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 MOTION TO ENTER EXTENSION OF SETTLEMENT AGREEMENT

Plaintiff and Defendants jointly move this Court to enter their Extension of Settlement Agreement [attached hereto as Exhibit A], pursuant to Federal Rule of Civil Procedure 41(a)(2). Plaintiff and Defendants request that the Court retain jurisdiction to enforce the Extension of Settlement Agreement. *See Am. Disability Ass'n v. Chmielarz*, 289 F.3d 1315, 1320 (11th Cir. 2002) ("[I]f the district court either incorporates the terms of a settlement into its final order of dismissal or expressly retains jurisdiction to enforce a settlement, it may thereafter enforce the terms of the parties' agreement.").

Given that the parties have resolved their disputes through entry of the Extension of Settlement Agreement, Plaintiff hereby withdraws its *Motion for Order to Show Cause Why the State Should Not Be Held in Civil Contempt of*

Court [Doc. 234], and Plaintiff respectfully asks the Court to vacate the hearing on that Motion, which was set for May 23, 2016 [*see* Doc. 256].

The *Amici* participated in negotiations of the terms of the Extension of Settlement Agreement and have authorized Plaintiff and Defendants to represent to the Court that they support the entry of the Extension of Settlement Agreement.

A proposed consent order is attached for the Court's consideration.

Respectfully submitted, this 18th day of May, 2016.

FOR PLAINTIFF:

VANITA GUPTA
Principal Deputy Assistant Attorney General
U.S. Department of Justice
Civil Rights Division

EVE L. HILL
Deputy Assistant Attorney General
Civil Rights Division

STEVEN H. ROSENBAUM
Chief
Special Litigation Section

MARY R. BOHAN
Deputy Chief
Special Litigation Section

ASHLEY McDONALD
KATHERINE HOUSTON
REGAN BAILEY
Attorneys

JOHN A. HORN
United States Attorney
Northern District of Georgia

/s/ Aileen Bell Hughes
AILEEN BELL HUGHES
Assistant United States Attorney
Northern District of Georgia
Georgia Bar No. 375505
600 Richard B. Russell Federal Bldg.
75 Ted Turner Drive, S.W.
Atlanta, GA 30303
Telephone: (404) 581-6000
Facsimile: (404 581-6163
E-mail: Aileen.Bell.Hughes@usdoj.gov

FOR DEFENDANTS:

SAMUEL S. OLENS
Attorney General
Georgia Bar No. 551540

DENNIS R. DUNN
Deputy Attorney General
Georgia Bar No. 234098

SHALEN S. NELSON
Senior Assistant Attorney General
Georgia Bar No. 636575

State Law Department
40 Capitol Square, S.W.
Atlanta, Georgia 30334
Telephone: (404) 656-3357

/s/ Jaime L. Theriot
JAIME THERIOT
Special Assistant Attorney General
Georgia Bar No. 497652
Troutman Sanders LLP
600 Peachtree Street, N.E., Suite 5200
Atlanta, Georgia 30308
Telephone: (404) 885-3534
Email: jaime.theriot@troutmansanders.com

JOSH BELINFANTE
Special Assistant Attorney General
Georgia Bar No. 047399
Robbins Ross Alloy Belinfante Littlefield
999 Peachtree Street, N.E.
Atlanta, GA 30309
Telephone: (678) 701-9381
Email: josh.belinfante@robbinsfirm.com

Exhibit A

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

EXTENSION OF SETTLEMENT AGREEMENT

1. The State of Georgia, the Governor of the State of Georgia, the Commissioner of the Department of Behavioral Health and Development Disabilities ("DBHDD"), and the Commissioner of the Georgia Department of Community Health (collectively, the "State") and the United States (together referenced herein as the "Parties") entered into a settlement agreement that the United States District Court for the Northern District of Georgia entered as an order of the Court on October 29, 2010, in Civil Action No. 1:10-CV-249-CAP ("Settlement Agreement").

2. Pursuant to Section VII.A.1 of the Settlement Agreement, the anticipated date by which the State would substantially comply with all provisions of the Settlement Agreement was July 1, 2015. Although the State has asserted compliance with a majority of the provisions of the Settlement Agreement by that date, the United States has asserted noncompliance with the following provisions of the Settlement Agreement: Section III.A.2.b.i.(D)-(F); Section III.A.2.b.iii; Section III.A.2.c.ii.(B)(3); Section III.A.4.d; Section III.B.2.c.ii.(A); Section III.C.3.a.v; and Section III.D. The parties have agreed to meet and confer as to the provisions with which the State asserts compliance, and the Parties agree to address the United States' assertions of noncompliance as set forth below.

3. Section VII.E of the Settlement Agreement provides that any modification shall be executed in writing, shall be filed with the Court, and shall not be effective until the Court enters the modified agreement and retains jurisdiction to enforce it.

4. The Parties therefore enter into this Extension of the Settlement Agreement ("Extension Agreement").

5. The State's obligations under all provisions of the Settlement Agreement remain in force until they have been terminated pursuant to Section VII.B of the Settlement Agreement.

PROVISIONS RELATED TO PERSONS WITH DEVELOPMENTAL DISABILITIES ("DD")

Transitions from State Hospitals to the Community

6. Between July 1, 2015, and June 30, 2016, the State shall transition at least 25 individuals with DD from the State Hospitals to the community. The State shall provide COMP waivers to accomplish these transitions.

7. Between July 1, 2016, and June 30, 2018, the State shall create and regularly update a planning list for prioritizing transitions of the remaining persons with DD in the care of State Hospitals for whom a community placement is the most integrated setting appropriate to his or her needs. The State shall transition individuals on the list to the community at a reasonable pace. The State shall provide COMP waivers to accomplish these transitions.

8. Any individuals with DD remaining in the State Hospitals on June 30, 2018, shall be served in the most integrated setting appropriate to their needs.

9. In determining whether to include an individual on the transition planning list, the State shall consider the recommendations of the individual's hospital treatment team and representatives from the Office of Transition Services who have experience with and knowledge of service delivery in the community, as well as the preferences of the individual, family member(s), and, as the individual indicates, other persons who are important to the individual and/or who may support the individual in the community.

10. The State shall notify the Independent Reviewer within 7 days of when the State determines that any individual's most integrated setting is a State Hospital or any public or private skilled nursing facility, intermediate care facility for developmental disabilities, or psychiatric facility. In that instance, the State shall provide the Independent Reviewer with all information relied upon to make that determination so that the Independent Reviewer may conduct an independent assessment and report the assessment to the Parties. If the State makes no such determination, the expectation is that the individual will be placed on the transition planning list (referenced in Paragraph 7) for transition to a community home.

11. The State shall form a transition planning team for every individual upon placement of that individual on the transition planning list. The transition planning team shall consist of the individual, hospital treatment team, case expeditor, support coordinator, Integrated Clinical Support Team, community service providers (once selected), the individual's family member(s), and, as the individual indicates, other persons who are important to the individual and/or who may support the individual in the community. The transition planning team must identify (using protocols or criteria established by DBHDD that employ person-centered planning) the types of supports,

services, adaptive equipment, supervision, and opportunities for community integration that will promote a successful transition for the individual. Prior to the individual's discharge, all contracted residential, day, clinical, medical, and other providers (once selected) shall participate in the transition process and receive training in any procedures or protocols needed to serve the individual. All non-contracted providers who will be providing services to the individual may participate in the transition process and receive training in any procedures or protocols needed to serve the individual. The transition planning team shall verify that the supports, services, adaptive equipment, and supervision identified in the transition plan are arranged and in place at discharge.

12. The State shall monitor individuals during and after transition from the State Hospitals (a) to identify and address identified gaps or issues with services, supports, adaptive equipment, and clinical, medical, day, residential, or other providers to reduce the risk of admission to other institutional settings, deaths, or injuries, and (b) to track community integration and positive outcomes. The State shall conduct post-transition monitoring with, at a minimum, in-person visits by the individual's support coordinator within 24 hours of transition, at least once a week during the first month the individual is in the community, and at least monthly for the next three months.

Supports and Services Provided to Individuals with DD in the Community

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 with DD 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 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.

14. High Risk Surveillance List

a. The State shall maintain a "High Risk Surveillance List" (the "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. The List shall include each individual's name, date of birth, provider(s), current address, region, HRST score, and a summary of critical incident reports and clinical findings that indicate medical or behavioral needs that may create a heightened risk for the individual. The State shall monitor the following information for all individuals on the List: critical incident reports, support coordination notes, and clinical assessments. The State shall update the List at least once per month.

b. Based on a records-based clinical review, uniform screening criteria, and other indications of heightened risk factors or concern, the State designated, and will continue to designate, certain individuals on the List as "High Risk." The State may escalate other individuals on the List to "High Risk" status in the following circumstances (or "escalation criteria"):

(i) Health-Related: an increase in HRST score; known emergency room visit or hospitalization; recurring serious illness without resolution; diagnosis with an episode of aspiration, seizures, bowel obstruction, dehydration, gastro-esophageal reflux disease (or GERD); or unmet need for medical equipment or healthcare consultation;

(ii) Behavioral: material changes in behavior, a behavioral incident with intervention by law enforcement, or functional or cognitive decline;

(iii) Environmental: threat of or actual discharge from a residential provider, change in residence, staff training or suitability concern, or accessibility issues that relate to the health or safety of the individual (including loss of involved family member or natural supports or discharge from a day provider).

(iv) Other: confirmed identification of any factor above by a provider, support coordinator, family member, or advocate.

c. For each individual on the List designated as "High Risk," the State shall conduct the oversight and intervention outlined in the following subparts, until the State determines that the individual is stable and no longer designated as "High Risk."

(i) Upon designation of an individual as "High Risk," the State (through the Office of Health and Wellness) shall oversee that the initial responses to the identified risk(s) are completed and documented on the schedule set forth below, until the risk is resolved:

(1) For an emergency, the provider shall initiate appropriate emergency steps immediately, including calling 911 or crisis services, and shall notify the individual's support coordinator, the Field Office, and the Office of Health and Wellness.

(2) For deteriorating health that is not imminently life-threatening, the provider shall respond and inform the individual's support coordinator within the first 24 hours. If the risk is not resolved within 72 hours, the support coordinator (or provider) shall notify the Field Office and the Office of Health and Wellness.

(3) For a health, behavioral, or environmental risk not resulting in destabilization of health or safety of the individual, the

provider shall respond, inform the individual's support coordinator, and verify completion of responsive steps with the support coordinator no later than the support coordinator's next visit, or 30 days, whichever is sooner.

(ii) If the risk is not resolved through the initial responses outlined in Paragraph 14.c.(i), the State shall conduct an in-person assessment of that individual in the time period indicated by the imminence and severity of the risk, but no later than 7 days after completion of the initial response.

(1) The assessment shall be conducted by a Registered Nurse or other trained medical professional with an advanced medical degree and expertise in the area(s) of risk identified for the individual. The assessment shall include direct observation of staff who work with the individual to verify the staff's knowledge and competencies to implement all prescribed risk reduction interventions (*e.g.*, meal time protocols or behavior support plans). The assessment shall, at a minimum, identify any concerns or issues regarding the individual's health or behavioral needs and identify necessary follow-up activities (with a schedule for completion) to address those concerns or issues.

(2) The findings of the assessment, plus any follow-up activities and schedules, must be noted on the List and recorded in the individual's electronic record for access by the individual's support coordinator, community providers, the Integrated Clinical Support Team, Field Office staff, and the Office of Health and Wellness.

(3) If the assessment finds service delivery deficiencies that jeopardize the physical or behavioral health of an individual, the State shall require all provider staff (including direct support staff, house managers, Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants) who are responsible for delivering services to that individual to receive competency-based training in that service delivery area (*i.e.*, training through which the staff demonstrates successful service delivery in a scenario closely resembling one in which the services will be delivered).

(4) The State (through the Office of Health and Wellness) shall oversee that the follow-up activities identified in the assessment are completed and documented (and repeated or revised, as needed), until the risk is resolved.

15. Statewide Clinical Oversight

a. The State shall implement statewide clinical oversight that is available in all regions 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 listed in Paragraph 14.b.(i)-(iv) above. 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.

b. Statewide clinical oversight is provided through a team of registered nurses with experience caring for individuals with DD, behavioral experts (with a master's level degree in behavior analysis, psychology, social work, or counseling), occupational therapists, physical therapists, and speech and language therapists. This team includes personnel in the Office of Health and Wellness and each regional Field Office.

c. No later than March 31, 2017, the State shall develop a protocol that includes the following components:

(i) The protocol shall state the responsibilities and timeframes for contracted providers and support coordinators to engage the statewide clinical oversight team to assist in addressing issues that place individuals at heightened risk. The protocol must include the following schedule for completion and documentation of the responses to the identified risk(s), until the risk is resolved:

(1) For an emergency, the provider shall initiate appropriate emergency steps immediately, including calling 911 or crisis services, and shall notify the individual's support coordinator, the Field Office, and the Office of Health and Wellness.

(2) For deteriorating health that is not imminently life-threatening, the provider shall respond and inform the individual's support coordinator within the first 24 hours. If the risk is not resolved within 72 hours, the support coordinator (or provider) shall notify the Field Office and the Office of Health and Wellness.

(3) For a health, behavioral, or environmental risk not resulting in destabilization of health or safety of the individual, the provider shall respond, inform the individual's support coordinator, and verify completion of responsive steps with the support

coordinator no later than the support coordinator's next visit, or 30 days, whichever is sooner.

(ii) The protocol shall determine the circumstances when, and set forth mechanisms through which, the statewide clinical oversight team receives electronic notification when individuals with DD in the community face a heightened level of risk, which may include the circumstances listed in Paragraph 14.b.(i)-(iv). The protocol shall set forth the timeframes for the State's review and response and shall require that the State's response be based on the imminence and severity of the risk.

d. No later than June 30, 2017, the State shall train its contracted providers and support coordinators on the protocol developed under Paragraph 15.c.(i), how to recognize issues that place an individual at heightened risk (including through critical incident reports and the State's support coordination tool), and how to request consultation and/or technical assistance from the Field Offices and the Office of Health and Wellness. The protocol shall become effective no later than July 1, 2017.

e. The State shall provide or facilitate consultation (by phone, email, or in person), technical assistance, and training to contracted providers and support coordinators who serve individuals with DD in the community who face a heightened level of risk due to the complexity of their medical or behavioral needs. No later than June 30, 2017, the State shall provide a centralized and continuously monitored hotline and email address to receive requests for consultation and/or technical assistance. The State shall assess, assign for response, and respond to such requests as indicated by the nature, imminence, and severity of the need identified in the request.

f. No later than June 30, 2017, 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 level of 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 healthcare practitioners.

16. Support Coordination

a. No later than July 1, 2016, the State shall revise and implement the roles and responsibilities of support coordinators, and the State shall oversee and monitor that support coordinators develop individual support plans, monitor the implementation of the plans, recognize the individual's needs and risks (if any), promote community integration, and respond by referring, directly linking, or advocating for resources to assist the individual in gaining access to needed services and supports.

b. No later than July 1, 2016, the State shall require all support coordinators statewide to use a uniform tool that covers, at a minimum, the following areas: environment (*i.e.*, accessibility, privacy, adequate food and clothing, cleanliness, safety), appearance/health (*i.e.*, changes in health status, recent hospital visits or emergency room visits), supports and services (*i.e.*, provision of services with respect, delivery with fidelity to ISP), behavioral and emotional status (*i.e.*, implementation of BSP, recent crisis calls), community living (*i.e.*, existence of natural supports, services in most integrated setting, participation in community activities, employment opportunities, access to transportation), control of personal finances, and the individual's satisfaction with current supports and services. The support coordination tool and the guidelines for implementation shall include criteria, responsibilities, and timeframes for referrals and actions to address risks to the individual and obtain needed services or supports for the individual.

c. At least annually, the State shall consider the data collected by support coordinators in the tool and assess the performance of the support coordination agencies in each of the areas set forth in Paragraph 16.a.

d. No later than June 30, 2017, the State shall provide support coordinators with access to incident reports, investigation reports, and corrective action plans regarding any individual to whom they are assigned. Support coordinators shall be responsible for reviewing this documentation and addressing any findings of gaps in services or supports to minimize the health and safety risks to the individual. (Support coordinators are not responsible for regulatory oversight of providers or enforcing providers' compliance with corrective action plans.)

e. The caseload for support coordinators shall be a maximum of 40 individuals. The caseload for intensive support coordinators shall be a maximum of 20 individuals.

f. Support coordinators shall have an in-person visit with the individual at least once per month (or per quarter for individuals who receive only supported employment or day services). Intensive support coordinators shall have an in-

person visit with the individual as determined by the individual's needs, but at least once per month. Some individuals may need weekly in-person visits, which can be reduced to monthly once the intensive support coordinator has determined that the individual is stable. In-person visits may rotate between the individual's home and other places where the individual may be during the day. Some visits shall be unannounced.

g. For individuals with DD transitioning from State Hospitals, a support coordinator shall be assigned and engaged in transition planning at least 60 days prior to discharge.

17. Crisis Respite Homes

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

b. Individuals living in crisis respite homes shall receive additional clinical oversight and intervention, as set forth in Paragraph 15.

c. The State shall track the length of stay in crisis respite homes, and, on a monthly basis, shall create a list of individuals who are in a crisis respite home for 30 days or longer, the reasons why each individual entered the crisis respite home, the date of entry to the home, and the barriers to discharge. The State shall provide these monthly lists to the United States and the Independent Reviewer.

d. The State shall assess its crisis response system for individuals with DD in the community, including the use of crisis respite homes and alternative models for addressing short-term crises. Following that assessment, and no later than June 30, 2017, the State shall meet with the Independent Reviewer, the United States, and the Amici to discuss the State's plans for restructuring the crisis system, including methods of minimizing the occurrence of individuals leaving their homes during crisis and limiting individuals' out-of-home lengths of stay at crisis respite homes.

18. Provider Recruitment

Within six months of the Effective Date of this Extension Agreement, the State shall develop and implement a strategic plan for provider recruitment and development that is based on the needs of individuals with DD in the State Hospitals and in the community. The plan shall identify the service capacity needed to support individuals with DD and complex needs in community settings. The plan shall take into account services and supports that promote successful transitions and community integration. The State shall use the plan to identify and recruit providers who can support individuals with DD and complex needs in community settings.

19. Additional HCBS Waivers

The State shall create a minimum of 100 NOW waivers and 100 COMP waivers between July 1, 2015 and June 30, 2016; 100 NOW waivers and 125 COMP waivers between July 1, 2016 and June 30, 2017; and 100 NOW waivers and 150 COMP waivers between July 1, 2017 and June 30, 2018, for individuals with DD who are on the waitlist to prevent admission to a public or private skilled nursing facility, intermediate care facility for developmental disabilities, or psychiatric facility.

Investigations, Mortality Reviews, Risk Management, and Quality Reviews

20. The State shall implement an effective process for reporting, investigating, and addressing deaths and critical incidents involving alleged criminal acts, abuse or neglect, negligent or deficient conduct by a community provider, or serious injuries to an individual.

21. The State shall conduct a mortality review of deaths of individuals with DD who are receiving HCBS waiver services from community providers according to the following:

a. An investigation of the death shall be completed by an investigator who has completed nationally certified training in conducting mortality investigations, and an investigation report must submitted to the Office of Incident Management and Investigations ("OIMI") within 30 days after the death is reported, unless an extension is granted by the State for good cause. The investigator must review or document the unavailability of: medical records, including physician case notes and nurses' notes (if available); incident reports for the three months preceding the individual's death; the death certificate and autopsy report (if available); and the most recent individual support plan. The investigator may also interview direct care staff who served the individual in the community. The investigation report must address any known health conditions at the time of death, regardless of whether they are identified as the cause of death. The State shall conduct a statistically significant sample of "look-behind" investigations to assess the accuracy and completeness of provider-conducted investigations of deaths, and the State shall require providers to take corrective action to address any deficiency findings.

b. The Community Mortality Review Committee ("CMRC") shall conduct a mortality review of all unexpected deaths, any expected death that is identified by the State's Medical Director or OIMI Director, and any expected death where a condition cited as a cause of death was identified fewer than 30 days before the death. The mortality review shall be completed within 30 days of completion of the investigation and receipt of relevant documentation. The

minutes of the CMRC's meetings will document its deficiency findings and its recommendations, if any.

22. The State shall require providers to take corrective actions in response to the CMRC's deficiency findings, and the State shall implement a system that records the deficiencies identified in investigative reports and mortality reviews and that tracks the corrective action plans, including the community providers' timely completion of required actions. The State shall separately track the CMRC's recommendations.

23. The State shall generate a monthly report that includes each death since July 1, 2015; any corrective action plan(s) resulting from the death; the community provider(s) involved; the corrective action taken by the community provider, as verified by the State; and any disciplinary action taken against the provider(s) for failure to implement corrective action (if applicable). The State shall provide the report to the United States and the Independent Reviewer.

24. The State shall collect and review its data regarding deaths of individuals with DD in the community to identify systemic, regional, and provider-level trends, if any. The State shall consider its mortality data, publicly available national mortality data, and recommendations from the CMRC. The State shall develop and implement quality improvement initiatives, including those to reduce mortality rates for individuals with DD in the community, as determined by the State from its assessment of mortality data and trends.

25. At least annually, the State shall publish a report on aggregate mortality data including the number of deaths, causes of death, classification of death, and trends.

26. DBHDD shall identify and attempt to address barriers to obtaining hospital records for the purpose of reviews of deaths of individuals with DD in the community.

27. The State shall develop a protocol for determining which deaths of individuals with DD in the community should result in an autopsy. The protocol (as may be amended) shall be applied to all deaths that occur after the protocol is effective. The State shall provide a copy of the protocol to the Independent Reviewer, the United States, and the Amici for comment before it is finalized.

28. By June 30, 2017, the State shall require all of its support coordination agencies and contracted providers serving individuals with DD in the community to develop internal risk management and quality improvement programs in the following areas: incidents and accidents; healthcare standards and welfare; complaints and grievances; individual rights violations; practices that limit freedom of choice or movement; medication management; infection control; positive behavior support plan tracking and monitoring; breaches of confidentiality; protection of health and human rights; implementation of ISPs; and community integration.

29. The State shall provide to the Department of Justice copies of the waiver assurances that the State submits to the Center for Medicare Services ("CMS"). Quality reviews, which are used to report waiver assurances as required by CMS, shall include, at a minimum, (a) data derived from face-to-face interviews of the individual, and, as indicated and available, relevant professional staff and other people involved in the individual's life, (b) assessments, and (c) clinical records. Quality reviews shall be conducted on a sample of individuals and providers in each region. The sampling shall be informed by data from DBHDD's incident management system, mortality reviews, and other indicators overseen by the Office of Health and Wellness. At least annually, the State shall consider these quality reviews, and shall either develop and implement quality improvement initiatives or continue implementation of existing quality improvement initiatives, as determined by the State from its assessment of the quality reviews.

PROVISIONS RELATED TO PERSONS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS ("SPMI")

30. For purposes of Paragraphs 31 to 40, the "Target Population" includes the approximately 9,000 individuals with SPMI who are currently being served in 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. The Target Population also includes individuals with SPMI and forensic status in the care of DBHDD in the State Hospitals, if the relevant court finds that community services are appropriate, and individuals with SPMI and a co-occurring condition, such as substance abuse disorders or traumatic brain injuries.

Bridge Funding and Georgia Housing Voucher Program

31. Bridge Funding and the Georgia Housing Voucher Program ("GHVP") are specific types of housing assistance that may include the provision of security deposits, household necessities, living expenses, and other supports during the time needed for a person to become eligible and receive federal disability or other supplemental income.

32. By June 30, 2016, the State shall provide Bridge Funding for at least an additional 300 individuals in the Target Population.

33. By June 30, 2017, the State shall provide Bridge Funding for at least an additional 300 individuals in the Target Population.

34. By June 30, 2016, the State shall provide GHVP vouchers for an additional 358 individuals in the Target Population.

35. By June 30, 2017, the State shall provide GHVP vouchers for at least an additional 275 individuals in the Target Population.

Supported Housing

36. Supported Housing is assistance, including psychosocial supports, provided to persons with SPMI to assist them in attaining and maintaining safe and affordable housing and support their integration into the community. Supported Housing includes integrated permanent housing with tenancy rights, linked with flexible community-based services that are available to consumers when they need them, but are not mandated as a condition of tenancy. Supported Housing is available to anyone in the Target Population, even if he or she is not receiving services through DBHDD.

37. Supported Housing includes scattered-site housing as well as apartments clustered in a single building. Under this Extension Agreement, the State shall continue to provide at least 50% of Supported Housing units in scattered-site housing, which requires that no more than 20% of the units in one building, or no more than two units in one building (whichever is greater), may be used to provide Supported Housing.

38. Under this Extension Agreement, by June 30, 2018, the State will have capacity to provide Supported Housing to any of the individuals in the Target Population who have an assessed need for such support.

39. Between the Effective Date of this Extension Agreement and June 30, 2018, the State shall continue to build capacity to provide Supported Housing by implementing a Memorandum of Agreement between DBHDD and the Georgia Department of Community Affairs, which includes 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;

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, training and certifying assessors, and analyzing and reporting statewide data;

c. maximization of the Georgia Housing Voucher Program;

d. housing choice voucher tenant selection preferences (granted by the U.S. Department of Housing and Urban Development);

e. effective utilization of available housing resources (such as Section 811 and public housing authorities); and

f. coordination of available state resources and state agencies.

40. The State shall implement procedures that enable individuals with SPMI in the Target Population to be referred to Supported Housing if the need is identified at the time of discharge from a State Hospital, jail, prison, emergency room, or homeless shelter.

OVERSIGHT AND MONITORING

41. The Parties have agreed that the Independent Reviewer for the Settlement Agreement, Elizabeth Jones, will be the Independent Reviewer for this Extension Agreement. Section VI.A of the Settlement Agreement shall apply in the event that a new reviewer must be selected.

42. The Independent Reviewer shall issue compliance reports semi-annually. These reports shall include a detailed reporting on each discrete task and timeframe in this Extension Agreement. Either Party or the Independent Reviewer may request a court status conference.

43. The Parties, the Independent Reviewer, and the Amici shall convene quarterly meetings (in person or via telephone) to discuss implementation of this Extension Agreement and address any barriers to achieving compliance. The Parties, Independent Reviewer, and the Amici may agree to modify the frequency of their meetings, without a formal amendment to this Extension Agreement.

CONSTRUCTION AND TERMINATION

44. The "Effective Date" of this Extension Agreement shall be the date on which this Extension Agreement is approved and entered by the Court.

45. The Parties agree that this is a court-enforceable modification of the Settlement Agreement, as provided for under Section VII.E of the Settlement Agreement.

46. Unless otherwise noted, all definitions, obligations, and terms and conditions in the Settlement Agreement remain in effect for the term of this Extension Agreement. This Extension Agreement supplements and does not supplant the Settlement Agreement.

47. The State may provide funding for the obligations set forth in this Extension Agreement through any legal means. If an unforeseen circumstance causes a failure to meet any requirements of this Agreement, the State shall notify the United States in writing within 30 calendar days after the State becomes aware of the unforeseen circumstance and its impact on the State's ability to perform under the Extension Agreement. The notice shall describe the cause of the failure to perform and the measures that the State has taken to prevent or minimize the failure. The State shall take all reasonable measures to avoid or minimize any such failure.

48. The Parties anticipate that the State will have substantially complied with all provisions of the Extension Agreement by June 30, 2018. Substantial compliance is achieved if any violations of the Extension Agreement are minor or occasional and are not systemic.

49. If the State believes it has achieved substantial compliance with a provision of this Extension Agreement, it shall notify the United States and Independent Reviewer in writing. Within 45 days of receipt of the State's notification, the United States and Independent Reviewer shall either deny or accept each assertion of substantial compliance in writing. If the Parties disagree about the asserted substantial compliance and are unable to resolve the dispute within 60 days following the response letter, the State may request that the Court hold a hearing to determine whether the State has achieved substantial compliance with the provision. The State shall be relieved of that provision of the Extension Agreement, if the United States and the Independent Reviewer agree with the State's assertion of substantial compliance, if the United States does not respond to the State's notification, or if the Court finds substantial compliance.

50. Section VII.A.3 of the Settlement Agreement is stricken and replaced with the following: The Parties may agree to jointly ask the Court to terminate the Settlement Agreement and the Extension Agreement before July 1, 2018, provided the State has substantially complied with all provisions of the Settlement Agreement and Extension Agreement. If the case has not yet been dismissed, the Parties agree to ask the Court for a non-evidentiary hearing on the status of compliance on or near July 1, 2018. If the Parties agree that there is non-compliance, or if there is a dispute about compliance, the Parties will inform the Court, and the Court may set additional hearing dates as appropriate. The Parties may agree jointly at any time to allow for additional time to resolve compliance issues.

Executed on this 3rd day of May, 2016.

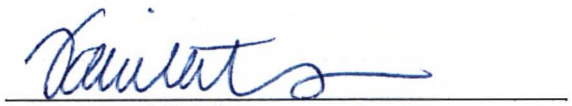
FOR THE UNITED STATES:

JOHN A. HORN
United States Attorney
Northern District of Georgia

AILEEN BELL HUGHES
Assistant United States Attorney
Northern District of Georgia

Executed on this 18 day of May, 2016.

FOR THE UNITED STATES:



VANITA GUPTA
Principal Deputy Assistant Attorney General
U.S. Department of Justice
Civil Rights Division

EVE L. HILL
Deputy Assistant Attorney General
Civil Rights Division

STEVEN H. ROSENBAUM
Chief
Special Litigation Section

MARY R. BOHAN
Deputy Chief
Special Litigation Section

ASHLEY McDONALD
KATHERINE HOUSTON
REGAN BAILEY
Attorneys
Special Litigation Section

Executed on this 18th day of May, 2016.

FOR THE STATE:

Nathan Deal

NATHAN DEAL
Governor, State of Georgia

FRANK W. BERRY
Commissioner, Georgia Department
of Behavioral Health and Developmental Disabilities

CLYDE L. REESE, III
Commissioner, Georgia Department
of Community Health

Executed on this ____ day of _____, 2016.

FOR THE STATE:

_____
NATHAN DEAL
Governor, State of Georgia

_____
FRANK W. BERRY
Commissioner, Georgia Department
of Behavioral Health and Developmental Disabilities

_____
CLYDE L. REESE, III
Commissioner, Georgia Department
of Community Health