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 REPORTS 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 jointly file the attached reports of the Independent Reviewer, titled "Individuals with DD at Heightened Risk" (Exhibit A) and "Supported Housing" (Exhibit B), both dated October 4, 2021.

Respectfully submitted, this 5th day of October, 2021.

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CERTIFICATE OF SERVICE

I hereby certify that on October 5, 2021, 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
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EXHIBIT A

REPORT OF THE INDEPENDENT REVIEWER

In The Matter Of

United States v. Georgia

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

Individuals with DD at Heightened Risk

October 4, 2021

Introductory Comments

For the first time since the onset of the pandemic, it has been possible to return to Georgia in order to complete fieldwork and on-site observation. However, the timing and scope of the site visits has remained limited. As a result, for this report to the Court, a carefully considered decision was made to concentrate monitoring efforts on those individuals with a developmental disability (DD) who have been determined to be at heightened risk due to medical, behavioral, or legal issues.

Three groups of individuals were selected for review: 1) individuals included on the High Risk Surveillance List; 2) individuals included on the Statewide Clinical Oversight List; and 3) individuals who have experienced lengthy stays in crisis respite homes.

A total of 34 men and women were reviewed for this report. The importance of the Settlement and Extension Agreements' obligations regarding people with DD at heightened risk and the findings from this set of reviews will lead to a similar set of reviews for the next report in Spring 2022.

The specific findings related to each person in the current sample have been shared with the Parties. The Department of Behavioral Health and Developmental Disabilities (DBHDD), the agency responsible for the services and supports to people included in the Agreements' targeted populations, was given the opportunity to discuss with the Independent Reviewer and her nurse consultants each of the individual reviews prior to the filing of this report with the Court.

Requirements of the Settlement Agreement and its Extension Agreement

The Extension Agreement, in particular, is focused on providing needed services and supports to vulnerable people with DD in the community. It has specific requirements related to: a) the safe and effective transition from a State Hospital to a community placement, b) the monitoring of individuals at heightened risk in the community, c) the clinical and programmatic interventions to be provided in a timely manner whenever risk is identified, and d) the investigation of deaths and serious reportable incidents and the implementation of corrective actions in response to deficiency findings related to mortality, along with implementation of quality improvement initiatives to reduce mortality rates for individuals with DD.

For this report, the emphasis was on the following Paragraphs included in the Extension Agreement:

Paragraph 13: The State shall operate a system that provides the needed services and supports to individuals with DD in the community through a network of contracted community providers overseen and monitored by the State or its agents. To identify, assess, monitor, and stabilize individuals in the community 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 shall maintain a High Risk Surveillance

List (the "List") as set forth in Paragraph 14, provide statewide clinical oversight as set forth in Paragraph 15, and administer support coordination as set forth in Paragraph 16.

Paragraph 14: The State shall maintain a High Risk Surveillance List that includes all individuals with DD who have transitioned from the State Hospitals to the community during the term of the Settlement Agreement and this Extension Agreement.

Paragraph 14.c. For each individual on the List designated as "High Risk," the State shall conduct the needed oversight and intervention in a timely manner (as outlined in detail in the Extension Agreement) until the risk is resolved.

Paragraph 15.a. The State shall implement statewide clinical oversight that is available in all regions in a timely manner to minimize risks to individuals with DD in the community who face a heightened level of risk due to the complexity of their medical or behavioral needs, as indicated by one or more of the circumstances set out in more detail in the Extension Agreement. This includes multidisciplinary assessment, monitoring, training, technical assistance, and mobile response to contracted providers and support coordinators who provide care and treatment to individuals with DD in the community.

Paragraph 17. a. Crisis respite homes are to provide **short-term** crisis services in a residential setting of no more than four people.

Although Support Coordinators were contacted for the majority of the individual reviews, a comprehensive assessment of support coordination, as set forth in Paragraph 16, was not undertaken.

As discussed in the narrative below, there are troubling findings about the care, treatment and protection from harm documented for certain individuals reviewed for this report. These findings are presented with the sincere desire to assist the State to reach compliance with its obligations and to successfully implement the Parties' stated 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.)

Summary of Findings

The State has not met the obligations of Paragraph 13. Serious deficits in the identification of risk, the implementation of preventive and remedial interventions, and the intensity of monitoring and oversight were documented through on-site observations, interviews with staff, support coordinators and families, and the review of clinical records and reports.

The efforts required to conduct a thorough independent review of individuals at risk for this report were complicated by a number of unanticipated factors:

1. Although the High Risk Surveillance List, as well as the Statewide Clinical Oversight List, and associated protocols, were completed in compliance with the 2017 timeline in the Extension Agreement, there has been no training on these protocols since 2017. As a result, none of the staff interviewed in a residential setting or in the crisis homes knew about the protocols, the Lists, or whether the individuals under their responsibility were designated with heightened risk. Only one Support Coordinator knew of the Lists or the protocol. As a result of this knowledge gap in the field, there was no understanding of the reporting requirements or sequential actions required by the Agreements.

2. Reporting of critical incidents was not consistent with the requirements of the Extension Agreement. For example, according to the Agreement, in an "emergency," providers are to notify the Support Coordinator, the field office, and the Office of Health and Wellness. In practice, however, staff at the residence simply completed a Critical Incident Report (CIR) and someone else submitted it within 24 hours per the parameters of DBHDD policy. Furthermore, although staff in provider agencies typically understood the requirement to contact the Support Coordinator, they were not aware that they were also to notify the Field Office or the Office of Health and Wellness. The notification of those two Offices was reported to happen electronically when the CIR was filed. Since the staff who complete the CIR do not file it directly, they were generally unaware of when it was filed. Moreover, they were unaware of any immediate next steps or any corrective actions that would be implemented unless informed promptly by their supervisor. These gaps in communication and notification are counter to the letter and spirit of the Extension Agreement.

3. With limited exceptions, staff working directly with the individuals at risk did not know who is assigned to the residence from the Field Office or the Office of Health and Wellness. It was incumbent upon the Support Coordinators to notify these Offices when assistance was required. However, according to the Support Coordinators interviewed for this report, nurses from the Field Office or the Office of Health and Wellness seldom complete in-person assessments of individuals in the community residences. If there are questions that arise from a CIR, they email the Support Coordinator to obtain information but they do not conduct an assessment.

4. The typical documentation maintained in the community residences did not include notes regarding the involvement of the Field Office or the Office of Health and Wellness. This information should be noted in the records at the residences. As a result, there is little or no evidence in the residences that the sequential steps and actions required by Paragraphs 14 and 15 were, in fact, implemented in a timely or comprehensive manner. Therefore, in order to make any conclusive determination about these responses, future monitoring will include requests for interviews with and documentation from the Field Office and the Office of Health and Wellness. It is not possible to evaluate this set of requirements by reviewing only the documentation kept by the provider agency staff or the Support Coordinator.

5. Throughout the course of the Agreements, it has been recommended that DBHDD ensure that the individual's records are transferred with him/her when provider agencies are changed. During this review, one man, who experienced abuse, was transferred from one residence to another without any of his records or assessments. This was particularly unfortunate because he arrived at his new residence with anecdotal reports of weight loss that could not be verified. It is generally accepted practice that an individual's records and belongings are secured by the state agency before releasing them to the new provider. The records belong to the person.

Despite the frustrating procedural and process problems referenced above, the individual reviews by the two nurse consultants and the Board Certified Behavior Analyst (BCBA) retained by the Independent Reviewer were able to evaluate the health or behavioral status and clinical oversight of 14 people on the High Risk Surveillance List; 8 people on the Statewide Clinical Oversight List; and 12 people with lengths of stay greater than 30 days in a crisis respite home. A summary of the findings for each person is included below.

High Risk Surveillance (HRS) List

All of the individuals who were transitioned from a State Hospital under the terms of the Agreements are included in the HRS List. DBHDD considers all of these people to be at heightened risk. For example, the List relied on for this report, referencing May 2021, included 442 individuals. However, only a much smaller set of incidents related to these individuals is actually highlighted in each of the monthly reports provided by DBHDD. (The May 2021 List highlighted incidents for only 37 individuals.) Individuals included in the highlighted subset are categorized separately by their medical or behavioral issues. Individuals who may have both medical and behavioral issues are not identified in both categories. Such separation is unwarranted and misguided because an individual's medical and behavioral concerns often intersect and must be looked at together when developing the clinical interventions required for proper treatment and the resolution of risks.

As stated above, the May 2021 HRS List was used to select the individuals reviewed for this report. None of these men and women were known to the Independent Reviewer or her nurse consultants. There were no preconceived ideas or expectations about their living situation, their staffing or their clinical supports.

The information summarized below is drawn from the Monitoring Questionnaires completed for each person. The nurse consultants conducting the reviews evaluated the interventions addressing emergencies or an individual's deteriorating health status in order to assess compliance with the obligations of both EA 13 and 14.c. In certain cases, the provider agency was working diligently and appropriately to address health-related risks, but even in those instances, additional resources were required and were not available through DBHDD. In those instances, there is a different finding for EA 13 and EA 14.c.

Table 1

Summary of Individual Findings
High Risk Surveillance List

Name	Compliance with EA13	Compliance with EA14c	Compliance with EA15c	Summary of Findings
PC	Yes	Yes	NA	After PC and all of his housemates were infected with the flu, PC was taken to the ER for treatment of dehydration despite efforts by residential staff. Nursing support in place. BSP in effect and being updated now.
RC	Yes	Yes	NA	RC is nonverbal. Positive communication strategies have been developed by staff so he can indicate needs. His insulin dependent diabetes is stable.
AC	Yes	Yes	NA	AC's behavioral risks have been addressed. Her seizures are properly monitored.
JD	No	No	NA	The current provider indicated that when JD came to this home from a previous provider, all of his belongings were in one small garbage bag. The clothing was stained and his one pair of shoes could not be worn. He complained of headaches and toothaches. He had not received dental care for several years and it was determined that he needed his teeth extracted, which was done. Until moving into his present home, it does not appear that his needs were met. In addition, he continues to be verbally aggressive/abusive towards his Host Home providers and his housemate. Yet, he does not have a BSP.

MF	No	No	NA	There was a poor transition to his new host home on 3/5/21. Nursing assessment completed on 3/10/21 recommended nursing services. The Host Home provider stated that nursing services were not initiated until three months later (6/21). Last dental exam was in 11/19 and did not include prophylactic care. Although a BSP was reported to have been in effect with the previous provider, it did not transfer to this Host Home. A new BSP was only received by the Host Home provider on 8/5/21—five months after MF's transfer to his current residence.
EH	Yes	Yes	NA	There is strong provider support for EH. Proactive clinical services have been implemented to address his health risks.
GH	No	Yes	NA	There is serious behavioral risk with his declining health and aspiration risk. His provider is attentive but the extent of monitoring from DBHDD appears to be inadequate. Although documentation of nursing oversight was provided by DBHDD, there were no details provided regarding outcomes. Poor oral hygiene was identified on 6/9/21 but nursing note simply states that GH is "behind" for a dental exam. There was no entry regarding the hospitalization on 5/7/20 due to a bowel blockage. Ongoing risks of glaucoma, rectal bleeding and aspiration were identified but not fully addressed.

SH	Yes	Yes	NA	SH's fall risks have been addressed.
BJ	No	No	NA	BJ is at heightened risk with 4 of 5 "Fatal Five+" medical conditions. He was hospitalized for 35 days in 7/20 with serious weight loss and decubiti. Questions remain regarding oversight by DBHDD while hospitalized from 7/13/20 to 8/20/20. His last dental assessment was 9/13/18.
LJ	No	No	NA	Abuse was substantiated at his previous placement. DBHDD took 14 months to move LJ to a new placement where his needs could be met. Just after the site visit for this report, he was hospitalized for a urinary tract infection and refusal to eat. He was moved to hospice care on 9/17/21. LJ died on 10/2/21.
IK	No	No	NA	IK has been declining for 6 months with repeated falls. Records provided by DBHDD after the site visit do not document clinical oversight. Written plans of care note oversight of neurologic condition and mobility, but there are no actual notes that document the registered nurse's findings, planned actions and collaboration with the medical team, including the PCP's notation that the falls may warrant a cardiac evaluation. There is no written documentation of information shared with the PCP, neurologist or cardiologist.
JN	Yes	Yes	NA	There was evidence of good

				follow-up with clinical supports to address her Fatal Five+ symptoms.
JT	Yes	Yes	NA	This appears to be a supportive home for JT. The behavioral interventions appear to be effective. JT has stable health.
RW	No	No	NA	At the time of our site visit, RW had lived in this home for almost four months. During that time, he has had three major incidents that resulted in police and/or the fire department being called; one incident resulted in injury to staff. The incident reports indicated that there was no BSP available. On 8/25/21, six weeks after the last incident, the Support Coordinator received a revised BSP. With the level of intensity of RW's behavior, it appears that there have not been adequate resources available to ensure that assessments and changes in behavioral strategies are done in a timely manner and are readily available to the staff for consistent implementation.

Statewide Clinical Oversight (SCO) List

The SCO List is comprised of individuals who are receiving community-based services under the HCBS Waivers. They did not transition from a State Hospital under the terms of the Agreements. Individuals on this List are categorized by medical, behavioral, or legal incidents. The SCO List is issued monthly. Typically, the List is lengthy, with more than 50 pages of names, but only a much smaller subset of incidents for these individuals is highlighted for review.

The same methods as described above for the HRS List were used to select and assess the men and women identified with medical incidents on the SCO List issued in May 2021. None of these individuals were known to the Independent Reviewer or her nurse consultants. There were no preconceived ideas or expectations about their living conditions, their staffing, or their clinical supports.

There were no differences noted in the implementation of intervention strategies or the documentation of information from those used for individuals on the HRS List. As referenced above, none of the residential staff were familiar with either List.

Table 2

Summary of Individual Findings
Statewide Clinical Oversight List

Name	Compliance with EA13	Compliance with EA14c	Compliance with EA15c	Summary of Findings
LC	Yes	NA	Yes	LC has very positive supports. Her health issues have been addressed. She is employed at Wendy's and has a very active life.
JC	Yes	NA	Yes	JC's health was stabilized with support from appropriate medical practitioners. No issues of concern were identified.
NH	No	NA	No	NH's host home is excellent but lacks timely assistance from DBHDD. Clinical oversight was documented as provided by DBHDD on 8/8/18, 7/2/20 and 1/8/21. NH's chemotherapy was discontinued in 6/21 due to serious side effects; a malignant lymph node was removed in 7/21. Nursing support was only initiated on 6/25/21.
LK	Yes	NA	Yes	LK died the day before the site visit. She lived with her family. There were multiple risks documented in her records. The HSRR was completed timely. The Support Coordinator attempted to support the family but they were guarded and were not receptive to her visits. Details related to LK's death are not fully

				known.
GM	No	NA	No	GM experienced serious neglect during his hospitalization/nursing home stays. There was inadequate oversight by DBHDD despite attempts and requests by provider staff. Documentation forwarded by DBHDD following our site visit did not include a plan of care to address his loss of mobility and independence as a result of the neglect he experienced. There is no evidence that any attempt has been made for an evaluation to determine if his bilateral knee and ankle contractions can be corrected, and if not, then to provide him with an appropriately fitted wheelchair that will allow him independence in mobility.
TN	No	NA	No	TN requires reassessment of his gastric tube. There is continued risk from pulling out the tube. DBHDD assistance is needed to help the provider obtain clinical resources. The documentation provided by DBHDD only notes that TN failed two swallowing studies. The nature of the studies was not described. Given that TN is able to drink thickened liquids and eat mashed potatoes, a non-instrumental swallowing assessment (as described by the American Speech-Language Hearing Association) should have been considered and recommended.
CT	Yes	NA	Yes	There was evidence of strong support in the host home. One:one staffing has been

				approved by DBHDD due to her decline from dementia.
MW	No	NA	Yes	Appropriate clinical oversight was not provided by DBHDD despite lengthy hospitalization for COVID-19, leading to serious adverse health consequences that had nothing to do with the virus. The residential provider has been attempting to address injuries from lack of care in the hospital.

Discussion of Findings

This initial review of 23 individuals selected from the HRS and SCO Lists raises a number of questions regarding the clinical resources and interventions available and/or implemented to prevent/minimize health risks and address adverse outcomes.

Based on the findings documented in each review, the following concerns should be analyzed and addressed:

1. Residential providers expressed that they needed, but were not getting, both additional clinical resources, including those in areas of specialization, as well as timely assistance in securing such resources. Paragraphs 15.e. and f. of the Extension Agreement required that the State shall have medical and clinical staff available to consult with community health practitioners, including primary care physicians, dentists, hospitals, emergency rooms, or other clinical specialists, who are treating individuals with DD in the community who face a heightened risk due to the complexity of their medical or behavioral needs and/or to provide assistance to community providers and Support Coordinators who report difficulty accessing or receiving services from community health practitioners. There are not yet sufficient resources statewide to meet this obligation. The model of clinical support developed with practitioners from Southwestern State Hospital has merit, but it has not been replicated elsewhere in the state. The broader availability of such knowledge, expertise and responsiveness would greatly strengthen community-based capacity in other areas of the state.

2. As reported, residential staff do not know about the HRS List, the SCO List, the action or notification requirements of the Extension Agreement, or the protocols to be implemented in emergencies or situations of deteriorating health. They do not know that the person under their responsibility has been determined to be of heightened risk according to the requirements of the Extension Agreement. This lack of awareness and understanding should be addressed. Any concerns about the availability of

clinical guidance from the Field Offices or the Office of Health and Wellness should be considered and resolved.

3. DBHDD should ensure that the HRST score is documented for every individual, especially those at heightened risk. The current HRST score could not be located in the records for eight (36%) of the individuals reviewed.

4. One residential provider failed to safely and responsibly transition an individual to another community provider. The lack of adequate preparation and the withholding of important documents, including health records, created stress on the new provider agency and imperiled the individual in an unacceptable manner.

5. The staff of the residential agencies who provide effective, individualized and responsive interventions to protect the health and safety of the men and women with heightened risk under their care and responsibility should be recognized and commended. Of particular note, the host home providers interviewed for this report demonstrated exceptional understanding and commitment.

6. Extended hospitalization or nursing home stays present serious risk for individuals with DD, especially if they are unable to speak for themselves. Although the pandemic has certainly created challenges for oversight, nonetheless, strategies and resources need to be implemented to prevent the risk of harm and to stop the risk if it begins to occur. Two of the men in this sample were seriously compromised, and have not fully recovered, as a result of their confinement in a hospital and/or nursing home. Although the residential providers attempted to safeguard these men to the best of their ability, additional resources, including someone to stay at the person's bedside, were needed but were not provided.

7. DBHDD should conduct its own investigation of any individual with DD alleged to have experienced poor quality care while placed in a nursing home or community hospital. As referenced in the review of one individual, the investigation completed by the Department of Community Health, a signatory to these Agreements and the agency responsible for the oversight of these facilities, lacked due diligence by failing to interview the complainant, neglecting to consider the health-related consequences endured by the victim, and omitting any investigation of the responsible hospital, despite the inclusion of this facility in the initial complaint.

Crisis Respite Homes

The Settlement Agreement required the development of 12 Crisis Respite Homes (CRHs) of four beds each. The State complied with that obligation. There are 12 homes with a total of 48 crisis beds located across Georgia. The Extension Agreement clarified that each setting should support individuals only on a short-term basis. In addition, Paragraph 17.b. of the Extension Agreement requires that the individuals living in CRHs shall receive additional clinical oversight and intervention, as set forth in Paragraph 15 (the SCO section).

The use of the CRHs for placements greater than 30 days is reported by DBHDD on a monthly basis. The Independent Reviewer and her consultant have monitored this information from the outset. Prior reports by the Independent Reviewer to the Court have emphasized the State's ongoing failure to comply with the expectation of short-term placements. For example, the report to the Court dated September 18, 2020 stated:

> 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.

There has been scant change in these circumstances since the last report. The monthly list submitted in July 2021 documents that 31 crisis beds (65%) are occupied by people with lengths of stay greater than 30 days. In fact, the 12 men and women reviewed for this report (39% of the extended stay group) have CRH admission dates that go as far back as 2018. Two of the men have been readmitted to a CRH after intervention from law enforcement, so their total time in a CRH is significantly longer than is reflected in their present stay.

Attention is again focused on this problem because it demands resolution. All of the people selected for review were evaluated to assess the strength of their behavioral programming. Either the Independent Reviewer (11 visits) or her nurse consultant (one visit) conducted a site visit to each individual's CRH in order to speak directly with staff about the difficulties with placement.[1]

DBHDD provided information about its attempts to secure placements in more integrated community residences. In addition, providers shared, from their perspective, why they declined to become involved. The reasons included: staffing shortages; the lack of additional capacity; the low rate of wages in a competitive market; the maladaptive behaviors of the individuals referred; the lack of support from DBHDD, phrased as "You are on your own;" and the criticism that the mobile crisis teams see the person when called but do not resolve the underlying issues.

The analysis of Behavior Support Plans (BSPs) by the Independent Reviewer's consultant and the numerous reports of critical incidents confirm that placement in a CRH alone does not sufficiently address the underlying and recurring issues associated with the individuals' maladaptive behavior. Police are still called to assist; property is damaged; self-injurious behavior, including pica, continues to occur; aggression is provoked between housemates.

[1] One individual currently hospitalized in a State Hospital was also reviewed but is not included in this analysis.

The behavioral consultant retained by the Independent Reviewer to examine the BSPs concluded that:

> All of the individuals reviewed clearly demonstrated a need for formal behavioral programming; however, it was evident that not all individuals who needed access to behavioral programming were currently receiving necessary behavioral supports and services.
>
> Overall, the majority of BSPs were found to be inadequate. More specifically, only two of the BSPs reviewed had more than half of the minimal elements of generally accepted practice. Overall, behavioral programming did not meet standards of generally accepted practice for most of the individuals reviewed.

More creative and individualized strategies are essential if there is to be a sustainable solution to the longstanding inability to treat and relocate individuals with heightened behavioral risks to more stable and permanent community housing with supports. It is recommended:

1. DBHDD should consider offering financial and other incentives to qualified provider agencies in order to obtain integrated, individualized community placements for those men and women who have been confined to a CRH for extended periods. These incentives should be authorized in order to expand the capacity of the community-based system to work with individuals demonstrating challenging behaviors, such as elopement, pica and aggression. Non-financial incentives could include educational opportunities and other training opportunities that enhance skills and possibly lead to credentialing or certification in a related field.

2. DBHDD should consider expanding the scope of responsibility of selected agencies now managing the CRHs in order to develop more independent apartment settings for those individuals who require familiar staff and a "place of their own." As was done in the early years of the Agreements, Georgia Housing Vouchers could be approved as a rental subsidy for individuals with a dual diagnosis.

3. DBHDD should continue to offer and expand opportunities for training in the development of individualized behavioral plans and supports. Staff in residential settings, including the CRHs, should be asked what could make a difference in their ability to work with people with challenging behaviors.

4. DBHDD should query providers regarding any concerns about the effectiveness of mobile crisis team response and the level of support they require from DBHDD itself.

5. DBHDD should consider replicating statewide the integrated team approach utilized by the clinical staff located on the grounds of Southwestern State Hospital.

Concluding Comments

The work completed for this report documents for the Court a series of issues that are known but not yet sufficiently addressed. These issues relate to procedure and substance. The Agreements' obligations related to all individuals with DD at heightened risk are dependent on the quality and availability of accessible clinical resources and supports, knowledgeable staff at all levels of responsibility, timely and adequate response to identify and prevent risks, and individualized strategies to remedy any risks that may occur.

The State recently announced its plan to retain a highly experienced consultant to assist it in addressing risk-related factors and strategies for people with DD. It is hoped that the information provided in the Monitoring Questionnaires and in this report will be helpful to that important effort.

As always, the opportunity to discuss this report's findings is important to ensuring accuracy. The Parties were provided a draft copy of this report and their comments and suggestions were carefully considered.

The Commissioner of DBHDD and her staff, the counsel for the Department of Justice and the State, advocates, families and community providers were accessible and generous in their assistance and guidance throughout the fact-finding completed for this report. This cooperation and collaboration is acknowledged and greatly appreciated.

Submitted by:

_____/s/_____
Elizabeth Jones, Independent Reviewer

With consultation from:

Marisa C. Brown, MSN, RN
Julene Hollenbach, RN, BSN, NE-BC
Patrick Heick, PhD, BCBA-D, LABA

SUMMARY OF DEMOGRAPHICS

High Risk Surveillance List

1. Number of Individuals: 14

1a. Number of Individuals per Region

Region 2: 7
Region 3: 7

2. Age Ranges

21-30: 0
31-40: 3
41-50: 1
51-60: 5
61-70: 3
71-80: 2
81-90: 0
91+: 0

3. Gender

Male: 10
Female: 4

4. Number of Residential Providers: 12

5. Type of Residence

Family/Own Home: 0
Host Home: 2
Supported Apartment: 0
Group Home (CLA): 12
Crisis Respite Home: 0

Statewide Clinical Oversight List

1. Number of Individuals: 8

1a. Number of Individuals per Region

Region 1: 1
Region 2: 6
Region 3: 1

2. Age Ranges

21-30: 2
31-40: 1
41-50: 1
51-60: 2
61-70: 1
71-80: 1
81-90: 0
91+: 0

3. Gender

Male: 4
Female: 4

4. Number of Residential Providers: 7

5. Type of Residence

Family/Own Home: 1
Host Home: 2
Supported Apartment: 0
Group Home (CLA): 5
Crisis Respite Home: 0

Crisis Respite Homes

1. Number of Individuals: 12

1a. Number of Individuals per Region

Region 2: 3
Region 3: 0
Region 4: 3
Region 5: 3
Region 6: 3

2. Age Ranges

21-30: 6
31-40: 5
41-50: 1
51-60: 0
61-70: 0
71-80: 0
81-90: 0
91+: 0

3. Gender

Male: 8
Female: 4

4. Number of Residential Providers: 2

5. Type of Residence

Family/Own Home: 0
Host Home: 0
Supported Apartment: 0
Group Home (CLA): 0
Crisis Respite Home: 11
Jail: 1

ATTACHMENT ONE

REVIEW OF BEHAVIORAL PROGRAMMING

Patrick Heick, PhD, BCBA-D, LABA
August 25, 2021

Introduction

The following *Summary* was prepared in response to the Independent Reviewer's request to review the behavioral services of a sample of twelve individuals with a developmental disability living in crisis respite homes for more than thirty days. These reviews compared the behavioral programming and supports that are currently reported to be in place with generally accepted standards and practice recommendations regarding the components of effective behavioral programming and supports. These components include: (1) level of need (i.e., based on behaviors that are dangerous to self or others, disrupt the environment, and negatively impact his/her quality of life and ability to learn new skills and gain independence); (2) Functional Behavior Assessment (FBA); (3) Behavioral Support Plan (BSP), including targeted behaviors for decrease and increase (e.g., functionally equivalent replacement behaviors); and (4) ongoing data collection, including regular summary and analysis. (However, it should be noted that it is not intended to offer these components as reflective of an exhaustive listing of essential elements of behavioral programming and supports.)

In order to obtain the information required for this *Summary*, several fact-finding steps were completed. First, as noted in Attachment 2, documentation was requested from the Department of Behavioral Health and Developmental Disabilities (DBHDD). Second, the Independent Reviewer or, in one case, a nurse consultant met the individuals at the respective crisis home and spoke with staff on site. (One individual, who is now confined to a County jail, was spoken with via a Zoom meeting in the presence of her attorney.) Third, interviews were then conducted by telephone with the assigned clinicians. Finally, a Monitoring Questionnaire was completed for each individual in the sample. Specific questions included in the Monitoring Questionnaire that relied on documentation (e.g., FBA, BSP) were answered only if the actual document (or evidence thereof) was provided for review. All Monitoring Questionnaires have been provided to the Parties.

Findings related to the quality of the behavioral programming described here were generally organized and summarized according to the framework set forth below.

> Demographic information. Minimal elements included birthdate, diagnostic information regarding medical, mental and behavioral health, legal status, date of initial plan and revisions, authoring clinician's name and credentials.
> History and rationale. Minimal elements included historical information, reason and rationale, and known history of previous services/interventions and their impact.
> Person centered information. Minimal elements included the individual's communication modality and identified preferences (potential reinforcers).
> Functional Behavior Assessment. Minimal elements included when and where the FBA was conducted, methods used and associated results. Emphasis was placed on the use of descriptive methods as well as the FBA conducted in the current setting.

Hypothesized functions of behavior. Minimal elements included identified function(s) for each behavior targeted for decrease, with emphasis placed on the use of generally accepted functions of operant behavior.
Behaviors targeted for decrease. Minimal elements included identified targeted behaviors for decrease, an objective operational definition for each behavior, method of measurement used to track each behavior, and ongoing data collection and analysis.
Replacement behaviors (behaviors targeted for increase). Minimal elements included identified functionally equivalent replacement behaviors targeted for acquisition, an objective operational definition for each replacement behavior/behavior targeted for increase, method of measurement used to track each behavior, and ongoing data collection and analysis.
Antecedent interventions. Minimal elements included proactive and/or preventative strategies to minimize the likelihood of target behaviors for decrease and/or promote the likelihood of target behaviors for increase, including specific strategies used to teach replacement behaviors.
Consequence interventions. Minimal elements included evidence-based strategies targeting behaviors for decrease and increase (e.g., use of differential reinforcement) and strategies that are least restrictive, most effective, and promote the acquisition of replacement behaviors and behaviors for increase, including the use of adequate reinforcement (e.g., identification of potential reinforcers, schedules of reinforcement).
Appropriate signatures and plan for training. Minimal elements included informed consent, signatures and associated dates, and the proposed plan to train staff or others who will implement the BSP. Emphasis was placed on the use of a behavioral skills model or similar strategies for staff training. Although the Monitoring Questionnaire did not specifically examine receipt of informed consent as evidenced by signatures of the individual or legal guardian, it was nonetheless included in the current review.

Summary of Findings

1. Due to the unavailability of requested documentation or the provision of reportedly outdated documentation, the current study was unable to fully examine the nature of the behavioral supports and services that were currently in place for some of the individuals sampled. Consequently, for those individuals, the findings of the current study are limited and incomplete.

2. Based on a review of the completed individuals' service records and other provided documentation, as well as the completed Monitoring Questionnaires, nearly all the individuals sampled demonstrated significant maladaptive behaviors that had unsafe and/or disruptive consequences to themselves and their households, including negative impacts on their overall quality of life including the ability to access their communities, to become more independent and to learn and exercise more skills. More specifically, of those sampled, all engaged in behaviors that could result in injury to self or others and nearly all engaged in behaviors that were disruptive to the

environment. In addition, most of the individuals engaged in behaviors that impeded his or her ability to access a wide range of environments. Closer examination of negative outcomes revealed that most of the individuals had one or more contacts with the police, as well as one or more emergency room visits or unexpected medical hospitalizations. One individual was currently in jail. In addition, over half of those sampled had an unauthorized departure, as well as one or more psychiatric hospitalizations. Consequently, these behaviors and outcomes are a strong indication that these individuals would likely benefit from formal behavioral programming or other therapeutic supports.

3. Although it was found that all sampled individuals would likely benefit from behavioral programming given their identified needs, evidence was not provided that all individuals were receiving behavioral programming through the implementation of comprehensive BSPs. For example, a verbal report regarding one individual indicated that a BSP was in place; however, this BSP was not provided following the document request and, therefore, could not be included in the current review. As noted previously, the identified number of BSPs was determined using receipt of the actual BSP. Consequently, the current finding likely underestimates the actual number of BSPs given that not all reported BSPs were provided for review and included in the analysis.

4. The current review noted that nearly all individuals had BSPs. However, not all BSPs were current (i.e., implemented or updated within the last twelve months), designed for the setting in which it was currently implemented, and/or developed by a Board Certified Behavior Analyst (BCBA). The BCBA is the nationally accepted certification for practitioners of applied behavior analysis. This certification is granted by the Behavior Analyst Certification Board (BACB), a nonprofit corporation established to develop, promote, and implement a national and international certification program for behavior analyst practitioners. In addition, many of the BSPs provided for this review were judged to be incomplete, inadequate, or outdated. More specifically, only the first page of a BSP was provided for one individual, very brief two- or three-page BSPs were provided for four other individuals, and an outdated BSP was provided for an additional individual.

5. As noted above, nearly all the sampled individuals had BSPs. However, evidence that an FBA was completed was only provided for seven of the eleven individuals (64%) with BSPs. More specifically, evidence that an FBA was completed was not provided for four individuals with confirmed BSPs. Generally accepted practice involves the completion of a comprehensive FBA to identify potential underlying function(s) of target behaviors and to inform the selection of function-based interventions when developing a BSP. Consequently, not completing an FBA to inform the development of a BSP limits the probability of developing an effective BSP.

6. Closer examination revealed that, of the seven FBAs, two were outdated and two were completed in prior settings. In addition, although all of FBAs included direct

methods of assessment as well as identified potential antecedents and consequences, not all identified hypothesized function(s) of target behaviors were included.

7. Upon closer examination of the BSPs (See Figures 1-3), it was noted that prescribed behavioral programming appeared inadequate for the majority of reviewed BSPs. For example, although demographic and person-centered information was found for eight (73%) of the eleven individuals with BSPs, adequate historical information, including descriptions of previous services and interventions (and their effectiveness), was only found for three (27%) of the individuals (See Figure 1). In addition, of the eleven individuals with BSPs, only five (45%) had adequate FBAs completed and only five (45%) had adequately identified function(s) for each target behavior for decrease (see Figure 1). Similar inadequacies were found regarding how target behaviors for decrease and increase were identified, defined, measured, and monitored. More specifically, behaviors for decrease were adequately identified, defined, and monitored over time for only three (27%) of the individuals with BSPs (see Figure 2). Unfortunately, none (0%) of the BSPs reviewed adequately identified, defined, and monitored functionally equivalent replacement behaviors over time. And, although a majority of BSPs contained some antecedent- and consequence-based strategies, very few contained all the minimal elements within each of these content areas. That is, only two (18%) and one (9%) of the individuals had BSPs with adequate antecedent and consequence interventions, respectively (see Figure 2). Nearly all the BSPs failed to include adequate preventative strategies as well as antecedent-based teaching strategies targeting the acquisition of functionally equivalent replacement behaviors or target behaviors for increase. Lastly, only one (9%) of the BSPs prescribed a specific training plan utilizing an evidence-based model of training (e.g., behavioral skills training). Evidence that informed consent had been obtained through appropriate signatures and corresponding dates was not evident for any of the individuals reviewed (See Figure 3).

Conclusion

1. Although all of the individuals reviewed clearly demonstrated a need for formal behavioral programming, based on the number of adequate BSPs currently being implemented in the crisis homes, it was evident that not all sampled individuals who needed access to behavioral programming were currently receiving necessary behavioral supports and services.

2. Overall, the majority of BSPs were found to be inadequate. More specifically, only two of the BSPs reviewed had more than half of the minimal elements of generally accepted practice. Overall, behavioral programming did not meet standards of generally accepted practice for most of the individuals reviewed.

Submitted By: _____/s/_____
Patrick Heick, PhD, BCBA-D, LABA
August 25, 2021

Attachment 1

Data Summaries:

Figure 1

BSP Content Area	Demographic Intormation	History and Rationale	Person Centered Information	Functional Behavior Assessment	Hypothesized Functions of Behavior
Total # with Minimal Elements	8	3	8	5	5
Percentage	73%	27%	73%	45%	45%

Figure 2

BSP Content Area	Behaviors Targeted for Decrease	Replacement Behaviors	Antecedent Interventions	Consequence Interventions
Total # with Minimal Elements	3	0	2	1
Percentage	27%	0%	18%	9%

Figure 3

BSP Content Area	Appropriate Signatures	Plan for Training
Total # with Minimal Elements	0	1
Percentage	0%	9%

Attachment 2

Information Request for Dr. Heick's Reviews

Requested Documents:

Psychological, Medical, and/or Psychiatric assessments

Behavior Support Plan (BSP) or similar document

Crisis or Safety Plan or similar document

Functional Behavioral Assessment (FBA) or related document

Blank daily or weekly data sheet (where direct support staff record data)

Behavior summaries/reviews by Behavior Analyst or Behavior Specialist

- Graphic data (last three months)

Individual Support Plan

Documentation related to any significant or critical incidents (e.g., elopement, individual injury, 911 or police contact, ER visit, hospitalization, etc.) over the past 12 months

- This may include, for example, admission and/or discharge documentation from Emergency Rooms, Critical Incident Reports or Investigative Reports.

List of all providers contacted regarding residential services and the response.

Requested Contact information (name, email address, telephone number):

Support Coordinator

Behavior Analyst or Behavior Specialist

On-site Crisis Residence Supervisor

EJ/6-11-21

PH/6_18_21

EXHIBIT B

REPORT OF THE INDEPENDENT REVIEWER

In The Matter Of

United States v. Georgia

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

Supported Housing

October 4, 2021

Introductory Comments

Every report to the Court has included discussion of the supported housing requirements negotiated by the Parties in the Settlement Agreement (SA) and its Extension Agreement (EA).

Stable permanent housing with individualized supports is the foundation for recovery from a serious and persistent mental illness (SPMI). It provides a safe and affordable place to live in an integrated community setting; offers opportunities for participation in community activities; promotes the retention and acquisition of skills that foster independence and achievement; enables social networks to be sustained and expanded; and helps to confer dignity and respect.

Among many other requirements, the Agreements include specific supported housing obligations to benefit the defined target population including: 1) the provision of housing supports either through the State's Georgia Housing Voucher Program (GHVP) or through federal funding assistance; 2) State bridge funding for deposits, household necessities, living expenses and other supports; 3) system-wide capacity to address the supported housing needs of the various sub-groups within the target population; 4) outreach to all of those sub-groups; and 5) coordination between the State's Department of Behavioral Health and Developmental Disabilities (DBHDD) and its Department of Community Affairs (DCA).

Summary of Key Findings

A more detailed discussion of these key findings is included in the attached report by Martha Knisley, the Independent Reviewer's consultant on supported housing. (See Attachment One)

Although there continue to be efforts that are not yet completed sufficiently for a recommended finding of compliance, there are encouraging developments that are to be commended and safeguarded.

Positive Accomplishments

First, DBHDD has significantly reduced the time to determine eligibility for supported housing. The process for eligibility determinations has been streamlined. As a result, the time required to review and approve applications has been reduced from 106 to 23 days.

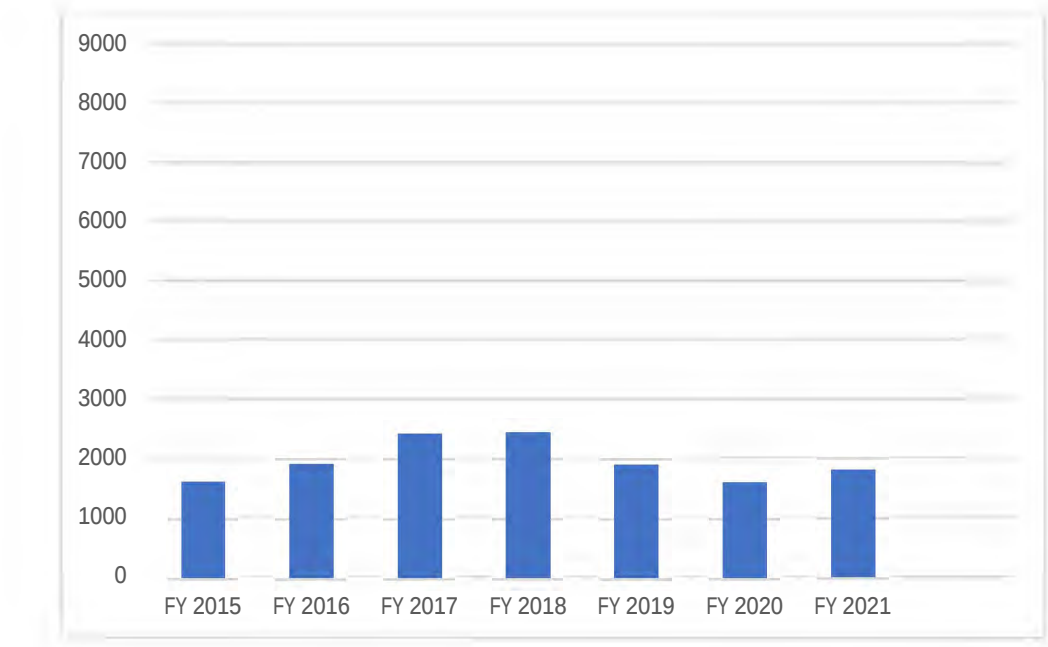
Second, DBHDD has initiated a comprehensive program to promote retention in supported housing and to reduce the separation rate. This initiative is being implemented now in four Regions of the state (Regions 1, 3, 4 and 5) and is planned to begin in the remaining two Regions (Regions 2 and 6) at the start of the next Fiscal Year. It is built on the principles and evidence-based research of the Housing First model. Through this initiative, tenants with SPMI in independent apartment settings will receive health and wellness checks as well as mental health services, if desired, and assistance in working with their landlords, if needed. Agencies were selected for this initiative through an RFP process and will receive training, technical assistance and fidelity review through a nationally recognized consultant retained by DBHDD. There is excellent evidence of collaborative effort already underway under the direction of the Division of Behavioral Health's leadership. Certainly, this initiative holds considerable promise; it is

expected to result in very positive outcomes for supported housing tenants with SPMI. The initiative will be followed closely and its progress will be referenced in future reports to the Court.

Third, there are community-based projects recently awarded through federal Mental Health Block Grant supplemental funds that will strengthen community partnerships and assist DBHDD in its outreach to members of the target population. The target population, as defined in the Agreements, includes individuals who are currently being served in the State Hospitals, who are frequently readmitted to the State Hospitals, who are frequently seen in emergency rooms, who are chronically homeless, and/or who are being released from jails or prisons. It also includes individuals with SPMI and forensic status if a court has found that community services are appropriate. Moreover, these individuals are to be referred to supported housing, when the need is identified at the time of discharge from a State Hospital, jail, prison, emergency room or homeless shelter. These new community-based projects are focused in part on individuals with SPMI in the criminal justice system, including local jails, and on individuals with SPMI who are homeless.

Fourth, after a decline in the number of tenants with an authorization for the GHVP in recent years, an upward trend appears to be emerging.

Chart A
Individuals in the Target Population with GHVP Leases at the End of Each FY



At the end of FY21, there were 1814 tenants with rental assistance through the GHVP, an increase of 199 tenants from the end of FY20[1].

[1] These totals do not include a few hundred additional individuals who have been approved for a GHVP voucher, but re still searching for a lease; it also does not include members of the target population who are getting federal upported housing assistance.

The State has continued to allocate funding for the supported housing. The funding for this current Fiscal Year, FY22, remains unchanged from last year's budget of $20,637,757. This amount includes $14,752,876 for GHVP rental vouchers and $5,884,881 for bridge payments. The State's average per person cost for a GHVP voucher is about $8,000 per year[2]. Given this annual per person average, the current amount allocated for GHVP vouchers means that the State's capacity to provide GHVP is roughly limited to about 1,844 units ($14.7M/$8,000). This effectively creates an upper limit on the number of individuals the State can serve with GHVP vouchers, regardless of how many individuals in the target population may need such support. However, DBHDD leadership has stated that it intends to fund supported housing for all those with an assessed need for it.

Areas Requiring Additional Intensified Effort

The obligations referenced below require additional and concentrated effort before a finding of compliance can be recommended to the Court. The efforts to implement these obligations appear to be lagging. It would be helpful for the Parties to have a much more detailed discussion about any obstacles to expected performance, including resources. In addition, it would be especially helpful if the State could develop a strategic blueprint with specific timelines for meeting these agreed-upon responsibilities. The committee of community stakeholders who advise DBHDD on housing-related matters would be an excellent partner in developing a strategic blueprint that is built on the principles of the Housing First model.

First, DBHDD has not tracked or reported data on the number of people in the target population who are referred to, assessed for, and then receive supported housing. This information will shed light on who is not being referred, assessed, or linked to supported housing. These data were routinely provided for many years and it is quite problematic that the practice was discontinued for some reason. The data are essential to assess compliance with the terms of the Agreements, especially given the current capacity limits for GHVP vouchers in the State's system.

Second, the State does not provide or track reliable data for all sub-groups within the target population. As a result, it is difficult to determine whether the supported housing obligations are actually met for these sub-groups. For example, the State does not report data on the number referred to, assessed for, or linked to supported housing from the sub-group of those being released from jails or prisons. DBHDD needs to provide that information.

In addition, DBHDD has not been able to report data about the number and circumstances of the separate sub-group of people with SPMI who are frequently seen in Emergency Rooms. The avenues for DBHDD obtaining this information directly from the hospitals are available right now. Indeed, the hospitals want to work in collaboration with the State agencies so that the essential needs of hospitalized people with SPMI and/or DD can be met. The hospitals simply need a contact person from DBHDD with whom to share the data and, also, to help them resolve difficult situations that risk prolonged hospital stays beyond medical necessity. These data are being collected now for the Independent Reviewer. The information will be shared with the Parties when it is available.

[2] In recent years, the average annual per-person total was about $8,000.

The State Hospitals are under the direct authority of DBHDD. It should be possible to implement efficient methods to capture data about supported housing referrals, assessments, and linkages that are envisioned under the Agreements.

Third, there are ongoing problems with regard to discharge planning and execution at the State Hospitals. As the pandemic restrictions began to ease earlier in the summer, the Independent Reviewer initiated review of discharge planning at the State Hospitals. Dr. Beth Gouse, consultant to the Independent Reviewer, was able to review 18 individuals with multiple admissions to two of the State Hospitals. This limited number of reviews will be supplemented by additional work for the next report; in the meantime, these individuals can be viewed as examples of the discharge processes established by DBHDD directives. Dr. Gouse's specific observations and recommendations are summarized in her memorandum. (See Attachment Two.)

Chart B below summarizes her findings across both State Hospitals; all of these actions are required by the discharge policy instructions issued by DBHDD. Although she found problems in important areas, there were also positive findings in several discrete requirements. Unfortunately, though, the most important items--related to taking key steps to link people to critical community services like supported housing and ICM/ACT--reveal subpar performance.

Going forward, it would be very helpful if DBHDD would begin to track and report its own data related to discharge planning at the State Hospitals on the numbers of those referred to, assessed for, and linked to supported housing as well as the discussion of supported housing as an option.

Chart B
Review of State Hospital Discharges
N: 18

Policy Requirement	Yes	No	CND	NA
1. Transition planning occurred throughout the admission	17			1
2. Are all required participants (hospital and community providers) in Individual Recovery Planning (IRP) meeting?	11	6		1
3. Community provider contacted, if already assigned?	14	1		3
4. Did social work staff provide education regarding discharge process?	18			
5. Did social worker assist with acquiring or confirming benefits?	16	1	1	
6. Housing needs documented by Social Worker at initial meeting?	15	2	1	
7. Do the SW notes or IRP reflect whether supported housing was discussed as an option?	4	12 (75%)		2
8. Mandated approvals of any discharge to shelter documented?				18
9. Did the intake appointment for ICM/ACT occur prior to discharge or did ICM/ACT team member meet with individual prior to discharge?	3	11 (79%)		4
Total:	98	33	2	29
Percentage:	60.5%	20.4%	1.2%	17.9%

Finally, advocates have raised concerns that some rental payments to landlords have been late and they worry that evictions may occur after the pandemic "eviction moratorium" has ended. This concern was brought to DBHDD's attention. In its response, several reasons for late

payment were outlined, as well as the methods being used to address specific problems. Since the information about late payments has been primarily related to individual cases, DBHDD will be requested to collect and report data on late payments so that there can be clearer analysis of the extent to which individual tenants are at risk of eviction.

Concluding Comments

The new initiatives now underway as a result of DBHDD's planning and problem solving hold great promise and may have a positive impact on both the individual and systemic levels. Access to supported housing is incredibly important for recovery from serious mental illness and for meaningful inclusion in community-based experiences. It continues to be imperative that DBHDD design and implement strategies that promote access to supported housing for members of the target population who need it.

This report, including the work performed by Ms. Knisley and Dr. Gouse, is the product of the assistance, information and thoughtful observations provided by numerous stakeholders, including individuals with SPMI, advocates, providers, counsel for the Parties, and the staff of DBHDD and DCA. These contributions are greatly appreciated.

The Parties were given the opportunity to comment on this report. All comments were carefully considered.

Submitted by: _____/s/_____

Elizabeth Jones, Independent Reviewer

With consultation from
Martha Knisley and Beth Gouse, PhD.

ATTACHMENT ONE

REVIEW OF SUPPORTED HOUSING OBLIGATIONS

Martha Knisley
August 24, 2021

Introduction

This is a brief report on the progress of the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Department of Community Affairs (DCA) on meeting the supported housing requirements for individuals with Serious and Persistent Mental Illness (SPMI) in the target population. These obligations are found in Sections III.B.1 and III.B.2.c. of the Settlement Agreement and Paragraphs 30-40 in the Extension Agreement. This report covers these requirements in five sections below.

The first section is broad, covering the State's obligations to provide supported housing to individuals in the target population with a focus on referrals and access to supported housing. It also includes reference to the State's procedures that enable referrals of individuals with SPMI in the target population to supported housing, including when they have an identified need for supported housing at the time of discharge from a State Hospital, jail, prison, emergency room, or homeless shelter (Paragraph 40 in the Extension Agreement).

The second section covers requirements for providing housing supports, including bridge assistance, as part of the Georgia Housing Voucher Program. The third section covers the scattered housing requirements. The fourth section covers the State's obligations for providing psychosocial supports, tenancy rights, and flexible supports.

The fifth and final section covers the State's obligations to build capacity to provide supported housing through a Memorandum of Agreement between DBHDD and DCA.

DBHDD and DCA provided data and information for this review. This review also included interviews with staff of the two agencies and with key stakeholders. The Director of DBHDD's Office of Supported Housing provided a comprehensive report that was helpful in reviewing the agency's efforts to achieve an adequate statewide supported housing system. DBHDD and DCA staff are well informed on their challenges and are taking steps to increase access and availability of housing and supports and to make policy changes in order to enable the State to meet Settlement and Extension Agreement requirements. The State's progress and plans to meet these requirements appear to be moving in the right direction, but remain incomplete, as described below.

Section One: Requirements and Findings

The State is required to provide supported housing to any of the 9,000 persons in the target population who need such support. The target population includes individuals with SPMI who are currently in State Hospitals, frequently re-admitted to the State Hospitals, frequently seen in emergency rooms, chronically homeless, and/or individuals being released from jails and prisons. The requirement also includes individuals on forensic status, if the relevant court finds that community-based services are appropriate, as well as individuals with SPMI and a co-occurring condition, such as substance abuse disorders or traumatic brain injuries.

The State is not in compliance with the requirement to provide supported housing for the target population because not everyone in the target population who may need supported housing is

getting referred to, assessed for, and possibly linked to supported housing. This is based on three findings:

1) The State is currently not reporting information or the number of individuals referred to, assessed for, and linked to supported housing in any of the sub-populations that are a part of the target population. Earlier in the implementation phase of the Agreements, DBHDD reported such data for some of the individuals in the target population except for individuals who are frequently seen in emergency rooms and individuals in State Hospitals on forensic status who have been found appropriate for community care.

DBHDD recently reported challenges in identifying the source of referrals as their reason for not reporting these numbers. Reporting the source of referral is a standard reporting requirement in state and federal supported housing programs. In most systems today, staff record the referral source on either a written or computerized referral form, easily retrievable for reporting purposes and often carried forward from one source document to another automatically. It has also been a standard reporting item on community services or hospital referral forms and is considered a valuable tool to ensure a state is reaching individuals most in need of supported housing.

2) Furthermore, the State has an uneven record in assisting individuals being released from jails or prisons to access supported housing, and has not designed and implemented an adequate referral process for individuals frequently utilizing emergency rooms. As reported in prior years, there are reliable assessment tools available that can verify eligibility and supported housing needs for individuals in the target population in these locations and, with assistance, could meet DBHDD requirements. There are also partners in hospitals, jails and prisons statewide willing to work with DBHDD and local providers to collaborate on developing a timely, accurate referral process. Many jails and most prisons and emergency rooms already have credible diagnostic information and information on an individual's housing needs.

The State could look to external sources for technical assistance on how to address outstanding issues, especially for those high utilizers who are frequently seen in emergency rooms and/or have frequent readmissions to the State Hospitals. For example, high utilizer programs are common today as identified and evaluated by the Center for Healthcare Strategies[1], numerous other healthcare organizations, and numerous state and local programs. Hospitals across the country have established protocols for identifying high utilizers of emergency rooms and this information could be used to plan more effective assertive engagement[2] with access to supported housing and community services. Identifying high utilizers also becomes a tool for shifting to effective alternative payment models that focus on assertive engagement. Local systems have established a range of options for establishing eligibility for high utilizer referrals and services. Atlanta area hospitals have begun addressing high utilizer issues through the Atlanta Regional Collaborative for Health Improvement (ARCHI) and through Atlanta regional hospital systems

[1] Hasselman D. Super-Utilizer Summit: Common Themes from Innovative Complex Care Management Programs. Center for Health Care Strategies, Inc. 2013: https://www.chcs.org/media/FINAL_Super-Utilizer_Report.pdf

[2] Assertive engagement is a term often used but not always defined. It generally indicates a persistent and active approach to an interaction and is best understood as the process whereby a worker uses their interpersonal skills and creativity effectively to make the environments and circumstances that service users encounter more conducive to change than they might otherwise be. Its roots in psychiatry come from Assertive Community Treatment (ACT) and became more refined and successful as an engagement tool by "Housing First" ACT teams.

to improve behavioral health connections. Although it has referenced some high utilizer initiatives, DBHDD has not yet reported results from this partnership.

3) The State should take effective steps to streamline the supported housing referral, assessment, and linkage process because, with no or delayed supported housing, certain members of the target population will become or remain high utilizers. The State of North Carolina has recently adopted a Referral Screening Verification Process (RSVP) that includes a simple one step online process to verify services and to determine supported housing eligibility. Individuals who do not have a safe, private place to live while they are engaged in the search for housing often move to short-term "bridge housing." Approximately 90% of individuals who move into bridge housing move into permanent supported housing within 90 days.

Likewise, CMS and state-level discharge planning policies and protocols require that discharge planning begin immediately upon an individual's admission to a hospital, including State Hospitals. States often gather information on the stability of an individual's housing at the time of their admission, which can then trigger a referral to supported housing. States often presumptively establish supported housing eligibility at that time and then rule it out later, if necessary. This presumptive process enables hospital and community staff to begin the process, including housing search, as soon as possible and well before discharge. Community and hospital-based treatment teams can begin to collaborate early in the process.

These are all important initiatives to consider and, along with the ARCHI initiative referenced above, could lead to more referrals for underserved groups in the target population and result in more eligible individuals gaining and keeping housing.

Recently, the State has taken some steps to initiate a process that establishes eligibility more quickly after identifying an individual as potentially in need of supported housing, which is referred to as the "referral and conversion" process. This includes establishing an on-line portal for the entire GHVP process and centralizing communication channels for issues related to the use of the platform. This is a significant improvement, especially in reducing the time between referral for a survey to determine eligibility and voucher approval or "conversion to referral" from 106.48 days to 22.91 days. In the larger sense, this demonstrates the State's ability to track and use data to make needed improvements. The percentage of referred individuals housed has increased from 38% in FY19 to 49% in FY 21.

DBHDD has shared its State Hospital discharge planning processes. With recent changes, these processes are more consistent with best practices for discharge planning. It is not clear at this point, however, that these processes are leading to increased referrals or linkages to supported housing and other community services and will be assessed further when the target population referral numbers are reported.

Stakeholders report that if an individual moves to a group home or personal care home they lose eligibility for a GHV. This is also counter to existing programs across the country where individuals retain their eligibility for supported housing if they must access transitional, bridge or even group living before they can find and move into suitable housing or even finish the referral process.

The State is making some progress in its operations and collaborative efforts to improve its referral system. The State is taking advantage of supplemental block grant funding allocated to states as a part of federal COVID-19 relief funding. DBHDD is allocating $6.15 million in one-time and multi-year federal funding to four re-entry collaboratives targeting individuals with serious mental illness: Pre-Trial and Jail In-reach Case Managers, Atlanta Policing Alternatives and Diversion Initiative, the Georgia Justice Project and the Trans Housing Coalition in Atlanta. These are promising collaboratives; their impact on the number of individuals in the target population getting supported housing and other community services will likely be evident in the coming year.

All of the initiatives referenced above must extend statewide to ensure that all sub-groups in the target population with a need for supported housing are referred, assessed, and then possibly linked to supported housing funded by State or federal programs.

As referenced in earlier reports, the State should analyze need, consult with stakeholders to review existing definitions for qualifying for supported housing, especially for individuals frequently re-admitted to State Hospitals, those who are frequent users of emergency rooms and/or those being released from jails and prisons, to ensure the existing requirements are not too restrictive for individuals with SPMI in need of supported housing.

Section Two: GHVP Requirements

Below is a chart depicting the number of individuals provided supported housing at the end of each of the last seven Fiscal Years based on DBHDD's reports:

Chart 1: GHVP Provided to Individuals in the Target Population FY 2015-FY 2021

FY 2015	**FY** 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
1,623	1,924	2,432	2,453	1,908	1,615	1,814

As is evident, the number with GHVP leases dropped significantly in recent years but moved back up again last Fiscal Year. As discussed above, there are encouraging signs the State can make more progress in the current Fiscal Year. However, the number of individuals reported as eligible for the GHVP in FY 21 was 261 less than in FY 20, which raises concerns about the presence of possibly too restrictive eligibility criteria and/or the failure to conduct sufficient outreach to all of the sub-groups of people within the target population. The FY 21 figure is not the result of fewer individuals with housing needs, although it is likely in part the result of the COVID epidemic that occurred for the entire FY 21. Naturally, the State's efficiency rate in establishing eligibility was higher in FY 21 (62%) than in FY 20 (51%). All of this points to the State's need to reach more eligible individuals and increase the availability of safe, affordable housing to meet their needs.

The State has identified four major factors impacting the availability of housing units for the GHVP and has made policy changes to help increase the availability of housing:

1) DBHDD has updated its payment standard in high population density areas by adopting a "Small Area Fair Market Rents" category, thus creating more opportunities to attract landlords and property owners. With a rapidly changing rental market, owners and landlords have raised rents beyond the current Fair Market Rental Payment Standards in some local areas. Georgia has a deficit of 216,839 rental units for individuals living at 50% of the Area Median Income; there are 140,557 units contributing to that deficit in the Atlanta metropolitan area.[3] This number is likely to increase if property managers continue to market to individuals who can afford to pay rent above the current Fair Market Rent Standard.

2) DBHDD, in partnership with DCA, has created a "Landlord Risk Mitigation" fund to cover damages or the cost of moving, which over time will likely help retain housing owners in the GHVP.

3) DBHDD is now allowing its community service provider agencies to "master lease" rental units to individuals. The agency itself holds the lease to these units. This is an effective tool so long as the individual retains tenancy rights, as required in the Settlement Agreement.

4) The State shifted its Unified Referral Process to a process described as "resource of first resort with requirements for future transition to alternate housing resources if/when available and appropriate." This positive shift enables the State to more quickly fill available apartment units, meets individual needs more promptly, and keeps people from dropping out of the queue. After the person is housed, when appropriate, the State can then seek to convert GHVP vouchers to vouchers funded by federal agencies. By doing so, the State can benefit from its share of federal resources and meet the housing needs of individuals in the target population.

Section Three: Scattered Site Housing Requirements

The State must meet an "integrated" housing requirement that at least half of the supported housing units connected to the Agreements be scattered-site housing, which includes apartments clustered in a single building with no more than 20 percent of the units in one building occupied by people in the target population. (SA III.B.2.c.i. (A), Extension Agreement §37). The Settlement Agreement requires that 60 percent of scattered-site supported housing be two-bedroom units and the other 40 percent be one-bedroom units. (SA III.B.2.c.i.(B).) The State has not reported data on this obligation; it has been requested to do so for the next report to the Court.

Section Four: Supported Housing Assistance

The Settlement Agreement requires that individuals get assistance, including psychosocial supports, to assist them in maintaining safe and affordable housing and integration into the community. This includes getting permanent housing with tenancy rights, linked to flexible community-based services that are available when individuals need them, but not mandated as a

[3] *The GAP: A Shortage of Affordable Homes.* The National Low Income Housing Coalition, Washington D.C. (March 2021)

condition of tenancy. Supported housing is available to an individual even if he or she is not receiving services through DBHDD.

DBHDD has struggled over time to meet these housing supports and requirements in an effective manner. However, over the past two years, the State has embarked on an initiative to ensure all GHVP enrollees will have basic housing supports to promote housing stability and success while living in the community. This initiative began with a cooperative arrangement with Step Up, an organization originally from California, and Pathways to Housing, a nationally recognized organization delivering and developing "Housing First[4]" ACT services. These organizations are delivering Housing First services in Fulton and Dekalb counties and providing consultation to DBHDD on "Housing First" development. DBHDD has since adopted a housing support model incorporating "Housing First" principles and will implement it with providers in two phases across the state starting in the Fall of 2021. DBHDD recently awarded five contracts for this program in Regions 1, 3, 4 and 5; it is targeting a launch in Regions 2 and 6 in July 2022.

The Pathways Housing First Institute will provide training, consultation, technical assistance and assistance with developing a GHVP program manual. DBHDD has already initiated an internal work group to oversee this initiative.

There are a number of challenges with this rollout. One will be ensuring that the linkage between these teams and an individual's service provider is effective, especially for individuals receiving their behavioral health services from providers who will not have a housing support contract. It will require careful coordination since it will occur between a housing support team incorporating "Housing First" principles and service providers who may be providing more traditional services that don't fully embrace the Housing First concepts. This challenge is further exacerbated because service providers are not getting new funding for services they currently provide; they have worked diligently during the pandemic with little relief. Another challenge will be ensuring full and successful implementation in order for a compliance review in the near future. A July 2022 start date for two Regions will delay a comprehensive statewide review.

Section Five: Capacity

The Extension Agreement includes a provision that the State shall continue to build capacity to provide supported housing by implementing a Memorandum of Agreement (MOA) between DBHDD and DCA. The MOA must include the following components:

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

[4] "Housing First" is a highly successful supported housing model with five core principles with established interventions: **1) immediate access to permanent housing with no housing readiness requirements;** 2) a rights-based, client-centered approach that emphasizes client choice in terms of housing and supports; 3) focus on an individual's recovery; 4) individualized services and supports; and 5) a focus on community integration.

b. A statewide determination of need for supported housing including developing a tool to assess need, forming an advisory committee to oversee the needs assessment, developing a curriculum to train assessors, certifying assessors, and analyzing statewide data;
c. Maximization of the GHVP;
d. Housing Choice Voucher (HCV) selection preferences (approved by the US Department of Housing and Urban Development);
e. Effective utilization of available resources (such as Section 811 and public housing authorities); and,
f. Coordination of available state resources and state agencies.

The State has taken steps to meet the requirements including convening a Statewide Advisory Council, ensuring coordination among state agencies and retaining the HCV preference. Although eligibility restrictions and limited outreach may be suppressing access to supported housing by all sub-groups in the target population, the State is attempting to maximize the GHVP.

DBHDD and DCA continue to utilize the Balance of State preference approved by HUD for individuals in the Agreements' target population deemed eligible for a HUD Housing Choice Voucher. There is a long waiting list for access to these vouchers, even with a preference, because these vouchers do not turn over often. Only 21 individuals accessed housing using this preference in FY21. There has been an average preference award of only 40 individuals per fiscal year, or 363 individuals overall, since HUD issued this preference in FY13.

The State tried, but no longer utilizes, a unified strategy at the point of referral. The State's attempt to do this was not effective. The process took too long, was not clear, and often did not give individuals choices of units that were accessible to them and/or located close to where their provider was located. Instead of creating the envisioned simpler assessment of need, the process became more complicated and less timely. However, DBHDD still attempts to utilize resources other than GHVs and works with DCA to switch individuals from GHVs to Housing Choice Vouchers, whenever appropriate.

Key personnel at DCA are demonstrating a clear focus on maximizing the availability of the Balance of State "preference" HCVs, Low Income Housing Tax Credit units and HUD 811. The agency recognizes the challenges with using HUD 811 and is taking positive steps to maximize the use of those funds for the target population.

Summary

There are encouraging signs that the State is moving forward to meet the Agreements' supported housing requirements. At this time, the State still needs to take decisive action in three critical areas. One, the State must be able to report the numbers of individuals in each of the target population sub-groups who have received authorization for a GHV and must demonstrate that individuals in all the sub-groups of the target population have access to supported housing. Two, the State must demonstrate that it can effectively implement a housing support system statewide, as identified in Paragraph 36 of the Extension Agreement, to ensure individuals have access to housing supports, regardless of where they reside. Three, the State must meet its obligation to provide supported housing to all individuals who need it.

In part, the State is falling short of having the capacity to serve those in need of supported housing because of the growing lack of affordable housing units in Georgia. But this problem also exists because the referral and eligibility process is slow and not effective and the eligibility criteria are too restrictive, failing those in need of supported housing and those individuals in need of more effective assistance to sustain their housing. With service system improvements, the State certainly can increase the number of individuals living in supported housing consistent with their identified needs, but availability of housing may continue to stymie efforts unless there are assertive actions taken to increase the supply of integrated community-based options.

Submitted by: _____/s/_____
Martha Knisley
August 24, 2021

ATTACHMENT TWO

REVIEW OF HOSPITAL DISCHARGES

Beth Gouse, PhD
August 9, 2021

Summary of June 2021 Visit to GRHA and ECRH

Sources of Information

Record reviews: A sample of 18 records was reviewed of patients with two or more psychiatric hospitalizations between July 1, 2020 and June 1, 2021.

14 individuals from GRHA
4 individuals from ECRH

Patients interviewed on site (only individuals in the sample who were still hospitalized):

2 individuals from GRHA
2 individuals from ECRH

Staff interviews:

Director of Social Work, ECRH
Director of Social Work, GRHA
Social Worker for Client #422443
Social Worker for #477508
Director of Office of Supported Housing

Findings/Recommendations

1. The participation by community service providers in treatment planning and the contacts between hospital social workers and community providers have increased over time. For example, at ECRH, there are weekly meetings between the hospital staff and the community providers.
2. No referrals to GHVP were found in this record review. According to the protocol used in Georgia's State Hospitals, in order for regional field office staff to complete the Need Supported Housing Survey, the patient must answer "yes" to the screening question (Does the individual agree to participate in the supportive housing process?). Not only is this a questionable requirement, there were often inconsistent responses in some records (e.g., in one chart, the 8/12 Social Worker note states the response as "yes," but in the 8/13 note, the response is "unable to answer at this time," and in the 8/21 note, the response is "no.") Most records indicated a "no" response. In addition, as a further complication, there was a technical issue with this question in AVATAR. The question is supposed to populate automatically in every Social Worker note; however, it did not appear in some records and was missing in successive Social Worker notes. It is recommended that DBHDD:
    a. Clarify operational instructions for completion of the screening instrument with Social Work staff. In light of significant turnover in Social Work staff, ensure that training occurs regularly regarding the referral process.
    b. Clarify with treatment teams how they are assessing the patient's interest in and appropriateness for supported housing, e.g., is this discussed in treatment plan meetings, are all team members familiar with all housing options.
3. Linkage with community providers is not routinely occurring prior to discharge. Specifically, while referrals to ACT teams occur more often than in the past prior to

discharge, a "warm handoff" (i.e., a member of the ACT team meeting with the patient prior to discharge or the actual intake with the patient occurring prior to discharge) is not routinely happening. Notes in the records included "individual will complete intake after discharge;" an intake appointment was scheduled for 3 days after the discharge date; an individual being discharged was referred to ACT the day before discharge, with enrollment scheduled for 7 days after discharge. It is recommended that DBHDD:

   a. Collect billing data from Beacon as far as actual visits from ACT teams and other community providers billed with the patients while hospitalized. (I suspect this number is quite low.)
   b. Remind/train social workers and community providers that community transitioning is a billable activity.

4. Similarly, for individuals already connected to an ACT team prior to admission, records indicate contact between the hospital Social Worker and the ACT team member during hospitalization, but not between the patient and the ACT team member.
   a. See recommendations directly above.
5. Review of GA Aftercare Follow-up forms (completed by Social Work staff after discharge) reveals that most are completed; however, most who are not discharged to jail are not following up with aftercare, especially those discharged to transitional housing and to family. It is recommended that DBHDD:
   a. Consider increasing its use of peer specialists with patients, as well as with family, in meetings prior to discharge.
   b. Increase efforts to establish/reinforce connections to community services prior to discharge.
   c. Analyze and address reasons for the failure to follow-up with aftercare instructions issued in prior admissions.
6. Georgia Readmission Assessments typically provide detailed recommendations and treatment planning meetings are routinely being held per policy; however, recommendations are not often followed (e.g., for one person, there was a recommendation for GHVP; however, the ACT team believed more supervision was necessary.) It is recommended that the Hospital:
   a. Ensure that the results of the GA Readmission Assessment are shared with the treatment team and discussed in the recovery-planning meeting.
7. There was evidence that Social Workers are assisting with benefits applications routinely, especially with those patients with a longer length of stay. However, COVID-related delays at Social Security have resulted in lengthier waits for applications to be processed.

Submitted by: _____/s/_____
Beth Gouse, PhD
August 9, 2021

See Attachment.

Review of State Hospital Discharges

State Hospital: Georgia Regional Hospital Atlanta
N: 14

Policy Requirement	Yes	No	CND	NA*
1. Transition planning occurred throughout the admission?	13			1
2. Are all required participants (hospital and community providers) in IRP meeting?	9	4		1
3. Community provider contacted, if already assigned?	10	1		3
4. Did social work staff provide education regarding discharge process?	14			
5. Did social worker assist with acquiring or confirming benefits?	13	1		
6. Housing needs documented by Social Worker at initial meeting?	12	2		
7. Do the SW notes or IRP reflect whether supported housing was discussed as an option?	2	12		
8. Mandated approvals of any discharge to shelter documented?				14
9. Did the intake appointment for ICM/ACT occur prior to discharge or did ICM/ACT team member meet with individual prior to discharge?	3	9		2
Total:	76	29		21
Percentage:	60.3%	23.0%	0.0%	16.7%

State Hospital: East Central Regional Hospital
N: 4

Policy Requirement	Yes	No	CND	NA*
1. Transition planning occurred throughout the admission	4			
2. Are all required participants (hospital and community providers) in IRP meeting?	2	2		
3. Community provider contacted, if already assigned?	4			
4. Did social work staff provide education regarding discharge process?	4			
5. Did social worker assist with acquiring or confirming benefits?	3		1	
6. Housing needs documented by Social Worker at initial meeting?	3		1	
7. Do the SW notes or IRP reflect whether supported housing was discussed as an option?	2			2
8. Mandated approvals of any discharge to shelter documented?				4
9. Did the intake appointment for ICM/ACT occur prior to discharge or did ICM/ACT team member meet with individual prior to discharge?		2		2
Total:	22	4	2	8
Percentage:	61.1%	11.1%	5.6%	22.2%

*Explanations for a Not Applicable (NA) rating are attached.

Explanation of Not Applicable (NA) Ratings

GRHA:

1. Individual returned to jail.
2. Individual returned to jail.
3. Provider was not yet assigned to these individuals.
8. No discharges to shelters.
9. One individual returned to jail; one moved out of state.

ECRH:

7. One individual has IDD and will require a Waiver setting; one individual will be discharged to an Intensive Treatment Residence (ITR).
8. No discharges to shelters.
9. See #7 above.