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

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

NOTICE OF JOINT FILING OF THE REPORT OF THE INDEPENDENT REVIEWER

On October 29, 2010, the Court adopted the parties' proposed Settlement Agreement and retained jurisdiction to enforce it. 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 January 31, 2020.

Respectfully submitted, this 3rd day of February, 2020.

FOR THE UNITED STATES:

BYUNG J. PAK
United States Attorney
Northern District of Georgia

/s/ Aileen Bell Hughes
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

ERIC S. DREIBAND
Assistant Attorney General
Civil Rights Division

STEVEN H. ROSENBAUM
Chief
Special Litigation Section

MARY R. BOHAN
Deputy Chief
Special Litigation Section

/s/ Richard J. Farano
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, N.E. – 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/ (Express Permission)
JAIME THERIOT
Special Assistant Attorney General
Georgia Bar No. 497652

Troutman Sanders LLP
5200 Bank of America Plaza
600 Peachtree Street, NE
Atlanta, GA 30308
Telephone: (404) 885-3534
Fax: (404) 962-6748
Email:
jaime.theriot@troutmansanders.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 February 3, 2020, a copy of the foregoing document, Joint Notice, 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/ Aileen Bell Hughes
AILEEN BELL HUGHES
Assistant United States Attorney

REPORT OF THE INDEPENDENT REVIEWER

In The Matter Of

United States v. Georgia

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

January 31, 2020

Introductory Comments

This brief report is intended to update the Court on the status of the Settlement Agreement and its Extension and to describe certain initiatives currently underway by the Department of Behavioral Health and Developmental Disabilities (DBHDD) and by the Independent Reviewer.

It will be noted that this report does not include the Independent Reviewer's recommendations for findings of compliance or non-compliance with the discrete provisions of the Settlement Agreement and its Extension. Those recommendations will be included in the next report to the Court. The Parties and the Independent Reviewer have agreed that the next report will be submitted to the Court in September 2020, after the completion of the current Fiscal Year (FY20).

The Settlement Agreement and its Extension remain in effect. There have not been any changes to either Agreement. The Parties and the Independent Reviewer continue to confer. DBHDD continues to strive to meet its obligations.

At the directive of the Governor's Office of Planning and Budget, DBHDD has proposed budget reductions for the current Fiscal Year (FY20) and for the next Fiscal Year (FY21). The Governor's Budget Report, released in early January, includes reductions in the DBHDD budget totaling approximately $34.3 million in FY20 and $46 million in FY21. In addition to these specific reductions, DBHDD will also internally redirect $13 million in both FY20 and FY21 to maintain current capacity for purchased private psychiatric beds. Other specific adjustments/enhancements of $21.5 million were also included in the Governor's FY21 budget, bringing the net reduction down to approximately $24.3 million. The specific reductions were accomplished through administrative/operating efficiencies, reductions to new funds for services that were not yet implemented, and adjustments to under-utilized services/contracts. DBHDD has reported that, despite the reductions and redirections, there will be no changes to DBHDD's current capacity to serve and no impact on individuals currently receiving services. In addition, DBHDD has stated that the budget cuts will not affect Settlement Agreement obligations. As part of the internal redirection, available funding was shifted from the Georgia Housing Voucher Program (GHVP). However, the Department of Justice and the Independent Reviewer have been advised by DBHDD leadership that funding is available to address the current identified need for the GHVP and enough funding remains to allow reasonable growth in the program for several years. Currently, $19.1 million remains as the annual budget for the GHVP along with approximately $4 million for its administrative support.

The Independent Reviewer's work is highly dependent on the Parties' cooperation. The candid discussions with DBHDD leadership, staff, and the attorneys for the State and the Department of Justice have been important to the fact-finding required for the Independent Reviewer's monitoring responsibilities. The responsiveness of the Director of Settlement Coordination and her Administrative Assistant has been especially appreciated. The unflagging interest and purposeful advocacy of the many stakeholders dedicated to systemic reform in Georgia continue to be valuable safeguards that better

ensure compliance with the obligations set out in the Settlement Agreement and its Extension.

As customary, a draft of this report was submitted to the Parties for comment. All comments were considered carefully and changes were made as appropriate.

Methodology

Information for this report was obtained from DBHDD. DBHDD leadership and staff shared their efforts to address both the requirements of the Settlement Agreement and its Extension, as well as other desired programmatic initiatives, in meetings and telephone conversations with the Independent Reviewer and her subject matter consultants. On December 10, 2019, a meeting was held at DBHDD with the State officials and counsel, lawyers for the U.S. Department of Justice and the Independent Reviewer.

In October and December 2019, the Independent Reviewer met with DBHDD staff and with stakeholders to review specific programmatic initiatives related to individuals with a developmental disability (DD) and the investigation of deaths. In addition, in October and December 2019, the Independent Reviewer and her subject matter consultant, Martha Knisley, attended meetings with leadership staff from DBHDD and the Department of Community Affairs (DCA) and with stakeholders especially interested in the Settlement Agreement's obligations regarding Supported Housing.

There was limited fieldwork completed for this particular report. Site visits were conducted in December 2019 to 11 community-based residences of individuals with DD. The Independent Reviewer and her nurse consultant, Julene Hollenbach, reviewed the status of Corrective Action Plans (CAPs) issued following the death of an individual in each of these residences. In each of these deaths, neglect was substantiated by DBHDD's own investigation. Support Coordinators for the 32 individuals currently living in these group homes were present and contributed to the findings. Reports from each visit have been forwarded to the Parties; preliminary observations/conclusions were discussed at the Parties' meeting and in subsequent telephone conversations with DBHDD leadership staff responsible for the Office of Health and Wellness and the Division of Accountability and Compliance.

Not all requested data were available, notably data related to Supported Housing. Efforts will be made to include supplemental data in the next report. Reliable data are essential for the forthcoming review of compliance/non-compliance with the provisions of the Settlement Agreement and its Extension.

Discussion of Settlement and Extension Agreement Obligations

The obligations examined in this report were the focus of discussions with the State. DBHDD provided information regarding the status of these obligations as well as the

broader context that surrounds them. It is anticipated that these obligations will continue to be prioritized during the remainder of the Fiscal Year and that recommendations regarding compliance/non-compliance can then be made in the report filed with the Court in September 2020.

Supported Housing

At this time, the Behavioral Health Division of DBHDD is engaged in a major initiative focused on an evaluation of its community-based residential service system for adults. The primary intent of this initiative, referred to as "Supportive Housing 2.0," is to improve both individual and systemic outcomes by: 1) aligning housing and supports with the practice model designed by the federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) and with other evidence-based practices, such as Housing First; 2) increasing accountability, data accuracy, transparency, evaluation and monitoring; 3) improving stakeholder engagement and collaboration; and 4) improving operational efficiency.

Five sub-committees have been organized and staffed within DBHDD to conduct the work required for this initiative. These sub-committees will be responsible for housing support/case management strategic planning; fidelity monitoring and tool implementation; program evaluation; Supported Housing staff inventory and analysis; and data and IT analysis (systems enhancement). Although the work of the sub-committees will be ongoing, there are discrete projects/consultations that have specific timelines:

- Consultation by Chris Gault, formerly the Assistant Commissioner for Behavioral Health and then the Director of the Division of Performance Management and Quality Improvement at DBHDD, will involve planning and implementing strategies for DBHDD's residential services. This work is underway and should be completed by July 1, 2020.
- A pilot program with Pathways/Step Up will be implemented in the six counties of Region 3 and will be led by Dr. Sam Tsemberis, who designed and successfully replicated the widely acclaimed Housing First model. The contract with Dr. Tsemberis has been signed and approved; preliminary planning/engagement has begun. In the first year, Dr. Tsemberis and his team will provide housing outreach, stabilization and support services to 180 individuals with severe and persistent mental illness (SPMI) in order to promote community integration and person-centered recovery. In collaboration with each new tenant, a Housing Service Plan will be developed. This Plan will outline goals that address both transition needs and long-term housing stability needs; supports will be provided to ensure that these identified needs are met.
- Implementation of the DBHDD Supported Housing Fidelity Monitoring Tool, which follows the overarching principles of the SAMHSA model, is expected to start on July 1, 2020.

DBHDD has stated that it "intends to continue to adhere to the provisions of the DOJ Settlement Agreement and does not consider Supportive Housing 2.0 to be in conflict with this critical work."[1] Nonetheless, DBHDD acknowledges that these substantial investments of time and resources in planning and development may delay growth in the utilization of the GHVP and may affect timely adherence to relevant provisions in the Settlement Agreement and its Extension. Problems with eligibility definitions and practices, the needs assessment, and speedy linkage to housing remain significant implementation concerns that have not yet been resolved.

As documented below, the use of the GHVP has been decreasing steadily since January 2018, despite clear evidence of need among members of the Target Population.

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

*Beginning with October 2019, the numbers have been cross-checked with DBHDD.

DBHDD's contract with Pathways/Step Up to implement the Housing First model in Region 3 is positive and greatly needed to reverse this troubling downward trend and, therefore, may help get the State back on the path towards compliance. The implementation of new strategies through this pilot program can help to address recurrent problems with existing processes for accessing the GHVP; this is critical to the State's compliance with the Agreements' obligations related to Supported Housing. The strengths of the Housing First model include successfully working with individuals with SPMI with difficult and challenging situations, including: those being discharged from jails, prisons, and psychiatric hospitals; individuals frequently using emergency rooms

[1] Supportive Housing 2.0 Power point presentation, December 2019, page 2.

and/or individuals who are chronically homeless. These individuals comprise the Target Populations of the Settlement Agreement and its Extension. The ability of Pathways/Step Up to initiate programs in new environments is well documented; their skills and knowledge are exceptional. If given this opportunity under the right circumstances, their entry into Georgia could be highly beneficial for achieving the outcomes required under the Agreements.

Finally, it must be noted that DCA plays a major role in the assignment of federally funded rental assistance for the individuals in the Target Population. DBHDD is cognizant of the problems being experienced with the Unified Referral process. Stakeholders confirm that it is a cumbersome and time-consuming requirement for access to Supported Housing. DBHDD and DCA need to work together to help address outstanding issues and constraints. Additionally, it has been very difficult to obtain reliable data about the use of federal rental assistance for adults with SPMI. These data are important to an accurate determination of the number of people with SPMI who are receiving Supported Housing resources. DBHDD and DCA are strongly urged to take efforts to tighten its data in this area.

Mortality Reviews of Individuals with DD

The Extension Agreement obligates the State to implement an effective process for reporting, investigating, and addressing deaths and critical incidents involving alleged criminal acts, abuse or neglect, negligent or deficient conduct by a community provider, or serious injuries to an individual. It is required that the State conduct a mortality review of deaths of individuals with DD, who are receiving HCBS waiver services from community providers, according to certain specific actions, including the completion of an investigation of the death within 30 days after the death is reported; the review of certain deaths by the Community Mortality Review Committee (CMRC); and the issuance and timely completion of Corrective Action Plans (CAPs) in response to any deficiency findings.[2] The State's adherence to these obligations has been a major focus of the Independent Reviewer's work and her discussions, over the years, with DBHDD leadership, especially the Director of the Division of Accountability and Compliance.

Since the last report to the Court, DBHDD, through its Division of Accountability and Compliance, has taken major steps to strengthen the effectiveness of its incident management and investigations system.

These actions include:

- Assignment of additional staff to expedite the timeliness of the investigation process. These staff include a workflow expediter, two experienced supervisors to conduct the initial quality review of the investigations, and two certified investigators.

[2] See Provisions 20, 21 and 22 of the Extension Agreement.

- Refining data collection and analysis, including reporting on poorly performing provider agencies and referral to the Provider Performance Management Committee, an oversight committee.
- Realigning and tightening up the steps/timelines related to the preparation and tracking of CAPs.
- Installation of software to improve information sharing among DBHDD personnel responsible for the oversight of provider agencies.
- Retraining investigators on the significance of evaluating Support Coordination performance as an integral part of the mortality review process.
- Inclusion of a module on the development of a CAP to the DBHDD Learning Library so that provider agencies will be better informed of their expected performance.

DBHDD has been tracking data on the timeliness of the discrete actions involved in the mortality review process. These data show a significant improvement in the timely completion of the investigation report and the average number of days to complete the supervisory review. Since December 2018, it has taken less than 30 days to complete the investigations that do not require an extension. (Extensions are granted for valid reasons, such as delays in the receipt of documentation from the provider or because additional interviewing is required to confirm factual information.) The number of days for supervisory review of the investigation has decreased from approximately 27 days on average in June 2019 to less than 5 days on average in November 2019.

Data provided to the Independent Reviewer confirm that the number of days required to accept CAPs from the responsible provider agency has declined, on average, from a high of approximately 300 days in December 2018 to approximately 100 days, on average, in August 2019. As acknowledged by DBHDD, although this is progress, the average rate of acceptance is still considerably higher than it should be. There continues to be ongoing work by DBHDD to address this issue.

The actions described above have substantially addressed prior concerns reported to the Court. The Independent Reviewer's fieldwork over the next six months will further examine the timeliness and thoroughness of the mortality review process. In addition, the Independent Reviewer will continue to track the sanctions taken against provider agencies with documented poor performance, including the substantiation of neglect. In 2019, the State did not renew its Letter of Agreement with two provider agencies. As a result of the failure to renew, these provider agencies could no longer conduct business in Georgia. The State also suspended two agencies with a total of five residential sites. Suspension blocks any new admissions to that agency.

One of the two suspended agencies was included in the most recent site visits conducted by the Independent Reviewer and her nurse consultant. At this site, where three women resided, the Support Coordinators had increased their presence and examination of the care provided to their assigned clients. A Support Coordinator clinical supervisor was also present during the site visit; her presence was part of the ongoing intensified scrutiny. Reportedly, on January 27, 2020, this residence and two others operated by this

provider agency had their provider numbers, authorizing payment for services, terminated. The individuals living in these three residences were to be relocated; further inquiry by the Independent Reviewer is underway.

As referenced earlier, the individual reports from the Independent Reviewer's site visits have been provided to the Parties. Overall findings are set out immediately below:

- The DBHDD death investigations were generally thorough and addressed salient issues, including areas of deficiency. The deficient practices were identified and cited. The Columbus Organization also reviewed the death of one individual, who had transitioned from a state hospital. Its investigation report confirmed DBHDD's findings.
- Support Coordinators who had been assigned to the deceased individual were informed of the circumstances surrounding the death. Timely notice was given to them by the provider agency.
- In the majority of the CAPs reviewed, the identified deficient practices were included and the remedial actions required for correction were cited. It is noted, however, that the CAPS are applicable only to the specific site where the individual died. There is no evidence that the remedial actions are recommended across the entire DD system as preventive measures. For example, although a CAP may address measures to prevent the risk of aspiration pneumonia for other individuals in the house where the deceased person lived, there are no cautionary alerts disseminated across all the homes in the state where other individuals are also at risk for aspiration pneumonia.
- According to DBHDD, eight of the CAPs (73%) had been implemented and the case was closed. Two agencies were referred for adverse action and extended work was required for a third agency. However, the site visits revealed an additional fourth agency with Healthcare Plans that lacked individualization, as was needed. Furthermore, although the CAP was already determined to be implemented in two agencies, the Independent Reviewer found evidence that implementation was not yet complete and continued oversight was needed to review ongoing medication errors in one agency, and to review the failure of staff to implement a Behavior Support Plan in the other agency. (The Support Coordinator had also identified the medication errors and had taken action to resolve this problem.) These adverse findings presented risks to the current residents. The Independent Reviewer's findings were transmitted to DBHDD.
- Strong supervisory action was noted in two agencies in their efforts to train residential staff to intervene as needed in an emergency requiring the use of CPR and the notification of emergency services. These two supervisors demonstrated commendable skill in seeking to reduce future risks.
- Support Coordinators not assigned to the deceased individual but still working with other residents in that house had not been informed of the deficient practices identified in the investigation. All Support Coordinators we spoke with expressed a strong interest in seeing the death investigation and stressed the importance of receiving that information in a timely manner. They indicated that such

information would have a positive impact on their interactions with their clients and the agency staff in the residence and elsewhere in the system.
- As cited above, the length of time between the completion of the investigation and the finalization of the CAP exceeded generally accepted standards of practice. DBHDD has begun to address this concern in its revision of the timelines for the completion of CAPs, effective as of September 2019.

DBHDD's efforts to strengthen the mortality review process are recognized and commended but more work is needed to come into compliance. The Independent Reviewer's fieldwork over the next six months will continue to examine the implementation of CAPs and their effectiveness in the reduction and elimination of risk to the individuals remaining in the residential setting and for similarly situated people across the system.

At Risk Individuals with DD

The majority of the provisions of the Extension Agreement seek to address the risks potentially experienced by individuals with DD due to their medical, adaptive or behavioral needs. These individuals require more intensive and proactive services and supports in order to prevent harm or other adverse circumstances. Such services and supports include clinical oversight, Intensive Support Coordination, specialized training for staff and the availability of individualized professional resources.

DBHDD's Office of Health and Wellness carries major responsibility for these critical intervention strategies within the Division of Developmental Disabilities.

Recently updated actions to address inherent risks have been initiated:

- A contract has been executed for Fiscal Year 2020 with Health Risk Screening, Inc. to provide a six module webinar series "Curriculum in IDD Healthcare" to clinicians in Georgia. At the completion of the series, participants who complete the program successfully, including post-tests, will be certified and will receive five hours of Continuing Medical Education credits. At DBHDD's request, Dr. Craig Escude, a physician experienced in the medical care of individuals with DD, will provide additional information to and discussion with program participants, including those physicians and nurses who work in local hospital Emergency Rooms statewide.
- Additional teaching modules related to treating individuals with DD have been added to the nursing school curriculum offered through Emory University.
- Support Coordinators interviewed for this report confirm that they receive notice of any critical incident reports issued for individuals under their responsibility. They report that they follow-up in response to these reports until the issue is resolved.
- Three additional Nurse Managers have been added to the Office of Health and Wellness, bringing the total number of such positions to six. Nurse Managers are responsible for the supervision of registered nurses in the regional Field Offices.

- Health Care Plan templates and clinical condition fact sheets have been included in the Provider Toolkit located on the DBHDD website. The Independent Reviewer's site visits confirmed that the 32 individuals reviewed had Health Care Plans in place, although the individualization and thoroughness of these plans were not uniform.
- Analysis of risk data is underway by the Office of Performance Analysis within DBHDD. Data are provided to program managers at biweekly meetings. Using an evaluation methodology "Results Oriented Program Evaluation (ROPE)," 12 domains have been identified for individuals with complex needs. The rationale, data indicators, and Quality Improvement Initiatives have been identified for each domain. Quality Improvement examples include identification of patterns of risk in the initial Health Risk Screening Tool (HRST) nursing assessments. The assessment process has started and analysis will follow.

The initiatives documented above are positive steps in the prevention and amelioration of risk to vulnerable individuals with DD. In its discussion of its efforts to monitor system response timelines, DBHDD has articulated three key goals:

- Valid, objective knowledge from a representative sample of events to generalize findings to the entire system;
- Avoid relying only on small samples of systems failures to determine fidelity;
- Continuous monitoring of how the system is responding to allow faster identification of process improvements that may be needed.

In light of these reasonable goals, it would be very helpful to the evaluation of compliance with the Extension Agreement's provisions related to risk, if DBHDD could provide graphed data that document the reduction in specific areas of risk, much as the Office of Transitions measures the use of crisis homes and the Office of Accountability and Compliance has graphed data on the timeliness of the completion of investigations and the average number of days for the acceptance of CAPs. It is critical that the outcomes from these initiatives demonstrate downward trending in the prevalence of risk, especially when it is known that certain risks can, in fact, be prevented if proactive strategies are firmly in place.

Individuals with challenging behavior have been highlighted in numerous reports to the Court. DBHDD has initiated actions to address several concerns regarding this group of people:

- Mobile Crisis Teams now refer an individual in crisis to the Autism and Crisis Manager, a new position in the Office of Transitions. This manager assesses each individual situation and, when appropriate, directs the Crisis Team to alternative resources, thereby diverting unnecessary admission to a crisis home. As a result, in December 2019, DBHDD reported that the statewide census in all crisis homes was at its lowest, 22 individuals, since 2018. In its revised service standards, DBHDD also has enforced the expectation that crisis homes will be used only for behavior stabilization, not as respite care or as a means to address housing

instability. Certainly, this expectation underscores the need for recruiting and retaining providers with the expertise and experience to work with those individuals with challenging behavior.

- The Autism and Crisis Manager is responsible for monitoring lengths of stay in order to more quickly identify barriers to discharge. Monitoring is coordinated with the Office of Health and Wellness, the Field Offices and with other stakeholders, chiefly Support Coordination, in order to address constraints preventing a timely discharge. Of the 22 individuals served in crisis homes in December 2019, 12 were reported to have committed providers who will support them after discharge. The majority of individuals are discharged to group homes, followed by family homes and host homes.
- Progress has occurred in the development of community placements for three individuals with lengths of stay exceeding two years. One individual will move to an established group home; one will live in a new two person residence; and the third person, a registered sex offender, will move to a new group home with the approval of the Sheriff's Office and the Probation Office.
- Georgia State University has developed a certification process for practitioners who complete training in best practices in providing behavior supports in the community.

The role of the Autism and Crisis Manager is a new development and will continue to be of great interest. The Independent Reviewer's next report will include more information on the status of the three individuals referenced above; they are good examples of the system's capacity to support adults with complex needs and complicated histories. In addition, it would be very helpful to have additional data from the Office of Transitions regarding the specific settings used for diversion from the crisis homes.

In spite of these actions, our onsite findings document ongoing concerns, especially for those with complex conditions. More work is needed.

Concluding Comments

It is generally recognized that an additional investment of time and effort is required to complete the systemic reforms desired by the leadership of DBHDD, including those obligated under the terms of the Settlement Agreement and its Extension.

The initiatives described in this brief report are intended to highlight the positive actions underway by DBHDD as this current Fiscal Year moves forward. At the same time, it has been necessary to include certain areas of continuing concern in order to underscore their significance to recommendations of compliance/non-compliance.

The Independent Reviewer and her subject matter consultants in Supported Housing and nursing will continue to document the outcomes of DBHDD's important work in anticipation of the comprehensive report to be filed in September 2020.

_____/s/_____

Elizabeth Jones, Independent Reviewer

January 31, 2020