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

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

UNITED STATES' MOTION FOR ORDER TO SHOW CAUSE WHY THE STATE SHOULD NOT BE HELD IN CIVIL CONTEMPT OF COURT

Plaintiff United States respectfully moves this Court for an order directing the State to show cause why it should not be held in civil contempt of the October 29, 2010 Order adopting the parties' Settlement Agreement. Both the Independent Reviewer and the United States have identified multiple areas of non-compliance. Five years of reports from Independent Reviewer, the United States' reviews, and the State's own investigations continually highlight the same systemic concerns. For the reasons detailed in the accompanying Memorandum, the State should be held in contempt and ordered to remedy its non-compliance.

Respectfully submitted, this 19th day of January, 2016

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Local Rule 7.1D Certification

By signature below, counsel certifies that the foregoing document was prepared in Times New Roman 14-point font in compliance with Local Rule 5.1B.

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CERTIFICATE OF SERVICE

I hereby certify that on this 19th day of January, 2016, I electronically filed the **MOTION TO SHOW CAUSE** with the Clerk of Court using the CM/ECF system which will automatically send email notification of such filing to all of the attorneys of record.

/s/ Katherine Houston
KATHERINE HOUSTON

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

UNITED STATES' MEMORANDUM IN SUPPORT OF
MOTION FOR ORDER TO SHOW CAUSE

Five years ago, the State of Georgia entered into a Settlement Agreement with the United States and committed to serve persons with developmental disabilities and mental illness in the community. The Independent Reviewer's reports and the State's own documents demonstrate that the State is not in compliance with significant provisions of the Settlement Agreement that require support coordination, quality assurance, transition and discharge planning, and supported housing to support persons with disabilities in the community.

In the face of this evidence, the State now contends that, "[t]he Settlement Agreement did not mandate provision of care in the community for persons with IDD...." State's Status Report, Jan. 5, 2016, ECF No. 226 at 2. Instead, the State

argues that the Agreement requires simply moving persons from one location to another, with no regard to the adequacy of their care at the new location.

The State has failed to comply with multiple provisions of the Settlement Agreement. Among other violations, the State has failed to ensure that individuals with developmental disabilities receive the services and supports they need to be safe, avoid harm, and be integrated in their communities. People with complex needs can be served in the community with adequate supports and services. *See* Declaration of Nancy K. Ray, Ed.D. ("Ray Declaration") Ex. 1 ¶13. Georgia is failing to meet the needs of many of the members of the target population that it serves.

Judicial intervention is necessary to bring the State into compliance with the Agreement. The recommendations of the Independent Reviewer, over the course of years, have not persuaded the State to take all necessary steps to bring itself into compliance. A court-ordered corrective action plan is necessary to ensure that the State will comply with the Settlement Agreement.

I. BACKGROUND

The Independent Reviewer's Year 5 Report found that the State is not in compliance with multiple provisions of the Settlement Agreement. She found:

"Although the State has proposed, and begun to implement, some reasonable plans to rectify these recurrent gaps in the community system, there has been inadequate progress statewide and a failure to establish and meet meaningful timelines." Report of the Independent Reviewer, Sept. 18, 2015, ECF No. 208-1 ("Year 5 Report") at 3. According to the Independent Reviewer, the State remains non-compliant in the following seven areas:

1. providing individualized support coordination services that ensure persons are safe and receive adequate supports and services (§ III.A.2.b.iii);
2. providing discharge and transition planning services to ensure that persons transition safely to the community (§ III.D);
3. transitioning persons with developmental disabilities from the state hospitals into the community according to the transition schedule (§§ III.A.2b.i(D),(E), and (F));
4. developing crisis respite capacity for persons with developmental disabilities according to the agreement (§ III.A.2.c.ii(B)(3));
5. annually assessing the quality of developmental disability services and taking appropriate action based upon the reviews (§§ III.A.4.d and IV.A);
6. providing training to community providers (§ III.C.3.a.v); and
7. establishing the capacity to provide supported housing to 9,000 people in the target population (§ III.B.2.c.ii(A)).

The Independent Reviewer also found noncompliance with many of these provisions in earlier reports. The State never challenged her findings or her methodology. On September 23, 2015, the United States provided the State with a Notice of Non-Compliance with the Settlement Agreement, pursuant to §VII.C of

the Agreement. Notice of Non-Compliance with the Settlement Agreement, Sept. 23, 2015, ECF No. 226-1. The parties have negotiated in good faith to craft an extension of the terms of the Agreement that will cure the non-compliance found by the Independent Reviewer, but they have not been able to agree.

II. APPLICABLE LAW

A court may enforce the terms of a settlement agreement "if the district court either incorporates the terms of a settlement into its final order of dismissal or expressly retains jurisdiction to enforce a settlement." *American Disability Ass'n, Inc. v. Chmielarz*, 289 F.3d 1315, 1317 (11th Cir. 2002). In the Eleventh Circuit, a court enforces a consent decree through the court's civil contempt power. *Reynolds v. Roberts*, 207 F.3d. 1288, 1298 (11th Cir. 2000). The civil contempt procedure is laid out in *Wyatt v. Fetner*, 92 F.3d 1074 (11th Cir. 1996):

> In his motion, the plaintiff cites the provision(s) of the injunction he wishes to be enforced, alleges that the defendant has not complied with such provision(s), and asks the court, on the basis of his representation, to order the defendant to show cause why he should not be adjudged in contempt and sanctioned. If the court is satisfied that the plaintiff has made out a case for an order to show cause, it issues the order to show cause. The defendant, following receipt of the order, usually files a response, either confessing his noncompliance or presenting an excuse, or "cause," therefor. The dispute is thereafter resolved at a show cause hearing, with the issues to be decided at the hearing framed by the show cause order and the defendant's response.

Wyatt, 92 F.3d at 1078.[1]

Courts have broad remedial powers to enforce their orders. *Milliken v. Bradley*, 433 U.S. 267 (1977); *Citronelle-Mobile Gathering, Inc. v. Watkins*, 943 F.2d 1297, 1304 (11th Cir. 1991) ("The measure of the court's power in civil contempt proceedings is determined by the requirements of full remedial relief.").

III. ARGUMENT

The Settlement Agreement is the functional equivalent of a consent decree, *see American Disability Ass'n*, 289 F.3d at 1317, and this Court has the authority to enforce its Order, *see Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 440 (2004). The Court should enforce compliance because the State has failed to comply with multiple provisions of the Agreement.[2]

[1] At the show cause hearing, the party seeking civil contempt "bears the initial burden of proving by clear and convincing evidence that the alleged contemnor has violated an outstanding court order." *Commodity Futures Trading Comm'n v. Wellington Precious Metals, Inc.*, 950 F.2d 1525, 1529 (11th Cir. 1992); *Citronelle-Mobile*, 943 F.2d at 1301. Once this prima facie showing of a violation is made, the burden then shifts to the alleged contemnor "to produce evidence explaining his noncompliance" at the hearing. *United States v. Rylander*, 460 U.S. 752, 757 (1983); *Citronelle-Mobile*, 943 F.2d at 1301. The contemnor "must go beyond a mere assertion of inability" to satisfy his burden by introducing detailed evidence that he was unable to comply. *United States v. Hayes*, 722 F.2d 723, 725 (11th Cir. 1984).

[2] The State has recently asserted that its obligation under the Agreement is merely to place a person on a waiver and into a community residence without care for the adequacy of the services provided under the waiver. Hearing Transcript, Jan 6, 2016 at 9. The State maintains that adequacy of services is not part of the Agreement. State Defendants' Status Report, Jan. 5, 2016, ECF No. 266 at 2, 10. The State's position is untenable. It is also belied by the State's own admissions. In the motion seeking modification, and in its own decision to impose a moratorium on community placements until it could address quality concerns, the State has conceded that the quality of the placements matters. Joint Motion to Modify Agreement, July 22, 2013, ECF No. 170 at 4 ("Consequently, the Parties wish to defer Ms. Jones's rating of the *quality* of DD placements for six months to provide that time, after which she would issue a report assessing the deferred provisions.") (emphasis added). *See also Doe v. Bush*, 261

A. The State is in Non-Compliance with the Agreement

1. The State violated the Agreement's requirement to provide individualized support coordination services.

The Agreement requires that "support coordination shall be provided to all participants" and requires the State to assemble "professionals and non-professionals who provide individualized supports" and who, "through their combined expertise and involvement," develop Individual Service Plans. Settlement Agreement § III.A.2.b.iii (p. 8). The Support Coordinator is required to assist the individual to gain access "to needed medical, social, education, transportation, housing, nutritional, and other services." *Id*. The State has failed to assemble professionals with expertise who can assess an individual's needs and connect the individual to services in a timely manner, and the failure to do so has placed persons at risk of serious and preventable harm.

For each of the five years of the Agreement, the Independent Reviewer has found the State out of compliance with § III.A.2.b.iii. In the Year 5 Report, the Independent Reviewer documented the State's fifth straight year of noncompliance

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F.3d 1037, 1047-8 (11th Cir. 2001) (holding that where a judgment required the state to maintain a waiting list for placements for people with developmental disabilities, the state could not contend that the judgment did not require them to actually and timely admit those on the wait list to services).

with this provision, finding that, "Support Coordination is the linchpin to the implementation of the Individual Service Plan. It is also an essential safeguard for minimizing adverse risk." Year 5 Report at 6. The Independent Reviewer further found that, when the State has made a remedial plan to address deficiencies, those plans have been inadequate: "Intensive Support Coordination resources still are available to a limited number of individuals in Region 4[3] only" and "there has not yet been an extension of these plans to other areas of the State or to other individuals who are currently institutionalized. The roles and expectations for Support Coordination have not yet been standardized statewide." *Id*.

In addition, numerous reports, assessments, and reviews developed by the State's consultants have repeatedly identified systemic failures to provide support coordination that the State has yet to correct. *See, e.g.*, Gap Analysis, Feb. 2015, Ex. 2 (filed under seal) at 10 (finding that "a major reason agencies have not participated in serving the ADA population is that the agencies recognize that they do not currently have the experience and expertise to successfully serve this high risk population."); Recommendations for Improving Support Coordination, Dec.

[3] The Georgia Department of Behavioral Health and Developmental Disabilities system of services is administered through field offices in six regions of the State. Region 1 is in the north; Region 2 is in the east; Region 3 is the Atlanta metropolitan area; Region 4 is in the southwest; Region 5 is in the southeast; and Region 6 is in the west.

2013, Ex. 3 at 3, 8 (recommending that the State, among other things, establish intensive support coordination that includes early engagement and more frequent monitoring and address concerns about "follow-through on corrective action plans, notification on critical incidents"). The State has long been on notice of these deficiencies and recommendations of how to fix them. It has not.

a. Individual Service Plans fail to identify and address needs.

Individuals in Georgia, including those with complex needs, can be transitioned safely into the community. Declaration of Kathy E. Sawyer ("Sawyer Declaration"), Ex. 4 ¶¶ 20, 22; Ray Declaration ¶ 13. The State has failed to provide the needed supports and services. Specifically, the State has failed to adequately assess the persons it serves and develop and implement Individual Service Plans (ISPs) to address their needs.

Seventy-nine of the approximately 503 persons who have been discharged from State hospitals under the Agreement have died. *See* Ex. 5 (filed under seal). The available records indicate many unaddressed medical needs. Ray Declaration ¶¶ 37, 41. This mortality data, viewed in light of ongoing noncompliance with transition planning and support coordination requirements, is deeply concerning.

While the majority of these persons had complex medical needs that are associated with higher mortality, many of the death reports document poor assessments, care, and oversight across the state. Ray Declaration ¶¶ 37, 40, and 41; *see, e.g.*, Mortality Review and Investigation, NS, Dec. 18, 2015, Ex. 6 (filed under seal) ("[NS] was in good health until she choked on a sausage biscuit given to her for breakfast on April 8, 2015. . . . [NS's] death appeared to have been preventable.") The State has also reported to the United States a number of deaths of persons with developmental disabilities living in the community on diversion waivers, and many of those reports evidence these same departures from accepted standards of care. *See, e.g.*, Investigative Report for AT, Feb. 18, 2015, Ex. 7 (filed under seal) (noting that AT's caregivers did not have any information about AT's treatment needs, did not know his medical history, and that an officer found pills, marijuana, and a large amount of cash wrapped around "pills from an unknown source" in the home).

In 2014, in response to the recommendation of the Independent Reviewer, the State arranged for an independent organization, Columbus, to conduct mortality reviews of unexpected deaths. Columbus repeatedly found that Individual Service Plans in place do not adequately identify and address the care

and treatment needs of persons in the target population. In addition, the State had not ensured that critical assessments were conducted and had not ensured that necessary follow-up tests or services were provided. *See* Mortality Review and Investigations, SG, RS, ME, GL, RH, BC, and BB. Exs. 8-14 (filed under seal). In addition, the State contracted with Columbus to make site visits in February 2014. Many of the Individual Service Plans reviewed by Columbus failed to include nursing care plans and did not include assessments for needed therapeutic supports and services such as evaluations for wheelchair alignment and fit or positioning options. March 2014 Supplemental Report, Columbus Community Services Consultant Report, March 24, 2013, ECF No. 184-4 at 5. The report stressed that frequent assessment is vital to meeting contemporary standards of care for persons with developmental disabilities who also have medically complex conditions. *Id.* at 4.

Even when assessments and recommendations are made, the State has failed to ensure effective corrective actions are implemented in response to identified quality concerns. Year 5 Report at 24; Ray Declaration ¶ 41. The failure to close this feedback loop can have disastrous consequences. For example, a July 2013 corrective action plan noted that the home provider for GL promised additional

training for the home's staff on issues including tracking and managing edema, fluid intake, and weight gain and promised improved medication reconciliation and reporting. Corrective Action Plan, July 25, 2013, Ex. 15 (filed under seal). GL died on April 1, 2014, less than nine months from the date of the corrective action plan. The mortality review by Columbus raised a concern that the acute medical event that led to his death "may have been preventable." Mortality Review and Investigation, GL, December 22, 2014, Ex. 11 (filed under seal) at 10.

b. Clinical supports are insufficient.

The State has not ensured that persons discharged from the State Hospitals get the services they need. The State's own reports show that such persons are not having their nutritional needs met, experience recurrent aspiration events, and are repeatedly hospitalized. Basic identified needs are not addressed. For example, DM was at high risk for aspiration, yet had a broken hospital bed – critical equipment needed to ensure proper positioning and minimize the risk of aspiration – for over three months. In October of 2014, the Independent Reviewer's nurse made a site visit to DM's home and found potential harm, including neglect. The nurse recommended a physical therapy consultation because of her history and risk

of aspiration "so that DM is not lying flat at the bottom of the bed…." Monitoring Questionnaire, Shirley P. Roth, MSN, RN, Oct. 16, 2014, Ex. 17 (filed under seal). This lack of sufficient clinical expertise is a long-standing problem. In December 2013, Georgia State University issued a report that showed that 66.7% of the population surveyed needed occupational therapy services but did not receive them, and nutritional services were missing for 33% of the population surveyed. Georgia DD Community Transition Quality Review Analysis, Dec. 2013("Georgia State Review"), Ex. 18 at 5.

After numerous persons discharged from Southwestern State Hospital had difficult transitions, the State began some heightened monitoring in Region 4. Many of the 43 persons tracked by the State continued to experience negative outcomes for months. *See, e.g.*, Monthly Oversight Report, June 2015, Ex. 19 (filed under seal). In the spring of 2015, the State launched a plan for clinical review in a single region, the Region 2 Pioneer Project. As part of the Pioneer Project, the State contracted with a team of experienced providers to assess persons who had transferred from a State Hospital. The team reviewed ISPs to assess whether the plan addressed an individual's needs. Any ISP that did not address the individual's needs was referred to a newly-formed Integrated Clinical Support

Team. Tellingly, 90 of 103 ISPs reviewed were referred to the Integrated Clinical Support Team, showing the State's near-universal failure to develop appropriate ISPs and ensure the needed supports and services called for in the plans are actually provided. *See* Year 5 Report at 4; 2015 Interim Quality Management Report, Ex. 20 at 39.

The single Integrated Clinical Support Team in Region 2 is not sufficient to meet the needs of the entire state. The Independent Reviewer concluded that, "Given the size of the State and the highly varied availability of clinical professionals, especially in rural areas, more than one ICST [Integrated Clinical Support Team] is required for successful oversight and the delivery of individualized clinical supports." Year 5 Report at 4. She also reported that a "greater sense of urgency is needed…" *Id.* at 8.

In addition, the State's current remedial plans focus only on persons recently discharged from the State Hospitals. The target population also includes "those who are at risk of hospitalization in the State Hospitals." Settlement Agreement III.A.2.a (p.5). The State's failure to expand this service to the entire target population across the State leaves hundreds of persons who were at risk of

institutionalization and received a diversion waiver without access to needed clinical assessments and services.

2. The State violated the Agreement's requirement to provide adequate discharge and transition planning services.

Sections III.D.1 and 3 of the Agreement require the State to provide discharge and transition planning.[4] Settlement Agreement §§ III.D.1 and 3 (p. 24).

Reports from the Independent Reviewer highlight the failure of the State to satisfy the discharge and transition requirements. For example:

> [S]upport coordinators did not participate in the discharge planning process from the State Hospital and only assumed responsibility after the community placement had occurred. This is not consistent with expected practice in the field. The early linkage of support coordination is crucial because the support coordinator is responsible for ensuring that the Individual Service Plan is individualized appropriately, is fully implemented, and is modified, after discharge from the State Hospital, to reflect any significant changes in health or wellbeing.

Supplemental Report of the Independent Reviewer, Mar. 24, 2014, ECF No. 184-1 at 8. The Independent Reviewer's sample of case reviews for the Year 5 Report also includes numerous examples of the State's failure to adhere to the discharge provisions for people with developmental disabilities: "One of the individuals

[4] In addition to § III.D. on Transition Planning, the parties agreed that §§ III.F.1,3, 4 and 5d of the 2009 Settlement Agreement between the United States and Georgia regarding discharge and transition planning are subsumed by and would be enforced under § III.D of the 2010 Settlement Agreement. *See* 09-CV-0119, *United States v. Georgia*, Notice of Termination of Settlement Agreement and Joint Request to Close, Feb. 5, 2014, ECF No. 187.

placed in 2011(MS) experienced very short community tenure. His provider at the time stated that his discharge was not adequately planned. The Independent Reviewer has followed his treatment trajectory for five years now. He remains confined to the State Hospital." Year 5 Report at 33.

In addition to the findings of the Independent Reviewer, site reviews of community homes by both the State and the United States found that critical documents – including discharge summaries, nursing care plans, and protocols to address heightened risks specific to an individual – were often missing. Columbus Consultant Report at 4-5. In other cases, the documents were available but had never been updated to reflect the person's routines in a community home, instead of an institution. *Id*.

In the face of numerous examples of poor and dangerous transitions, the State has repeatedly told the United States that it was substantially changing its transition process. *See* Ex. 21; Report of the Independent Reviewer, Sept. 19, 2013, ECF No. 175 at 21; Report of the Independent Reviewer, Sept. 18, 2014, ECF No. 192-1 at 2; Supplemental Report of the Independent Reviewer, Mar. 20, 2015, ECF No. 200 at 11; Year 5 Report at 5. In November 2015, the State adopted a new Community Transitions from State Hospitals Manual. The manual

is too recently-adopted and there have been too few discharges to evaluate how effectively it will be implemented.

At a minimum, adequate transition and discharge planning for individuals with developmental disabilities requires:

> comprehensive assessments of the person's needs; identification and employment of qualified providers who are trained and competent to service those needs; acquisition of all needed services and supports, prior to movement, including needed adaptive equipment; and assignment of support coordinators (or case managers) familiar with the person, the person's needs, and their individualized service plans.

Sawyer Declaration, Ex. 4 ¶ 17A. The State is not providing adequate transition and discharge planning services.

3. The State violated the Agreement's transition schedule for placing persons with developmental disabilities from the state hospitals.

The Agreement requires the State to create waivers to move a minimum of 600 people with developmental disabilities from the State Hospitals to the community over a five-year period. Settlement Agreement §§ III.A.2.b.i(D), (E), and (F) (pp. 6-7). The Agreement also requires the State to serve any persons remaining in the State Hospitals on July 2, 2015, in the most integrated setting appropriate to their needs. Settlement Agreement § III.A.2.b.i(F) (p. 7). The State

has moved 503 persons out of the hospitals over the five year period, and approximately 266 persons remain institutionalized. Year 5 Report at 5. The State admits that "it did not meet its numeric targets for the number of people" with developmental disabilities transitioned from the State Hospitals. Response to Notice of Non-Compliance, Nov. 9, 2015, ECF No. 226-2 at 9.

The State imposed two temporary moratoriums on placements during the Agreement. The temporary moratoriums on transitions were appropriate in light of significant evidence of poor placements. However, the moratoriums do not excuse the State from its obligations under the Agreement. Since the most recent moratorium was lifted in December 2014, only four persons have been discharged through the State's pilot program, the Pioneer Project. Year 5 Report at 5. An additional 12 persons with forensic histories have been discharged through the courts. *Id*. The Independent Reviewer reports that "266 individuals are still confined to state hospitals and the completion of a comprehensive transition plan/process has been pushed forward to July 1, 2016." *Id*.

All of these individuals could be transitioned to the community. *Amici Curiae's* Statement Regarding January 6, 2016 Non-Evidentiary Hearing, Jan. 5, 2016, ECF No. 228 at 5. In fact, 14 other states have closed all of their state-run

institutions for people with developmental disabilities. *Id.* Persons with complex needs can be served in the community with adequate supports and services. Ray Declaration ¶ 13.

In this fifth year of the Agreement, major barriers to discharge remain unaddressed, and the State has managed to complete only a handful of successful discharges in the past year. This non-compliance goes to the heart of the *Olmstead* claims brought by the United States – that persons with disabilities languish needlessly in the highly restrictive and segregated settings of the State Hospitals.

4. The State violated the Agreement's requirement to develop crisis respite homes for persons with developmental disabilities.

The Agreement requires the State to establish 12 crisis respite homes. Settlement Agreement III.A.2.c.ii.(B)(3) (p. 9). Although the State has established 11 homes, they do not function as crisis homes. Independent Reviewer Year 5 Report at 28. Crisis respite homes are intended to provide "short-term crisis services" in a residential setting for persons "experiencing an emotional/behavioral change and/or distress."[5] Instead, the State is using them as long-term, non-

[5] Community-Based Services for Individuals Living with Developmental Disabilities, Department of Behavioral health and Developmental Disabilities, https://dbhdd.georgia.gov/dd-community-based-services, last visited Jan. 15, 2016.

integrated placements for persons whose community placements were insufficient to support their needs. The Year 5 Report found that "crisis respite homes have been used for long-term residential placements instead of their intended purpose of seven to ten days of respite care." Year 5 Report at 28. The individuals reviewed by the Independent Reviewer remained in crisis placements for six months to more than three years, and there were no plans to move them into appropriate community settings. *Id*. Several individuals had no Behavioral Support Plans, staff was not trained on positive behavioral supports, and there was no involvement by behavioral specialists. *Id*.

The State has failed to ensure that individuals with developmental disabilities in need of crisis services receive services that are person-centered and based upon individual assessments. The misuse of these crisis facilities demonstrates noncompliance with both the crisis services provisions of the Agreement and the Support Coordination provisions discussed above.

5. The State violated the Agreement's requirement to take appropriate actions to address the quality of developmental disability services.

The Agreement requires the State to assess annually the quality of developmental disabilities services and take appropriate action based on each assessment. Settlement Agreement, § III.A.4.d (p. 11); § IV.A (p. 25). The State has completed annual assessments, but it has failed to take appropriate remedial actions to address identified problems. As the Independent Reviewer notes, "there was no evidence that the negative findings from the annual quality service reviews were addressed in a timely and complete manner." Year 5 Report at 24.

The State's own Quality Management Reports have consistently noted ongoing issues related to compliance with the support coordination provisions of the Agreement. For example, the most recent annual review found serious deficiencies for persons recently discharged: Only 18.6% had a "person centered focus supported in documentation;" only 62.8% had their "human and civil rights maintained;" and only 42.1% had "means to identify health status and safety needs." Annual Quality Management Report, January 2014-December 2014 ("Annual Quality Management Report, 2014"), Ex. 22 at 45. The State's interim report from 2015 further notes that only 7% of plans support real community integration. 2015 Interim Quality Management Report, Ex. 15 at 54. Moreover, the State fails to address the deficiencies identified by the Independent Reviewer.

The survey tool used by the Independent Reviewer's nurses shows that of the 225 reviewed, 40% of the cases showed evidence of harm and neglect; 47% had serious health needs not being met; and in 61% nursing does not meet professional standards of care. *See* Ex. 23.

The State's efforts to develop an effective quality review system have yet to bear fruit. In 2014, the State retained consultants from Ernst and Young to help address deficiencies identified by the Independent Reviewer. They developed a series of subject-matter corrective action plans that echo prior recommendations to improve support coordination. *DBHDD Moving Forward*, Jan. 22, 2014, Ex. 24 at 5. The State has failed to demonstrate that they have taken appropriate remedial actions to address these identified problems.

6. The State violated the Agreement's requirement to train community providers.

The Agreement requires the State to train community providers so that services can be maintained in a manner consistent with the Agreement. Settlement Agreement § III.C.3.a.v (p. 24). The Independent Reviewer found that "compliance with training requirements was not maintained by a significant number of provider agencies." Year 5 Report at 23. She noted that the State had

provided a two-day "training for provider agencies on critical aspects for the prevention of aspiration, bowel obstruction, GERD, seizures and dehydration." *Id*. at 7. Her report found, "Clearly, this instruction is of very high importance and it is critical that there be much more training of this nature statewide." She also found, "During the reviews conducted this summer, at least two provider agencies asked the Independent Reviewer's nurse consultants for additional guidance on preventing aspiration pneumonia. Descriptive material on the importance of oral hygiene was forwarded to them after the visits." *Id*. Similarly, the State's own Quality Management Report found that 41% of the provider professional staff were not properly trained, licensed, credentialed, experienced, and competent; job descriptions were not in place for 64% of the personnel; and 52% of all staff having direct contact with consumers did not have all required annual training within the first sixty days and annually thereafter. 2015 Interim Quality Management Report, Ex. 15 at 50. The State must ensure that service providers are adequately trained so that they can safely support people in the community. The State is out of compliance with this provision.

7. The State violated the Agreement's requirement to provide supported housing to all individuals with serious mental illness who need it.

The Agreement requires the State to have the capacity, by July 1, 2015, to provide Supported Housing to any of the 9,000 persons with serious and persistent mental illness in the target population who need such support. Agreement § III.B.2.c(A) (p. 19). The State has failed to comply with this provision.

In her September 2015 report, the Independent Reviewer found that, although the State was in compliance with many of its obligations to persons with mental illness, "compliance had not been achieved" with this requirement because "the State does not yet have" the Supported Housing capacity to meet the needs of the target population. Year 5 Report at 19. The Independent Reviewer reported that the State agreed that they are not yet in compliance with the Supported Housing requirement and that more time would be needed. *Id.* at 10.

Over the last five years, the State has taken significant steps, as required by the Agreement, to build a system to provide Supported Housing to individuals with mental illness. Still, persons with mental illness continue to face significant barriers to accessing Supported Housing. The Independent Reviewer's housing consultant, Martha Knisley, found that individuals with mental illness "haven't had

opportunities to move into their own home." Georgia Supported Housing and Bridge Funding, Sept. 14, 2015, ECF 208-1 at 5. The State must take its Supported Housing program to scale, as required by the Agreement, to provide Supported Housing for everyone in the target population who needs it.

IV. CONCLUSION

For the foregoing reasons, the United States respectfully requests that the Court:

1. Issue an order directing the State to show cause why it should not be held in civil contempt of the October 29, 2010 Order adopting the parties' Agreement;

2. Hold an evidentiary hearing, as scheduled to begin on March 28, 2016;

3. Find the State in contempt of the October 29, 2010 Order;

4. Order a corrective action plan that includes deadlines for compliance;

5. Hold quarterly status conferences with the parties and Amici at which the State must report to the Court on its progress on implementation; and

6. Order other relief as appropriate.

Respectfully submitted this 19th day of January, 2016.

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Local Rule 7.1D Certification

By signature below, counsel certifies that the foregoing document was prepared in Times New Roman 14-point font in compliance with Local Rule 5.1B.

/s/ Katherine Houston
KATHERINE HOUSTON
Attorney
U.S. Department of Justice
Civil Rights Division
Special Litigation Section

Exhibit 1

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

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

DECLARATION OF NANCY K. RAY, ED.D.

1. I am an independent consultant specializing in the transitions of individuals from institutional to community-based services.

2. I have worked in the field of mental health and developmental disabilities services for over 35 years.

3. From 1978 to 1995, I worked at the New York State Commission on Quality of Care, where I directed the various program evaluations of disability services statewide. In 1993, I became First Deputy at the Commission, a position that required my supervision of most of the agency's overall operations.

4. In 1995, I established a private consultation business, NKR & Associates. Over the past 20 years, I have worked in 20 states in a variety of roles,

including as a federal court monitor, as a consultant to state and municipal departments of mental health and developmental disabilities, as an expert consultant for the Department of Justice and Health and Human Services' Office of the Inspector General, and as a special consultant to various federal and state court monitors and monitoring panels. My work has also included consultation regarding local correctional facilities and statewide youth secure detention services.

5. From 2000 – 2013, I served as the Court Monitor to the district court judge in *United States v. Tennessee* (W.D. Tenn.), a case involving the closure of the Arlington Developmental Center and the building of a comprehensive system of community-based services to meet the needs of the over 700 class members with developmental disabilities. This work involved monitoring of both institutional and community services, as well as working with all stakeholders to ensure that newly developing community services were of high quality and individualized to meet class members' needs.

6. In my role as a Court Monitor, I had final approval on each individual's transition from the institution to the community. This involved ensuring that the individual had been matched with a provider who could meet his or her needs, all necessary services were in place prior to the transition, necessary equipment was in place in each home, that a primary physician had been located,

and that staff had been trained on any protocols necessary to keep the person safe and healthy (such as mealtime and positioning protocols), among other things. Once individuals had transitioned to the community, my work involved using data analysis (such as incident reports and feedback from monitoring notes from support coordinators) to track high risk individuals, follow up on deficient providers, and track incident and death reviews. I also directed and supervised quality reviews of community providers supporting the class members who had transitioned to the community from the institution.

7. I have served as a consultant in the development of quality assurance systems with special attention to protection from harm issues in community and institutional services for persons with disabilities in Louisiana, Connecticut, Hawaii, New Mexico, Arizona, Georgia, Tennessee, Ohio, and Wisconsin. In this capacity, I have helped states develop appropriate quality enhancement programs for community services and effective and efficient incident management and abuse and neglect investigation systems.

8. I have also assisted states in downsizing their state hospitals and developmental centers and safely transitioning former residents to more integrated community living arrangements.

9. I also have a strong background in program and systems evaluation. I have completed evaluations of many aspects of New York's service system for

people with mental disabilities, of community mental health services in Denver and Washington DC, and of community services for persons who have developmental disabilities in West Tennessee.

10. In 2011, I became an expert consultant to the United States Department of Justice on the *United States v Georgia* case (09-CV-119), which focused on improving conditions and reducing harm within Georgia's State Hospitals.

11. In 2013, I became an expert consultant to the United States Department of Justice on the *United States v Georgia* case (10-CV-249). During the course of my work, I have reviewed the following documents: 1) reports and investigations of deaths of individuals receiving community services; 2) reports of the Independent Reviewer assessing compliance with the Settlement Agreement; 3) deficiency reports issued by support coordinators assigned to individuals in community services who had transitioned from State hospitals; and 4) the State's statewide quality management reports pertaining to community services.

12. In addition, I reviewed various documents prepared by State officials responding to specific concerns in its community services system. These have included, but are not limited to:

(i) New protocols for transition planning for individuals who have developmental disabilities (DD) leaving State hospitals for community homes;

(ii) The State's Priority Plan (for community services for individuals with DD);

(iii) Various State documents pertinent to the improvement of the provision of clinical and health care services to individuals with DD in the community;

(iv) Various State documents pertinent to the improvement of support coordination services for individuals enrolled in its Home and Community-Based Waivers;

(v) Independent mortality reviews provided to the United States of individuals with DD who died during the course of the Agreement;

(vi) Provider Manual for residential and other agencies providing Waiver services under contract with Georgia; and

(vii) Various documents related to the rate reimbursement structure and service delivery in Georgia's Home and Community-Based Waivers.

13. Based on my extensive review of the documents described above, it is my professional opinion that there are fundamental flaws with Georgia's community service system for individuals with DD that place these individuals at significant risk of harm. These flaws include an ineffective support coordination system, lack of accountability in the quality management system, and insufficient capacity to provide critical medical, clinical, and behavioral services. As a result of these problems, many of the individuals with DD who have transitioned from Georgia's State Hospitals or who have been diverted from admission under the Settlement Agreement are not getting the supports and services they need to be safe, healthy and integrated in their communities. In my experience, people with

complex needs can be served in the community with adequate supports and services.

The State's Support Coordination Has Significant Structural Flaws

14. Based on my experience with Medicaid funded Home and Community-Based Waiver programs across the country, states assign a case manager, usually called a support coordinator, to help the individual and his/her family identify and request Waiver services that meet the individual's needs, choose a provider, oversee and monitor the individual's health, safety and welfare, and ensure that the individual is receiving the services identified in their individual plan of care.

15. The Independent Reviewer, in her compliance reports to the Court, has expressed repeated concerns about the State's system for providing support coordination. In my extensive review of the State's documents, its proposed plans to remedy these fundamental problems lack specificity in describing the action steps and do not contain timelines for needed reforms.

16. My review of the State's support coordinator monitoring reports, among other documents, shows that the State does not have an effective support coordinator program.

17. Although the State has recognized that individuals with complex needs may need what is referred to as intensive support coordination, it has only

offered it to a handful of individuals in only one region of the State. This type of intensive support coordination is critical for people who have complex medical or behavioral issues. Intensive support coordinators have a lower caseload (typically no more than 10-15) and have particular expertise around people with complex needs.

18. The State also has provided inadequate oversight of its support coordination contractors, which has resulted in poor quality services and left many individuals at risk of harm. Frequency of visits by support coordinators to Waiver participants, the nature and thoroughness of these visits, and most important, the implementation of corrective actions to resolve identified problems appear to be poorly monitored by State. Although some support coordinator reports do eventually come to the attention of State employees in either the Department of Behavioral Health and Developmental Disabilities' (DBHDD) Central or Regional offices, I have seen no documentation of consistent and accountable response to these reports. Because it appears that support coordinators in Georgia have no authority over contracted Waiver provider agencies, State action in responses to these reports is essential to addressing identified problems.

The State's Support Coordinator Deficiency Reports Show that that Identified Problems Do Not Get Addressed

19. I recently reviewed approximately 230 deficiency reports issued by support coordinators covering the time period of September 2014 to August 2015. Most of these reports cited serious problems related to individuals' health and safety – yet documentation frequently failed to confirm follow-up corrective actions by State officials. Indeed, my review indicated that more than 80 of the 230 reports cited at least one serious deficiency that the support coordinators had cited previously – but there was no evidence that they had been corrected. Sixteen individuals had four or more deficiency reports. Twenty-eight individuals had three or more reports.

20. The most common health-related concerns cited were related to medication problems, including individuals not receiving prescribed medications. Another common problem was staff's failure to adequately track and monitor important measures of health status, including the individual's weight, food and fluid intake, bowel movements, or blood pressure. Tracking and monitoring these measures is critically important to identifying problems for people with complex medical needs.

21. One individual (CB), who was the subject of four support coordinator deficiency reports over the course of three months, was noted to have repeated

problems with her care. Her records were missing 16 days of documentation in the seizure log and 14 doses of anti-seizure medication in the medication administration record. Separate reports by a regional quality review team, which I describe below, also cited problems with seizure documentation, as well as bowel monitoring and repositioning logs. One report also cited a lack of staff to monitor her during mealtimes, as required by her treatment plan to ensure that she did not choke or aspirate food into her lungs. There was no documentation in the records I reviewed that these problems were addressed.

22. Another individual (JM), who receives all of his nutrition through an enteral tube, had two deficiency reports issued in March and again in April 2015, each citing essentially the same serious healthcare concerns: the nurse required to oversee his tube feedings each day had not been present for several days, his bowel management protocol was not followed, and the home did not have sufficient staff to ensure that he had two staff members to assist him in repositioning, which was required every two hours. There was no documentation in the records I reviewed that these problems were addressed.

23. These are just two examples of dozens of similar circumstances I found in my reviews of the support coordinator deficiency reports, where serious health problems were repeatedly identified, but not corrected.

The State's Regional Quality Review Reports Further Evidence the Ineffectiveness of the State's System to Identify and Address Problems

24. I was also asked to review Regional Quality Review reports (RQR reports) generated by the DBHDD's six Regional Offices as a part of their quality review process. These reports memorialize site visits that regional office staff (including some contractors) make to homes with individuals who had transitioned from Georgia's State Hospitals under the Settlement Agreement.

25. The RQR reports primarily covered the period September to November 2015, although a small subgroup of the reports pre-dated this period and a few reports were dated in the first few days of December 2015.

26. I found that the number of individuals who were reviewed by their region's quality team varied widely. For example, the Region 1 reviews were conducted on only 18% of the 73 individuals who transitioned, and in Region 2, on only 13% of the 111 transitioned individuals. By contrast, in Region 6, 57% of the 44 transitioned individuals were reviewed; in Region 3, 64% of the 90 transitioned individuals were reviewed; and in Region 5, almost all (96%) of the 49 transitioned individuals were reviewed. There was no discernable or uniform criteria used by the regions to determine which individuals to review.

27. I also found that the regions differed greatly in the frequency of their RQR reviews. For example, in Regions 3 and 6, most individuals were reviewed several times a month or even weekly, but in Regions 1 and 2, most individuals

were reviewed only one time over the entire 90-day period. In Region 5, individuals were usually reviewed monthly.

28. It appears that the varying frequencies were region-specific and did not correlate with the seriousness of the identified problems from prior reviews. In many cases, especially in Regions 3 and 6, the RQR reports indicated that visits were weekly or even more frequent, even for individuals for whom no serious concerns had been previously identified. In other cases, especially in Regions 1 and 2, very serious reports had no follow up.

29. What the regional office reviewers actually reviewed or assessed during their visits likewise varied significantly. An assortment of different review tools were used by the different regions, and they varied dramatically in both depth and scope of the issues assessed. Some regions did not use formal review tools, but instead had reviewers summarize most or all of their findings in brief narrative notes (Regions 4, 5 and 6).

30. In my professional experience working on quality management systems in over a dozen states, consistency is critical. Overall, the methodologies of the regional offices' quality review activities reflected in the RQR reports were so dissimilar that they would make it difficult for the DBHDD Central Office to properly assess the relative importance of their findings or to be assured that

problems identified by one region's quality reviewers would have been detected (if present) by another region's quality reviewers.

31. The findings of support coordinators – whose job is to identify problems with an individual's care -- are a critical piece of information for any quality management system and certainly should be part of the RQR reports. Yet in all but one region, regional reviewers did not appear to rely on support coordinators' review findings in their monitoring. I found virtually no reference to support coordinators' findings in the RQR reports filed by Regions 1, 2, 4, 5, and 6. In addition, the regional reviewers did not appear to follow up with support coordinators who had apparently missed serious concerns during their own monitoring.

32. Perhaps most important of all, however, was that RQR reports across the regions, regardless of their differences, consistently failed to document follow-up of cited deficiencies through to remedy.

33. This was most notable in Regions 1 and 2 when most individuals were reviewed only one time, regardless of the severity of the deficiencies – but it was also notable in Regions 5 and 6 where narrative RQR notes usually did not clarify what, if anything, was fixed from visit to visit. Only in Region 4 did most of the narrative RQR review notes close with a sub-section clarifying issues from previous reviews that had or had not been resolved.

34. It was likewise not evident from any of the RQR reports that the Central Office of DBHDD was overseeing its regional offices' quality assurance review activities. Nothing in the reports suggests that they are shared with Central Office personnel or supervisors. Tracking identified deficiencies and the implementation of corrective actions is an essential part of a quality assurance system. I have seen no evidence that the State effectively tracks recommendations for corrective actions to address deficiencies identified in these RQR reports, or in other reviews.

35. The State's failure to ensure identified findings were addressed exposes individuals to unnecessary risk of harm. Despite the variability in the regions' methodologies and the likelihood that some regions' approaches were not sufficiently rigorous, individuals with serious risks were identified in the RQR reports from each of the six regions of the State.

The State's Death Investigations Also Show Inadequate Systems to Prevent, Identify, and Address Problems with Care

36. I reviewed available reports on the deaths of 79 of the 503 individuals who had transitioned from Georgia's State Hospitals to community homes.

37. The State conducted investigations in only 38, or approximately half, of these deaths. It was notable that in 17 of the 38 investigations, there was at least one concern or deficient practice associated with the death. Most commonly, the investigations cited delays in the individual receiving needed medical

interventions. There were also several investigations that associated failure to ensure implementation of needed health care protocols (for choking, falls, aspiration, and bowel management) with the individuals' deaths. The cause of death is listed as unknown for 29 of the 79 reported deaths.

38. In addition to the 38 State death investigations, residential provider agencies conducted 19 self-investigations of people who died in their care. These investigations were not thorough, and included little more than a time line of the events in a day or two prior to the individual's death. Significantly, no deficiencies or concerns were cited in 17 of these 19 provider self-investigations.

39. No death investigations were done for 22 of the 79 total deaths.

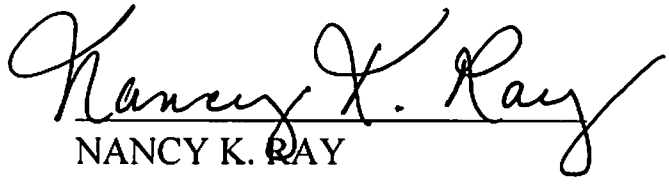
40. In addition, I also reviewed 39 independent mortality reviews conducted by two health care consulting firms under contract with the State. Many of these reviews cited concerns related to: timely medical care, nursing care, clinical therapy evaluations and consultations, and preventive measures for falls, choking, weight loss, aspiration, and bowel management.

41. While the majority of the persons who died had complex medical needs that are associated with higher mortality, many of the death reports document poor assessments, care, and oversight of service provisions across the state.

[End of Declaration]

I declare under penalty of perjury of the laws of the United States and the State of New York that the foregoing is true and correct to the best of my knowledge, information, and belief.

Dated this 19th day of January, 2016.



NANCY K. RAY

Exhibit 4

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

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

DECLARATION OF KATHY E. SAWYER

1. I am an independent consultant on health, mental health, and human services issues based in Montgomery, Alabama.

2. I currently serve as the court-appointed Independent Compliance Administrator in *Evans v. Bowser*, overseeing the District's Department of Disability Services in its efforts to comply with court orders to provide community-based services to class members with developmental disabilities who had formerly been institutionalized in the District of Columbia.

3. In 2010, I served as an expert consultant to the United States Department of Justice in *United States v. Georgia*.

4. In 2008 to 2010, I served as a consultant to the Governor of Alabama on the State's plan to replace Bryce Hospital, the state's largest psychiatric hospital, with a smaller, state of the art hospital.

5. From 2005 to 2008, I served in various positions in the District of Columbia, including *Evans* Compliance Consultant in the Executive Office of the Mayor. In 2006, I was appointed by Mayor Anthony Williams as Interim Director of the District's Mental Retardation and Developmental Disabilities (MRDD) Administration and was re-appointed in 2007 by Mayor Adrian Fenty. During this time, the MRDD Administration was established as a full cabinet level agency. As Interim Director, I oversaw all departmental and contracted community based services for persons with developmental disabilities, which included Medicaid funded disability services in community settings.

6. From 1999 to 2005, I served as the Commissioner of the Alabama Department of Mental Health and Mental Retardation (Alabama Department), having first been appointed by Governor Don Siegelman and re-appointed in 2002 by Governor Bob Riley. As Commissioner, I oversaw the administration of all state operated facilities and contracted community based services for persons with psychiatric or developmental disabilities and a budget of over $600 million. The disability services I oversaw included Medicaid-funded services in both institutional and community settings.

7. Prior to my appointment as Commissioner, I served for fourteen years as the Alabama Department's Director of Advocacy Services and, for eight years prior to that, as Regional Coordinator of mental retardation services for the Alabama Department's thirteen (13) northern counties. A copy of my curriculum vitae is attached as Attachment A.

8. During my term as Alabama's Commissioner, Alabama settled a long-standing lawsuit titled *Wyatt v. Stickney*, which had been filed by a class of residents of Alabama's state-operated institutions in the United States District Court for the Middle District of Alabama. I was responsible for negotiating this settlement, which called for a significant expansion of community services for institutional residents in Alabama.

9. When I began as Commissioner, Alabama operated four state facilities for persons with developmental disabilities: the Albert P. Brewer Center in Daphne, Ala.; the J.S. Tarwater Developmental Center in Wetumpka, Ala.; the Lurleen B. Wallace Developmental Center in Decatur, Ala.; and the William D. Partlow Developmental Center in Tuscaloosa, Ala. These facilities, which were licensed as Intermediate Care Facilities for the Mentally Retarded[1] ("ICF"), housed approximately 600 individuals with developmental disabilities, and included

[1] These facilities are now called Intermediate Care Facilities for individuals with intellectual and developmental disabilities ("ICF-IDD"), pursuant to changes in accepted terminology in the field and in applicable regulations.

individuals with significant behavioral issues and individuals who were medically fragile.

10. Following the settlement in *Wyatt*, Alabama elected to consolidate its institutional services through the structured and monitored closure of three of the above-referenced ICFs. Residents and their families were provided with a choice of whether they wanted to live in the community or at Partlow Developmental Center, which at the time would become Alabama's only state-operated ICF. Most residents, including many at Partlow, opted to move into the community.

11. Many of the former staff in the state-operated facilities that closed found jobs with community services providers, supporting individuals who left the state institutions. Transition for these staff was more financially feasible because many of the private community providers were participants in the State's retirement system. With the leadership of the Governor, other staff were given priority for vacant positions in other parts of state government.

12. In re-designing Alabama's system of care for persons with developmental disabilities, the Alabama Department relied upon the opinion of professionals with experience in the field, advice of persons with developmental disabilities and their families, and advice of members of the advocacy community. For example, in partnership with the Alabama Developmental Disabilities Council, the Alabama Department instituted a self-advocacy initiative that allowed persons

with developmental disabilities to provide feedback and commentary on the Alabama Department's services. Advocates with developmental disabilities were also hired to organize self-advocacy groups in state institutions and regions throughout the state. Further, during my tenure, individuals with developmental disabilities, including institutional residents, met with Governor Riley and other state officials on numerous occasions to advise on developmental disabilities issues and their experiences.

13. The decision to transition individuals to community settings also required the Alabama Department to expand its provider capacity and to develop additional community supports and services, largely for rural areas that cover most of Alabama. As a result of our work with community providers, both inside and outside Alabama, we were able to convince many providers to expand their services to support individuals leaving state institutions. The services we developed included small residential waiver homes, individualized supportive housing into which the former institutional resident and his or her support persons could move, and in-home supports and services that enabled individuals to reside at home with their families.

14. To develop additional housing needed for individuals leaving institutions, we partnered with the Alabama Housing Finance Authority, which develops housing for low-income persons using state and federal funds. The

Housing Finance Authority agreed to set aside 25% of the housing it developed for individuals moving out of state operated facilities. This set-aside was approved by the United States Department of Housing and Urban Development.

15. To ensure that individuals with developmental disabilities in rural or underserved areas had access to needed medical care, dental care, behavioral staff, and crisis intervention services, Alabama created regional community clinical services teams. These teams typically consisted of multiple disciplines, including a physician, a psychologist, nurses, and behavioral specialists. Clinical services were made available to individuals residing primarily in rural areas, where availability and access to these services were initially limited and provider capacity had to be further developed to adequately serve individuals with these special needs. Medical and dental services were made available onsite at the Regional Centers, and special teams of nurses, social workers, and behavioral specialists could be deployed to the individual's community residential or day program site for intervention in crisis situations.

16. Ultimately, the number of individuals successfully moved into the community far exceeded Alabama's obligations under the *Wyatt* settlement agreement. The State's success in transitioning hundreds of former institutional residents and closing three of its four ICFs enabled Alabama to successfully close the Partlow Developmental Center, its last state-operated ICF, in 2011.

17. Based on my experiences both in Alabama and the District of Columbia, in order to achieve the successful and positive outcomes for persons with developmental disabilities as described in the foregoing pages, the following systems and plans are required, at a minimum:

A. Service Planning and Coordination System: An effective service planning and coordination system is necessary to ensure adequate institutional transition and discharge planning, as well as the ongoing provision of critical supports and services. The purpose of the transition and discharge planning process, in general, is to identify a person's needs, identify what services are necessary to meet those needs in the most integrated setting appropriate, identify barriers to discharge, and to develop and implement strategies to address them. Successful transition and discharge planning for individuals with developmental disabilities requires, at a minimum: comprehensive assessments of the person's needs; identification and employment of qualified providers who are trained and competent to service those needs; acquisition of all needed services and supports, prior to movement, including needed adaptive equipment; and assignment of support coordinators (or case managers) familiar with the person, the person's needs, and

their individualized service plans. The support coordinator is critical to ensure that all these necessary supports and services are in place prior to the person's move and throughout the duration of the person's community placement.

B. Comprehensive Quality Assurance and Improvement Plan: A comprehensive quality assurance and improvement plan is necessary to protect individuals from harm while protecting individual rights and promoting consumer choice and satisfaction. An effective quality assurance and improvement plan must identify performance indicators for all providers of services, including government agency staff and contract providers; monitor service delivery; regularly collect, analyze, and report performance data; and improve deficient performance through a system of progressive training, technical assistance, sanctioning, and other enforcement activities.

C. Effective Incident Management and Prevention System: An Effective Incident Management and Prevention System that protects people from harm while enhancing the quality of services is of critical importance in providing services for individuals with developmental disabilities. The system should include guidelines

and requirements for identifying, timely reporting, reviewing and, where indicated, conducting thorough investigations of allegations and other incidents of neglect, abuse, serious physical injury, or other mistreatment of individuals being served. The system should also mandate that corrective and other enforcement actions be taken and verify corrective actions for providers who violate protection from harm procedures.

D. Enhanced High Risk Monitoring Plan: An Enhanced Monitoring Plan should be in place to identify and closely monitor individuals with the highest risk of harm, due to their medical or behavioral conditions, to ensure their special needs are carefully monitored and timely addressed. Special protocols developed for common needs such as feeding, positioning, or ambulating, for example, must be adhered to at all times to prevent harm. Individualized protocols also ensure that all staff assigned to work with individuals are knowledgeable of their conditions. Staff must be trained on the interventions in these protocols.

E. Home and Community Based Waiver: Home and Community Based (HCBS) Waivers, through the Centers for Medicaid and Medicare (CMS), enable states to receive federal matching funding

for an array of residential and day programs, services and other supports that facilitate the community integration of persons with developmental disabilities. Alabama relied heavily on its HCBS waivers to fund community placements and services for individuals discharged from its developmental centers as part of the *Wyatt* Settlement Agreement. This has also been my experience in the District of Columbia, where during my tenure as Interim Director of the Department of Disability Services, the District's HCBS waiver was drastically expanded to provide increased services to individuals by maximizing the use of federal dollars. The expansion and increase of the waiver has continued over recent years. In my opinion, maximizing funding of the waiver program is essential for a state to have a cost-effective way to provide services to this population.

18. As a former Commissioner and a resident of a neighboring state, I am generally familiar with the geography and demographic composition of Georgia. In addition, while serving as a consultant to the Department of Justice in this matter in 2010, I visited and toured Northwest Georgia Regional Hospital in Rome, Georgia, one of the five state-operated ICFs in Georgia at the time.

19. I reviewed the records of a number of individuals served in Georgia's facilities in 2010. More recently, I have reviewed reports of the court-appointed Independent Reviewer in this case that describe the individuals currently being served, their demographics, and their support and service needs.

20. The level of need and severity of the disabilities of the individuals I observed at the ICF in Rome and described in the Independent Reviewer's recent reports are similar to those of institutional residents in Alabama during my tenure as Commissioner and individuals currently being served in communities throughout the District of Columbia. Indeed, many of the individuals who were moved into the community in Alabama had more severe disabilities than I observed in the residents at Rome. Accordingly, I believe the needs of individuals being served in Georgia are not greater than the needs of the individuals we served successfully in the community in Alabama.

21. Finally, like Georgia, Alabama has many institutional residents who come from rural areas. Indeed, Alabama is a predominantly rural state.

22. Based on the foregoing experiences and review, it is my opinion that Georgia can transition individuals with developmental disabilities who are unnecessarily institutionalized into safe and appropriate community residences, using strategies like those used successfully in other states to build community services and supports.

23. In addition to the significant steps Alabama took to downsize and close its ICFs and expand community services for people with developmental disabilities under *Wyatt* and other initiatives, Alabama also significantly decreased its reliance on institutions to serve people with significant mental illness and expanded community services for people with significant mental illnesses.

24. The types of community services that Alabama created for individuals with serious mental illness are similar to those that Georgia is required to create under the Settlement agreement, including Assertive Community Treatment teams, a range of crisis services, and supported housing.

25. The creation of supported housing was been key to Alabama's efforts to keep people with serious mental illness in the community and out of our psychiatric hospitals. Supported housing is not only assistance in obtaining affordable, permanent housing; it also includes accesses to services that assist the individual in stably living in the community. In my experience, without access to supported housing, people otherwise will be unnecessarily placed in inpatient care, homeless shelters, or more segregated congregate housing.

[END OF DECLARATION]

I declare under penalty of perjury of the laws of the United States and the State of Alabama that the foregoing is true and correct.

Dated this 19th day of January, 2016.

KATHY E. SAWYER