BIENNIAL REPORT

FY 2012 2013

Office of Disability Services Ombudsman

Governor Nathan Deal

Biennial Report

Corinna Magelund
Georgia Disability Services Ombudsman and Olmstead Coordinator

Mission Statement: The mission of the Office of the Disability Services Ombudsman (ODSO) is to promote the safety, well-being, and rights of individuals with disabilities and to coordinate state compliance with the 1999 US Supreme Court Olmstead decision.(O.C.G.A. §37-2-35).

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Biennial Report Objective: Georgia law stipulates that the biennial report should document the types of complaints and problems reported by consumers and others on their behalf and include recommendations concerning needed policy, regulatory, and legislative changes. O.C.G.A. § 37-2-35

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Message from the Ombudsman and Olmstead Coordinator

To Governor Nathan Deal, the General Assembly, Commissioners, and the general public:

In accordance with my statutory responsibility, I am pleased to submit the following biennial report of the Governor's Office of Disability Services Ombudsman. This report is centered on summarizing the fulfillment of the responsibilities of this office and provides an overview of our activity during the FY 12-FY 13 biennium. It is important to note that the responsibilities of the Governor's Office of Disability Services Ombudsman would have been impossible to fulfill without the solid commitment and cooperation that has been demonstrated statewide. Therefore, I begin with expressing my appreciation in particular to the Governor, the legislature and the Department of Behavioral Health and Developmental Disabilities, as well as other state agencies, advocacy groups, and individuals who have contributed to the advancement of our state's priorities in promoting the safety, rights, and well-being of individuals with disabilities in Georgia.

During the FY 12-FY 13 biennium, Governor Nathan Deal combined the Disability Services Ombudsman and Olmstead Coordinator positions in the Office of the Disability Services Ombudsman (ODSO). The effect of combining the two positions has proven synergistic in responding to requests for assistance and complaints and in reducing institutionalization of individuals with disabilities. As Disability Services Ombudsman, I am focused on the safety, well-being and rights of individuals with disabilities. As Olmstead Coordinator, I am focused on helping individuals with disabilities live in integrated settings in our communities and not in institutions. When combined, the responsibilities of the Ombudsman and Olmstead Coordinator are complementary and involve all levels of government. ODSO has unprecedented access to state, regional, and local resources to assist individuals with disabilities and to improve their quality of life. This biennial report includes data from the Office of the Disability Services Ombudsman and information about Olmstead compliance in Georgia.

Our work most often begins with requests for assistance or complaints involving individuals seeking discharge from state hospitals. In January 2011, there were 470 individuals with mental illness and 626 with developmental disabilities in our state hospitals. In June 2013, there were 354 and 338 respectively. These numbers will continue to decline. Individuals with developmental disabilities are no longer admitted to a state hospital; rather, they are served in our communities.

Northwest Georgia Regional Hospital has closed and work is ongoing to close the James B. Craig Nursing Center and Southwestern State Hospital. As an alternative to state hospital care, state agencies are building a more comprehensive system of care in our communities. Hospital closures combined with improved community care have major positive impacts on Olmstead and ombudsman issues.

The Olmstead priority has been the Georgia/Department of Justice Settlement Agreement. The Settlement Agreement has been a national model for expanding services and reducing unnecessary institutionalization for individuals with mental illness and developmental disabilities. To meet requirements in the Settlement Agreement, Georgia has invested significant funding to transition individuals out of state hospitals, to expand the community system of care, and to prevent future institutionalization of individuals with disabilities. These dramatic changes have enabled our state to move from a hospital-based system of care to a community-based system of care. These changes have also impacted requests for assistance and complaints about institutionalization to the Ombudsman. We try to refer callers to community solutions as the expectation is that individuals in state institutions will be transitioned to the community when feasible and individuals in the community should be served there whenever possible.

In addition to our core missions, ODSO has been involved with special projects to strengthen the community system of care. These projects have been designed to improve community integration, reduce chronic homelessness, transition individuals with disabilities from the criminal justice system, and protect at-risk adults. Through these collaborative efforts, we have seen noteworthy success in arrests of people guilty of fraud or abuse of individuals with disabilities; increased housing options; and better understanding of integrated housing. ODSO has provided recommendations and lessons learned from the complaint investigation process, calls for assistance, ongoing ombudsman community visits, hospital meetings, and participation in state level meetings.

ODSO has continued its vital role of listening to individuals with disabilities, family members, and concerned others to identify needs and to determine workable and affordable solutions. After two years of improving office procedures and infrastructure, ODSO provides timely referrals, resolves complicated requests for assistance, and investigates complaints. At the same time, we have provided recommendations to the Governor's Office, met with state and community leaders, and advocated strongly to protect the safety, well-being, and rights of individuals with disabilities.

Despite great progress in difficult economic times, we continue to hear from individuals with disabilities whose unmet needs jeopardize their safety, well-being, and rights. State and federal agencies are not always able to provide timely and effective services and supports; providers may

be inadequately funded or not meeting standards of care; and some individuals with disabilities are distraught as they try to maneuver through eligibility and application processes. Their hope, and our challenge, is to reduce bureaucratic obstacles and meet their needs through an effective, responsive, and sustained community-based system of care

With the continuing economic problems nationally and in our state and the end of the Settlement Agreement in 2015, it is imperative that we build strong strategies for the future. We must continue our collaborative efforts and listen carefully to individuals with disabilities, their families, and stakeholders. I have included ODSO priorities for the next two years that will assist in sustaining our momentum achieved during this biennium.

This biennial report also provides more detailed information regarding the work accomplished by ODSO, the Medical Review Group, Olmstead initiatives, and the special projects mentioned above. At the conclusion of the report, we have compiled a list of policy, regulatory, and legislative actions that are in progress or have been completed.

While this report completes a two year reporting cycle for ODSO, it is also a starting point for the next biennium. Thank you for taking the time to read this report and for supporting the Governor's Office of the Disability Services Ombudsman. I welcome your questions or comments.

Sincerely,

Corinna Magelund
Ombudsman and Olmstead Coordinator
Governor's Office of Disability Services Ombudsman

Responsibilities of the Office of Disability Services Ombudsman[1]

- **Establishes** priorities, policies and procedures for receiving, investigating, referring, and attempting to resolve complaints made by or on behalf of consumers concerning any act, omission to act, practice, policy, or procedure of provider of services that may adversely affect the safety, well-being, and rights of consumers and any policies and procedures necessary to implement the provisions of this article;
- **Investigates** and make reports and recommendations to the department and other appropriate agencies concerning any act or failure to act by any provider of services with respect to the safety, well-being, and rights of consumers and is authorized to: (a) Prioritize investigations, reporting, and recommendations based on the seriousness and pervasiveness of the alleged act or failure to act; and (b) Refer to the services' provider those complaints deemed appropriate for resolution by the services' provider;
- **Establishes** a uniform state-wide complaint process;
- **Collects** and records data relating to complaints and findings with regard to services' providers and analyze such data in order to identify adverse effects upon the safety, well-being, and rights of consumers;
- **Promotes** the interests of consumers before governmental agencies and seek administrative and other remedies to protect the safety, well-being, and rights of consumers by: (a) Analyzing, commenting on, and monitoring the development and implementation of federal, state, and local laws, regulations, and other governmental policies and actions that pertain to the safety, well-being, and rights of consumers; and (b) Recommending any changes in such laws, regulations, policies, and actions as the ombudsman determines to be appropriate;
- **Makes** a biennial written report documenting the types of complaints and problems reported by consumers and others on their behalf and include recommendations concerning needed policy, regulatory, and legislative changes. The biennial report shall be submitted to the Governor, the General Assembly, the commissioner, and other appropriate agencies and organizations and made available to the public. The ombudsman shall not be required to distribute copies of the biennial report to the members of the General Assembly but shall notify the members of the availability of the report in the manner which he or she deems to be most effective and efficient. The report shall not identify any consumer by name or by implication without the express written consent of the consumer, or if applicable the parent of a minor consumer, the guardian of the consumer, or the health care agent of the consumer if the agent is so authorized to make such a decision and the consumer is unable to do so; and
- **Reports** suspected criminal activity, abuse, neglect, exploitation, abandonment, or violation of professional code.
- **Coordinates** and leads the medical reviews of all deaths in state hospitals and state operated community residential services.
- **Coordinates** state compliance with the 1999 US Supreme Court Olmstead decision.

[1] O.C.G.A. §37-2-35

Intake Overview

The Office of Disability Services Ombudsman responds to complaints as well as requests for assistance and information as it relates to the safety, well-being and rights of individuals with disabilities in Georgia. During the 2012 and 2013 fiscal years, the Office of Disability Services Ombudsman (ODSO) opened 733 cases and responded to 1,308 issues. The issues responded to ranged from complaints of abuse and neglect to requests for assistance or information regarding disability benefits. From fiscal year 2012 to fiscal year 2013, there was a 106% increase in the number of issues responded to by the ODSO.

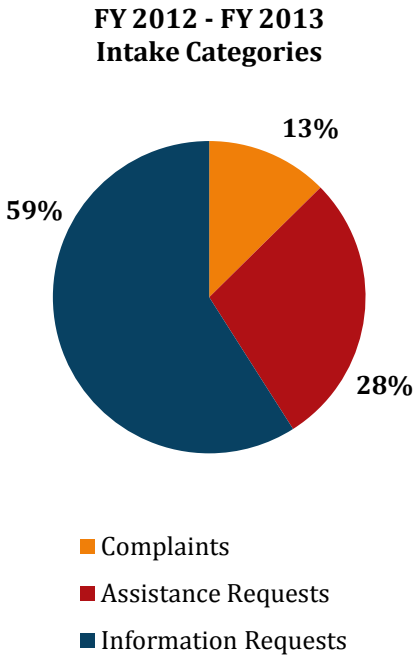


Figure 1

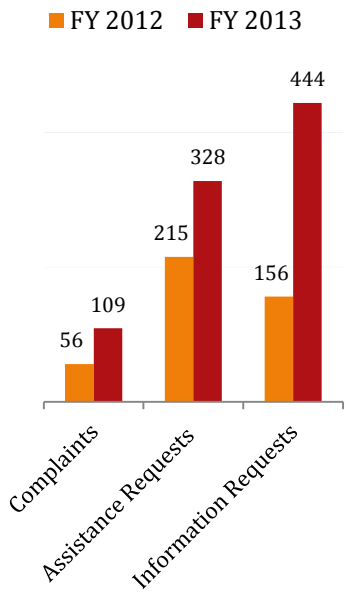


Figure 2

Top 10 Most Frequent Issues Across all Intake Categories	FY 2012 and 2013	Percentage
Benefits	249	19%
Treatment	215	16%
Employment	124	9%
Legal	122	9%
Discharge	106	8%
Housing	71	5%
Client Rights	37	3%
Financial	33	3%
Abuse/Neglect	30	2%
Safety	28	2%
Subtotal (10 most frequent issues)	**1,015**	**76% of total**
Total (of all issues responded to)	**1,308**	**100%**

Figure 3

Intake Categories

Information Requests	Calls to the Office of Disability Services Ombudsman (ODSO) often concern how to determine benefit eligibility or how to apply for a benefit. In most instances, these inquiries can be resolved by providing a telephone number or point of contact. ODSO staff routinely verify that the contact information is valid before providing it to a caller. ODSO staff continuously update the office's resource listing and points of contact to support individuals with disabilities.
Assistance Requests	Requests for assistance are more involved than requests for information and often require extensive work by ODSO staff. ODSO cannot provide legal, financial, or medical advice. ODSO staff will provide contact information for these technical services. If a caller has difficulty obtaining a benefit or service, ODSO staff can facilitate the connection to the agency responsible for the benefit, service, or support. These calls are not transferred to other helping agencies until ODSO has worked to resolve the request in the office and has provided the caller with a workable solution.
Complaints	Complaints are regarded as more serious and normally require an investigation to determine if the complaint is substantiated or not. Although ODSO often works with state agencies to resolve complaints, ODSO is an independent office that is legislatively required to determine the facts in an investigation and take appropriate action to correct the situation and to prevent a future reoccurrence. ODSO makes its final determinations independent of any provider or state agency. Any call concerning the safety, well-being, and rights of an individual with disability is considered a priority.

FY 2012: Intake by Department of Behavioral Health and Developmental Disabilities (DBHDD) Service Regions[2]

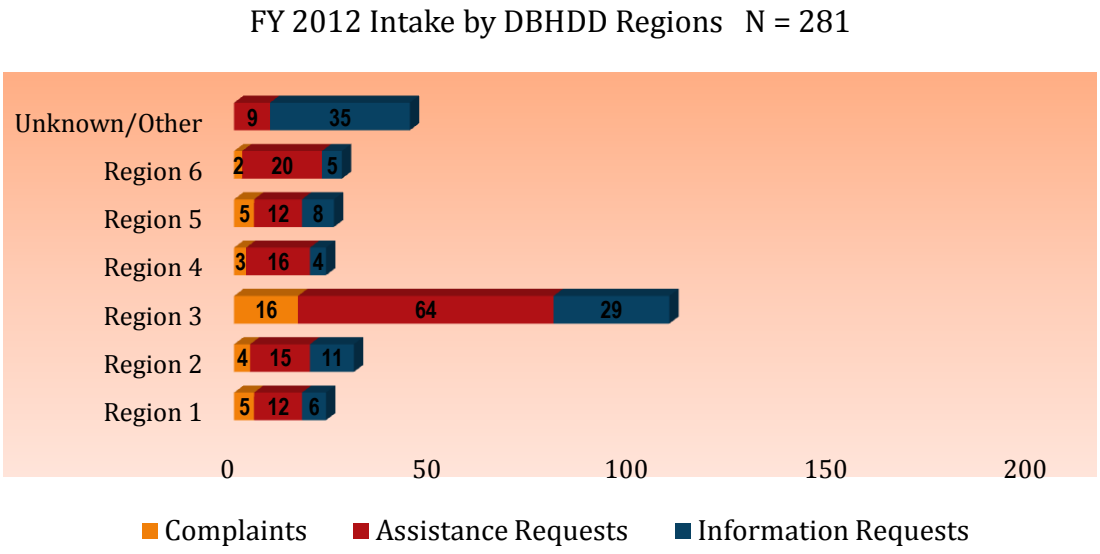


Figure 4

FY 2013: Intake by Department of Behavioral Health and Developmental Disabilities (DBHDD) Service Regions[3]

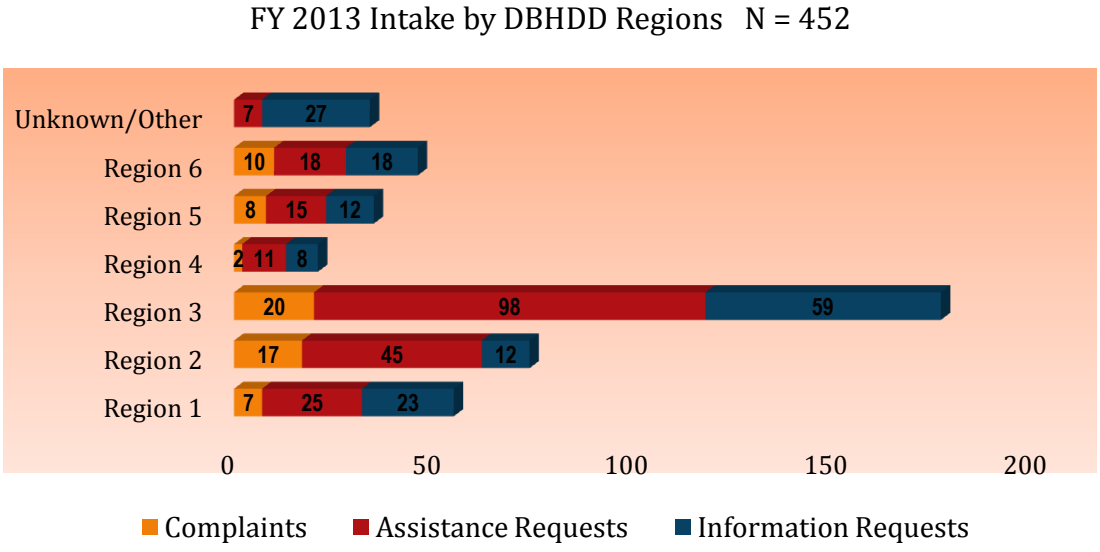


Figure 5

[2] Map of DBHDD service regions can be found in Appendix A

[3] Map of DBHDD service regions can be found in Appendix A

Disability Populations

The Office of Disability Services Ombudsman (ODSO) serves all individuals with disabilities, their families, and those who provide support and advocacy. The table below lists the disability populations served during fiscal years 2012 and 2013 - highlighting the highest intake category for each (Figure 4). Mental illness disabilities accounted for the majority (fifty percent) of the ODSO's total intake during the biennium. This includes complaints reported by individuals with a disability or on their behalf, as well as requests for assistance and information. This information is useful in outreach planning, policy formulation, legislative recommendations, and Olmstead planning.

Total Disability Population Served	FY 2012	FY 2013	Total Cases	Highest Intake Category based on disability type
Mental Illness	177	231	408	Request for Assistance
Developmental Disability	24	34	58	Request for Assistance
Addictive Disease	4	5	9	Request for Information
Physical Disability	19	108	127	Request for Information
Brain Injury-Mental Illness	3	3	6	Request for Assistance
Co-Mental Illness and Addictive Disease	12	15	27	Request for Assistance
Co-Mental Illness and Developmental Disability	6	8	14	Request for Assistance
Co-Occurring (Other)	0	26	26	Request for Assistance
Not Determined/Not Available	28	18	46	Request for Information
None	8	4	12	Request for Information
Total	**281**	**452**	**733**	

Figure 6

Complaints Received

To emphasize the availability of ombudsman services, the Office of Disability Services Ombudsman (ODSO) has established a state-wide complaint process, distributed posters about the complaint process, and provided contact information for ODSO. The Ombudsman discusses the complaint process with individuals with disabilities, providers and state agencies during visits to the community, meetings, conferences, and any other public forum.

During the intake of complaints, the Office of Disability Services Ombudsman (ODSO) gathers and evaluates initial information from the complainant to determine how to proceed in the investigation. This is primarily done through a phone intake process. Sixty-seven percent (67%) of complaints are initiated directly by individuals with disabilities and the other thirty-three percent initiated by relatives, agency personnel and other advocates.

O.C.G.A. § 37-2-39

The ombudsman shall prepare and distribute to each services provider in the state a written notice describing the procedure to follow in making a complaint, including the address and telephone number of the office and the ombudsman. The administrator or person in charge of such services provider shall give the written notice required by this Code section to each consumer who receives disability services from such services provider and the consumer´s guardian, parent of a minor consumer, or health care agent, if any, upon first providing such disability services. The administrator or person in charge of such services provider shall also post such written notice in conspicuous public places in the facility, premises, or property in which disability services are provided in accordance with procedures provided by the ombudsman and shall give such notice to any consumer and his or her guardian, parent of a minor consumer, or health care agent, if any, who did not receive it upon the consumer´s first receiving disability services.

As a result of the complaint process, ODSO staff routinely investigate and make reports and recommendations to the Department of Behavioral Health and Developmental Disabilities (DBHDD). However, not all complaints are related to DBHDD services. In fiscal years 2012 and 2013, thirty-one percent of complaints were unrelated to services provided by DBHDD or DBHDD contracted providers. The range of problems investigated and an overview of the complaint outcomes during fiscal years 2012 and 2013, follow.

Complaint Issues

- The percentage of complaint cases increased by 83% from FY 2012 to FY 2013.
- The percentage of complaint issues increased by 95% from FY 2012 to FY 2013.
- The increase in complaint cases is attributed, in part, to the growing awareness of the Office of Disability Services Ombudsman.

For reporting purposes, the number of complaint cases equals to the number of complainants. Therefore, ODSO not only tracks how many individuals report problems (complaint cases/complainants), but also the various problems that are reported by complainants (complaint issues).

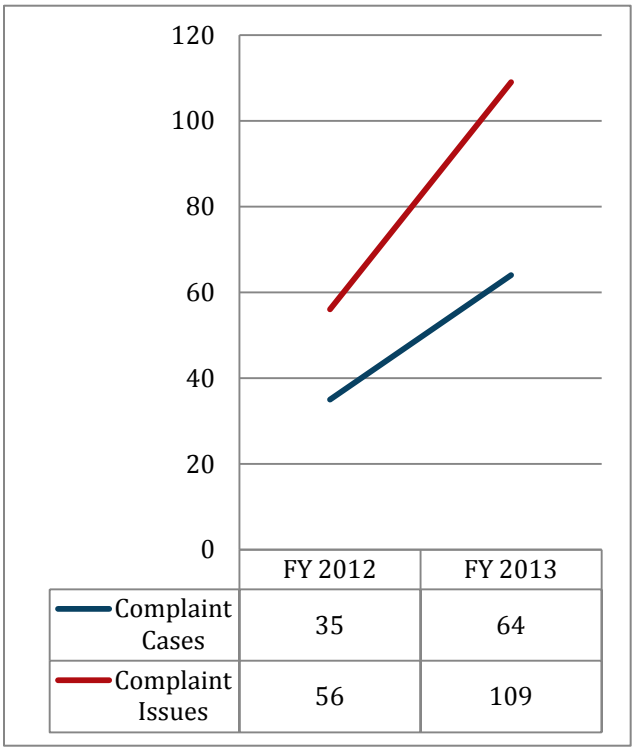


Figure 7

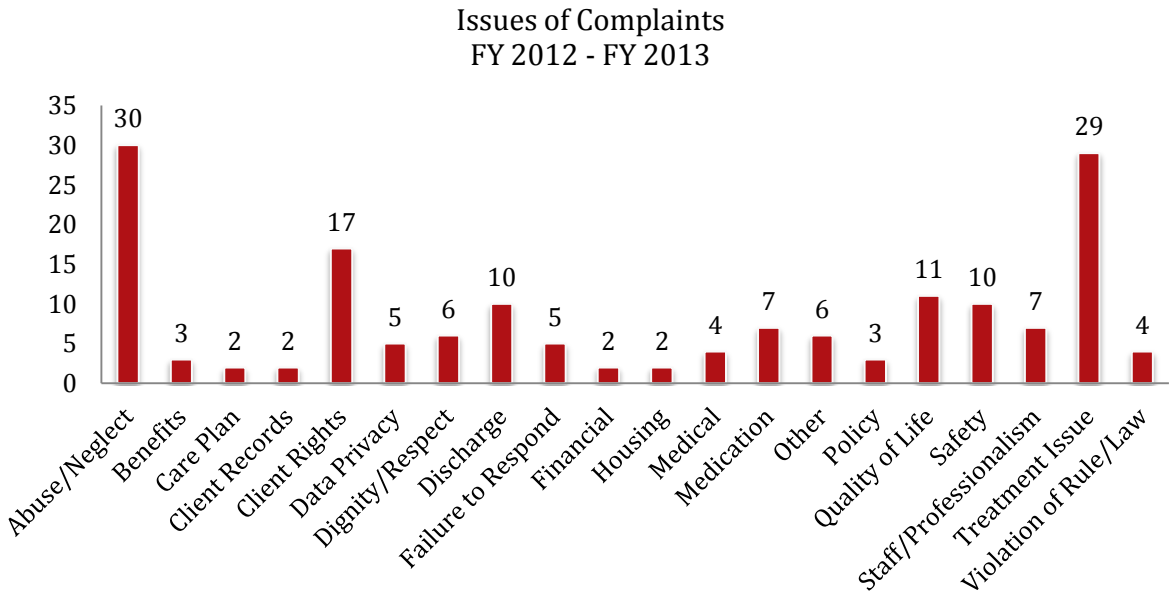


Figure 8

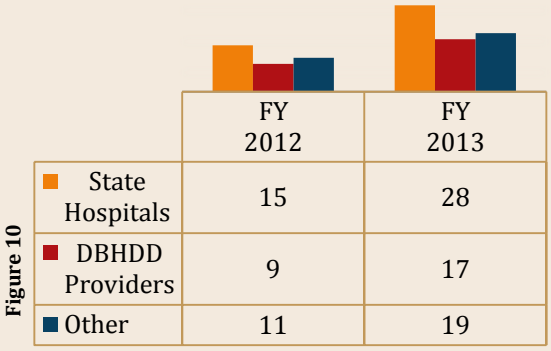
Complaint Outcomes

During the complaint investigation process, the Office of Disability Services Ombudsman (ODSO) looks for and analyzes the facts of each complaint issue. This is done while also maintaining impartiality as well as necessary confidentiality. All available sources of information are considered, including: applicable laws, rules, regulations, policies and or procedures, important documentation, and phone interviews. Often, the investigation process involves communicating with state agency points of contact, and in some instances, private service providers who are not contracted with a state agency. Non-jurisdictional cases involving services not provided by or contracted through a state agency may rely more on the process of informal mediation to assist with resolving the problem(s).

Complaints are substantiated if information received during the investigation supports the allegations presented. If the investigation does not support the allegations, the complaint is unsubstantiated. If ODSO staff are unable to obtain information to make a substantiated/unsubstantiated determination, the complaint is reported as inconclusive. As reflected in Figure 7, the majority of complaints investigated during fiscal years 2012 and 2013 were unsubstantiated or inconclusive. However, an unsubstantiated or inconclusive outcome does not mean that there are no presenting issues that need attention and does not discourage the ODSO from working with the reporter beyond the investigation to determine alternative actions to work towards resolution and to determine what can be done to address the situation. It is not uncommon for a complaint case, regardless of the determination, to include substantive assistance in facilitating communication between key parties and coordinating resources with the goal of addressing identified needs of the individual with disability.

FY 2012 and 2013 Complaint Outcomes	Percentage of Complaints
Substantiated	13%
Partially Substantiated	6%
Unsubstantiated	46%
Inconclusive	17%
Referred to another agency	15%
Pending (still open)	2%

Figure 9



	FY 2012	FY 2013
State Hospitals	15	28
DBHDD Providers	9	17
Other	11	19

Figure 10

Assistance and Information Requests

Most citizens do not contact the Office of Disability Services Ombudsman (ODSO) to make a complaint about an agency or services' provider.[4] Instead, they contact ODSO because they are having a problem and they need help or information so that it can be resolved. They are often frustrated by what they perceive as bureaucratic obstacles or by their lack of understanding or knowledge of a process or available resources. Therefore, ODSO intake staff spend a significant amount of effort coaching individuals; researching policies, procedures, regulations, and resources on their behalf; and facilitating communication between individuals and other agencies.

Below are examples of the various ways that the Office of Disability Services Ombudsman helped address 1,143 issues during the 2012 and 2013 fiscal years that stemmed from assistance and information requests:

- Provided individuals with relevant phone numbers, websites, and resource information relevant to issues of their concern;
- Coached individuals in understanding processes to help develop their ability to advocate in the future;
- Contacted involved agencies or other involved individuals to facilitate the resolution of misunderstandings or miscommunications about a policy, process or action taken;
- Facilitated informal mediated negotiations between local law enforcement officials and requesting individuals that supported a better understanding of the system of care and supports needed for individuals with disabilities;
- Coordinated actions between different agencies and levels of government to assist individuals and providers in need of information, assistance, and support; and
- Researched problems and made sure involved parties develop a shared understanding of the facts, issues, and possible solutions.

[4] During the 2012-2013 biennium, only thirteen percent (13%) of intake cases were categorized as complaints, whereas, eighty-seven percent (87%) were categorized as information or assistance requests (Figures 1 and 2, p. 7).

Most Frequent Issues: Assistance and Information Requests

Top 10 Most Frequent **Assistance Request Issues**	FY 2012 and 2013	Percentage
Discharge	94	17%
Benefits	79	15%
Treatment	65	12%
Legal	64	12%
Housing	30	6%
Medication	25	5%
Financial	18	3%
Safety	17	3%
Care Plan	16	3%
Client Rights	14	3%
Subtotal (10 most frequent assistance request issues)	**422**	**79% of total**
Total (of all issues assistance requests)	**543**	**100%**

Figure 11

Top 10 Most Frequent **Information Request Issues**	FY 2012 and 2013	Percentage
Benefits	167	28%
Treatment	121	20%
Employment	117	20%
Legal	58	10%
Housing	39	7%
Financial	12	2%
Client Records	10	2%
Transportation	6	1%
Data Privacy	6	1%
Client Rights	6	1%
Subtotal (10 most frequent information request issues)	**542**	**92% of total**
Total (of all information requests issues)	**600**	**100%**

Figure 12

Medical Review Group

The Governor appoints a Medical Review Group (MRG) to review all deaths of individuals with disabilities in state hospitals or state operated community residential services. The MRG consists of the ombudsman and four board certified physicians, one of whom must be a psychiatrist. Three members of the MRG constitute a quorum. The ombudsman serves as the chairman and appoints the vice chairman. The Office of Disability Services Ombudsman staff provide administrative support to the MRG.

Supported by O.C.G.A. §37-2-45[5], the medical review group makes four determinations as to whether:

1) the death was the result of natural causes or may have resulted from other than natural causes;
2) the death requires further investigation or review;
3) to make confidential recommendations to the ombudsman, the department, the division, the state hospitals, and state operated community residential services regarding consumer treatment and care, policies, and procedures, which may assist in the prevention of deaths; and
4) to report to the appropriate law enforcement agency any suspected criminal activity or suspected abuse and shall report any suspected violation of any professional code of conduct to the appropriate licensing board.

Medical Review Group Meetings

The Medical Review Group (MRG) convened four times in FY 12 and five times in FY 13 to review the deaths that met the legislative guidelines. The MRG reviewed 100 deaths during the biennium. Ninety-five (95) of the cases were closed; five (5) require additional investigation.

[5] The legislation that supports the Medical Review Group can be found in Appendix B.

Medical Review Statistics

FY 2012 Medical reviews					
Medical Review Dates	**New cases reviewed**	**Cases w/follow from previous meeting(s)**	**Total cases reviewed**	**Cases requiring additional review**	**Cases Closed**
November 16, 2011	13	0	13	3	10
January 20, 2012	22	3	25	8	17
February 24, 2012	15	0[6]	15	2	13
May 18, 2012	8	8[7]	16	4	12
TOTAL	**58**	**11**	**69**	**17**	**52**

Figure 13

FY 2013 Medical reviews					
Medical Review Dates	**New Cases reviewed**	**Cases w/follow from previous meeting(s)**	**Total cases reviewed**	**Cases requiring additional review**	**Cases Closed**
July 20, 2012	10	6	16	2	14
October 26, 2012	9	2	11	3	8
January 25, 2013	6	3	9	2	7
March 22, 2013	6	2	8	2[8]	7
June 19, 2013	11	2	13	5	8
TOTAL	**42**	**15**	**57**	**14**	**44**

Figure 14

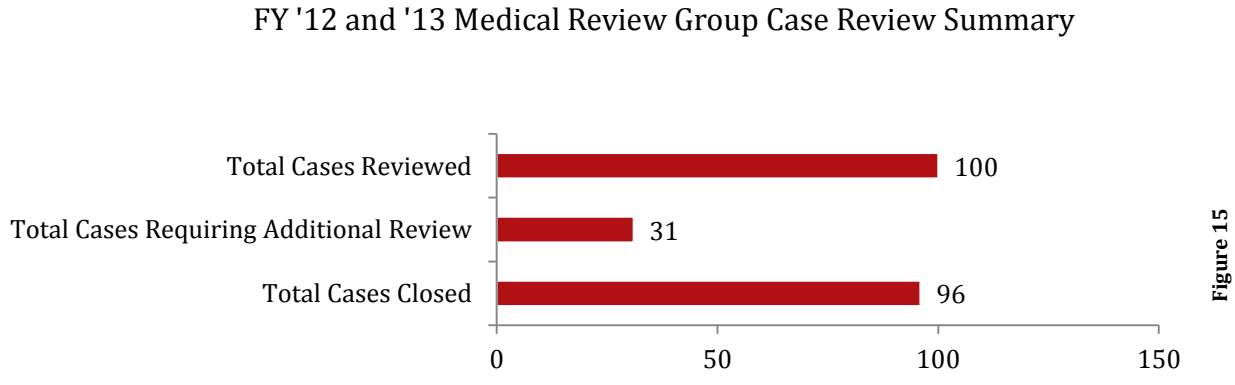


Figure 15

[6] 8 cases from previous meeting were reviewed on May 18, 2012.

[7] 2 cases from previous meeting were reviewed on July 20, 2012.

[8] 1 case previously closed was reopened.

Medical Review Group Discussion Topics

The Medical Review Group provides The Department of Behavioral Health and Developmental Disabilities and state hospitals, insight regarding treatment and prevention of deaths. Examples of topics discussed during this reporting period are:

- Death notification to the Medical Examiner's Office of the Georgia Bureau of Investigation (GBI).
- GBI investigation when a death occurs in a state hospital.
- Decision to perform an autopsy.
- Screening, assessment, and treatment of substance use disorder.
- Difficulty in treating methamphetamine use.
- Training and maintenance of "crash carts".
- Sharing of medical information.
- State hospitals' medical capacity.
- Referral to community emergency rooms.
- Operation of hospital laboratories.
- Notification of completed laboratory work.
- Education for local hospitals regarding state hospital capabilities.
- Suicide risk assessment.
- Discharging individuals at risk of suicide.
- Medical screenings in 23 hour observation units.
- White blood cell level.
- Dot Not Recussitate/Do Not Intubate instructions.
- Coordination with community emergency rooms.
- Opportunities for staff training.
- Interpretation of lab results.
- Using textbooks: 5-Minute Emergency Medicine Consult and The 5-Minute Clinical Consult, 2011.
- Treatment of deep vein thrombosis.
- Medications in treating pneumonia.
- Treatment of abdominal pain.
- Physician communication regarding medications.

Medical Review Group Special Events

Georgia Regional Hospital-Atlanta (GRHA). The Medical Review Group (MRG) visited Georgia Regional Hospital-Atlanta to view medical facilities and equipment. The MRG also had the opportunity to discuss staffing issues and treatment. The MRG conducted their regularly scheduled meeting at the end of the tour.

GBI Medical Examiner's Office. The MRG toured the office of Chief Medical Examiner. The office is part of the Georgia Bureau of Investigation. This visit provided the MRG an opportunity to learn about the medical examiner's investigative process and to discuss autopsy procedures. The MRG conducted their regularly scheduled meeting at the end of the tour.

Olmstead Compliance

The Olmstead Coordinator monitors state compliance with the U.S. Supreme Court Olmstead decision and is chairman of the Olmstead Planning Committee (OPC). OPC members are appointed by the Governor. Other individuals with disabilities, family members, and stakeholders participate in OPC meetings. The Olmstead Coordinator visits state hospitals, providers, and individuals with disabilities who have transitioned into the community. These visits result in the identification of barriers to transitioning from state hospitals, lessons learned, and recommendations for state agency action. Olmstead initiatives support ombudsman efforts to assist individuals with disabilities.

U.S. Supreme Court Olmstead Decision

On June 22, 1999, the U.S. Supreme Court issued a decision in the case of *Olmstead v L.C.*, finding that the unjustified institutionalization of individuals with disabilities is a violation of the Americans with Disabilities Act of 1990 (ADA). This decision was the Court's first interpretation of the ADA, which was enacted by Congress to prevent discrimination on the basis of disability. The Supreme Court ruled that:

- Unjustified institutionalization of individuals with a disability is a form of discrimination,
- States are required to provide community-based services for individuals with disabilities when:

    1. …the state's treatment professionals reasonably determine that community placement is appropriate,
    2. …the individual does not oppose placement,
    3. …the placement can be reasonably accommodated, taking in account the resources available to the state and the needs of others receiving state-supported disability services.

ODSO is frequently asked to explain the Olmstead decision and to participate in discussions that are Olmstead related. The Olmstead decision does not require individuals with disabilities to leave state hospitals; they are given the option to move to a community setting. The Olmstead decision does not require the state to treat individuals with disabilities in state hospitals; they may be served in the community. ODSO is participating in ongoing Olmstead discussions including the 2010 Georgia/DOJ Settlement Agreement, closure of state hospitals, and the Olmstead Planning Committee.

2010 Georgia/Department of Justice Settlement Agreement

Georgia and the Department of Justice (DOJ) signed a Settlement Agreement in October 2010. The Settlement Agreement is the priority Olmstead action in Georgia. The Settlement Agreement focuses on individuals with mental illness and/or developmental disabilities. Georgia is transitioning individuals with disabilities from state institutions and supporting persons at risk of institutionalization with planning, services, and supports. Our goal is for individuals with disabilities to live in an integrated setting - where they live in their own homes, interact routinely with non-disabled people, and enjoy life in the community.

The Georgia and DOJ Settlement Agreement is a national model for meeting Olmstead requirements and integrating individuals with mental illness and developmental disabilities into our communities. Georgia continues to invest significant resources to provide planning, services, and supports specified in the Settlement Agreement.

Closure of State Hospitals

During the biennium, Northwest Georgia Regional Hospital in Rome closed and planning for the closure of the James B. Craig Nursing Center in Milledgeville is well underway. Southwestern State Hospital in Thomasville has also begun planning for closure at the end of 2013. Hospital closures support the Olmstead vision for states to shift from hospital-based systems of care to home and community-based systems of care.

These hospital closures comply with the Georgia/DOJ Settlement Agreement which requires the state to transition individuals from state hospitals into community-based settings of their choice. In 2011, Georgia's General Assembly passed legislation ending admissions to state hospitals for individuals with a primary diagnosis of a developmental disability.

State hospitals and DBHDD region staff work together in developing and implementing Individualized Service Plans (ISP), which define person-centered needs for successful transition to integrated settings in the community. Individuals with disabilities leaving state hospitals move to a community setting of their choice. Services and supports are provided according to the ISP. Communities are receiving additional funding for services and supports for individuals at risk of institutionalization.

In some instances, families have opposed hospital closures and transitioning to the community. The Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Olmstead Coordinator have prioritized education about the success stories of individuals with disabilities living in our communities. The Olmstead Planning Committee is also responsible to provide information about the Olmstead decision and successful community placements.

Reduction in State Hospital Consensus

The state hospital census has continued to decline during the biennium. The census reduction reported is:

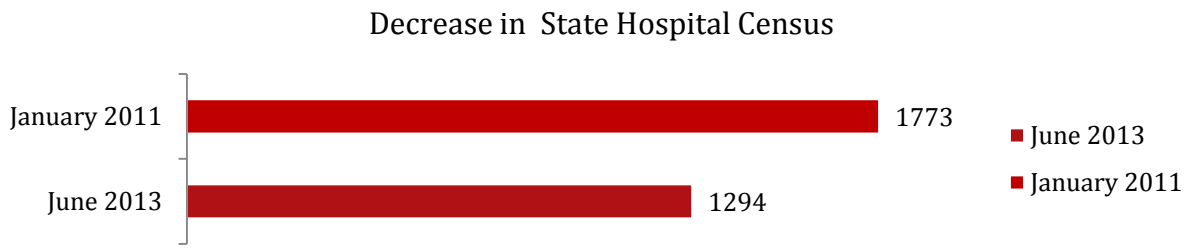


Figure 16

Program	As of January 2011	As of June 2013
Adult Mental Health	383	293
Developmental Disability	670	293
James B. Craig Center	150	105
Total Census	**1773**	**1294**

Figure 17

The reduction in census is primarily due to fewer admissions, successful transitions to the community, and an improved community system of care. Increased funding and the emphasis on home and community-based services have been major factors in this success. The Settlement Agreement includes requirements for continued reductions through 2015. One of our Olmstead initiatives for the next two years is to sustain the reductions in hospital census beyond 2015.

Olmstead Planning Committee

The Olmstead Coordinator reconvened the Olmstead Planning Committee (OPC) in 2012. The primary purpose of the OPC is to develop and implement an Olmstead Plan. OPC conducted workgroup meetings in April and May 2012 to develop a draft plan. OPC considered the workgroup's draft plan in September 2012. OPC did not approve the plan due to undefined costs in the plan objectives, concern regarding the state agency staffing requirements to implement the plan, and the necessary prioritization of the Georgia/DOJ Settlement Agreement. Today, we are working to determine how to use the work completed on the 2012 draft Olmstead Plan with the "post Settlement Agreement strategy" after 2015 as an Olmstead initiative.

Special Projects

SAMHSA National Panel: Community Integration and Persons with Serious Mental Illness (SAMHSA/CMHS)

In February 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) convened a national panel to "….identify a set of data indicators that States can use to assess their current level and trends with regard to the degree of community integration for persons with serious mental illness." Recognizing Georgia's important role in Olmstead, SAMHSA invited the Olmstead Coordinator to participate in the national panel.

The Statement of Work for the project included identification of a technical expert panel, determination of data indicators to assess community integration, a pilot test of the proposed data indicators, and a proposed plan to provide states a self- assessment tool for determining the degree of community integration for individuals with serious mental illness. Initial work focused on defining community integration. Many definitions of community integration were identified. Generally, the national panel agreed that community integration was the ability for individuals to live in their own home, enjoy family and friends, obtain meaningful work, and enjoy life as a member of the community.

The national panel examined existing federal, national, and state-level data sets; issues and barriers regarding community integration; and factors that provide indications of the degree of community integration. A pilot test was conducted using the indicators and existing data sets, SAMHSA is

using the input of the national panel and the results of the pilot test to develop the self-assessment tool which will be provided to states. Georgia should receive the self-assessment instrument in 2013. The Office of Disability Services Ombudsman will use the instrument during community visits and in community integration discussions with state agencies and other partners.

At-Risk Adult Working Group

In April 2012, the Georgia Bureau of Investigation (GBI) convened the At-Risk Adult Working Group. GBI is the lead agency for the working group which is tasked to reduce abuse, neglect, and exploitation of at-risk adults. At-risk adults include the elderly and adults with disabilities. Members of the working group are:

- Multiple state and local law enforcement agencies,
- Georgia Division of Aging Services/Forensic Special Investigations Unit (Department of Human Services),
- Healthcare Facility Regulation (Department of Community Health),
- Department of Public Health,
- Governor's Office of the Disability Services Ombudsman, and
- Governor's Office of Consumer Protection.

The initial working group meeting focused on law enforcement and state agency responsibilities regarding abuse, neglect, and exploitation of at-risk adults. The working group is striving to reduce barriers in carrying out these responsibilities and in sharing data and other information. Subsequent meetings have emphasized interventions for at-risk adults in need of emergency placement due to suspected abuse, neglect, or exploitation.

In May 2012, House Bill 1110 passed. This bill amended Title 30, Title 31, and Title 35 of the Official Code of Georgia to clarify provisions relating to the neglect of elder persons and disabled adults. The bill was entitled the "Disabled Adults and Elder Persons Protection Act". The bill makes Georgia a national leader in protecting disabled and elderly adults, who are often the victims of physical and financial abuse. Passage of the bill has been an important step in beginning to address abuse and neglect of at-risk adults as a major crime problem in our state.

The Director, GBI continues to facilitate the working group meetings and to bring important legislation to the General Assembly. The working group has emphasized sharing of information among state agencies and law enforcement with timely, effective interventions to assist at-risk

adults. This has improved interagency collaboration and our law enforcement and state agency response. We have seen an increase in arrests for those suspected of abuse, neglect, and exploitation of at-risk adults.

The Office of Disability Services Ombudsman will continue to participate in this working group and use it as a forum for promoting the safety, well-being, and rights of individuals with disabilities who are at risk for abuse, neglect, or exploitation.

SAMHSA Olmstead Policy Academy

In June 2012, The Substance Abuse and Mental Health Services Administration (SAMHSA) invited Georgia to participate in their Olmstead Policy Academy to "…assist with state readiness and strategic planning; the provision of targeted technical assistance from HUD, CMS, and SAMHSA in areas such as housing, MEDICAID, and other resources to support Olmstead implementation; and a learning community among state leaders to share lessons learned and best practices in policy and program development to achieve Olmstead goals."

Georgia competed and was one of five states selected to send seven representatives to the Olmstead Policy Academy in Washington, D.C. on September 20-12, 2012. States were selected based on their potential to benefit from the Policy Academy with related technical assistance and to implement strategies for children and adults with mental disorders. After the Policy Academy, SAMHSA selected Georgia as one of five states to receive targeted technical assistance in 2013 to support community integration.

SAMHSA Policy Academy: Reduce Chronic Homelessness

In February 2013, SAMHSA announced that Georgia has been selected to participate in a Policy Academy on Chronic Homelessness. The Georgia team is charged with addressing the problem of chronic homelessness. SAMHSA is coordinating federal staff participation to assist the local team which is led by the Department of Community Affairs (DCA). DCA invited the Disability Services Ombudsman to participate in the project.

The Georgia team is designing a strategy with measurable outcomes to reduce chronic homelessness. After monthly phone conferences and completion of a strengths/weaknesses/opportunities/threats (SWOT) analysis, SAMHSA, federal partners, and the Georgia team completed a two day working session (May 29-30, 2013) at the Carter Center in Atlanta. Objectives for the meeting included developing a logic model that succinctly

communicates the state plan, identifies pilot project opportunities, reviews possible state policy changes, and identifies technical assistance that would assist the state in refining the plan. A second meeting is planned in late summer 2013.

This effort compliments other state agency work to improve housing availability throughout the state. DCA has led the development of a collaborative housing strategy that is impacting the Georgia/DOJ Settlement Agreement, Olmstead initiatives, and Ombudsman response to requests from individuals with disabilities. Housing is often the key resource in facilitating transitioning from institutions and in preventing institutionalization. Progress in housing is evident during Ombudsman visits to communities.

Behavioral Health Coordinating Council Transition Care/ Reentry Partnership Project

In March 2013, the Behavioral Health Coordinating Council (BHCC) created a working group to "…investigate the barriers, infrastructure, staffing, services, housing, and educational needs for diverting and transitioning individuals with behavioral and developmental issues under the jurisdiction or care of the Department of Corrections, Pardons and Parole, Department of Juvenile Justice, and DBHDD's forensic services." The "Transition Care/Reentry Work Group" reports regularly to the BHCC on its progress and remaining barriers. The anticipated work product is a plan and interagency agreement (MOU) that describes responsibilities in transitioning a targeted number of individuals into the community. The Transition Care/Reentry Work Group completed its fourth meeting in June 2013. The Disability Services Ombudsman is a member of the Behavioral Health Coordinating Council along with the BHCC Executive Committee and is providing representation on the work group.

Policy, Regulatory, and Legislative Changes

The biennial report is required by Georgia law to include recommendations concerning policy, regulatory, and legislative changes.

Recommendations for Change

1) **Formal Appeal Process for NOW/COMP Waiver.** Currently there is no formal appeal process for denial of waiver funding. The Department of Behavioral Health and Developmental Disabilities' (DBHDD) application process includes provider, region, and department level review. An application can be denied at any level. The DBHDD, as the lead agency should implement an appeal process for all levels of the application process. The process should be promulgated and transparent to all applicants, family members, advocates, and stakeholders. The appeal process should include a senior level department review before any request for a new waiver or additional funding is denied.

2) **Admission to Substance Use Disorder Services.** The Office of Disability Services Ombudsman (ODSO) received a complaint from an individual who was denied substance use disorder services because the individual refused to disclose the medications he was taking. ODSO worked with DBHDD and the provider to open services for the individual. While we recognized that the provider's medical director should not prescribe additional medications without knowing about other drugs being consumed, we advocated that counseling and other non-medication related treatment should be started. Later in treatment, the trust between provider and individual with a substance use disorder should increase and the medication information would become available. Denying access to treatment for failure to disclose medications is an unacceptable policy for a provider.

3) **Olmstead List.** DBHDD has maintained an Olmstead List for individuals in state hospitals. The policy now is that an individual in the state hospital for more than 45 days is placed on the list. Previously, the time was 60 days. When an individual is on the Olmstead List, hospital and DBHDD region staff increase the level of transition planning. As hospital census continues to decline, the DBHDD Olmstead List should include anyone admitted to the hospital. Planning for their transition and return to home and community-based services should begin immediately.

4) **Co-Occurring Mental Health and Substance Use Disorder Screening and Assessment.** Co-occurring substance use disorder and mental illness are no longer the exception for the individuals we serve; rather they are the expectation. State hospitals and community providers must have the capability to screen for, and if appropriate, to assess co-occurring treatment needs and services. We cannot adequately serve individuals without knowing the complete diagnosis.

5) **Lack of Services.** Georgia has substantially increased funding of services and supports for individuals with disabilities. However, ODSO has encountered situations where there are inadequate services for brain injury, traumatic brain injury, and dementia. Also, community service boards have received funding reductions in core services, which in at least two instances have resulted in denial of care except for specific populations. As the State moves from a hospital-based system of care to a community-based system of care, we must continue to work for adequate funding to meet service needs.

6) **"Youth Aging Out" Gap in the System of Care.** Youth with developmental disabilities who age out of the school system too often are not continued in services. No agency is responsible for managing their care after they leave school. This problem should be studied and solutions within available resources determined.

7) **Community Integration Not Always Understood and Achieved.** Individuals transitioning from state institutions should live in integrated community settings. They should not be institutionalized in our communities. They should have the opportunity to live and work with individuals who do not have disabilities. As discussed previously, the integration setting should enable the individual with a disability to live in their own home, enjoy family and friends, obtain meaningful work if possible, and enjoy life as a member of the community. We must continue our education programs and insist on true integration for individuals living in our communities.

8) **Crisis Intervention Training (CIT).** CIT has proven cost effective nationally and in Georgia. Yet, we have seen communities that do not embrace the CIT concept. CIT assists law enforcement in responding properly to crises involving individuals with mental illness and/or developmental disabilities. All law enforcement agencies should have some CIT capability. We should encourage participation and seek additional funding for CIT training of our law enforcement personnel.

9) **Who is Responsible for the Community System of Care?** The Department of Behavioral Health and Developmental Disabilities (DBHDD) has subordinate regions, community service boards, and other providers serving our communities. As we have moved to a community system of care, it is unclear who is responsible for unifying community, state, and in some instances, federal resources. We have not fixed responsibility for leading and directing our community system of care. DBHDD, working with other state agencies, should develop a model for community leadership for our system of care.

10) **Inadequate Data Management Capability.** State hospitals have developed data management that is linked to the DBHDD state office. There are problems with timely, effective management of data regarding our service delivery. This problem is exacerbated in the community. As we continue to transition individuals into the community and increase our prevention efforts, there must be an effective data management system to manage large populations and to ensure quality long term care. Effective data information systems and management do not exist today and will increasingly be a problem for the future.

11) **Quality of Personal Care Homes.** The Office of Disability Services Ombudsman receives frequent calls about substandard living conditions in personal care homes. This is a major problem confronting the At-Risk Adult Working Group (Special Projects, p. 24). Multiple state agencies are involved in funding and providing services in these homes. Inspection standards are not aligned between agencies and in some cases, the standards are not adequate. Operators of personal care homes are too often unwilling, or unable, to assist residents. Safe, healthy housing is a critical resource that we must provide individuals with disabilities who are transitioning into the community. The Department of Community Affairs (DCA) housing collaboration is an important initiative that should be supported. We must improve maintenance, funding, and management accountability of personal care homes.

12) **Timely Medical Appointments.** Too often, individuals are discharged from state hospitals or criminal justice facilities without the necessary medications to treat their mental illness. DBHDD policy is to provide five days of medications and a 30 day prescription. The handoff to the community provider may result in a delay in medical appointments resulting in no medication and eventual decompensation for an individual who was stable at the time of his release. Coordination during transition/reentry must be more effective. Adequate medication must be provided. Formularies should be considered to avoid changing medications whenever possible. Improved medical management is imperative.

Changes Implemented During the Biennium

1) **Death Notification.** At the start of the biennium, the Department of Behavioral Health and Developmental Disabilities (DBHDD) policy was to notify local coroners about a death in a state hospital. State law requires that this notification should be given to the state medical examiner, who will accept or decline jurisdiction. The medical examiner also determines if an autopsy is required. ODSO facilitated discussions between DBHDD and the GBI Medical Examiner's Office to align policies in both agencies to comply. The resultant procedural changes mandated by policy revisions have improved the reporting and subsequent investigation of deaths that occur in state hospitals.

2) **Developmental Disability Admissions to State Hospitals.** The Georgia/DOJ Settlement Agreement stipulates that "…by July 1, 2011, the State shall cease all admissions to the State Hospitals of all individuals for whom the reason for admission is due to a primary diagnosis of a developmental disability." During the biennium, this became department policy and has been promulgated in state law.

3) **Reporting DNR/DNI Status.** DBHDD Form, "Transfer to Outside Facility for Emergency or Other Services" did not indicate if the individual was Do Not Resuscitate/Do Not Intubate. Failure to indicate this may affect the care provided by the receiving facility. After recommendation by the Office of Disability Services Ombudsman, the DBHDD Form was modified to include whether or not the individual was DNR/DNI.

4) **State Hospital Laboratory Reporting Measures.** Laboratory work completed in state hospitals should be reported to physicians in a timely manner and tracked as performance measures. All state hospital laboratory managers now track and report the following Laboratory Performance measures: testing done on date specified, specimen properly collected, test turn-around time, critical value reporting and test results charter. These procedural changes have improved timeliness and overall use of state hospital laboratories.

5) **Recording of Vital Signs in 23 Hour Observation Unit and during Pain Assessments.** State hospitals now record vital signs at least once per shift but more often as clinically indicated during stays in the 23 Hour Observation Unit. Vital signs are now recorded during pain assessments in state hospitals. Vital signs are important indicators for physician review during assessment and care.

Priorities for Fiscal Years 2014 and 2015

We are in the first month of the second biennium for Disability Services Ombudsman and Olmstead Coordinator reporting. At the start of this fiscal period, the priorities of the Office of Disability Services Ombudsman include to:

1) Work on the recommendations for policy changes (pp. 27-29).

2) Continue to support DBHDD and other state agencies in meeting the requirements of the Georgia/DOJ Settlement Agreement.

3) Work with DBHDD and state agencies to determine a "post Settlement Agreement strategy" that sustains the successes that have been achieved and sets new objectives beyond the 2015 completion date.

4) Determine how to use the work completed on the 2012 draft Olmstead Plan with the "post Settlement Agreement strategy" for Olmstead initiatives after 2015.

5) Participate in the SAMHSA chronic homelessness policy academy and the BHCC prison transition/reentry effort.

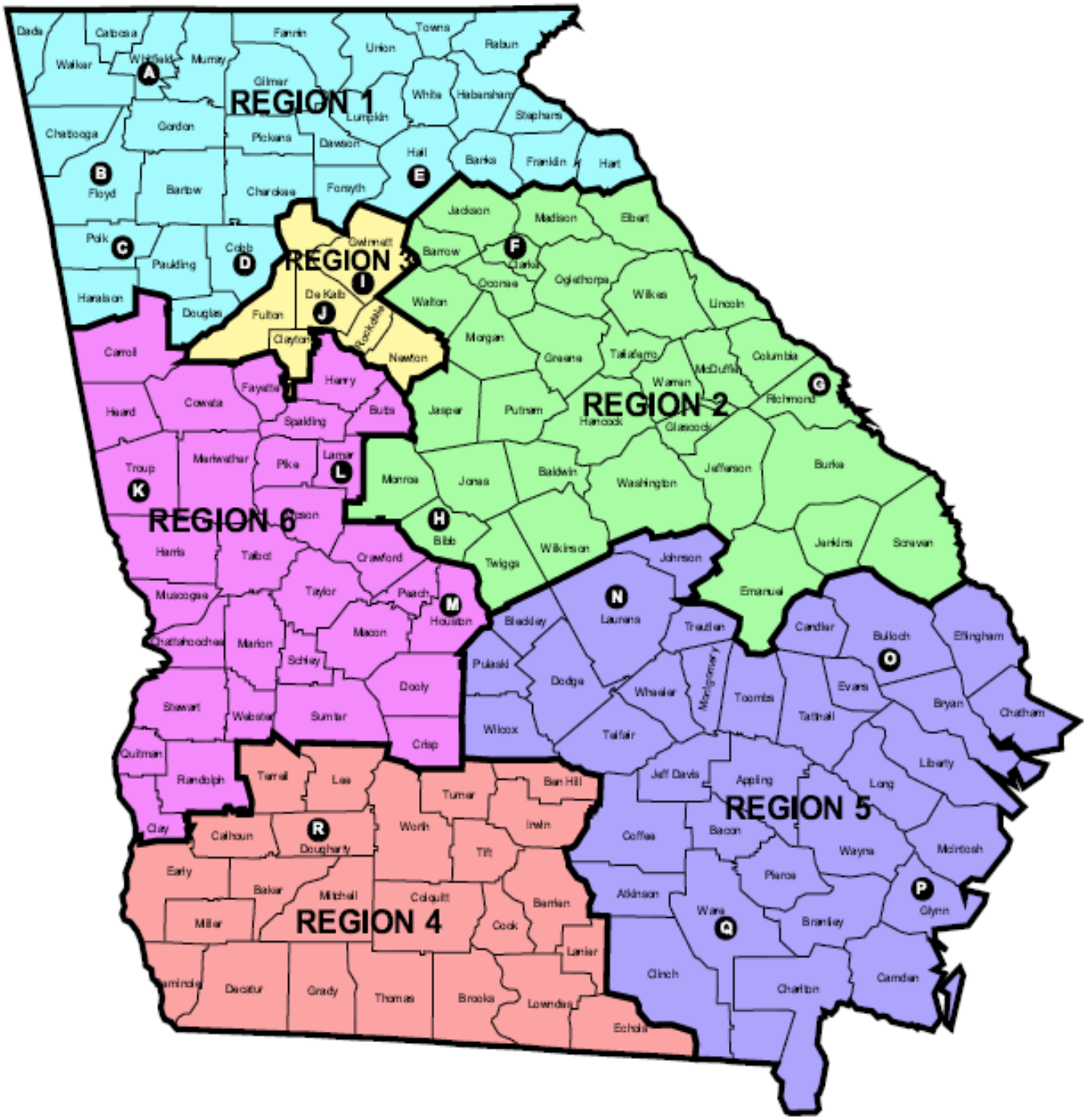
6) Provide opportunities to involve members of the Olmstead Planning Committee in the work and discussions above.

7) Continue to visit hospitals, community placements, providers, and crisis programs to monitor our Olmstead progress.

8) Monitor the closures of the James B. Craig Center in Milledgeville and Southwestern State Hospital in Thomasville.

Appendices

Appendix A – Department of Behavioral Health and Developmental Disabilities – Map of Service Regions



Appendix B – Medical Review Group Legislation

O.C.G.A. § 37-2-45. Medical review group to review the deaths of consumers

a) The Governor shall appoint a medical review group to conduct medical reviews of all deaths of consumers in state hospitals or state operated community residential services, which shall serve at the pleasure of the Governor. The medical review group shall consist of the ombudsman and four board certified physicians, one of whom shall be a psychiatrist. Three members of the medical review group shall constitute a quorum. The ombudsman shall serve as the chairperson and shall appoint a vice chairperson.

b) The physician members of the medical review group shall receive such compensation, if any, as may be fixed by the Governor. Such physician members shall be reimbursed for expenses incurred by them in performance of their duties such as transportation, lodging, and subsistence, at the same rate as members of the General Assembly.

c) The medical review group:

1) Shall be a review organization and shall conduct reviews of deaths of consumers in state hospitals and state operated community residential services as peer reviews pursuant to Article 6 of Chapter 7 of Title 31;

2) Shall review, within 60 days of notice of the death, all deaths of consumers:

A. Occurring on site of a state hospital or state operated community residential services providing services under this title;

B. In the company of staff of a state hospital or state operated community residential services providing services under this title; or

C. Occurring within two weeks following the consumer's discharge from a state hospital or state operated community residential services;

3) Shall have access to all clinical records of the consumer, all investigations conducted by the department, state hospitals, or state operated community residential services regarding the death, and all reviews of the death, including peer reviews;

4) May interview staff of the state hospitals and state operated community residential services, and other persons involved in the events immediately preceding and involving the death;

5) Shall determine whether the death was the result of natural causes or may have resulted from other than natural causes;

6) Shall determine whether the death requires further investigation or review;

7) May make confidential recommendations to the ombudsman, the department, the division, the state hospitals, and state operated community residential services regarding consumer treatment and care, policies, and procedures, which may assist in the prevention of deaths; and

8) Shall report to the appropriate law enforcement agency any suspected criminal activity or suspected abuse and shall report any suspected violation of any professional code of conduct to the appropriate licensing board.

d) All peer review records submitted to or produced or created by the medical review group and the findings and recommendations of the medical review group, except for the quarterly reports, shall remain confidential and shall not be considered public records under Article 4 of Chapter 18 of Title 50.

Appendix C – Acronyms

BHCC	Behavioral Health Coordinating Council
CIT	Crisis Intervention Training
CMS	US Centers for Medicare and Medicaid Services
CSH	Central State Hospital
DAS/FSIU	Division of Aging Services, Forensic Special Investigations Unit
DBHDD	Department of Behavioral Health and Developmental Disabilities
DCA	Department of Community Affairs
DCH	Department of Community Health
DCH/HCF	Department of Community Health, Healthcare Facility Regulation
DHS	Department of Human Services
DNR/DNI	Do Not Resuscitate/Do Not Intubate
DOJ	Department of Justice
ECRH	East Central Regional Hospital
FY	Fiscal Year
GBI	Georgia Bureau of Investigations
GRHA	Georgia Regional Hospital at Atlanta
GRHS	Georgia Regional Hospital at Savannah
HUD	U.S. Department of Housing and Urban Development
ME	Medical Examiner
MOU	Memorandum of Understanding
MRG	Medical Review Group
ODSO	Office of the Disability Services Ombudsman
OPC	Olmstead Planning Committee
NOW/COMP	New Options Waiver/Comprehensive Supports Waiver
NWGRH	Northwest Georgia Regional Hospital
PCH	Personal Care Home
SAMHSA	Substance Abuse and Mental Health Services Administration
SWOT	Strengths/Weaknesses/Opportunities/Threats Analysis
SWSH	Southwestern State Hospital
WCGRH	West Central Georgia Regional Hospital

Governor Nathan Deal

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