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

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	CIVIL ACTION NO.
	)	1:09-CV-119-CAP
THE STATE OF GEORGIA, et al.,	)	
	)	
Defendants.	)	
_____	)	

DECLARATION OF CARLA JO OSGOOD

Pursuant to 28 U.S.C. § 1746, I, Carla Jo Osgood, do hereby declare:

A. Background

1. I am an independent consultant for public and private human service agencies. I design and develop comprehensive state and facility-wide quality management systems to oversee quality improvement and risk management programs, identify organizational strengths and needs, and investigate abuse, neglect, and other civil rights violations.

2. I currently serve as an expert consultant to the United States Department of Justice ("DOJ") in monitoring the State of Georgia's compliance with the January 2009 settlement agreement ("Agreement") under the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, in United States

v. Georgia, Case No. 1:09-cv-00119-CAP. Before entry of the Agreement, I served as the United States' expert consultant in its investigation of the Georgia Psychiatric Hospitals.

3. I have 19 years of experience and professional expertise in developing, implementing, and administering social service programs in both the community and in federally-regulated institutions. For the past 10 years, I have worked for states in developing and monitoring institutional systems for incident, risk, and quality management. As part of that work, I have consulted to the State of Iowa in United States v. Iowa, No. 04-CV-636 (S.D. Iowa 2004), and to the State of Indiana in United States v. Indiana, No. 1:00-CV-1991-SEB-JVS (S.D. Ind. 2000), to help those states comply with DOJ agreements under CRIPA with respect to protection from harm. Previously, I developed and implemented a housing supportive services program to homeless individuals with disabilities, provided treatment planning and crisis intervention and stabilization services for at-risk youth, and designed academic and recreational activities based on the biopsychosocial needs of at-risk youth. My curriculum vitae is attached as Attachment A.

4. I serve or have served as an expert consultant to the United States in cases pertaining to the care and treatment provided at institutions for individuals with mental illness and/or developmental disabilities, including United States v. Tennessee, No. 92-2062 (W.D. Tenn. 1992), United States v. Nebraska, No. 8:08-CV-271 (D. Neb. 2008), and United States v. Arkansas, No. 4:09-CV-00033-JLH (E.D. Ark. 2009).

5. In my role as expert consultant to DOJ in this case, I have examined protection from harm systems and conditions in the Georgia Psychiatric Hospitals. My review has included the following:

   a. On-site visits to the following Georgia Psychiatric Hospitals: Georgia Regional Hospital at Atlanta ("GRHA"), Northwest Georgia Regional Hospital ("NWGRH"), Georgia Regional Hospital at Savannah ("GRHS"), Central State Hospital ("CSH"), East Central Regional Hospital ("ECRH"), and West Central Georgia Regional Hospital ("WCGRH"). I visited GRHA on September 17-21, 2007; NWGRH on October 29 through November 2, 2007; GRHS on December 17-21, 2008, and June 22-26, 2009; CSH on April 8, 2009, June 30 through July 1, 2009, November 2-7, 2009, and

January 11-15, 2010; ECRH on May 4-8, 2009; and WCGRH on November 30 through December 3, 2009.

b. Evaluation of the State's policies and procedures, and, as applicable, individual hospital policies, procedures, and protocols.

c. Review of the clinical records of hundreds of individuals in the Georgia Psychiatric Hospitals.

d. Interviews with administrators, clinical staff, direct care staff, and the individuals who reside in the Georgia Psychiatric Hospitals.

e. Examination of the physical plant conditions of the Georgia Psychiatric Hospitals.

f. A representative sample of the interviews that I have conducted, meetings that I have attended, and documents and records that I have reviewed can be found at pages 5-6 and 8-10 of the compliance report for the May 2009 ECRH inspection, and pages 2-3 of the compliance report for the June 2009 GRHS inspection, attached to the United States' Motion as Exhibits 3 and 4, respectively.

ASSESSMENT OF PROTECTION FROM HARM

6. My expert opinion, based on my 19 years of training and experience in the field of social service programs in community-based and federally-regulated

facilities, including 10 years of experience in the area of institutional protection from harm, and on my review of the systems of care in the Georgia Psychiatric Hospitals, is that individuals in the Georgia Psychiatric Hospitals live in unsafe environments subject to serious and frequent harm such as patient-on-patient assaults and self-injurious behaviors, including suicide, because the Georgia Psychiatric Hospitals systematically fail to identify and respond to risks of harm.

7. Numerous aspects of the protection from harm systems in the Georgia Psychiatric Hospitals substantially depart from generally accepted professional standards. During my review of the Georgia Psychiatric Hospitals, I found statewide systemic deficiencies in incident, risk, and quality management that pose an immediate and serious threat to the life, health, and safety of the individuals in the Georgia Psychiatric Hospitals.

8. In my review, I found that incident management practices at the Georgia state and hospital levels are significantly deficient. These deficiencies include, but are not limited to, insufficient reporting criteria, inadequate and untimely reporting, unreliable data collection practices, and ineffective data analyses to reduce patient harm. Such inadequacies give direct cause to the

serious and recurring harm, including death, experienced by thousands of patients served within the Georgia Psychiatric Hospital system.

9. I found that internal investigations into patient abuse, neglect, and suspicious injuries in the Georgia Psychiatric Hospitals systematically fail to include information that is necessary to finding the root cause of an incident or to delve sufficiently into the possible origins of incidents, including whether quality of care, abuse, or neglect contributed to an injury. Investigations should determine the underlying cause of an incident by systematically identifying, collecting, preserving, analyzing, and presenting evidence.

10. I found that the Georgia Psychiatric Hospital system, at both the State and facility levels, routinely fails to recognize adverse trends that, if adequately reviewed, could prevent the recurrence of serious and life-threatening conditions. The lack of reliable and adequately analyzed data renders State and facility officials incapable of recognizing adverse trends and correcting issues that directly lead to patient harm and death. Moreover, when hospitals have attempted to review serious incidents, such as in mortality reviews, those efforts have failed to adequately examine relevant information contributory to patient harm, including death. The Georgia Psychiatric Hospital system's failure to recognize and adequately address

statewide thematic trends also has directly affected patients' health and safety and has resulted in serious and recurring harm. The absence of generally accepted quality assurance mechanisms at the State and facility levels perpetuates the likelihood that serious and life-threatening harm will continue to befall the patients served within the Georgia Psychiatric Hospital system.

11. I found that the Georgia Psychiatric Hospitals systematically fail to develop or implement corrective and preventive actions that reduce risks of harm. I found that the Hospitals fail to identify actual or potential risks and, for risks that they identify, the Hospitals fail to implement corrective and preventive actions in a timely manner, if at all. For corrective and preventive actions that the Hospitals implement, they fail to monitor those actions as necessary to reduce or eliminate the risk of harm. An incident and risk management system should implement corrective and preventive actions to reduce or eliminate an identified risk of harm, and monitor and modify those actions as necessary.

12. I found that, at both the State and facility levels, the Georgia Psychiatric Hospitals' quality management system fails to adequately collect the data necessary to track and trend the quality of care provided in the Hospitals

and, for those trends in their existing data, the Hospitals often fail to adequately identify and respond to them. In addition, I found that, for the corrective actions that the Hospitals take, their quality management system lacks accountability and oversight. A quality management system should incorporate data capture, retrieval, and statistical analysis to identify and track trends and to monitor the effectiveness of corrective actions taken in response to identified problems.

13. The systemic failures in the Georgia Psychiatric Hospitals' protection from harm systems substantially depart from generally accepted professional standards and result in the Hospitals' failure to identify, respond to, or prevent harm. Consequently, individuals in the Georgia Psychiatric Hospitals suffer serious harm that is frequent, recurrent, and preventable.

14. For example, in April 2006, a patient at NWGRH committed suicide within 24 hours of her admission by climbing high into a tree and jumping to her death in front of staff and patients. The young woman had been an emergency involuntary admission with a diagnosis of paranoid schizophrenia and a history of auditory and visual hallucinations. At admission, she refused to answer whether she was suicidal. NWGRH placed her on routine observation. When her unit was taken outside, she climbed a

tree, tried to hang herself with her shoelaces, and then jumped out of the tree to her death.

15. In July 2006, a patient at GRHA attempted to commit suicide by obtaining a razor and making multiple cuts to her abdomen, which required sutures. Less than two weeks later, she attempted to commit suicide by breaking a ceiling light and swallowing the glass, which required treatment at the emergency room. The following month, she attempted to commit suicide again by breaking a light bulb and lacerating her arms, which required attention at the emergency room. During a subsequent admission in March 2007, she again attempted to commit suicide by breaking a ceiling light, lacerating her arms, and ingesting glass, which required emergency room treatment. A corrective action plan was developed after the patient's suicide attempt in July 2006, but it was not implemented before her subsequent discharge or after her readmission in March 2007, despite the similarities in her suicide attempts.

16. In October 2006, a patient at NWGRH with a history of suicide attempts and self-mutilation attempted to commit suicide by slitting his throat from ear to ear with a razor. A staff member had given the patient the razor for shaving and had let the patient go into the bathroom unattended. After the incident,

NWGRH never reassessed the patient's emotional stability or risk of harm, and never made or modified treatment or behavioral interventions.

17. Also in October 2006, a patient at NWGRH had his jawbone broken bilaterally by a fellow patient. Another patient needed sutures to close a large wound to his scalp after being assaulted by a fellow patient.

18. In January 2007, a patient at GRHA broke a light fixture and threw a couch across his unit's day room. The following afternoon, he punched another patient in the forehead. A few days later, he pushed his physician during an examination and broke furniture in the day room. Ten days later, he pushed a fellow patient to the ground who struck his head on a chair as he fell, lacerating an eyelid and eyebrow. The following day, he threw chairs across the cafeteria and then went outside and began shaking a staff member's vehicle. That evening, he hit another patient in the face. Within the next few weeks, he attacked a staff member, putting him in a choke hold and wrestling him to the ground. The patient's treatment team never developed a behavioral support plan to address his aggression or assaultive behavior to other patients and staff.

19. In February 2007, a patient at GRHA choked another patient. The aggressor patient was assigned to line-of-sight observation. The staff member

assigned to him failed to maintain this observation level and only discovered the choking after hearing loud noises coming from his bedroom. The victim required emergency room treatment.

20. Also in February 2007, a patient at NWGRH alleged that a staff member physically abused her. A nurse or other medical professional never examined the patient to determine whether she had injuries consistent with her allegation, and NWGRH did not begin investigating the allegation of abuse until nearly two weeks later. The investigation report concluded that the allegation could not be substantiated because of the staff member's denial and the supporting statement of another staff member. The report is dated February 21, 2007, but includes a staff interview that is stated as having occurred on March 1, 2007.

21. In March 2007, a patient at GRHA was found with vomit that contained blood on his sheets and floor less than 19 hours after he had been admitted. The patient was transferred to the hospital, where he died five weeks later. The medical examiner suggested that the patient likely incurred an injury at GRHA by ingesting a foreign substance, but the investigation failed to examine his supervision level or to interview any of the staff who cared for him during his brief stay at GRHA. The investigation report concluded:

"Staff followed hospital and DHR protocol in ensuring that [the patient] received appropriate care."

22. In April 2007, a patient at NWGRH with a history of silent aspiration, difficulty in swallowing, and placing her hands in her mouth as a soothing mechanism, suffered from aspiration pneumonia after ingesting hair barrettes (the ingestion of inedible objects is known as pica). At approximately 4:00 p.m. that day, a staff member saw a few broken hair barrettes on the patient's sheets but did not report them to anybody. Between 4:30 p.m. and 8:00 p.m., the patient exhibited increasing signs of choking, until she began to cough and gag repeatedly. Only then did the staff member report having seen the broken barrettes. The patient was sent to the hospital for observation and readmitted to the hospital twice over the following two days for aspiration pneumonia. X-rays revealed a metallic object in her gastric area, and the hospital removed at least two broken barrettes during surgery. NWGRH never reported her ingestion of hair barrettes as pica and did not complete a safety plan for the patient until June 2007.

23. In May 2007, a patient at GRHA attempted to commit suicide by cutting his neck and arms with a razor. He was rushed to the emergency room to stop

the arterial bleeding. When staff initially entered his blood-spattered room, he shouted that he had told the staff that he was suicidal.

24. In June 2007, a patient at NWGRH attempted to commit suicide by strangling herself and was rushed to the emergency room for treatment. NWGRH did not report the suicide attempt in accordance with Hospital and State policy, investigate the suicide attempt, or take any corrective actions in response to the suicide attempt.

25. In June 2007, a patient at GRHA sexually assaulted another patient. The aggressor patient was on "sexual protocol," which required that he be on line-of-sight observation and that he sleep in a single bedroom to prevent him from sexually assaulting other patients. The first night that he was assigned to a bedroom with four other patients, in violation of this protocol, he sexually assaulted one of them. He was discharged to a personal care home several weeks later, but none of his progress notes, discharge summary, or aftercare plan documented the sexual assault.

26. In July 2007, a patient at NWGRH fell when a staff member attempted to transfer him to a wheelchair. The staff member was not trained on proper transfer techniques and, when the United States visited three months later, still had not been trained.

27. In August 2007, a patient was admitted at GRHA after running into traffic with a broken glass bottle in her hand, threatening to kill herself. Approximately one week after her admission, she was discharged to a homeless shelter. Three days after her discharge, she was readmitted to GRHA with suicidal ideation. Seven hours after she arrived on a residential unit, she was found lying face down in a pool of blood outside her bedroom doorway, unresponsive, with a cord wrapped tightly around her neck, and bleeding from her mouth and nose. Although the patient's observation level required that she be observed by staff every 15 minutes, staff had not checked on her for more than 30 minutes. Progress notes and eyewitness statements describing this lapse in observation and an argument between the patient and staff shortly before the suicide attempt then were removed from the patient's medical record.

28. In August 2007, a patient at NWGRH assaulted other patients every day for a week, but NWGRH's aggregate incident report data did not include any of these incidents.

29. In August and September 2007, a patient admitted at GRHA was physically and sexually assaulted 20 days apart. Neither assault was investigated; both were perpetrated by the same aggressor.

30. In September 2007, a patient at NWGRH twice was attacked by another patient, each time suffering a laceration that required sutures. In the same month, on the same unit at NWGRH, a patient was assaulted by another patient, suffering a fractured nose.

31. Also in September 2007, a patient at NWGRH suffered a fractured clavicle. Staff noticed a large bruise on the patient's shoulder but did not report the bruise until a day later. The investigator never questioned the patient about the injury or how it occurred, and the investigation report never determined the cause of the fractured clavicle.

32. On September 8, 2007, a melee occurred on the adolescent unit at GRHA. Six adolescents began throwing tables and chairs at the window protecting the nurses' station. Three of the adolescents forced open the door to the lobby of the unit by kicking and slamming it with their bodies. The patients broke tables and cabinets in the lobby area and attempted to force open the outside door. One patient held a piece of plexiglass to his neck, threatening to cut himself, and then cut his neck before staff was able to take the piece of plexiglass from him. Other patients not involved in the destructive behavior refused to stay in their rooms and began running around the unit. Staff and

facility police were unable to restore order and had to call DeKalb County police officers to diffuse the situation.

33. In August 2008, a patient at WCGRH assaulted and killed another patient. Earlier that morning, the victim had assaulted the aggressor, and both patients had a history of aggression. When the aggressor later verbally accosted the victim, and the victim retaliated by assaulting the aggressor, nearby staff, one of whom was an instructor in techniques for de-escalation of aggression, did not physically intervene. The aggressor then assaulted the victim, who fell and struck his head, knocking him unconscious and causing blood to trickle out of his ear. Staff never called an emergency code blue, and an ambulance did not arrive for 50 minutes. The victim died a few days later from blunt force trauma to the head. The aggressor was transferred to CSH, and his discharge summary from WCGRH to CSH contained no information about this incident or the extent of his aggressive behaviors. This individual currently remains at CSH without adequate behavioral interventions to prevent him from seriously injuring others.

34. In October 2008, a patient at WCGRH died of a ruptured spleen due to blunt force trauma. Earlier that morning he had complained of not feeling well. Hours later, when he was found naked on the floor in his own urine, he was

treated with antipsychotic medication despite displaying no documented psychotic symptoms. The mortality review focused primarily on the timeliness of the code blue call and failed to recognize the need for an investigation into how the patient suffered trauma so significant that it ruptured his spleen.

35. In April 2009, a patient at ECRH was discovered with a fractured arm of unknown origin. When the United States visited ECRH five weeks later, the investigation into the cause of the injury had yet to be initiated, and no time line for even starting the investigation had been established.

36. In April 2009, a patient at CSH assaulted and killed another patient. The aggressor was supposed to be on close observation because he had allegedly murdered two other individuals in the past, including his jail cell mate immediately before his transfer to CSH in January 2009. Systemic deficiencies contributing to this incident include the failure of staff to supervise patients, and of hospital supervisors to supervise staff.

37. In July 2009, a 64-year-old gentleman at SWSH known to be easily frightened and intimidated by others, was threatened and raped by a 22-year-old gentleman while in the restroom. The perpetrator has a history of sexually assaultive behavior and, in 2008, was found incompetent to stand

trial for charges he molested a seven-year-old boy. The victim and perpetrator had previously been roommates but were separated after the perpetrator was found lying in the victim's bed in 2008. In that instance, the victim originally reported that consensual sex had occurred, yet the incident never was investigated. After the rape in July 2009, the victim reported that, in fact, the perpetrator had threatened to harm him in December 2008 if he did not report the sex as consensual.

38. In August 2009, at ECRH, an individual with intellectual disabilities reported being raped by a peer on his living unit. On August 7, the investigation concluded that the allegation was unsubstantiated because of a lack of physical evidence. On August 11, however, the emergency services rape examination revealed semen in the victim's peri-anal region. There is no evidence that ECRH re-opened its investigation to determine when and by whom the victim was sexually assaulted. In addition, all three patients interviewed as part of the investigation reported that they had experienced sexual relations on other units at ECRH, yet there is no evidence that these statements were investigated further.

39. In August 2009, a patient at GRHS committed suicide, two months after GRHS was warned on-site of risks in its suicide assessments and risk

management system. The patient committed suicide by tipping his bed up on end to create a tie-off point on which to hang himself, despite my having repeatedly warned the Georgia Psychiatric Hospitals of the dangers posed by these beds during my on-site visits.

40. In September 2009, a patient at ECRH attempted to commit suicide by hanging himself with a sheet tied around his neck. The patient lost consciousness and vital signs before being revived by CPR. The patient had attempted suicide in similar fashion in January 2009 while at CSH, yet the investigation report for the September 2009 suicide attempt never investigated or addressed how the attempt could have been avoided. It focused primarily on staff's response to the emergency code blue call and recommended only that "ECRH should review with staff the need for accuracy in reporting, particularly of times of events."

41. In October 2009, a patient at CSH was physically assaulted by a staff member when the staff member pulled the patient out of his chair, walked him down the hallway, pulled him into his room, shut the door, and beat him.

42. In November 2009, after repeated warnings about the suicide risk of beds that can be tipped up on end, and two months after the patient committed

suicide at GRHS by tipping his bed up on end, I found a virtually identical strangulation risk in a seclusion room at CSH—a room to which patients in crisis often are sent for their own protection. In addition to the opportunities for self-hanging on this bed, underneath the bed was a thick sheet of plastic loosely attached to the bed frame with half-inch rusty industrial staples. Such staples are easily removed and used for self-mutilation and/or suicide, as evidenced by a CSH patient who repeatedly had inserted staples far into her abdomen, including one that required surgical removal.

43. On January 6, 2010, at SWSH, a 23-year-old woman committed suicide within 24 hours of being transferred to an alternative unit on campus grounds. Originally admitted in December 2009 for attempting to hang herself, her third attempt in recent years, the patient successfully acquired a shoe string while at SWSH and used it to strangle herself. One day prior to her successfully taking her life, the woman expressed suicidal thoughts, paranoia, and significant anxiety regarding her transfer. SWSH did not complete a suicide risk assessment before the transfer, in violation of State policy, and her discharge summary for the transfer stated that her suicidal thoughts had completely disappeared.

* * *

The foregoing is based on my professional expertise and personal knowledge of conditions and policies governing protection from harm in the State Psychiatric Hospitals, gained through my examination of documents including clinical records, my observations, and interviews with hospital staff, patients, and administrators, as well as State administrators and employees.

I certify under penalty of perjury that the foregoing is true and correct. Executed this 28 day of January, 2010.

CARLA JO OSGOOD

Attachment A

CARLA JO OSGOOD

BACKGROUND

Nineteen years developing, implementing and administering social service programs in community-based and federally regulated settings. Extensive experience working with culturally and socio-economically diverse individuals in the human services and disability communities. Four years executive-level management in the financial services industry. Area of concentration include:

CIVIL RIGHTS & INCLUSION ADVOCACY
- Protection from Harm Investigatory Review
- Community Integration & Independent Living
- CRIPA, ADA, Section 504 & Fair Housing Act

QUALITY MANAGEMENT & PROGRAM DEVELOPMENT
- Quality Improvement and Compliance
- Integrated Services Review
- Incident/Risk Management

KEY ACCOMPLISHMENTS

- Designed a comprehensive Quality Management program for multi-institutional use by the Iowa Department of Human Services;
- Leader in developing a comprehensive Quality Management system for state-operated institutions in the State of Indiana;
- Designed and implemented a HUD-funded community-based transitional services program in the Greater Cincinnati area for homeless and/or institutionalized individuals with mental, physical, cognitive and/or sensory disabilities; program exceeded service projections by over 400% and was subsequently replicated in the State of Kentucky.

PROFESSIONAL EXPERIENCE

CEO/INDEPENDENT CONSULTANT **2005 - PRESENT**

Osgood Consulting, LLC, Greensburg, IN

Consultancy services for public and private human service agencies seeking to improve consumer services, organizational outcomes, and operational efficiency. Areas of focus include:

Quality Management
- Organizational strengths and needs assessment;
- Program design and development; and
- Quality improvement, risk management and compliance monitoring.

Civil Rights Review
- Investigations into abuse, neglect and other related civil rights violations;
- Strength-based program development and review;
- Consumer-driven lifestyle planning and case management; and
- Inclusion barriers affecting community participation and living, accessibility and coordinated supports.

Projects have included:

Iowa Department of Human Services

Contracted to assist the State reach and maintain compliance with its 2004 USDOJ consent decree by:
- Designing and instituting a comprehensive quality management system to improve the quality of services at state-operated ICF/MRs and waiver homes;
- Drafting state-level policies for use in all state-operated institutions; and
- Developing standardized processes for monitoring program implementation, remedial action plans and client outcomes.

United States Department of Justice – Civil Rights Division

Consultancy and expert witness services to assist the Department investigate, pursuant to its authority under the *Civil Rights of Institutionalized Persons Act*, civil rights violations in various institutional settings throughout the United States.

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CARLA JO OSGOOD

ASSISTANT SUPERINTENDENT/DIRECTOR OF QUALITY MANAGEMENT **2002 – 2005**
Liberty Healthcare Corporation, Bala Cynwyd, PA

Position held at Muscatatuck State Development Center (MSDC), Butlerville, IN. Management team member contracted by the State of Indiana to 1) regain Medicaid certification of the 300-bed state-operated ICF/MR, and 2) resolve the US Department of Justice investigative findings pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). Responsibilities included: ensuring facility compliance with all state/federal laws and regulations including Title XIX and the State of Indiana's Settlement Agreement with the DOJ under CRIPA. Establish and implement facility and statewide policies involving client protection, quality assurance, and compliance. Develop and monitor continuous quality improvement initiatives; assist clinical departments in identifying quality indicators and developing clinical QA/QI monitoring systems to ensure improvement initiatives were implemented in accordance with professional standards of practice. Develop and monitor corrective action plans in response to deficiencies noted by internal monitors and regulatory bodies. Prepare and submit facility reports to state and federal agencies, General Counsel, etc. Oversee risk management processes to ensure client protection; conduct and oversee all investigations into client mistreatment and/or other civil rights violations. Work collaboratively with DOJ representatives and expert witnesses to improve service delivery and ensure compliance with the state remedial plan. Direct supervision of the following departments: Risk Management and Program Evaluation; Civil Rights/Advocacy; Medical Records/Information Management. Serve as the HIPAA Privacy Officer and chairperson for Cabinet-level committees, e. g. Risk Management, Mortality Review, etc.

Accomplishments in position: Facility regained certification as an ICF/MR Medicaid provider pursuant to Title XIX of the Social Security Act (2002); MSDC Quality Management functions brought into full compliance with the State of Indiana/DOJ Settlement Agreement (2004).

DIRECTOR OF PROGRAM EVALUATION **1999 – 2002**
Liberty Healthcare Corporation, Bala Cynwyd, PA

Position held at MSDC, Butlerville, IN. Responsibilities included: quality improvement program development and implementation; design and coordination of facility's QA monitoring programs to ensure compliance with all federal and state laws and regulations; risk management and ICF/MR compliance review; systems assessment and operational change; data analysis and presentation; policy development and monitoring; departmental administration and management; intra-departmental relations and collaboration. Facilitated all sentinel event reviews and monitored the implementation of corrective action plans to ensure compliance and program efficacy. Chairperson of committee charged with investigative review and establishing remedial action plans.

Accomplishments in position: Developed risk management reporting system for Indiana's division of MR/DD services. Developed comprehensive data analysis/reporting system to monitor the efficacy of systems addressing facility risk management and clients' bio-psycho-social risk issues.

PROGRAM COORDINATOR **1997 – 1999**
Center for Independent Living Options, Cincinnati, OH

Developed innovative grassroots housing/supportive services program serving homeless individuals with disabilities in the Greater Cincinnati area. Responsibilities included: program design, development, marketing and administration; developing and maintaining collaborative coalitions with community service agencies, homeless shelters and transitional housing providers; site surveying with shelters and other public/private housing providers to address accessibility barriers while

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providing modification solutions consistent with ADA Accessibility Guidelines (ADAAG). Serve as a liaison with community agencies to assist individuals in securing subsidized housing, Section 8, vocational rehabilitation services, Social Security, etc.; monitor individual's progress towards independence and stability, providing on-going advocacy and case management services as needed. Provided consultations to public/private agencies regarding the ADA, Section 504, and the Fair Housing Act; solicit and promote disability-related services and accommodations with community members, boards, and businesses. Completed proposal writing, grant administration and federal reporting as required by HUD.

Accomplishments in position: Successfully developed and integrated the program throughout the Greater Cincinnati area, obtaining additional grant funding for the program's expansion into the Northern Kentucky region. The program exceeded its service projection by over 400% while remaining below each fiscal budget.

CASE MANAGER **1994 – 1997**

St. Joseph Villa, Cincinnati, OH

Comprehensive case management and family preservation services for at-risk juveniles and their biological and/or foster families. Duties included: developing, implementing and monitoring treatment plans based on clients' assessed needs; coordinating interdisciplinary team development to ensure continuity of care; developing goals and objectives to promote family preservation as appropriate; evaluating individual/family progress and making treatment and/or placement recommendations to juvenile and family courts, child protective agencies, probation officers, etc, as needed. Provided direct crisis intervention and stabilization in home and community settings. Worked collaboratively with school personnel to develop and monitor meaningful Individualized Education Programs (IEPs), advocating for IEP changes as needed based on youth's progress and status. Provided parental skills training and supervised assigned foster parents to ensure safe parenting and appropriate placement. Completed all required referrals, reports, and case summaries as required by agencies, courts, etc.

ASSISTANT DIRECTOR OF RECREATION **1991 – 1993**

Marion County Guardian Home, Indianapolis, IN

Therapeutic recreational programming for 100-bed residential facility serving abused and neglected children. Responsibilities included: developing, implementing and supervising recreational and academic programming to support and enhance children's lives; designing individualized programming and learning activities to meet the bio-psycho-social needs of youth. Developed therapeutic arts program, coordinated and enhanced summer camp program; and worked collaboratively with community agencies and vendors to secure diverse community activities to enrich ethnic, cultural, and spiritual development.

FINANCE AND LENDING ADMINISTRATOR **1986 – 1990**

Household International, Prospect Heights, IL

MORTGAGE ORIGINATION SPECIALIST

Promoted to the position in 1989. Responsible for Household's mortgage origination and consumer lending for the state of Indiana and Northern Kentucky. Duties included: developing referral base with realtors, builders, appraisers, etc., to secure regional real estate lending opportunities; origination training and evaluation of staff throughout all Indiana branch office locations. Executed loan application process in full, including all preliminary underwriting to ensure loan closure. Developed additional consumer lending opportunities and portfolio growth for Household Finance and Household Bank offices in the tri-state area.

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CARLA JO OSGOOD

BRANCH MANAGER
Promoted from Assistant Manager position in 1988. Operations management for multi-million dollar Household Finance branch office in Indianapolis, IN. Duties included: administration and management of all branch operations including staff training and supervision; operational expenses and budget planning; business development and marketing; real estate, consumer, and retail underwriting and loan closure. Responsible for all branch office lending and insurance sales productivity; portfolio growth; profitability margins, and compliance with all state and federal regulations. Recognized as regional leader in mortgage origination and loan closings, branch profitability and portfolio expansion.

EDUCATION

Graduate Studies, Health Ministries/Pastoral Family Studies **1994 - 1999**
College of Mt. Saint Joseph, Cincinnati, OH
Cincinnati Bible Seminary, Cincinnati, OH

B.A., Liberal Arts/Political Science **1982 - 1986**
Purdue University, West Lafayette, IN

AFFILIATIONS, RECOGNITIONS, ETC.

- National Association of the Dually Diagnosed (NADD)
- American Association on Mental Retardation (AAMR)
- Delta Society
- Regional leader in Mortgage Origination for Household International 1988 (OH, IN, KY, MI, IL)
- NCAA swimming scholarship – Purdue University

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