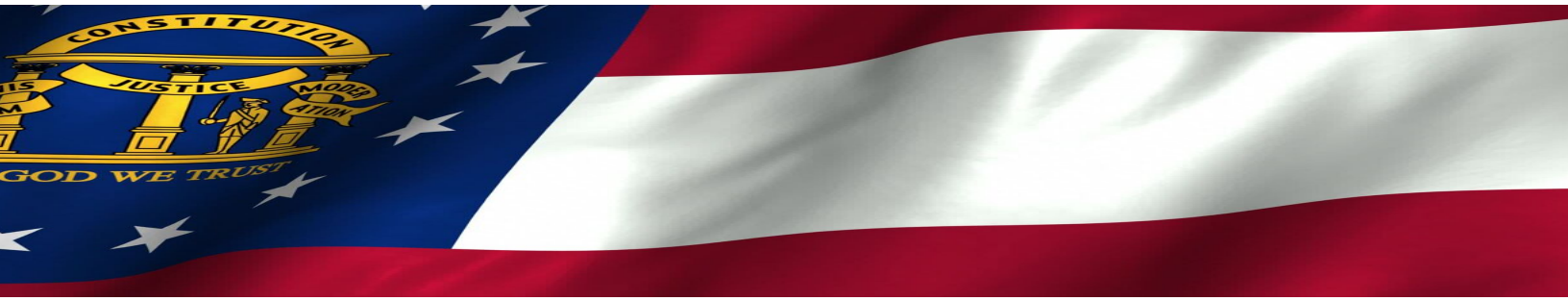
BIENNIAL REPORT

FY 2014 2015

Office of Disability Services Ombudsman

Governor Nathan Deal



Biennial Report

Lavinia Luca
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:

It is my honor to serve as Ombudsman and Olmstead Coordinator, a position I assumed on December 1, 2015. The Office of Disability Services Ombudsman (ODSO) combines the roles of Ombudsman and Olmstead Coordinator and fully embraces the mission of promoting the safety, rights, and well-being of individuals with disabilities in Georgia. This office responds to complaints and requests for assistance and information while also working to support community integration and consumer choice in accordance with the U.S. Supreme Court's 1999 Olmstead decision.

The enclosed report provides an account of the work accomplished by ODSO and the Medical Review Group, as well as a list of policy, regulatory, and legislative changes during fiscal years 2014 and 2015. Within this biennium, the ODSO saw a 2.8 percent increase in the total cases opened compared to the previous biennium, while seeing a 37 percent decrease in the total number of issues raised by complainants. The majority of inquiries received were from or on behalf of individuals living with a mental illness.

Of note, since the submission of the previous report in 2013, ODSO has been monitoring efforts by the Department of Behavioral Health and Developmental Disabilities (DBHDD) to expand community-based capacity and transition individuals from institutional settings into the community. In 2013 and 2015 respectively, the department closed Southwestern State Hospital and the James B. Craig Nursing Center. This work to support community integration aligns with ODSO's priorities.

ODSO seeks to partner with federal, state, and local agencies and stakeholders to improve service delivery for all disability populations in Georgia. We reaffirm our commitment to listening to the disability community and the general public to identify issues and determine effective solutions. Thank you for your interest and support of the work of the Office of Disability Services Ombudsman.

Sincerely,

Lavinia Luca
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 (ODSO) 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 2014 and 2015 fiscal years, ODSO opened 754 cases and responded to 821 issues. The issues responded to range from complaints of abuse and neglect to requests for assistance or information regarding disability benefits. From fiscal year 2014 to fiscal year 2015, there was a decrease of 33% in the number of issues responded to by the ODSO.

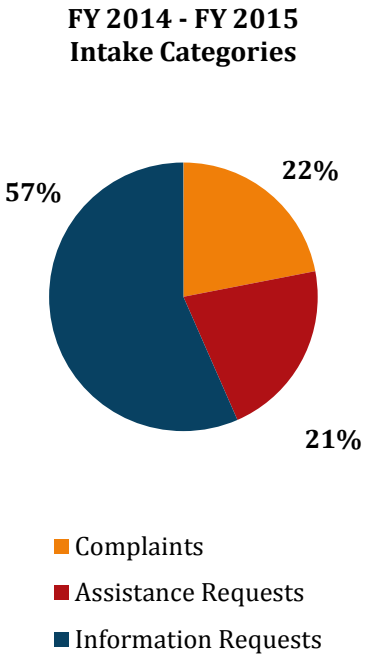


Figure 1

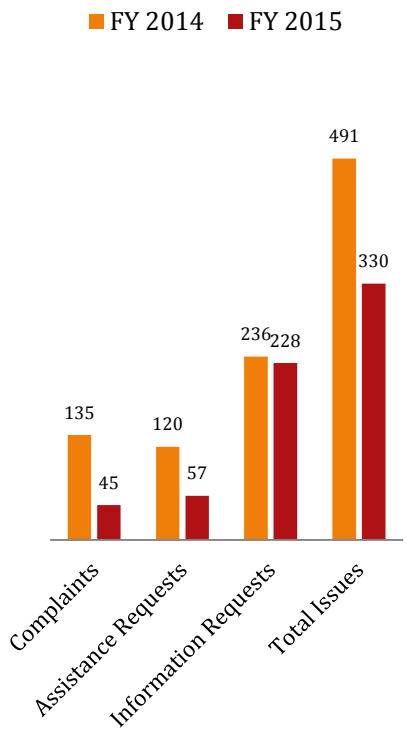


Figure 2

Top 10 Most Frequent Issues Across all Intake Categories	FY 2014 and 2015	Percentage
Benefits	252	31.0%
Legal	76	9.3%
Other	71	8.6%
Abuse and Neglect	64	7.8%
Housing	62	7.6%
Discharge	36	4.4%
Client Rights	35	4.3%
Treatment Issue	32	3.9%
ADA Accommodations	27	3.3%
Medication	23	2.8%
Subtotal (10 most frequent issues)	**678**	**83% of total**
Total (of all issues responded to)	**821**	**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 2014: Intake by Department of Behavioral Health and Developmental Disabilities (DBHDD) Service Regions[2]

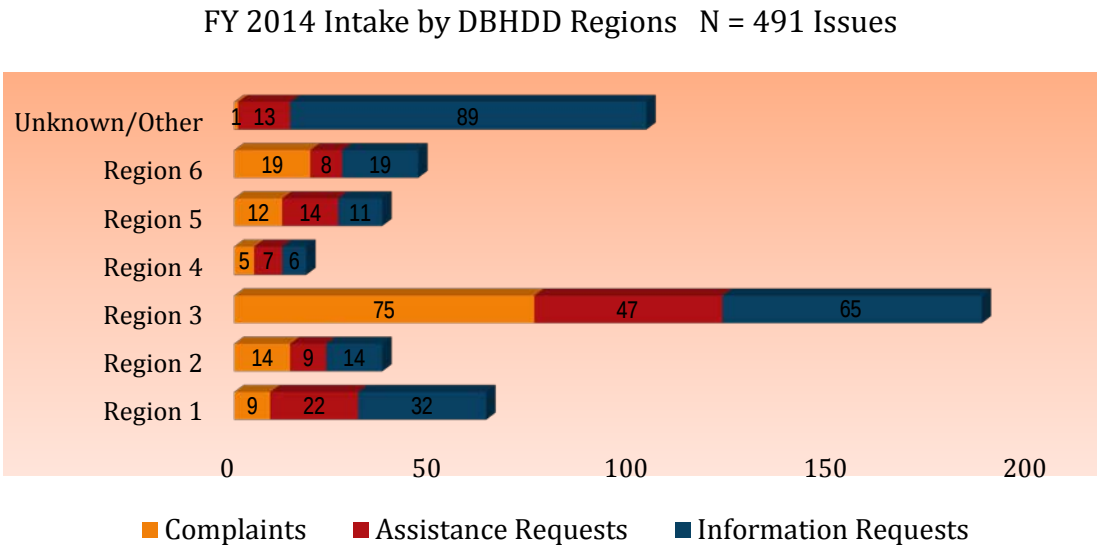


Figure 4

FY 2015: Intake by Department of Behavioral Health and Developmental Disabilities (DBHDD) Service Regions[3]

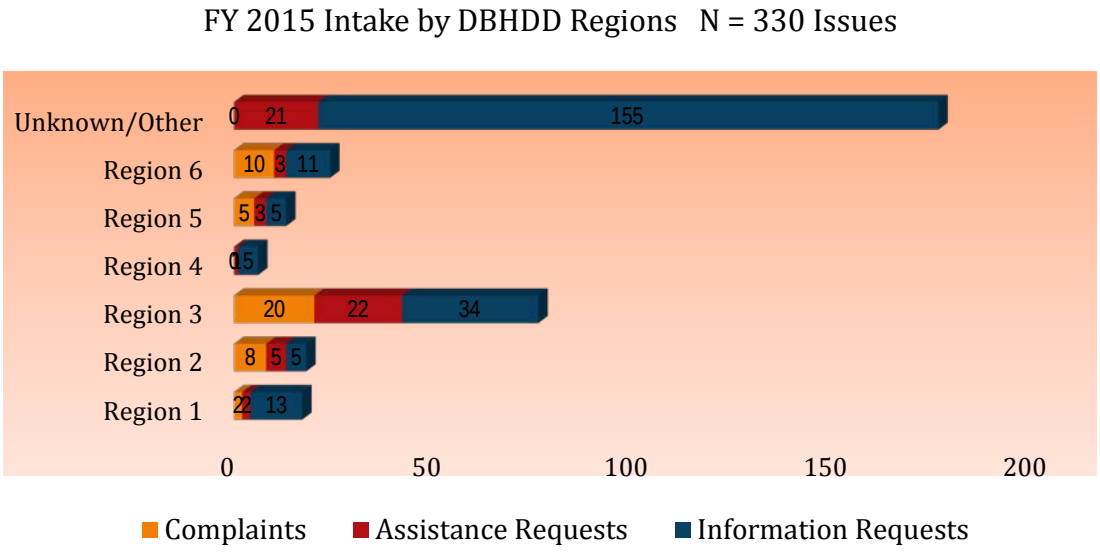


Figure 5

[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 2014 and 2015 - highlighting the highest intake category for each (Figure 4). Mental illness disabilities accounted for the majority (40 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 2014	FY 2015	Total Cases	Highest Intake Category based on disability type
Mental Illness	189	114	303	Request for Information
Physical Disability	147	62	209	Request for Information
None/Not Determined/Not Available	44	81	125	Request for Information
Intellectual and Developmental Disability	34	41	75	Request for Information
Co-Mental Illness and Addictive Disease	15	1	18	Request for Information
Co-Mental Illness and Intellectual and Developmental Disability	9	2	11	Request for Information & Complaints
Co-Occurring (Other)	6	1	7	Request for Assistance
Brain Injury-Mental Illness	2	3	5	Request for Information & Assistance
Addictive Disease	1	0	1	Request for Assistance
Total Cases by Disability Type	**447**	**305**	**754**	

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, 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-two percent of cases involving issues of complaint are initiated directly by individuals with disabilities and the other thirty-eight percent are 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

During the complaint investigation process, 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. The range of issues investigated and an overview of the complaint outcomes during fiscal years 2014 and 2015, follow.

Complaint Issues

- The percentage of complaint cases decreased by 68% from FY 2014 to FY 2015.
- The percentage of complaint issues decreased by 66% from FY 2014 to FY 2015.

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).

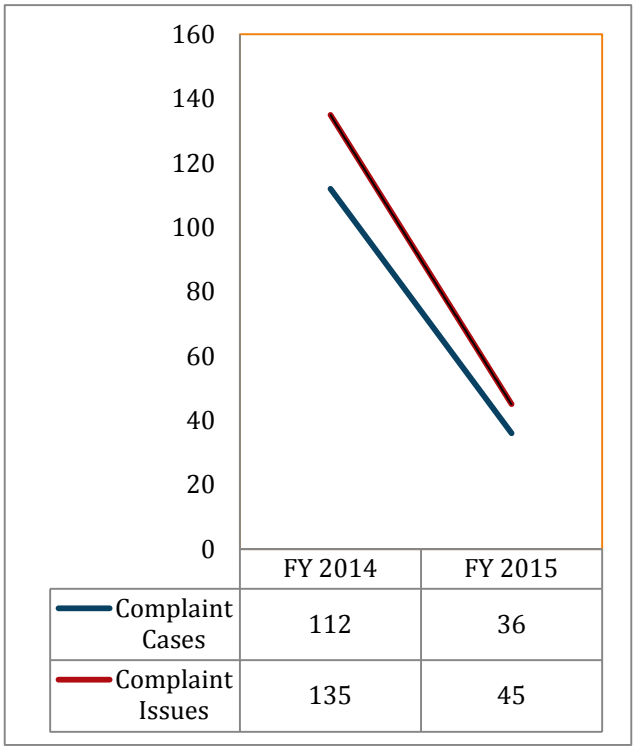


Figure 7

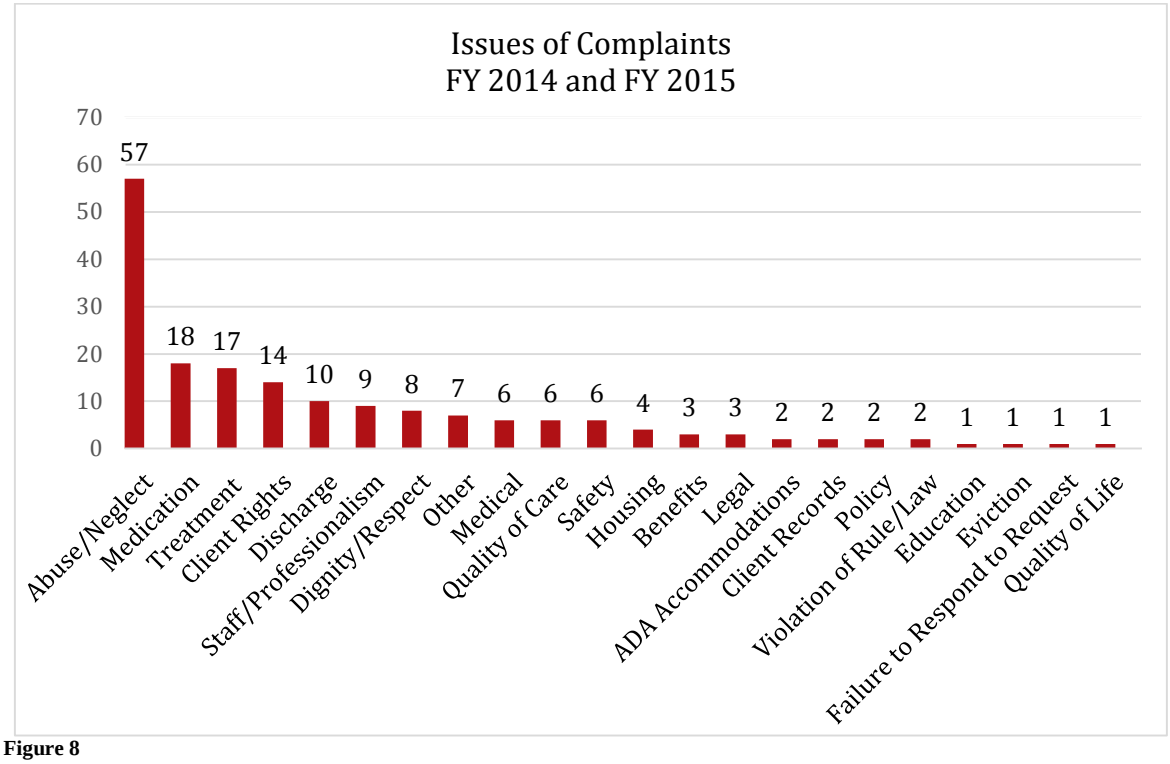


Figure 8

Complaint Outcomes

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 is unable to obtain information to make a substantiated/unsubstantiated determination, the complaint is reported as inconclusive. As reflected in Figure 9, the majority of complaints investigated during fiscal years 2014 and 2015 were unsubstantiated. However, an unsubstantiated 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.

As a result of the complaint process, ODSO staff routinely investigates 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 year 2014, thirty-nine percent of complaints were unrelated to services provided by DBHDD or DBHDD contracted providers, and in fiscal year 2015, twenty-two percent were unrelated (Figure 10).

FY 2014 and 2015 Complaint Outcomes	Percentage of Complaints
Substantiated	14.0%
Unsubstantiated	67.2%
Inconclusive	1.1%
Referred to another agency	4.4%
Pending (still open)	3.3%

Figure 9

Cases Involving Complaint Issues

	FY 2014	FY 2015
State Hospitals	38%	64%
DBHDD Providers	23%	14%
Other	39%	22%
Total	100%	100%

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 ODSO helped address 641 issues during the 2014 and 2015 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;
- Served as a liaison between a mother and a regional office of DBHDD to facilitate mother's understanding of the next steps of completing a Medicaid waiver application for her adult child with a MH and IDD diagnosis;
- Communicated patient's medical concerns to state hospital, resulting in patient receiving a precautionary medical examination;
- Contacted involved agency on behalf of individual with disability after their attempts to get a response to inquiry was unsuccessful;
- Contacted involved agencies or other involved individuals to facilitate the resolution of misunderstandings or miscommunications about a policy, process or action taken;
- 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 FY 2014-2015 biennium, only twenty percent (20%) of intake cases involved one or more issues of complaint, whereas, eighty percent (80%) of cases involved issues of information and/or assistance requests only.

Most Frequent Issues: Assistance and Information Requests

Top 5 Most Frequent **Assistance Request Issues**	FY 2014 and 2015	Percentage
Benefits	35	19.7%
Legal	23	12.9%
Discharge	19	10.7%
Housing	10	5.6%
Other	18	10.2%
Subtotal (5 most frequent assistance request issues)	**105**	**59% of total**
Total (of all issues assistance requests)	**177**	**100%**

Top 5 Most Frequent **Information Request Issues**	FY 2014 and 2015	Percentage
Benefits	214	46.1%
Legal	50	10.7%
Housing	48	10.3%
Other	46	9.9%
ADA Accommodation	18	3.9%
Subtotal (5 most frequent information request issues)	**376**	**81% of total**
Total (of all information requests issues)	**464**	**100%**

Medical Review Group (MRG)

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, who serves as the chairman, and four board certified physicians, one of whom must be a psychiatrist.

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.

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

MRG Meetings

The MRG convened three times in FY 14 and two times in FY 15 to review the deaths that met the legislative guidelines. The MRG conducted 51 total reviews during the biennium, of which 43 were initial reviews. Due to the vacancy of the Ombudsman during January 1, 2015 – November 30, 2015, the MRG did not meet in the 2015 calendar year.

Medical Review Statistics

FY 2014 and FY 2015 Medical Reviews					
Medical Review Dates	New death cases reviewed	Cases w/follow up from previous meeting(s)	Cases Closed	Cases reviewed that are still pending	Total cases reviewed
September 27, 2013	12	5	16	1	**17**
December 13, 2013	6	2	7	0	**8**
May 2, 2014	7	0	7	0	**7**
September 4, 2014	10	0	9	1	**10**
December 4, 2014	8	1	9	0	**9**
TOTAL	**43**	**8**	**48**	**2**	**51**

Figure 13

Policy, Regulatory, and Legislative Changes

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

Recommendations for Change

1) **Quality of Personal Care Homes.** ODSO continues to receive frequent calls about substandard living conditions and care in personal care homes. Multiple state agencies are involved in funding and providing services in these homes. Safe, healthy housing is a critical resource that we must provide individuals with disabilities. The At-Risk Adult Working Group lead by the Georgia Bureau of Investigation (GBI) continues to facilitate ways to break down barriers to combat the abuse, neglect and exploitation of older adults and adults with disabilities. We must continue supporting these efforts to improve maintenance, funding, and management accountability of personal care homes.

2) **Community Integration Not Always Understood and Achieved.** The U.S. Supreme Court's 1999 Olmstead decision is a clear response to the question about the importance of living a life of independence in a community setting. People transitioning from state institutions should live in community settings where they live and work with people who do not have a disability. Our communities should not further institutionalize and isolate people with disabilities. Community integration should mean a person with a disability can live in their own home, enjoy family and friends and obtain meaningful work if possible. We must continue to educate our communities and insist on true integration for people with disabilities living in our communities.

Changes Implemented During the Biennium

1) **At-Risk Adults Mobile Tool.** The Georgia Abuse, Neglect, and Exploitation (GANE) mobile application was developed through the collaboration of the Georgia Department of Human Services Division of Aging Services, the Georgia Chapter of the Alzheimer's Association and the Georgia Bureau of Investigation. GANE is a resource to help law enforcement and social workers make critical decisions about older adults and adults with disabilities in vulnerable situations. The GANE app provides information on laws, makes it easier to report a missing adult and provides guidance on evaluating whether an adult may have been abused, neglected or exploited.

2) **Supported Housing Assessment Tool.** Access to housing is an essential part of the recovery process and community integration. In 2015, the Department of Behavioral Health and Developmental Disabilities (DBHDD) developed the Supported Housing Needs and Choice Evaluation tool to be administered to individuals meeting the ADA Settlement criteria. This tool informs community-based adult mental health service providers of an individual's housing preferences and needs, within the appropriate available housing options across the state, as well as the level of support needed to remain in the housing the individual have chosen.

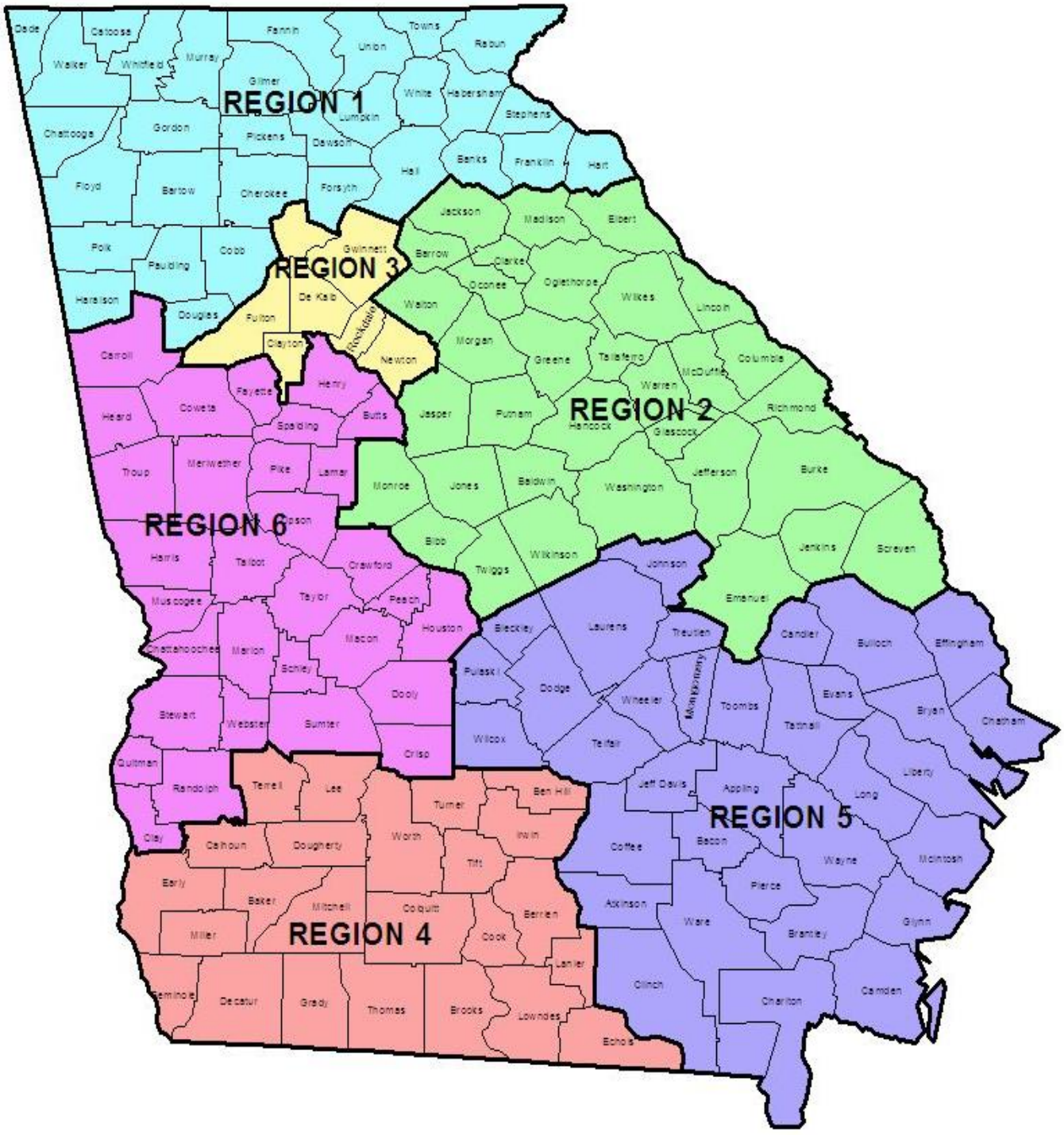
3) **State Hospital Closures.** ODSO has been collaborating with DBHDD to transition individuals from institutional settings into the community and expand community-based capacity. In 2013 and 2015 respectively, the department closed Southwestern State Hospital and the James B. Craig Nursing Center. As a result of these hospital closures, the number of individuals with intellectual/developmental disabilities that have transitioned into the community since the ADA Agreement is 505 as of December 2015. During this biennium, the department continued its efforts to expand community based services and in regions of the state that experienced hospital closures added a number of services such as: behavioral health crisis centers, crisis respite apartments, assertive community treatment teams, case managers, and a PATH team (Projects for Assistance in Transition from Homelessness program).

4) **Chest Pain Protocol.** State hospitals provide basic medical care but are not equipped with the diagnostic equipment needed to fully assess many major medical signs or symptoms. Therefore, DBHDD has guidelines to assist clinicians with early recognition of impending medical emergencies and to know when a rapid transport to a medical facility is warranted. Based on recommendations from the Medical Review Group, DBHDD made revisions to the Chest Pain protocol providing additional guidance to clinicians on procedures to

appropriately assess and determine when to initiate emergency transfer for individuals experiencing chest or abdominal pain.

5) **DBHDD Mortality Review Report.** In 2015, DBHDD published its first annual mortality report on adults who died while receiving waiver-funded intellectual and developmental disability Medicaid waiver services from DBHDD and its contracted providers. The purpose of the report is to identify trends and indicators that will help direct training and education efforts to assist the department and service providers with improving the quality and efficiency of services rendered.

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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