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

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

JOINT NOTICE OF FILING OF THE REPORT OF THE INDEPENDENT REVIEWER

On October 29, 2010, the Court adopted the parties' proposed Settlement Agreement and retained jurisdiction to enforce it. Order, ECF No. 115. On May 27, 2016, the Court entered the parties' proposed Extension Agreement and similarly retained jurisdiction to enforce it. Order, ECF No. 259. Both Agreements contain provisions requiring an Independent Reviewer to issue reports on the State's compliance efforts. Settlement Agreement ¶ VI.B; Extension Agreement ¶ 42.

On behalf of the Independent Reviewer, the parties hereby file the attached *Report of the Independent Reviewer*, dated September 18, 2020.

Respectfully submitted, this 21st day of September, 2020.

(signature pages follow)

FOR THE UNITED STATES:

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

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
4 Constitution Square
150 M Street, NE, Suite 10.133
Washington, DC 20530
Telephone: (202) 307-3116
Fax: (202) 514-0212
Email: richard.farano@usdoj.gov

FOR THE STATE OF GEORGIA:

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 Pepper Hamilton Sanders LLP
600 Peachtree Street, NE, Suite 3000
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 September 21, 2020, a copy of the foregoing document, was 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 v. Georgia

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

September 18, 2020

Introductory Comments

The Settlement Agreement (SA), filed on October 19, 2010, and the Extension Agreement (EA), filed on May 18, 2016, both require the Independent Reviewer to file reports each year with the Court. This report is focused on the activities of the Department of Behavioral Health and Developmental Disabilities (DBHDD) during the period from July 1, 2019 until June 30, 2020, the State of Georgia's Fiscal Year 2020 (FY 20).

COVID-19

The COVID-19 pandemic currently threatening the population of the United States has seriously impacted all aspects of life and work, including the State's agencies, workforce and contracted providers. Beginning in March 2020, DBHDD was compelled to impose restrictions on access to its State Hospitals and community-based programs in order to protect the health and safety of vulnerable individuals, including members of the SA's and EA's Target Population, and their staff.

The lack of sufficient personal protective equipment hampered the initial response to the pandemic. Nonetheless, it appears that DBHDD responded responsibly and thoughtfully to the threats of the pandemic by issuing information and protocols to reduce potential risk, introducing reasonable flexibility in the requirements for billing for the services provided in community settings, funding emergency hotel/motel stays, tracking COVID-19 related information on its website and monitoring requests for crisis counseling at the local level. DBHDD also created a website to disseminate information related to the number of confirmed cases of COVID-19 among residents of its State Hospitals, as well as the number of hospitalized individuals and staff who tested positive, recovered or died.

As of September 15, 2020, 586 individuals and staff have tested positive in the five State Hospitals, 503 people have recovered and there have been six deaths (three hospitalized individuals and three staff). The number of positive tests and deaths in the community system is not reported on the website. However, the mortality investigations routinely provided to the Independent Reviewer document that at least ten individuals with a developmental disability (DD) died from COVID-19 in the period from March 18 to June 30, 2020. These individuals ranged in age from 32 to 70 years. Four individuals lived in Region 4 (southwest Georgia), one of the most affected areas in the State. To place the death figures in context, over 13,000 individuals with DD receive Waiver services in the community throughout the State. Data about the COVID-19 related deaths of individuals with serious and persistent mental illness (SPMI) receiving community-based services were not available.

The restrictions on movement outside of the home and the subsequent closure of day programs and other gathering places created considerable stress on individuals and staff. This stress has continued and is being addressed in multiple ways, as the period of isolation and restriction persists. For example, although mobile crisis teams and ACT teams have continued face-to-face visits as necessary, Support Coordinators have reached out to their clients through telephone calls and online meetings in lieu of on-site visits. Electronic records have been accessed, when possible. Webinars are used for training and regularly scheduled meetings. One creative example

of outreach is the virtual gathering "Community Strong" developed by self-advocates with an intellectual disability. "Community Strong" is a weekly Zoom gathering led by self-advocates for self-advocates. The show is hosted by Uniting for Change, an expanding self-advocacy network focused on "uniting Georgians and influencing change by speaking up and taking control of our lives."

DBHDD is responsible for authorizing the resumption of home visits and the opening of day programming. At this time, it has not been determined when that permission will be granted.

DBHDD is to be commended for making retainer payments to community providers who have not been able to provide full services during the pandemic; this action has prevented further erosion of community services.

Budget Cuts

In addition to the service-delivery difficulties presented by the spread of the pandemic, DBHDD, with brief notice, was required by the Governor to propose and then implement major budget cuts for this current Fiscal Year. These cuts are in addition to the approximately $24.3 million previously reduced for FY 20 and the $46 million projected reduction for FY 21. By the end of the legislative session in June 2020, the total reduction for DBHDD for FY 21 was increased to $91,303,445; this includes cuts not just to services for adults, but includes cuts to services for children and adolescents. For purposes of this case, the State cut approximately $29 million in adult DD services and approximately $7 million in adult mental health services. Overall, DBHDD community funding is back to levels seen in FY19.

DBHDD prioritized protection of its community crisis services, State Hospitals, the Home and Community-Based Waivers and funding for private psychiatric hospital beds. Funding for the Georgia Housing Voucher Program -- community housing with supports for people with SPMI -- was preserved, although it has been under-utilized in recent years as the placements into Supported Housing have declined. Although the peer mentor positions in each State Hospital were maintained, other peer support services have been reduced. State-funded staffing throughout the system was reduced by 357 positions: 192 filled and 165 vacant positions. Community providers have expressed concern about the staff reductions in Regional field offices. There has also been concern raised about the elimination of consultant contracts related to high risk/complex individuals with DD. Although the State plans to shift those responsibilities to DBHDD staff, that transition has not yet been accomplished and there is a lingering question as to whether or not the State has sufficient internal expertise to address the needs of the high-risk group. Funding for individual and family supports was drastically reduced. According to DBHDD staff, there will be a case-by-case review of each of the 6,618 individuals with DD who receive that funding. These supports will now be means-tested and restricted to specific expenses. Pre-vocational services for individuals with DD are to be examined as part of the reduced funding; transferring some individuals into employment or community-based resources is anticipated, but not finalized.

As referenced above, there are 13,407 individuals with DD receiving community-based supports under the NOW or COMP Waivers. All of the funding to support these existing Waiver services

was preserved. Although DBHDD did not request any additional funding, the General Assembly has authorized 100 additional Waivers in FY 21 for individuals on the waiting list. This is positive news.

It is premature to assess the full impact of these major budget cuts, as they have only begun to be implemented. Ongoing issues related to the pandemic will continue to complicate any determination of the effect of the cuts on outcomes. Ironically, it is possible that the reductions in certain funds may lead to more productive outcomes for some individuals, if the projected next steps are implemented. For example, transitioning a person with DD from a lengthy stay in a pre-vocational program to supported employment would be a positive action. DBHDD's leadership has been very forthcoming thus far with regard to discussions about the budget reductions; these discussions will need to continue in the months ahead. It is likely that the Independent Reviewer will need additional data going forward.

Although fieldwork for this particular report to the Court was initiated in mid-February 2020, it was necessary to discontinue those efforts due to the COVID-19 restrictions on travel and access to programmatic sites. DBHDD's offices are not yet open and staff continue to work from home. Access to community residences and State Hospitals remains restricted. As a result, this report is much more limited in breadth and scope than was anticipated at the start of the year. The inability to conduct on-site visits to make first-hand observations and to meet with a wide range of stakeholders has forced the Independent Reviewer to report only on those provisions with supporting documentation that could be confirmed by both discussion and data. In addition, because of the limitations on fact-finding, there will not be any recommendations regarding compliance included in this report. In many respects, this report should be viewed as a "placeholder" until the Independent Reviewer is able to access all information, places and people necessary to complete a thorough independent review.

Despite the constraints on fact-finding and meaningful access to people, the Independent Reviewer made a conscientious attempt to obtain information that is reliable. The Independent Reviewer's fact-finding benefitted greatly from access to the Commissioner of DBHDD and her leadership team, as needed. Staff members throughout DBHDD were instrumental in providing the Independent Reviewer with information relevant to this independent review. In particular, the Director of Settlement Coordination and her Administrative Assistant were incredibly responsive to the many information and document requests from the Independent Reviewer as this report was being prepared. Community providers throughout the State also responded promptly and courteously when the Independent Reviewer reached out to them to confirm certain facts.

The assistance thoughtfully provided by the attorneys for the United States Department of Justice and the State of Georgia continues to be especially helpful.

Finally, appreciation again must be expressed to the advocates, individuals with a disability and family members who have reached out to the Independent Reviewer on numerous occasions to express their concerns, insights and recommendations. They have helped to keep this report grounded in reality. The ongoing meaningful involvement of Georgia's residents is critical to the successful implementation of the Agreements and the Parties' intent that "the principle of self-

determination is honored and that the goals of community integration, appropriate planning and services to support individuals at risk of institutionalization are achieved." (SA, I., K.)

Methodology

Reports, statistics and other essential documents were provided by DBHDD. It has not been possible to verify all of this information through independent review; concerns about accuracy or completeness are noted below when appropriate. Discussions occurred periodically with DBHDD staff to clarify the information that was provided.

Throughout FY 20, conversations were held with numerous stakeholders including individuals with a disability, family members, attorneys, advocates, judges, sheriffs, and providers of community-based supports. In October and December 2019, and in January and February 2020, meetings and site visits took place in Georgia. After February 21, 2020, all discussions with stakeholders and DBHDD staff were conducted by telephone.

The Department of Justice continued to request detailed data regarding the implementation of services and supports, the budget reductions and the State's response to COVID-19. 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 SA and EA:

- Martha Knisley continued to review compliance with the Supported Housing provisions of the SA and EA. Discussions were held with DBHDD and with the Department of Community Affairs (DCA). Comments and relevant information were received from advocates and providers throughout the year.
- Beth Gouse, PhD, reviewed the records of 36 individuals with SPMI who experienced two or more readmissions to the State Hospitals in FY 20.
- Julene Hollenbach, RN, MSN, NE-BC, reviewed 26 death investigations of individuals with DD. Each of these investigations, completed by DBHDD investigators, substantiated neglect.

The Independent Reviewer and her subject matter consultants are more than willing to discuss their findings with the Parties. On August 6, 2020, Ms. Hollenbach summarized her findings in a call with DBHDD.

The Independent Reviewer and her consultants realize that we placed numerous demands on DBHDD staff during our fact-finding efforts. We truly appreciate the assistance given by so many people to enable us to complete our work.

As required, the Parties were provided with a draft of this report and were given the opportunity to comment on its findings. The Independent Reviewer carefully considered those comments before finalizing this report.

Components of the Community System

In order to reduce reliance on institutional settings, the SA and EA focused primarily on the expansion of an enhanced community-based system of care for adults with DD and adults with SPMI. Current data and analysis regarding key elements of that expansion are highlighted below.

Behavioral Health

- Assertive Community Treatment (ACT) Teams: As required by the SA, 22 ACT teams remain. They are located in each Region of the State. There are three teams in each Region except for Region 3, which has seven teams. As of June 30, 2020, 1,533 adults were enrolled in ACT services statewide. The average team caseload ranges from 55 to 94 with the median caseload at 70 individuals. As noted in 2018, existing ACT capacity is far greater than utilization. At a 1:10 staff to client ratio, with ten non-psychiatry staff on each team, the 22 ACT teams could support 2,200 individuals; the 1,533 figure represents about 667 slots of unused ACT capacity in the system. In essence, this means the State is paying for ACT capacity but not utilizing it; the State should take effective steps to close the gap so that more individuals in need will be able to access ACT services that are already funded. This is especially important given that there are a number of adults with two or more admissions to a State Hospital or a private psychiatric hospital in this last Fiscal Year who might benefit from ACT team support.
- Community Support Teams (CSTs): There are ten CSTs; the SA required eight teams. As of June 30, 2020, on average, teams provided CST services to 312 individuals. Team caseload averages ranged from 10 to 53 with a median caseload size of 28 to 33 individuals.
- As of June 30, 2020, 4,792 individuals received Supported Employment services this Fiscal Year. However, funding for Supported Employment has now been reduced to permit only 2,539 adults to receive this service.
- Peer Support services were provided to 3,986 individuals during FY 20. Peer Support services for trauma training, workforce training and respite centers have had funding reduced in FY 21.
- Intensive Case Management (ICM) is available through 14 agencies in all Regions but one; there is no ICM in Region 4. As of June 30, 2020, DBHDD reported that the ICM teams had a total of 1,672 individuals on their caseloads.
- DBHDD has confirmed that there are 23 Crisis Stabilization Units in operation across Georgia.
- Crisis respite apartments now have a statewide capacity of 75 beds. Under the SA, there were to be 18 apartments, each with a capacity of two individuals. Based on the information provided for this report, there has been a twofold increase in the level of crisis respite apartment supports. However, the number of beds in each apartment has not been confirmed.

Developmental Disabilities

- There are 12 crisis respite homes, with four beds each, available statewide. This is the number of respite homes required under the SA.

- There are 1,401 Host Homes with no more than two individuals in residence.
- There are 3,232 Group Homes. With one exception, all residences have 4 or fewer individuals.

Blended Mobile Crisis Teams

- All mobile crisis teams now respond to individuals either with DD, a mental illness or a combination of the two diagnoses. Response times were reported separately for individuals with DD and for individuals with mental illness. The average response times for both groups of people were reported as one hour five minutes and one hour six minutes respectively. The SA required an average response time of one hour or less. However, the range of response times indicated that certain crisis callers waited up to 13 hours for a behavioral health crisis and up to four hours for an individual with DD in crisis. Detailed information about the response times was not available for this report. Information requested about outcomes from the crisis interventions was not provided as requested and, therefore, has not been included in this report.

Provisions Related to Individuals with DD

Status of Transitions of Individuals with DD from State Hospitals

The carefully planned transition of adults from the State Hospitals is a major focus of both Agreements. All reports filed with the Court have documented the efforts made to move individuals from institutions to less restrictive, more integrated settings with appropriate supports.

Parental/guardian opposition to community placement continues to be a factor despite efforts to provide information about community-based options. The pandemic prevented any placements after March 2020. At this time, it is uncertain as to when transitions will begin again.

During FY 20, under the terms of the Agreements, there were 17 placements of adults with DD from the State Hospitals:

Georgia Regional Hospital Atlanta	6
Central State Hospital	2
East Central Regional Hospital	2
Georgia Regional Hospital Savannah	3
West Central Regional Hospital	4

Since it was not possible to visit any of the individuals transitioned in FY 20, any detailed discussion must be deferred. However, two of the placements are known to have been unsuccessful, at least initially. L.T., who was placed from Central State Hospital on January 29, 2020, has been in a crisis respite home since February 11, 2020. There are no plans for a new residential placement. R.S. now has moved to another provider after his initial placement on

January 28, 2020 from Georgia Regional Hospital Savannah. His current placement appears to be stable.

As of June 30, 2020, 108 adults with DD still reside at Gracewood, a separate facility under the administration of East Central Regional Hospital, in Augusta. In FY 20, there were no placements from this institution, primarily due to parental or guardian opposition. Currently, only one person is on the list for transition planning. There are seven individuals who remain institutionalized at Gracewood who were transferred there when the Craig Center at Central State Hospital was closed on April 28, 2015. None of these individuals are projected for community placement.

Currently, there are 18 individuals with DD residing in the Skilled Nursing Unit at Georgia Regional Hospital Atlanta. Six of these individuals were transferred from the Craig Center. None of the 18 individuals are on the planning list for transition to a community setting.

At the initiation of the SA in October 2010, there were 726 individuals with DD institutionalized in State Hospitals. As of June 30, 2020, in all State Hospital units, there are 198 individuals with DD who remain institutionalized:

Georgia Regional Hospital Atlanta	25
Central State Hospital	18
East Central Regional Hospital	126
Georgia Regional Hospital Savannah	16
West Central Regional Hospital	13

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 or adolescents under age 18 in any of the State Hospitals. Admissions of individuals with a DD diagnosis alone have stopped. Adults who are dually diagnosed with a mental illness and DD continue to be admitted periodically and courts still order the admission of some adults with DD and a forensic status.

For the first time since the initiation of the SA, DBHDD has acknowledged that three adults with DD, ages 23, 29 and 30, were admitted, with authorization by DBHDD, to an institution in Florida. The first admission occurred in September 2018; the second and third individuals were admitted in September 2019 and April 2020 respectively. Each individual has a history of behavioral disturbances. These individuals remain in Florida. In early August 2020, during the preparation of this report, a parent contacted the Independent Reviewer about his adult son with DD who had been taken to a local Emergency Room by the police. When the hospital attempted to discharge the individual, GCAL, the crisis response center, advised inpatient treatment. A placement in South Carolina was recommended. The family refused and their son was eventually

placed in a crisis respite home. Although DBHDD staff stated that these out-of-state institutional placements are few in number, they are of considerable concern to the Independent Reviewer and will continue to be monitored. Institutional placement in other states should not be an option. Rather, the State should expand its service capacity in the community to enable the at-risk individual to stay in the most integrated setting in Georgia.

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

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

> **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)

DBHDD has notified the Independent Reviewer when an individual from Gracewood or the Skilled Nursing Unit at Georgia Regional Hospital Atlanta is transferred to a nursing home or a hospice care setting. These transfers have been medically necessary.

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

> **Agreement Requirement:** The SA requires that individuals with forensic status be included in the DD Target Population. (SA III.A.3.b.)

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

DBHDD has complied with the requirement to develop and update transition-planning lists for all individuals with DD who are institutionalized in State Hospitals. However, the pace of transitions has slowed. Currently, there is one individual on the transition-planning list for Gracewood. As of June 30, 2020, there are a total of 27 individuals on the list for placement from the five State Hospitals:

Georgia Regional Hospital Atlanta	4
Central State Hospital	6
East Central Regional Hospital	4
Georgia Regional Hospital Savannah	7
West Central Regional Hospital	6

Individuals with a forensic status have been included consistently in the transition to community residential settings. At least two of the individuals placed before the end of the Fiscal Year had forensic status since they were discharged from Central State Hospital, the forensic hospital in Milledgeville.

On June 30, 2020, there were 595 individuals in forensic units at the State Hospitals. On that date, there were 51 adults with I/DD in these forensic units (9%).

Georgia Regional Hospital Atlanta	1
Central State Hospital	18
East Central Regional Hospital	13
Georgia Regional Hospital Savannah	11
West Central Regional Hospital	8

The transition-planning list referenced earlier includes 17 individuals with forensic status (65%).

Host homes continue to sponsor no more than two individuals. With one exception, group homes have four or fewer residents.

The EA's requirements regarding the transition process itself could not be reviewed for this report. Additionally, DBHDD did not issue its anticipated Support Coordination Performance Report; therefore, information regarding post-discharge monitoring by Support Coordinators, as defined in the EA, was not available. The resources for post-move monitoring were reduced when the State terminated the CRA Consulting contract due to the budget cuts. (The CRA Consulting contract provided clinical oversight and supports to individuals with DD living in community-based settings.) DBHDD has stated that it intends to contract directly with clinicians throughout the State but, based on the information available, those plans are in very early stages of implementation.

Support Coordination

> **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.)

Support Coordination is provided by seven Support Coordination agencies. The role of the Support Coordinator, as described in policy, is consistent with the expectations described above.

The pandemic has seriously disrupted Support Coordination. Visits to community residences are not permitted and there is uneven access to the technology and secure meeting platforms required for virtual meetings. As a result, Support Coordination agencies have been forced to rely on telephone conversations and access to electronic records, if utilized by a residential provider agency. The Independent Reviewer's discussions with staff from Support Coordination agencies revealed the difficulties the agencies have in working through the obstacles imposed by the pandemic, as well as their very commendable efforts to ensure that ongoing contact is made with the individuals assigned to each caseload. Reasonable efforts have been made to review any incident reports. One Support Coordinator even notified law enforcement and Adult Protective Services when she learned of bruises on one individual. Additional complications have included the inability to recruit and train Support Coordinators in a timely manner, ongoing problems with the IDD Connects computer system, and the need to conduct Individual Service Plan (ISP) meetings by telephone or through a HIPAA-approved meeting platform. All Support Coordination staff expressed deep concern about their inability to conduct in-person visits with the individuals on their caseloads during the pandemic.

Given the current circumstances under which Support Coordinators are working and the lack of comprehensive information available at this time, the only provision that can be specifically addressed in this report is the EA requirement regarding caseload size.

> **Agreement Requirement:** The EA requires specific caseload limits. 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. (EA 16.e.)

Information provided by DBHDD has been reviewed/revised with the Support Coordination agencies. The ongoing problems with IDD Connects required caseload sizes to be counted manually. The computerized lists in IDD Connects are not accurate or reliable. This is a very serious barrier to tracking the delivery of supports, monitoring performance and ensuring remedial action as needed.

The information in the chart below was obtained directly from the seven Service Coordination agencies. The caseload for each Service Coordinator was reviewed. The number of Service Coordinators reported for each agency includes all Service Coordinators, including those who provide Intensive Support Coordination.

Support Coordination Agency	Number of SCs	In Compliance	Percent Compliance
Benchmark Human Services	36	28	78%
CareStar	14	13	93%
Columbus Medical Services	136	130	96%
Compass Coordination	16	12	75%
Creative Consulting Services	111	88	79%
Georgia Support Services	46	45	98%
Professional Case Mgmt.	68	68	100%

Individuals with Complex Needs

As discussed earlier, due to the COVID-19 restrictions, there is a lack of current, reliable and complete information about individuals with DD receiving community-based residential services throughout Georgia. This is especially true regarding individuals with complex behavioral or health risks that require careful and proactive oversight. Despite diligent efforts by Support Coordinators, clinical professionals, Regional field office staff, and advocates, it has been impossible for them to conduct routinely scheduled on-site visits in order to ascertain the well being of these individuals. Even families have been prohibited from visiting. The use of virtual meetings and telephone conversations, while certainly helpful, is not an adequate replacement for on-site face-to-face visits. Until unimpeded visitation is resumed, including unscheduled visits, it will not be possible to have complete and objective facts about the status of each individual.

Individuals residing in their own or family homes also have been impacted by the pandemic. The inability to interact with friends and meaningful others and to participate in typical community activities has disrupted daily routines and caused some problems. Behavioral crises have escalated for some individuals with deleterious effect on caregivers and on the individuals themselves.

The EA requires the maintenance of adequate oversight and intervention for individuals with high-risk and/or complex needs.

> **Agreement Requirement:** For all individuals with DD receiving services in the State's system, 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, the State is to identify, assess, monitor and stabilize them, provide them with Statewide Clinical Oversight (EA 15) and provide them with Support Coordination (EA 16) per EA criteria. The EA also requires the State to maintain a High Risk Surveillance List (HRSL) 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 HRSL shall include identifying data, as well as Health Risk Screening Tool (HRST) score and a summary of CIRs and clinical findings that indicate heightened risk due to complex medical or behavioral needs. For all individuals on the HRSL, the State is to monitor CIRs, Support Coordination notes, and clinical assessments. The State is to update the HRSL at least once a month. (EA 14.a.) The EA also requires the State to implement a Statewide Clinical Oversight (SCO) 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. (EA 15.a.)

DBHDD has complied with the obligation to develop the HRSL. This List is maintained in the Office of Health and Wellness, with input from staff working throughout the Regions. The last list included in the electronic files submitted to the Department of Justice and the Independent Reviewer was posted in July 2020. It includes a summary of the High Risk incidents by Region, individual, and descriptor of the identified risk. The risks are reflective of the criteria specified in the EA:

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.)

The EA also requires the State to provide interventions in a timely manner. The specific timeframes for oversight, initial intervention, and follow-up as warranted, as well as the requirements for timely notification of 911 or crisis services, the Support Coordinator, the Field Office and the Office of Health and Wellness are detailed in EA 14.c. and 15.c. Unfortunately, data remain insufficient to show if the required interventions were prompt enough to satisfy the EA criteria. Moreover, when reviewing death investigations, discussed further below, in too many cases, it was found that interventions were not delivered in a timely manner to individuals in decline or in crisis.

Each event included in the July 2020 report lists the intervention taken to address the risk and, in some cases, the actions that will be taken for ongoing oversight. Although the descriptions and the interventions are set out, it is not possible to verify the accuracy of the specific representations without on-site observation and monitoring. As discussed above, this is not possible at the present time. The responses to the risks are largely email reports submitted by the residential provider, who may have a self-interest in softening rough edges and not revealing all pertinent details if there is a negative outcome for the individual. There needs to be State oversight and a more independent determination of whether interventions were timely and adequate. Furthermore, there are a number of incidents without any description of the follow-up. For example:

- On 6/7/20, M.M. was taken to the hospital after complaining that his stomach hurt. It was determined that he had a small bowel obstruction and he was admitted for closer observation and treatment. Although there is a notation that the medical issue was resolved, there are no updates as to his treatment, recovery status or preventative actions that will be implemented. There is no information provided regarding the notification of the Support Coordinator, the Field Office and the Office of Health and Wellness. In addition, there is a question regarding staff's reaction to M.M.'s complaint of pain. Although he was vomiting, in pain and gagging when given his medication, M.M. was

put to bed and not taken to the Emergency Room until the next morning, after he refused breakfast and said his stomach hurt when he walked.

- On 6/13/20, J.A. was involved in an altercation while shopping. His staff person participated in the altercation and was placed under suspension pending the completion of the investigation. There was to be an updated follow-up note, but this entry has not been completed, so it is not known if there was any disciplinary action.
- On 6/20/20, staff physically abused L.J. The incident was appropriately referred to the Support Coordinator and to law enforcement. The staff person was suspended. However, there are no follow-up activities documented.

The EA (EA 15.a.) also requires the State to implement a Statewide Clinical Oversight (SCO) 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.

The last SCO list provided to the Department of Justice and the Independent Reviewer is dated July 2020. It lists the individuals with medical, behavioral and legal risks. However, there is minimal information and the Status is primarily noted as "Continue to Monitor," with no details.

Support Coordinators have expressed their concern about their inability to thoroughly examine the current circumstances of the individuals on their caseloads without on-site observation and communication. Although Support Coordinators continue to receive incident reports, they have not been able to verify the adequate implementation of Corrective Action Plans (CAPS) or any other remedial measures. As such, any detailed comments or evaluation of DBHDD's adherence to the oversight and intervention activities required by the EA (EA 14.c., EA 15.c.)) must be deferred.

In March 2020, DBHDD's Office of Performance Analysis completed a pilot fidelity review of a random sample of 32 events that rose to the level of SCO. For each event, this study asked 14 questions consistent with the notification and response requirements included in the EA. (EA 15.c.) The overall findings from this initial effort were promising. For example, nursing assessments of destabilizing risks were completed, emergency services were notified and competency-based staff training was provided for any identified deficiencies. However, two items that did not achieve the standard of acceptable performance included timely notification of Support Coordinators and the documentation of assessment findings on the individual's HRST or Emergency Medical Record. This is a very limited study in scope. Nonetheless, it is a promising example of the analysis that can and should be conducted in order to gauge adherence to the requirements of the EA and to generally accepted standards of professional practice.

The EA also requires:

> The State shall provide or facilitate (by phone, email, or in person), technical assistance, and training to contracted providers and support coordinators who serve individuals with DD in the community who face a heightened level of risk due to the complexity of their medical or behavioral needs. (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 Support Coordinators who report difficulty accessing or receiving needed services from community health care practitioners. (EA 15.f.)

The impact of the recent decision to terminate external clinical consultation due to budget cuts cannot yet be measured. Certainly, there is trepidation expressed from the community sector because clinical resources in certain parts of Georgia remain very limited. The consultation provided by clinicians retained by CRA Consulting is to be replaced by consultation from local clinicians, clinicians in the Field Offices and clinicians assigned to the Office of Health and Wellness. At this time, the changes required due to the budget reductions remain in a transitional stage.

DBHDD reports that it has continued or expanded relationships with a variety of professional and academic organizations. These resources will assist with the provision of clinical supports, either through direct involvement with individuals with complex needs or through the training/education of clinicians. For example:

- Emory University continues to offer a 12-week nursing curriculum addressing the clinical challenges faced by many individuals with DD.
- Faculty and graduate level students at the University of Georgia have begun collaboration on the clinical review of individuals with complex behavioral needs.
- A Behavior Analysis Peer Review Committee has been established to review challenging individual cases. All members of the Committee are highly qualified Board Certified Behavior Analysts at the Doctoral level (BCBA-D).
- In September 2019, training began for residential and day providers in the Positive Behavior Supports (PBS) curriculum published by the American Association on Intellectual and Developmental Disabilities. To date, 34 staff from 17 provider agencies have been trained as trainers of this curriculum. The curriculum is focused on knowledge and performance competencies. As part of the training, best practice standards for behavioral supports are being reinforced. The goal is to train 100 providers and all Regional behavior analysts and behavior specialists as instructors. Training has been interrupted due to COVID-19, but is planned for resumption as soon as possible.

The efforts to strengthen clinical resources related to behavioral health services are especially important given that serious and significant gaps still remain in the provision of these interventions and supports in the State's system. For example:

- L.V., a 28 year-old woman, has been hospitalized at Georgia Regional Hospital Atlanta since December 21, 2017. Prior to her admission, she lived in a group home. She has a history of serious self-injury and disruptive behavior. She is on the transition-planning list, has been accepted by a residential provider and is in the process of selecting a behavior services provider who can meet her needs. No discharge date has yet been confirmed.
- F.D., a 37 year-old man, was admitted to East Central Regional Hospital on August 8, 2018, from the County Jail. He was found Incompetent to Stand Trial on charges of

aggravated assault. The Independent Reviewer and her consultant reviewed F.D. while he was placed in a Crisis Respite Home; subsequent placements were unsuccessful. There are no community placement plans at this time.

- S.R., a 34 year-old woman, transitioned from Central State Hospital under the terms of the EA on September 28, 2016. She was re-admitted to Central State on November 26, 2019, due to threatening behavior towards her group home staff. There are no discharge plans at this time.

The most recent SCO List, dated July 2020, lists 74 individuals who have had a combined total of 111 behavioral crises involving law enforcement in the period from June 2019 to July 2020. It is not known how often jail stays were imposed as a result of the crises. However, ten of these individuals (14%) were charged with criminal conduct. DBHDD has informed the Independent Reviewer that they do not monitor the number or status of individuals with DD in local jails.

For prior reports to the Court, the Independent Reviewer and her BCBA-D consultant have reviewed a sample of individuals from the SCO List with these designations. This work requires site visits. It will be started again once the pandemic has subsided.

Crisis Respite Homes

> **Agreement Requirement:** The EA requires the State to provide individuals living in the Crisis Respite Homes (CRHs) with additional clinical oversight and intervention per the SCO 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.)

Given the current restrictions due to COVID-19, detailed reliable information could not be obtained independently about each of the individuals residing in the CRHs. It is not known to what extent additional clinical oversight and intervention have been provided. DBHDD has complied with the requirement to issue a monthly list regarding individuals with a stay of 30 days or more. The most recent report, from July 2020, provides only brief documentation about the 24 individuals who have been in CRHs 30 days or more:

- C.B. has been in the same CRH since October 2017. Her parents/guardians refuse any placement outside of Region 5; there have not been any viable options offered to them in that area of Georgia.
- Four individuals were admitted to a CRH in 2018. Two individuals, J.W. and M.H., have pending placements but no definite discharge date. C.B. was released from jail to a CRH and is currently hospitalized for medical care. Future plans are unresolved according to the documentation available. J.D. has agreed to consider other providers as his previously committed provider had delays due to zoning issues. The search for alternative options is underway.
- Five individuals were admitted to a CRH in 2019. J.H. was discharged to a residential provider on July 28, 2020. N.B. has an assigned provider and was to have an ISP meeting in August. The placement for D.R. is pending. There are no definitive plans for W.R. and H.P.

- The remaining 14 individuals were admitted to the crisis homes during the current calendar year. There are no discharge dates confirmed for any of these individuals although potential placements are planned for four of the individuals including S.J., R.H., D.W. and A.G.

  In February 2020, at the request of a Superior Court Judge, J.D. was introduced to the Independent Reviewer at his previous group home. He asked for help in finding another place to live. He was placed in the crisis home after an encounter with law enforcement. He has self-injurious behavior and a history of pica. Although he is articulate, interested in work, friendly and responsive to others, at least ten providers have refused to serve him. Appropriate options will need to be created for him.

  In January 2020, L.T. was transitioned from Central State Hospital to a group home. She was admitted to the crisis home 13 days later due to disruptive and self-injurious behavior. Since placement in the crisis home, one finger has been partially amputated due to her self-harm. Her parents have reported to the Independent Reviewer that they do not think her transition was planned carefully.

As discussed in previous reports, the barriers to discharge from a CRH continue to be formidable for many of the individuals on the monthly list. These barriers continue to include behavioral management issues and the insufficient number of qualified residential providers with the skills and resources to support individuals with challenging behaviors, often the result of trauma, the lack of stability and the absence of meaningful relationships. Ongoing discussions with advocates, family members, Support Coordinators, clinical professionals and residential providers confirm the inadequacy of supports in the current system.

Investigations and Mortality Reviews

Since the beginning of the SA, DBHDD has provided the Independent Reviewer with Critical Incident Reports (CIRs), investigations and Corrective Action Plans (CAPs) for the deaths of all individuals with DD who either transitioned from a State Hospital under the terms of the Agreements or received Home and Community-Based Waivers. Until the contract was cancelled in July 2020, the Columbus Organization reviewed the investigations completed by DBHDD and commented on the findings. Their reports were also provided to the Independent Reviewer.

Following receipt, each document is reviewed by the Independent Reviewer and then categorized by year of death, provider agency, residential address and whether the DBHDD investigator substantiated neglect.

Despite the pandemic, the receipt of death investigations has continued. Due to the circumstances, there have been delays in the completion of the investigations, although extensions have been granted. DBHDD has reported that the current average time for completion is 45 days. However, DBHDD's on-site review of the completion of CAPS has been discontinued by necessity. There has not been a timeline established for the renewal of these on-site reviews.

DBHDD has worked diligently to strengthen its investigation process. There is evidence of effort and thoroughness. Areas of weakness identified in the investigation process, including supervisory oversight and consistency in the scope of interviews, have been largely corrected. Although the Columbus contract was cancelled due to budget reductions, it is advantageous that the Georgia Advocacy Office, the Protection and Advocacy system for Georgia, has access to un-redacted investigations and CAPS when there is probable cause of abuse, neglect and/or exploitation. GAO's investigators are also very experienced and they are effective in pursuing any issues of concern.

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

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.)

FY 20 Deaths of Individuals with DD

Deaths reported to the IR	195
Investigations Completed*	107
Deaths with Substantiated Neglect	27 (25%)

*55% of the deaths had investigations. As permitted by policy guidelines, 75 deaths were closed without an investigation. One investigation is pending completion. For 12 deaths, only a CIR has been received at this time.

In July 2020, the State provided its annual mortality report for Calendar Year (CY) 2019. The State reported 221 deaths of adults with DD in 2019, with a death rate of 16.7, up from 13.3 for CY 2018. The State reported very elevated death rates for adults with DD and high health risks—a death rate of 51.2 for Health Care Level (HCL) 5, the second highest risk level, and a death rate of 66.1 for HCL 6, the highest risk level.

The Independent Reviewer's nurse consultant, Julene Hollenbach, examined 26 investigations with findings of substantiated neglect. (The 27th death was the result of a traffic accident that killed both the individual and the staff person who was driving too fast.) Her review indicated the following:

- The quality of the investigations has greatly improved. They were more thorough with an extensive review of documents and interviews with the appropriate people. The conclusions were well founded and complete.
- Investigations were timelier. In most instances, if an investigation was not completed within 30 days, an extension had been approved. Completing a thorough investigation as soon as possible is extremely important as it may identify issues that place other individuals at risk. Once identified, those risks can then be minimized or eliminated quickly.
- 42% of the 26 investigations identified the deficient practice of staff not responding in a timely manner to a change in the condition of the person, thus resulting in a delay in obtaining needed care. This deficient practice was identified in the 2019 annual mortality report as one of the consistent areas of deficiency for the past two years. Specifically, the State's mortality report concluded that there were deficient practices with regard to "individual care and prevention" and that this includes sub-categories such as "response to emergency/change in condition," meeting "medical care needs," and "care coordination." The report concluded that these deficient practices may "indicate additional areas for systemic improvement." It appears that the system improvements that have been implemented to correct this issue have not been as effective as necessary.
- 83% of the investigations concluded that Health Care Plans had not been completed, were incomplete, were not individualized, or were not accurate. This deficiency resulted in a finding of neglect in three of the investigations. Health Care Plans have been identified as a critical tool to provide information to staff in order to enable them to provide essential, consistent care to individuals and to ensure that health needs are met and risks are minimized/eliminated. It appears that Health Care Plans are not being developed and utilized effectively.
- The HRST was identified in the annual mortality report as a highly effective tool to identify and assess high-risk individuals. However, 31% of the investigations concluded that the HRST was not current, so it did not accurately reflect each person's risk.
- The lack of staff with current training was cited in 50% of the investigations. Two of the trainings that were identified were CPR and CPI (Crisis Prevention and Intervention). Six of the investigations concluded that staff were not knowledgeable and/or did not implement emergency procedures, including CPR, in a timely manner, as required.
- It appeared that monitoring by Support Coordinators was being done quite consistently. However, 73% of the Support Coordinators did not identify the deficient issues and ensure that they were corrected, e.g., incomplete/missing/inaccurate Health Care Plans, lack of staff training, inaccurate Medication Administration Records (MARS), missing physician orders, inaccurate HRST, etc. This finding leads to critical questions about the thoroughness of the Support Coordinators' monitoring and the value they are adding to the objective of protecting individuals from harm.
- 62% of the investigations cited medication administration issues. Those deficiencies included: medications not signed for on the MARS, medications not administered as ordered, and missing physician orders. One of the individuals reviewed, C.R., died as a result of seizure activity. Neglect was substantiated against the provider for failure to administer her seizure medications as ordered and for failure to respond immediately to her change in condition. Neglect was also cited in the failure to assign trained staff to work with C.R. Her medication records documented that her anti-epileptic medication

was not signed as administered by nursing staff. At the time of this report, the death certificate was not completed and the cause of death was unknown. It cannot be determined if she received her medication or if this had any impact on her death, but it does identify the high risk involved when medication administration practices are not followed consistently. Medication management was also identified in the recent annual mortality review as one of the consistent areas of deficiency for the past two years. It appears that there is a need for systemic improvements.

In a separate memorandum, the Parties will be provided further detail from Ms. Hollenbach's findings for each deceased individual. She has already discussed her conclusions with the Director of the Office of Health and Wellness.

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 and recommendations. (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)

As referenced above, the pandemic has prevented both DBHDD's and the Independent Reviewer's on-site examination of the implementation of CAPS. There is agreement to collaborate on the reviews once access is restored. DBHDD has acknowledged that its reviews to date have indicated that only 40% of the CAPS have been implemented as expected.

As required by EA 25, the State has published in a timely manner its 2019 Annual Mortality Report. The report is carefully prepared and the data appear reliable. The "crude mortality rate" has been reported as follows:

Year	Deaths per 1,000 Individuals
2015	12.5
2016	14.0
2017	16.4
2018	13.3
2019	16.7

The "crude mortality rate" is a measure of how many people out of every thousand served by DBHDD died within the calendar year. The annual reports issued to date have concluded that the mortality rates do not differ significantly across 2016-2019. Further discussion with DBHDD about the 2019 report will be requested. DBHDD leadership is reviewing the findings to determine any next steps.

Provisions Related to Individuals with Mental Illness

Supported Housing and Bridge Funding

The basic building blocks of a comprehensive community-based behavioral health system have been discussed earlier in this report. They were established in the early years of the SA. Although there have been some changes in scope and the actual impact of the recent budget cuts is yet to be determined, these supports have been largely sustained.

This section of the report is focused on two major obligations remaining from the SA and EA:

> **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 Section 8 program. (SA III.B.2.c.ii.(A)
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> **Agreement Requirement:** The SA requires the State to provide Bridge Funding for up to 1,800 individuals with SPMI in the Target Population. (SA III.B.2.c.ii.(C). Bridge Funding includes money for security deposits, household necessities, living expenses, and other supports during the time the person is becoming eligible for federal disability or other supplemental income. (SA III. B.2.c.i.(C); see also EA 31.) Funding for this program would come exclusively from the State. The EA requires the State to provide Bridge Funding for an additional 600 individuals, for a grand total of 2,400 individuals with SPMI in the Target Population (EA 32, 33).

The State continues to fund and administer the GHVP, including allocating Bridge Funding. The provision of housing, with the offer of support services, if needed and desired by the tenant, is a critically important part of a responsive community-based system and it carries substantial weight in both Agreements.

The number of individuals with SPMI who have an active authorization for the GHVP has been tracked throughout the course of the Agreements. Documentation since July 2015 shows an initial period of increasing authorizations followed by a steady decline between March 2018 and June 2020.

Number with Active Authorizations for GHVP

July 2015	1,623
July 2016	1,924
July 2017	2,432
January 2018	2,628
February 2018	2,582

March 2018	2,534
April 2018	2,511
May 2018	2,482
June 2018	2,453
July 2018	2,405
November 2018	2,224
March 2019	2,147
May 2019	2,039
June 2019	1,973
October 2019	1,830
November 2019	1,810
December 2019	1,776
January 2020	1,767
February 2020	1,740
March 2020	1,692
April 2020	1,677
May 2020	1,647
June 2020	1,615
July 2020	1,630
August 2020	1,672

The Notice To Proceed (NTP) is DBHDD's indicator for individuals who qualify for Supported Housing and have approval to search for housing. On June 30, 2020, the number of individuals with a NTP was approximately 200 people below the figure on the same date in June 2018 -- a 42 percent drop.

Number of Individuals with a Notice to Proceed (2015-2020)

GHVP Assistance	6/30/15	6/30/16	6/30/17	6/30/18	6/30/19	6/30/20
Individuals with a Notice to Proceed	236	321	360	469	CND	270
Individuals with a signed lease	1,623	1,924	2,432	2,405	1,973	1,630

At this time, there are some encouraging developments that are helping to stop the decline and begin to increase the number of individuals in the Agreements' Target Population with GHVs.

In 2018, the nationally recognized Pathways Housing First program, initiated in New York City, and Step Up on Second, a successful Housing First program that started in California, developed a Housing First program for individuals living in Atlanta who are homeless and have SPMI. In large part, this occurred because of a generous grant for supportive services from the Sparks Foundation, as well as access to housing vouchers through the City of Atlanta. In 2019, DBHDD began discussions with Dr. Sam Tsemberis, the Executive Director of the Pathways program, and with Step Up staff to develop a pilot program in the greater Atlanta area that would provide housing and tenancy support for individuals who qualify for the GHVP.

DBHDD entered into a contract with Step-Up to support 180 individuals in two categories: 1) 105 new referrals of individuals who are not currently housed, but would be assigned a GHV;

and 2) 75 individuals, disconnected from services, but currently housed with a GHV, who would receive new supportive services and be assisted with obtaining a lease renewal.

The purpose of the pilot program is to test the Housing First model with these two groups, with modifications in the GHVP referral process, in order to: 1) understand and evaluate the different challenges and outcomes for each group; and 2) better inform the final design of the housing support service model.

The pilot began on January 1, 2020 with a startup period of 60 days to hire staff and become operational. Unfortunately, the onset of COVID-19 impeded the process of getting staff hired. Nonetheless, by the end of June, the pilot had 85 referrals with 12 individuals moving into housing, 11 individuals with lease renewals and all 23 individuals receiving supportive services from Step Up.

With their record of accomplishment in other jurisdictions, this Pathways/Step Up model holds a great deal of promise. In order to ensure that it works as planned, it will be important to allow time for it to succeed and to give attention to ensuring that data are available to analyze the process and to measure outcomes. Given the information being generated by both Step Up and Pathways, this pilot will enable insight into the unique challenges of providing and funding these services in Georgia. To date, DBHDD has not identified a sustainable funding model beyond the pilot; it predicts that it may take two years to develop and secure necessary long-term resources. Robust targeted data on existing crisis services and viable alternatives incorporating supported housing may help determine if some other available funding, such as the $19,214,550 spent on private hospital beds in FY 20, could be re-purposed, at least in part, to ensure sustainability of the pilot initiative; however, this typically takes time and start-up funds.

As the pilot demonstrates tangible success, another key action going forward will be establishing a timeframe for expanding the Housing First model across the State. This pilot was initiated with a generous foundation grant and with the support of experienced leaders and staff from two highly successful programs. These strengths cannot be underestimated in the planning and implementation of expansion, which is not under consideration at this point.

The Atlanta based Continuum of Care (CoC), funded in part by HUD, the City of Atlanta, and with donations and other grants, is an essential partner with DBHDD, providing services and housing for individuals who are chronically homeless in the Atlanta area. Over the last few years, this CoC has been successful in initiating and completing major projects designed to reduce reliance on large shelters. These shelters often house individuals with SPMI who cycle through institutions, including state psychiatric hospitals and emergency rooms, as well as individuals who have been living on the street for many years. For both DBHDD and the Atlanta CoC to be successful in meeting their respective obligations, they need to share responsibility and resources.

As a result of COVID, the Atlanta CoC arranged for the use of a hotel, available due to the high hotel vacancy rate, for housing for individuals and families who are homeless. This hotel is only available until September 30, 2020.

This summer, the CoC asked DBHDD for assistance, through the use of GHVs, for individuals with SPMI who are housed temporarily at the hotel referenced above. The CoC has specifically requested assistance for expedited assessments and access to GHVs for at least 40 individuals. To date, it is not clear that such assistance will be offered by DBHDD in time to help individuals move directly from the hotel to housing with a GHV. If this cannot be accomplished, individuals with SPMI will not have the opportunity to live safely in a rental unit rather than return to the streets of Atlanta, where they remain vulnerable for exposure to COVID-19 and other risks to their health and safety.

A second encouraging development was implemented in March 2020. DBHDD and DCA announced changes to their unified referral strategy. (EA 39.a.) The unified referral strategy is included in the Memorandum of Agreement (MOA) between the two agencies. It was to be implemented for anyone in the Target Population in order to provide education, outreach and then access to housing. (EA 39.a.) The MOA required exhausting federal funding sources for supported housing before accessing the State-funded GHVP. But, this strategy has been the focus of numerous longstanding complaints; it was neither timely nor effective in directing individuals to preferred housing options. Although some stakeholders blamed the unified strategy concept itself, in Georgia, it appeared to be an implementation problem. (The unified referral strategy has worked in other states and communities.)

The two agencies have agreed to change their practice in order to utilize the GHVP as the first choice for a housing voucher. This policy change will permit expedited access to Supported Housing for individuals in the Target Population. After one year of authorization for the GHV, it is intended that the individual and the property manager would shift to another source of available funding, likely federal funding. Although this is a welcomed policy change with clear short-term advantages, leadership personnel at DCA have acknowledged that this may present difficulties in the long-term. For example, the rental subsidy for the GHV may be higher than the federal subsidy. Federal subsidies come with additional requirements that may be rejected by landlords. It is for this reason that the Parties agreed to SA III.B.2.c.ii.B to ensure that at least 2,000 individuals in the Target Population get supported housing if they are "deemed ineligible for any other benefits."

Unfortunately, the State has not aggressively encouraged or assisted local Public Housing Authorities (PHAs) to apply for HUD disability-based Mainstream Vouchers. There are 188 PHAs in Georgia; not all qualify for or have the capacity to administer the Mainstream program. However, the Executive Directors of the two leading PHAs stated that they would have applied for the funding if they had been contacted by DCA and DBHDD. Compounding the urgency, funding for federal housing programs, such as the Mainstream program, are not available on a regular basis. Currently, there are no additional funds available to expand this program. In 2020, HUD made awards for the PRA 811 program, a project-based rental housing program, to 13 states. Georgia was not successful in its application for additional funds. The scoring results that explain the award decisions have not been released so it is unclear why Georgia was not included in the group of 13 successful states. However, it is clear that greater attention needs to be paid to federal grant opportunities as they arise and that the State could maximize its chances if stronger collaboration existed with the PHAs.

The expansion of resources for affordable housing, and the best strategy for ensuring access, will continue to require careful attention and targeted performance by the State as it works towards compliance with its obligations under the Agreements. It is commendable that new directions are being planned and implemented. Recently, DCA leadership inquired about potential contacts in other states where vouchers have been shifted successfully from state to federal resources.

In FY 20, Bridge Funding was provided to 404 participants. However, the total expenditure for Bridge Funding in FY 20 was $963,161, approximately 36% less than in FY 19, and 45% lower than in FY 18. Individuals have up to $2,500 in available Bridge Funding. The average "bridge" cost per participant was $1,711, a reduction of 50% from FY 18. However, additional funding, up to $1,500 per person, was made available for emergency shelter in response to the impact of COVID-19.

Individuals in the Target Population

> **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)

Even before the pandemic, there was only limited information available about outreach to the adults with SPMI included in the Target Population. There never have been reliable data for people seen in emergency rooms, and outreach to people with SPMI in jails and prisons has been exceedingly limited. Since the end of February 2020, access to electronic records, state and private hospitals, jails, shelters and housing has been restricted. In addition, the 12 Housing Outreach Coordinator positions were eliminated as part of the mandated budget reductions.

With regard to readmissions to the State Hospitals, in FY 20, DBHDD reported that 228 adults with SPMI had two or more admissions to the five State Hospitals. A sample of 36 people was selected for review. The State provided admission and discharge records for these individuals for each hospital episode. The records were analyzed to determine the location to which each individual was discharged. It should be noted that, although this review was focused on readmissions in FY 20, the overwhelming majority of the individuals in the sample had multiple admissions predating FY 20. The purpose of this analysis was to determine the extent to which

Supported Housing was utilized for discharges from inpatient hospitalization. Individuals discharged to Supported Housing are more likely not to be re-admitted than individuals discharged to friends, family or others where housing may be temporary or unstable.

With the possible exception of one individual who was discharged first to a hotel and then to an unspecified apartment, there were no referrals to Supported Housing documented in the records reviewed. For example:

- Georgia Regional Hospital Savannah (GRHS): Nine individuals were reviewed. Six individuals had three admissions and three individuals had four admissions in FY 20. The average Length of Stay (LOS) ranged from 5 to 19 days for all but one individual. None of them were linked to Supported Housing prior to discharge. Instead, there were referrals to rooming or boarding houses and shelters.

  Since it revised its policy in February 2016, DBHDD tracks the number of hospital discharges to shelters, hotels and motels. Based on the information reviewed, discharges to shelters have declined over time. Reportedly, they are now averaging 4% of all discharges. However, based on the documentation reviewed, it is still of considerable concern that one individual with 65 episodes of hospitalization was discharged to a shelter rather than to supported housing.

- Georgia Regional Hospital Atlanta (GRHA): Nine individuals were reviewed. Seven had three admissions and two had four admissions in FY 20. The average LOS ranged from 6 to 67 days. Individuals were discharged to group homes, family homes, personal care homes, and transitional residences. One individual was discharged to a shelter following his first two admissions and then to a transitional residence following the third admission. This gentleman had a history of at least five hospitalizations. Once again, there is no evidence that these individuals were linked to Supported Housing prior to discharge from GRHA.

- Two individuals were admitted to two different hospitals in FY 20. Each had a total of two admissions. Information for all admissions was incomplete. However, one individual was discharged to family once. The second individual was discharged to a hotel and to his own apartment.

When access to the State Hospitals and their electronic records are again permitted, the admission/discharge patterns for these 36 individuals will be further reviewed. In addition, attempts will be made to interview each individual.

In addition to the State Hospitals, DBHDD contracts with 11 private hospitals to provide inpatient beds for adult mental health care. In FY 20, there were 6,100 admissions to these private hospitals with contracted beds at a cost to DBHDD of $19,214,550. The private hospitals are located in three Regions of the State—Regions 1, 4 and 6. Of the total number of admissions, 544 individuals were hospitalized two or more times in FY 20. The names of the 544 individuals have been provided. An inquiry regarding the availability of their admission and discharge records has been made by the Independent Reviewer in order to select a sample for review to

determine how many were assessed for and/or linked to important community services, such as Supported Housing and ACT, at the time of discharge.

DBHDD has just reported an adjustment to its housing needs survey system in order to allow private hospitals with contracted beds to administer the survey and make referrals to the GHVP. This change went into effect in June 2020. DBHDD reports that training about the survey process has been provided to over 40 hospital staff.

As referenced above, the State has never been able to provide any information regarding the individuals in the Target Population frequently seen in Emergency Rooms. It is anticipated that some information about the use of Emergency Rooms might be extracted from the review of private hospital admissions.

Although requested every year, and again for this report, DBHDD did not provide any information about the eligibility status of the individuals living in Supported Housing on July 1, 2020. Therefore, the number of people served in each of the Target Population sub-groups is unknown.

The Housing Outreach Coordinators were the principal link to jails and prisons. With the termination of those positions, it will be important to further explore the extent to which DBHDD is able to undertake the vital outreach efforts that were to be completed by the Housing Outreach Coordinators and, thus, to determine to what extent the people incarcerated in jails and prisons have access to GHVs.

Linkage to Community-Based Services/Supports

The Supported Housing model does not require adults with SPMI to accept mental health-related services as a condition of tenancy. Both the SA and EA recognize this principle.

> **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)

However, it is well recognized, and documented, that individuals who initially refuse services may in fact change their minds, if trust is established with provider staff. In fact, DBHDD has acknowledged the importance of support services to people in housing and the need to find ways to gain acceptance of needed services in its contract with Pathways and Step Up on Second, described above.

As discussed in previous reports, the State has been challenged in its efforts to help individuals maintain linkage to flexible and needed services. Based on DBHDD's most recent report, approximately 33% (559/1672) of the individuals living in Supported Housing units were not engaged in services. As referenced in last year's report, a review of other states suggests the expected number of non-engaged individuals should be in the 10% range. Georgia's higher percentage is an indicator that community staff are not applying well-tested engagement

strategies, such as assertive outreach techniques, and/or staff are not skilled in those techniques. Retention of housing is associated with effective long-term engagement by outreach and clinical staff. The loss or abandonment of housing, typically under negative circumstances, is often associated with less contact and engagement.

Fortunately, there are well-tested recovery-based approaches to effective engagement with individuals moving into Supported Housing. DBHDD's work with Step Up and Pathways is important. Also, DBHDD reported that it is exploring a partnership with the Department of Human Services' Division on Aging to potentially create a pilot initiative that would provide peer-based behavioral health coaching to older adults who are housed through the GHVP. This pilot program is intended to support housing stability. It was hoped to have a start date of July 1, 2020, but a target date for later this year has now been established due to the pandemic. These are fresh and promising steps but neither will address the underlying engagement issues with the current system, unless the State commits to a shift in its expectations for the system as a whole.

As stated in last year's report, effective linkage requires effective engagement, monitoring and provision of incentives. In FY 19, DBHDD reported that it had revised its policy to require a "health and safety check-in" once a month, a widely used method to engage individuals and ensure their safety and wellbeing. This year's numbers do not reflect a positive change since adopting this policy. Given the known benefits of the "health and safety check-in," DBHDD is advised to analyze how this policy is being applied in its Supported Housing program.

In summary, the State's provision of Supported Housing remains a crucial cornerstone to its mental health system. Housing is the gateway to the myriad opportunities that exist in community-based settings for social integration and meaningful participation in typical activities of everyday life. Although there are recent initiatives that are promising, at this time, there remains a significant gap in ensuring that every sub-group in the Target Population has reliable access to these resources. In the end, the initiatives planned and implemented by DBHDD must demonstrate statewide outcomes that are documented by reliable data.

Quality Management

Although there has been little opportunity to discuss DBHDD's Quality Management system, brief documentation was provided regarding a series of projects, in various stages of planning and implementation. These initiatives include:

- An analysis of behavioral assessments will review data across different data sources to understand trends and patterns of specific behavioral risk factors, conditions and situations that may be associated with adverse outcomes that rise to a level of high-risk surveillance. This project is in the planning stages.
- Members of the BH/DD Steering Committee sub-groups will address various issues pertaining to dually diagnosed individuals, including workforce development and

training, program and service development and policy and organizational structure. This work has commenced but is now on hold due to the demands of COVID-19.

- Documentation will be reviewed for selected individuals in order to identify any gaps. It is intended that when an individual moves between providers, his/her documents follow as well. Approval is pending. (This is a longstanding problem identified in numerous site visits conducted by the Independent Reviewer's consultants over the years.)
- Strategies will be developed to facilitate cross-divisional communication in order to best serve individuals who are dually diagnosed. The Executive Summary from this work has been presented.
- An assessment for trauma in individuals with DD will be implemented. Guidance is being sought from stakeholders to determine the best way to advance the project.
- The Office of Health and Wellness will identify sources/indicators of heightened risk not captured by current procedures. Data sources have been identified; data are pending.
- A Fidelity Tool will be used to assess the appropriateness of responses for individuals with DD who are at heightened risk for adverse health outcomes. This Tool consists of an infrastructure review, a provider record review, and an in-person assessment as needed. The pilot of the Fidelity Tool is complete. The findings will continue to be discussed and assessed during Quality Council meetings. (The Independent Reviewer was given a copy of the Fidelity Tool; the pilot is discussed earlier in this narrative.)

There is one project that has not been implemented as planned that continues to cause numerous problems in the community system for individuals with DD. This initiative is IDD Connects. It was intended to permit analysis of ISP development and implementation processes in order to better understand the strengths and barriers to creating effective ISPs in an efficient manner. Community providers reported numerous complaints. DBHDD has acknowledged "the implementation of IDD Connects is still an issue as there are continued modifications, updates and improvements." This system was implemented over a year ago and is essential to accurate reporting, monitoring and requests for the authorization of community services.

Additional information about each of these initiatives will be requested from DBHDD for inclusion in future reports.

Concluding Comments

For most of this Fiscal Year, the pandemic has forced restructuring priorities, policies, routines and resources in order to protect health and safety. DBHDD is to be strongly commended for its leadership and for the manner in which it has responded to this crisis.

There are a number of issues identified in this report that will be reviewed again over the months ahead. These issues include: 1) the impact of the budget cuts on the delivery of community-based services, including the planned transition of clinical expertise and resources from external consultants to DBHDD staff; 2) the status of health/medical and behavioral resources for individuals with DD at high-risk; 3) the pace and quality of transitions from institutions to community-based residences; 4) the development of alternatives to crisis respite settings; 5) the performance of Support Coordinators; 6) the implementation and monitoring of Corrective

Action Plans resulting from death investigations and their impact on prevention of harm; and 7) the progress of the widely-anticipated pilot to increase and sustain Supported Housing for individuals with SPMI in the Target Population.

Although there were constraints on the gathering, analysis and corroboration of fact-finding for this report to the Court, conscientious effort was made to outline key areas of accomplishment as well as problems that impede compliance. It is hoped that this report can provide a basis for further discussion and collaboration.

Respectfully Submitted,

Elizabeth Jones, Independent Reviewer

September 18, 2020