policies and Procedures for Support Coordination Services and Intensive Support Coordination Services, COMP & NOW Waiver Programs, Georgia Department of Community Health, Division of Medical Assistance, Revised: January 1, 2018.
- DBHDD Support Coordination Performance Report, GA DBHDD, February 16, 2018.

Specific Provisions

> **14.c.(i).(1).** For an emergency, the provider shall initiate appropriate emergency steps immediately, including calling 911 or crisis services, and shall notify the individual's support coordinator, the Field Office, and the Office of Health and Wellness.
>
> **14.c.(i).(2).** For deteriorating health that is not imminently life-threatening, the provider shall respond and inform the individual's support coordinator within the first 24 hours. If the risk is not resolved within 72 hours, the support coordinator (or provider) shall notify the Field Office and the Office of Health and Wellness.
>
> **14.c.(i).(3).** For a health, behavioral, or environmental risk not resulting in destabilization of health or safety of the individual, the provider shall respond, inform the individual's support coordinator, and verify completion of responsive steps with the support coordinator no later than the support coordinator's next visit, or 30 days, whichever is sooner.

Findings: The Support Coordination Agencies reported generally that performance in this area is dependent upon the relationship between the Support Coordinator (SC) or Intensive Support Coordinator (ISC) and the service location, and the relationship developed between the SCA and the provider agencies generally. Intensive Support Coordinators are much more likely to be informed due to the frequency of their contacts with a provider or natural support(s). One agency meets regularly with the providers it works with in group meetings to establish on-going communications and to reinforce expectations.

Data is not available to verify compliance with this provision.

> **16.a.** No later than July 1, 2016, the State shall revise and implement the roles and responsibilities of support coordinators, and the State shall oversee and monitor that support coordinators develop individual support plans, monitor the implementation of the plans, recognize the individual's needs and risks (if any), promote community integration, and respond by referring, directly linking, or advocating for resources to assist the individual in gaining access to needed services and supports.

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

1. Caseload size by Support Coordinator;
2. Number of ISPs approved by the DBHDD Field Office within the past month;
3. Participant Face-to-Face Visit Requirements Performance; and

4. Number of Quality Outcome Measures Reviews Completed/ number due per policy requirements.

DBHDD does not report on Service Coordination performance in the area of ISP development.

The DBHDD document, Ongoing Quality and Performance Improvement Based on the June 2017 Support Coordination Performance Report, dated February 8, 2018, lists as the first item:

- *Revision of ISP and QA Process – Training Provided*
    - *Intended to improve submission timelines and quality of ISPs*
    - *Division of DD pulling regular reports and notifying SCAs if submissions fall short of policy requirements. DBHDD reviews these reports to verify compliance with Support Coordination roles and responsibilities.*

This would support that DBHDD does monitor this critical function and it does require some improvement. The Support Coordination Agency Executive Directors reported that the State regional offices were timely in the review of ISPs.

The STAR process is a request submitted by a Support Coordinator to the regional office to obtain approval for a new service or an increase in the amount of a service. If the STAR is approved, the Support Coordinator must then submit an ISP amendment to the regional office for approval and funding authorization.

In this reviewer's August 17, 2017 report, it was identified that the STAR process was not timely leading to significant delays in receipt of new or increased levels of services. In the same DBHDD document, Ongoing Quality and Performance Improvement Based on the June 2017 Support Coordination Performance Report, dated February 8, 2018, under Audit and Review Results, the document lists:

- *Increasing efficiency of STAR processing*
    - *Field Offices are maintaining data regarding the timeliness of decisions for STAR requests and maintaining categories of requests by type.*
    - *Standardized STAR Process for Field Offices written and distributed for 2/1/18 implementation.*

Four out of seven (57%) SCA Executive Directors confirmed that the STAR process continued to be delayed, and that performance varied by region. The SCA Executive Directors also confirmed that the State was aware of the need to improve this process and that new procedures were being implemented to improve the timeliness of approvals.

In this review, the Georgia Advocacy Office reported, and four of seven SCA Executive Directors confirmed, that the regional offices are also experiencing backlogs and subsequent delays in completing the HRST (for individuals self-directing services) and other regional required nursing assessments.

The DBHDD policy and procedure, Outcome Evaluation: "Recognize, Refer, and Act" Model, 02-435, last reviewed January 19, 2018, describes the State's methods for this provision's component to " …monitor the implementation of the plans, recognize the individual's needs

and risks (if any), promote community integration, and respond by referring, directly linking, or advocating for resources to assist the individual in gaining access to needed services and supports." DBHDD refers to this as "coaching and referral" in its data and performance reports, and is tied to the Individual Quality Outcome Measures Review (IQOM) Tool referenced below in 16.b.

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

In the February 16, 2018 Support Coordination Performance Report, DBHDD evaluated the number of coaching and referrals per person for each Support Coordinator Agency. This represents the first time this analysis was completed, and DBHDD indicates that "one should exercise great caution before proceeding to draw conclusions on the number and frequency comparisons for several reasons." Those reasons being that it is a new metric that requires additional analysis, that there are other positive outcomes occurring for individuals in the system regardless of the rate of coaching and referrals made, or some support coordinators may simply not be documenting coaching efforts.[2]

DBHDD also evaluated which topics were the subject of coaching and referrals and provided the following analysis:

> "Coaching and referral activities (combined) are ordered from highest to lowest, are listed below, and the order of the tables below follow this order. As can be seen, appearance/health and supports/services, not surprisingly, are the areas where support coordinators have focused the highest volume of coaching and referral activities.
>
> 1. Appearance/health
> 2. Supports/services
> 3. Environment
> 4. Home and community option
> 5. Financial
> 6. Behavioral and emotiona
> 7. Satisfaction

- As with the overall system performance perspective, Compass most frequently delivered the largest number of coaching and referral activities per individual across most area; conversely, Columbus most frequently delivered the fewest coaching and referral activities per individual

[1] ADA Settlement Extension Agreement Parties Meeting Materials, PowerPoint Presentation, January 12, 2018
[2] GA DBHDD Support Coordination Performance Report, February 16, 2018, p. 21

across most areas.

- Appearance/health is the busiest area of activity for support coordinators, and appearance/health has over half of all open referrals beyond the expected close date. This indicates that support coordinators are experiencing barriers to resolving appearance/health issues for individuals, and support coordinators may need additional support to facilitate improved appearance/health outcomes.
- Support coordinators also dedicated substantial resources towards producing positive outcomes for supports/services areas by delivering coaching and referral activities second most frequently in this area. Almost 25 percent of all open referrals beyond the expected close date are also in this area, which suggests that support coordinators may need additional support to facilitate improved supports and services outcomes."[3]

The Support Coordination Agency Executive Directors universally agreed that the coaching process generally worked well. Three of seven agencies reported that when a referral is made, there is less satisfaction with the support received by the regional office or the State. This included satisfaction with the type or amount of assistance received, and with being informed about what the regional or State staff might have done or is doing to support the resolution of a referral. It appeared that SCAs that were more aggressive in follow-up or had stronger relationships with DBHDD felt the referral system was effective.

The DBHDD Ongoing Quality and Performance Improvement Based on the June 2017 Support Coordination Performance Report dated February 5, 2018 indicates that "DD staff complete look-behinds for individuals on high risk surveillance list and notify Robert Bell and Joelle Butler if there are any concerns." This was also a recommendation made by this reviewer (to complete a look behind of SC performance in the field to evaluate if support coordinators were accurately identifying issues) in the August 2017 report on Support Coordination Performance. On February 13, 2018, this reviewer requested from DBHDD, through the Independent Reviewer, the number of look behinds that have been completed, and a copy of the tool. DBHDD responded on February 15, 2018, indicating that the "look behind" was the administration of the National Core Indicators Adult Consumer Interview. This is in line with DBHDD's interest in evaluating outcomes rather than process but does not necessarily address the spirit of this provision.

DBHDD officials indicated that they have spent a significant amount of time training the Administrative Service Organization, Delmarva, to ensure that it is current with DBHDD expectations, processes, updated policies and forms. This is a critical function for DBHDD as Delmarva is the external quality assurance review agency.

> **16.b.** No later than July 1, 2016, the State shall require all support coordinators statewide to use a uniform tool that covers, at a minimum, the following areas: environment (i.e., accessibility, privacy, adequate food and clothing, cleanliness, safety), appearance/health (i.e. changes in health status, recent hospital visits or emergency room visits), supports and services (i.e.,

[3] *Ibid,* p. 22

> provision of services with respect, delivery with fidelity to ISP, recent crisis calls), community living (i.e. existence of natural supports, services in most integrated setting, participation in community activities, employment opportunities, access to transportation), control of personal finances, and the individual's satisfaction with current supports and services. The support coordination tool and the guidelines for implementation shall include criteria, responsibilities, and timeframes for referrals and actions to address risks to the individual and obtain needed services or supports for the individual.

As noted in the previous report, DBHDD has implemented the use of a uniform tool and published guidelines for implementation of the tool as required. This reviewer recommended reviewing this tool and splitting some multipart questions apart to improve data analysis in her August 2017 report. DBHDD completed a review of the tool and has implemented a revised tool effective January 1, 2018 that addressed that recommendation. Coaching and referral actions resulting from findings were addressed under 16.a above.

> **16.c.** At least annually, the State shall consider the data collected by support coordinators in the tool and assess the performance of the support coordination agencies in each of the areas set forth in Paragraph 16.a.

Findings: DBHDD produced a second report, *DBHDD Support Coordination Performance Report*, February 16, 2018, evaluating data for the period October 2016 to October 2017. This report evaluated performance findings for Support Coordination Agencies in the following areas:

1. Caseload Size
2. Face-to-Face Visits
3. Coaching and Referrals
4. Outcomes

This report did not address ISP development. The Parties' Meeting Materials also describes a quality improvement cycle where data is shared with quality councils on a quarterly basis, but an example of that data was not made available to the reviewer. The Ongoing Quality and Performance Improvement based on the June 2017 Support Coordination Performance Report indicates that audit and review results led one agency to be placed under corrective action based on repeated performance deficits.

Coaching and referrals discussed in 16.a and ISPs are most relevant to this provision. As noted above, DBHDD is not yet prepared to draw conclusions about SCA performance based on coaching and referral data and did not report data regarding development of ISPs in this report. This report did include more analysis of coaching and referral data and results of the Individual Quality Outcome Measures Review (IQOMR) Tool. Comparisons of IQOMR results from October 1, 2016 to October 1, 2017 for people receiving Support Coordination and Intensive Support Coordination is illustrated below[4]:

[4] GA DBHDD Support Coordination Performance Report, February 16, 2018, p. 31

	Baseline October 1, 2016	As of October 1, 2017	Statistically Significant Change
SC			
Environmental	87.1%	88.9%	Yes
Appearance / Health	98.9%	98.9%	Not Significant
Supports and Services	94.6%	93.3%	Yes
Behavioral and Emotional	82.7%	78.8%	Yes
Home / Community Options	89.5%	94.3%	Yes
ISC			
Environmental	96.3%	97.1%	Not Significant
Appearance / Health	98.4%	98.3%	Not Significant
Supports and Services	93.3%	89.6%	Yes
Behavioral and Emotional	70.6%	67.0%	Not Significant
Home / Community Options	84.7%	90.1%	Yes

The report also evaluated IQOMR results by SCA and considered the number of coaching and referrals made by topic areas versus the performance in that area. The report noted that there are decreasing positive outcomes in supports and services, and the lowest scoring area is the achievement of positive behavioral and emotional outcomes. The report also notes that behavioral and emotional outcomes also received the second lowest number of coaching and referrals from support coordinators.[5] As this is the only area where outcomes fall below 85%, this should be a primary focus of DBHDD quality improvement efforts. All SCAs reported that additional behavioral support services providers were needed.

> **16.d.** 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 of 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.)

Findings: DBHDD is not in compliance with this provision at this time. DBHDD provided access to the Reporting of Critical Incidents (ROCI) application to the CRAs and published a User's Guide on June 7, 2017. The February 2018 GA *DBHDD Support Coordination Performance Report* reported on the number of Critical Incidents by SCA as a possible performance measure for SCA's. However, it was reported by the Georgia Advocacy Office that SCAs were not able to view Critical Incident Reports (CIRs) entered by provider agencies in the ROCI system.

[5] GA DBHDD Support Coordination Performance Report, February 16, 2018, p. 43

Subsequent interviews with the SCA Executive Directors confirmed that in all agencies CIRs were not made available to the SCA, or were significantly delayed in transmission by several months, and that the SCA did not receive notice of a completed Incident Investigation Report or a Corrective Action Plan.

DBHDD officials did not share information with this reviewer that the Critical Incident System was not operating as described in the DBHDD policy. DBHDD did indicate that the original strategy to track support cooridnation compliance with conducting follow-up on CIRs did not work as planned (support notes entry and, as a result, a new procedure was implemented December 1, 2017 requiring the support coordinator to open a referral to track the follow-up. Performance should be evaluated in this area once the CRI system is on-line again.

> **16.e.** The caseload for support coordinators shall be a maximum of 40 individuals. The caseload for intensive support coordinators shall be a maximum of 20 individuals.

Findings: The DBHDD Support Coordination Performance Report dated February 16, 2018 reported on caseload compliance using a standard of 85% for substantial compliance. As of October 1, 2017, five SCAs maintained caseloads above 85% and two were below 85%. One of those agencies, CareStar, was at 100% compliance for four consecutive months and then dropped to 70 and 75% for August and September of 2017.

DBHDD provided caseload data for support coordination as of January 7, 2018 to the Independent Reviewer for this report. DBHDD provided summary statistics at the end of the report listed below:[6]

Employer	Number of SC's	Number in Compliance	Percentage in Compliance	*Reviewers Findings*	
Benchmark	22	22	100%	21/22	95.45%
CareStar	8	7	87.50%	7/8	87.5%
Compass	8	6	75%	6/8	75%
Columbus	119	104	87.39%	99/115	86.06%
Creative	103	95	92.23%	95/103	92.23%
Georgia Support	44	44	100%	44/44	100%
PCSA	73	67	91.78%	64/71	90.14%
Total	369	345	93.50%	336/371	90.56%

This reviewer found discrepencies in the summary data in her review. The source data indicates Benchmark ISC LJ carried a caseload of 16 intensive and 6 non-intensive individuals which violates the DBHDD policy that ISC may not carry more than 20 individuals for a compliance rating of 95%. Columbus data totaled 115 SC's (not including managers or clinical supervisors), with 11 exceeding the SC caseload limit of 40, 1 exceeding the mixed caseload of 40 and 4 exceeding the ISC caseload

[6] Point in time data provided via email from Evelyn Harris, February 24, 2018

of no more than 20, for a total number of 99 in compliance or 86.08%. PCSA had 71 SCs (not including managers or supervisors) with 64 in compliance for a rate of 90.14%

The policy and data can also be confusing. The policy states that "if an ISC has a caseload mix that includes traditional SC participants, the maximum caseload remains twenty(20)." In the data, not all support coordinators were identified as either an Intensive Support Coordinator or a traditional Support Coordinator. In one instance, a traditional Support Coordinator maintained a caseload of 9 individuals identified as intensive and 13 individuals identified as traditional. That could be interpreted as violating the policy of carrying no more than 20 individuals, if serving as an Intensive Support Coordinator, or, as being in compliance as a traditional support coordinator with a total of no more than 40 (9x3 + 13).

> **16.f.** Support coordinators shall have an in-person visit with the individual at least once per month (or per quarter for individuals who receive only supported employment or day services). Intensive support coordinators shall have an in-person visit with the individual as determined by the individual's needs, but at least once per month. Some individuals may need weekly in-person visits, which can be reduced to monthly once the intensive support coordinator has determined that the individual is stable. In-person visits may rotate between the individual's home and other places where the individual may be during the day. Some visits shall be unannounced.

Findings: The February 2018 GA *DBHDD Support Coordination Performance Report* provided data on face to face visits for the period July through September 2017. Performance for Support Coordination ranged from 89% (Columbus) to 99% (Creative). For Intensive Support Coordination, data were illustrated by month:[7]

[7] GA DBHDD Support Coordination Performance Report, February 16, 2018, p. 18

SC/ISC Agency	Month	Mean Visits per month	In Compliance	Total Individuals	Percent Compliance
Benchmark	2017-07	1.93	225	244	92.21
	2017-08	1.58	238	244	97.54
	2017-09	1.51	237	244	97.13
CareStar	2017-07	1.37	125	127	98.43
	2017-08	1.5	126	127	99.21
	2017-09	1.22	126	127	99.21
Columbus	2017-07	1.25	376	409	91.93
	2017-08	1.39	373	409	91.20
	2017-09	1.17	363	409	88.75
Compass	2017-07	1.82	140	144	97.22
	2017-08	1.69	143	144	99.31
	2017-09	1.8	140	144	97.22
Creative	2017-07	1.27	375	387	96.90
	2017-08	1.42	382	387	98.71
	2017-09	1.34	382	387	98.71
Georgia Support	2017-07	1.42	128	130	98.46
	2017-08	1.27	128	130	98.46
	2017-09	1.28	124	130	95.38
PCSA	2017-07	1.74	203	206	98.54
	2017-08	1.24	202	206	98.06
	2017-09	1.33	200	206	97.09

In the same report, DBHDD completed additional analysis to study whether people with higher health care levels (drawn from the HRST) received more frequent visits. Findings revealed that "support coordination agencies have positive performance overall not only for delivering the number of face-to-face visits but also are visiting individuals more frequently as their health risk and age increase."[8]

> **16.g.** For individuals with DD transitioning from State Hospitals, a support coordinator shall be assigned and engaged in transition planning at least 60 days prior to discharge.

Findings: All SCAs reported that this provision remained in compliance. DBHDD also reported compliance in the materials presented to the Parties. No other data are available to report on this provision.

[8] *Ibid* p. 20

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

DBHDD revised the Provider Manual for Community Developmental Disability Providers for the Department of Behavioral Health and Developmental Disabilities for Fiscal Year 2018 to include this requirement. The Revision was posted on June 1, 2017 with an effective date of July 1, 2017.

Conclusion

Performance in the areas of ISP development and approval, timely processing of STAR requests and the effective operation of the critical incident management system should be evaluated during the next review.

ATTACHMENT E

INDEPENDENT REVIEW: BEHAVIORAL PROGRAMMING FOR NINE INDIVIDUALS WITH LAW ENFORCEMENT ENCOUNTERS

Submitted by:
Patrick F. Heick, Ph. D., BCBA-D
February 19, 2018

The following *Summary* and *Addenda* were prepared and submitted in response to the Independent Reviewer's request to summarize a small sample of reviews completed as part of her analysis of supports provided to twenty-two individuals with complex medical and/or behavioral needs. More specifically, the following summary is based upon the reviews of the behavioral support and services for nine individuals. These reviews compared the behavioral programming and supports that are currently reported to be in place with generally accepted standards and practice recommendations with regard to components of effective behavioral programming and supports – these components included: (1) level of need (i.e., based on behaviors that are dangerous to self or others, disrupt the environment, and negatively impact his/her quality of life and ability to learn new skills and gain independence); (2) Functional Behavior Assessment (FBA); (3) Behavioral Support Plan (BSP); (4) ongoing data collection, including regular summary and analysis; and (5) care provider and staff training. It should be noted this reviewer does not intend to offer these as reflective of an exhaustive listing of essential elements of behavioral programming and supports. Furthermore, these reviews were based on the understanding that all existing documents were available onsite and/or provided in response to the Independent Reviewer's initial request or this reviewer's subsequent request. It should be noted that one of the onsite visits occurred at an individual's (J.J.) day program as the family declined a visit to their home where he was living at the time.

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

Summary

Findings

1. Based on a review of the completed individuals' service records and other provided documentation as well as the completed Monitoring Questionnaires, most of the individuals sampled demonstrated significant maladaptive behaviors. These behaviors had dangerous and disruptive consequences to these individuals and their households, including negative impacts on the quality of these individuals' lives and their ability to become more independent. More specifically, of those sampled, nine (100%) engaged in behaviors that could result in injury to self or others, nine (100%) engaged in behaviors that disrupt the environment and six (67%) engaged in behaviors that impeded his/her ability to access a wide range of environments. In addition, of those sampled, five (56%) engaged in behaviors that impeded their abilities to learn new skills or generalize already learned skills. Overall, eight (89%) of the individuals sampled appeared to demonstrate significant maladaptive behaviors that negatively impacted their quality of life and greater independence. Only one of the individuals sampled appeared to have isolated incidents that did not appear to reflect a longstanding and global pattern of responding. However, all (100%) of the individuals sampled experienced one or more contact with

the police. And, eight (89%) individuals accessed crisis services, seven (78%) experienced psychiatric hospitalizations, and six (67%) experienced transfers to different settings due to their maladaptive behavior. Of those sampled, however, only seven (78%) individuals were receiving formal behavioral programming through Behavior Support Plans (BSPs) at the time of the on-site visit. It should be noted that one individual (J.H.), who did not have a BSP, appeared to this reviewer as the lone sampled individual who might continue to be successful without formal behavioral programming. And, although another individual (J.J.) had a BSP implemented at his day program, it was unknown if similar programming was in place at his home. Nonetheless, it appeared that at least eight individuals would likely benefit from positive behavioral programming and supports implemented within their homes or residential programs (see Figure 1).

2. As noted above, seven (78%) individuals had BSPs implemented at the time of the onsite visits. However, of these seven, only five (71%) individuals had BSPs that were considered current (i.e., updated or implemented within the last 12 months) and only three (43%) individuals had BSPs that were actually designed for the setting in which it was currently implemented. Indeed, of the seven BSPs, only three (43%) and two (29%) BSPs were actually trained and overseen by the plan's author, respectively (see Figure 2).

3. As noted above, seven (78%) individuals had BSPs. However, of these seven, only six (86%) appeared to have had Functional Behavior Assessments (FBA) previously completed. However, when closely examined, of the six FBAs completed, only three (50%) appeared to utilize descriptive methods of assessment and only three (50%) were completed in the current setting. Overall, only one (17%) FBA was considered current and complete. Generally accepted practice recommendations include developing a BSP based on results of a comprehensive FBA completed within the natural environment (current setting), including an emphasis on the use of descriptive (e.g., systematic direct observation) methods, in addition to indirect methods, when identifying and supporting potential hypotheses regarding underlying function(s) of target behavior (see Figure 3).

4. As noted above, seven (78%) individuals had BSPs and each individual with a BSP was noted to have a corresponding Crisis Safety Plan (CSP). These CSPs were provided as either independent documents or crisis strategies integrated within the BSP. When closely examined, of the seven CSPs, only five (71%) were considered current (i.e., updated or implemented within the last 12 months) and only four (57%) were actually designed for the setting in which it was currently implemented. Indeed, of the seven CSPs, only four (57%) and three (43%) CSPs were actually trained and overseen by the plan's author, respectively (see Figure 4).

5. As noted above, seven (78%) of the individuals had BSPs. Upon closer examination of these BSPs, it was noted that prescribed behavioral programming appeared inadequate (see Individual Summary of Findings for specific information). For example, of the seven BSPs reviewed, only four (57%) BSPs adequately identified and operationally defined target behaviors. And, evidence of adequate ongoing data collection on these target behaviors was found for only one (14%) BSP. In addition, only two (29%) BSPs adequately identified and operationally defined functionally equivalent replacement

behaviors (FERBS). And, evidence of adequate ongoing data collection of FERBS was not found for any (0%) BSPs. Overall, evidence of adequate ongoing collection, summary, and regular review of both target and replacement behaviors was not found for any (0%) of the BSPs. And, although six (86%) and seven (100%) BSPs included antecedent- and consequence-based interventions, respectively, none (0%) of the BSPs appeared to be implemented with a high degree of integrity. It should be noted that this estimate is somewhat incomplete as scores reflective of implementation fidelity for one BSP (J.J.) were not obtained. Lastly, evidence that all staff who support the individual had been trained on the BSP was only found for three (43%) BSPs. Overall, this reviewer noted significant inadequacies in behavioral programming for all of the individuals with BSPs (See Figure 5). It should be noted that, although several sampled FBAs and BSPs (e.g., J.J. & K.W.) appeared of higher quality than other sampled FBAs and BSPs, behavioral programming associated with these plans was limited due to inadequate training, data collection, and/or ongoing monitoring. Generally accepted practice recommendations include specifying target behaviors and FERB as well as ongoing data collection and regular review to promote data-based decision making and facilitate revisions, when necessary. In addition, generally accepted practice includes promoting adaptive behavior and weakening maladaptive behavior through the use of both antecedent- and consequence-based strategies that are well-trained and implemented with a high degree of integrity.

6. As noted above, seven (78%) individuals had BSPs. Upon closer examination of these BSPs, it was revealed that only two (29%) were developed by a Board Certified Behavior Analyst (BCBA). However, at the time of the onsite review, these BCBAs were no longer supporting individuals (J.J. & M.H.) selected for this sample. Consequently, of these seven BSPs, zero (0%) were trained and directly monitored by a BCBA. It should be noted that verbal reports indicated that at least two of the BSPs (M.L. & M.H.) were reviewed and approved by a supervising BCBA; however, evidence the BSPs were reviewed and approved was not found on the BSPs. The BCBA is the nationally accepted certification for practitioners of applied behavior analysis. This certification is granted by the Behavior Analyst Certification Board (BACB), a nonprofit corporation established to develop, promote, and implement a national and international certification program for behavior analyst practitioners.

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

Figure 1

Name	BSP	item 162	item 163	item 164	item 165	item 166	item 189	item 190	item 194	item 197
J.J.	1	1	1	0	0	1	1	1	1	1
M.L.	1	1	1	0	0	1	1	0	0	1
T.V.	1	1	1	1	1	1	1	1	0	1
M.H.	1	1	1	1	1	1	1	0	1	1
J.H.	0	1	1	0	0	0	1	1	0	0
L.L.	1	1	1	1	1	1	1	1	1	1
L.M.	1	1	1	1	1	1	1	1	1	1
H.J.	0	1	1	1	1	1	1	1	1	1
K.W.	1	1	1	1	0	1	1	1	1	1
total (N=9)	7	9	9	6	5	8	9	7	6	8
percentage	78%	100%	100%	67%	56%	89%	100%	78%	67%	89%

Figure 2

Name	BSP	BSP is Current	BSP Designed for current setting	BSP Overseen by author	BSP trained by author	BSP overseen by Behavior Clinician
J.J.	1	1	0	0	1	0
M.L.	1	1	1	0	0	1
T.V.	1	1	0	0	0	1
M.H.	1	0	0	0	0	1
J.H.	0					
L.L.	1	1	1	1	1	1
L.M.	1	0	0	0	0	0
H.J.	0					
K.W.	1	1	1	1	1	1
total (N=9)	7	5	3	2	3	5
percentage	78%	71%	43%	29%	43%	71%

Figure 3

Name	BSP	FBA	FBA is current & complete	FBA used descriptive methods	FBA completed in current setting
J.J.	1	1	0	1	0
M.L.	1	1	0	cnd	1
T.V.	1	0	0	0	0
M.H.	1	1	0	1	0
J.H.	0	0			
L.L.	1	1	0	0	1
L.M.	1	1	0	cnd	0
H.J.	0	0			
K.W.	1	1	1	1	1
total (N=9)	7	6	1	3	3
percentage	78%	86%	17%	50%	50%

Figure 4

Name	BSP	CSP	CSP is current	CSP designed for current setting	CSP overseen by author	CSP trained by author
J.J.	1	1	1	0	0	1
M.L.	1	1	1	1	1	1
T.V.	1	1	1	0	0	0
M.H.	1	1	0	1	0	0
J.H.	0	0				
L.L.	1	1	1	1	1	1
L.M.	1	1	0	0	0	0
H.J.	0	0				
K.W.	1	1	1	1	1	1
total (N=9)	7	7	5	4	3	4
percentage	78%	100%	71%	57%	43%	57%

Figure 5

Name	BSP	item 124	item 127	item 129	item 132	item 149	item 134	item 135	item 146	item 147	item 144
J.J.	1	1	cnd	1	0	cnd	1	1	cnd	cnd	1
M.L.	1	0	0	1	0	0	1	1	0	0	0
T.V.	1	0	0	0	0	0	0	1	0	0	0
M.H.	1	1	0	0	0	0	1	1	0	0	1
J.H.	0										
L.L.	1	0	0	0	0	0	1	1	0	0	0
L.M.	1	1	0	0	0	0	1	1	0	0	0
H.J.	0										
K.W.	1	1	1	0	0	0	1	1	0	0	1
total (N=9)	7	4	1	2	0	0	6	7	0	0	3
percentage	78%	57%	14%	29%	0%	0%	86%	100%	0%	0%	43%