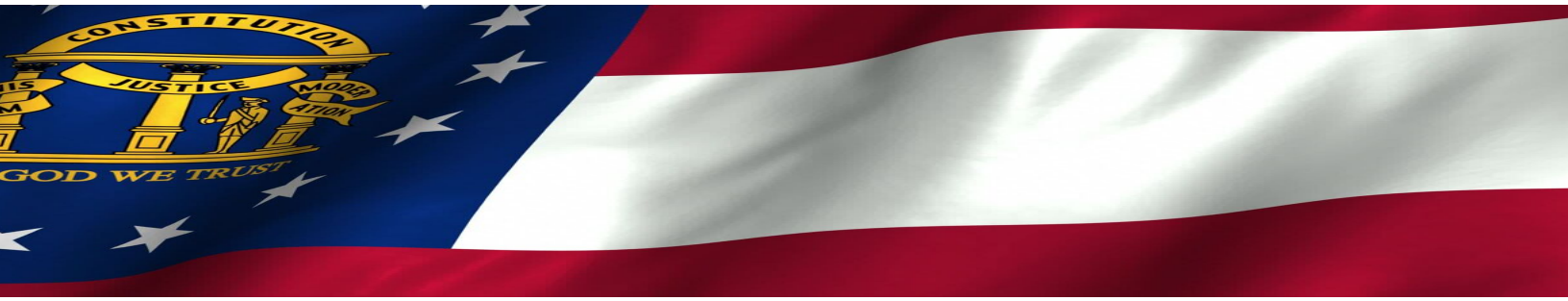
FY 2016 2017 BIENNIAL REPORT

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:

In accordance with O.C.G.A. §37-2-35, I am pleased to submit the biennial report of the Governor's Office of Disability Services Ombudsman (ODSO). This office seeks to promote the safety, rights, and well-being of Georgians with disabilities by responding 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 ruling in the 1999 *Olmstead* case.

The enclosed report provides an account of the work accomplished by ODSO and the Medical Review Group during fiscal years 2016 and 2017. During this biennium, ODSO saw a 51 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.

A major role of ODSO is to connect people with disabilities to Georgia's public safety net of community-based providers, which is managed by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). From this vantage point, ODSO was able to see firsthand the transformative work of DBHDD as it has focused its attention and resources on strengthening Georgia's community-based system of care. As reflected in this report, DBHDD has made substantial progress in two significant areas. The department shifted to a Housing First model for people with severe and persistent mental illness needing supported housing. The program had a stability rate of 84 percent in fiscal year 2017. Additionally, due to the success of new policies that both standardized and personalized the transition process for individuals with intellectual and developmental disabilities, DBHDD lifted the 2014 suspension on transitions from state hospitals to the community.

In May 2016, the State of Georgia and the U.S. Department of Justice (DOJ) agreed to a settlement agreement extension modifying the original terms of the 2010 Americans with Disabilities Act (ADA) settlement agreement. The extension agreement represents an acknowledgement by the DOJ of the state's compliance with the majority of provisions in the

original ADA settlement agreement. The work outlined in the extension is a reflection of many of the existing strategic priorities of DBHDD.

Despite great progress, ODSO continues to hear from individuals with disabilities whose unmet needs jeopardize their safety, rights, and well-being. We recognize the limitations of state and federal agencies, and providers to always deliver timely and effective services and supports, whether due to inadequate funding or bureaucratic barriers.

ODSO seeks to partner with federal and state agencies, and other 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 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 2016 and 2017 fiscal years, ODSO opened 400 cases and responded to 422 issues. The issues responded to range from complaints of abuse and neglect to requests for assistance regarding housing for individuals with disabilities. From fiscal year 2016 to fiscal year 2017, there was a decrease of 51 percent in the number of issues responded to by the ODSO.

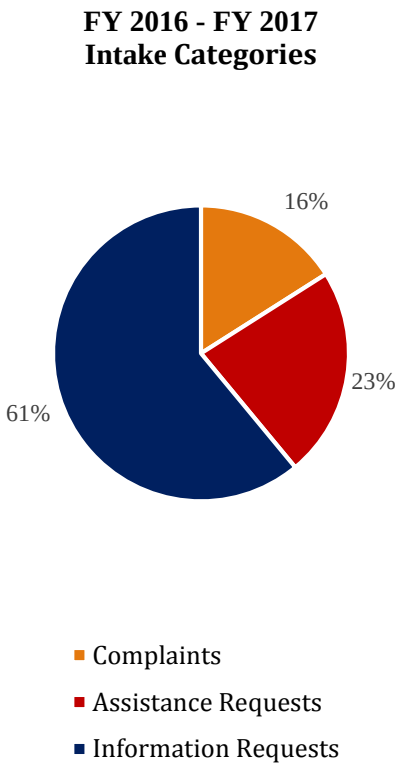


Figure 1

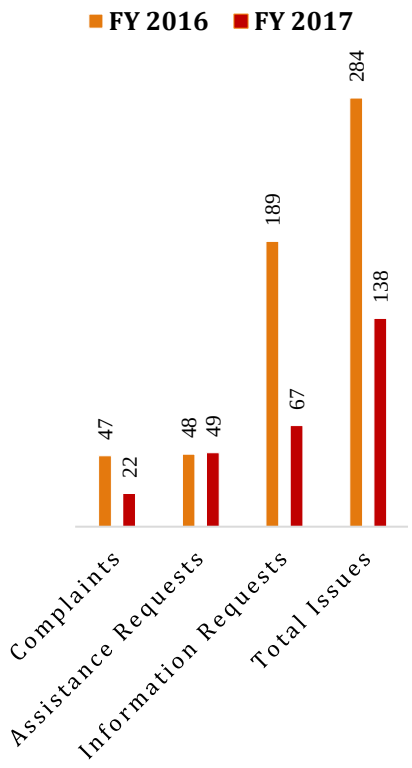


Figure 2

Top 10 Most Frequent Issues Across all Intake Categories	FY 2016 and 2017	Percentage
Benefits	114	27.0%
Other	97	23.0%
Housing	59	13.9%
Abuse and Neglect	41	9.7%
Discharge	25	5.9%
Legal	21	5.0%
Staff/Professionalism	11	2.6%
Transportation	11	2.6%
Medication	10	2.4%
Education	7	1.7%
Subtotal (10 most frequent issues)	**396**	**94% of total**
Total (of all issues responded to)	**422**	**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 2016: Intake by Department of Behavioral Health and Developmental Disabilities (DBHDD) Service Regions[2]

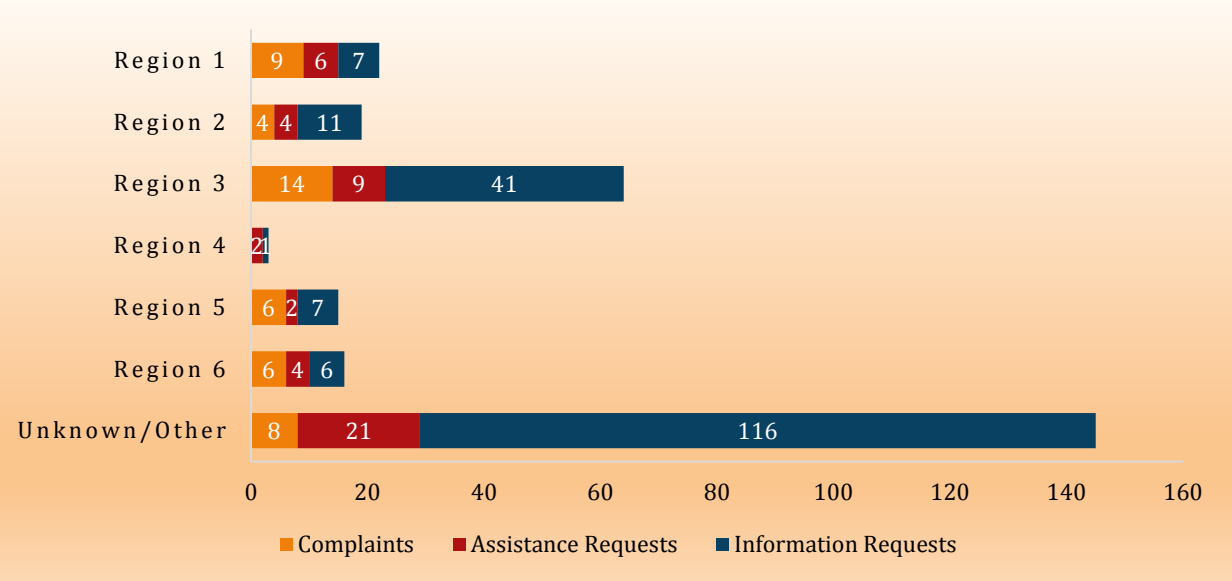


Figure 4

FY 2017: Intake by Department of Behavioral Health and Developmental Disabilities (DBHDD) Service Regions[3]

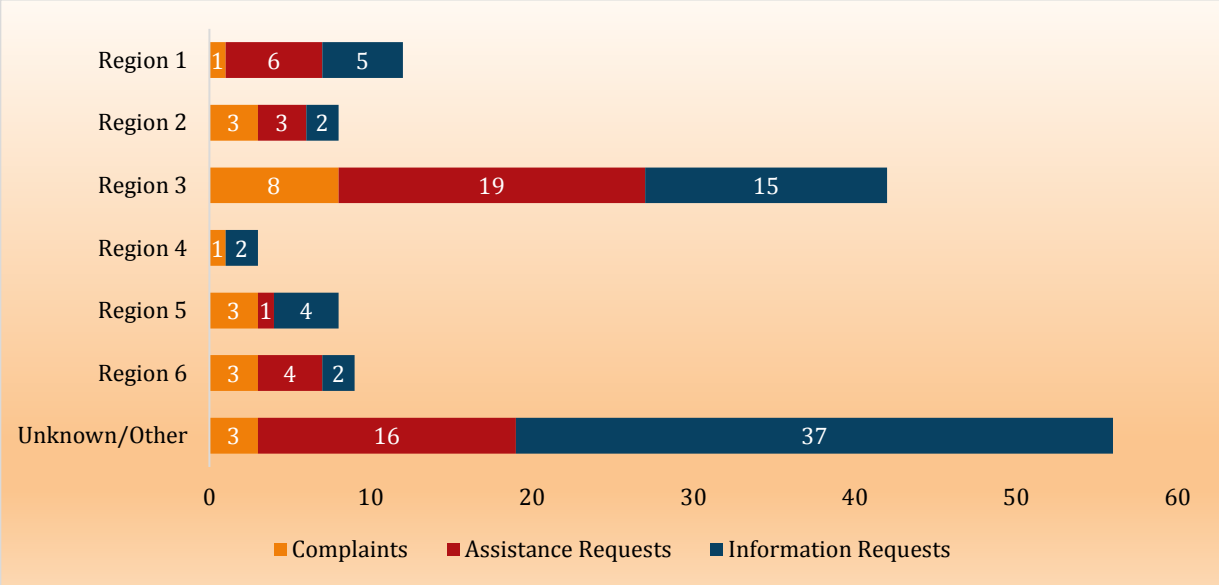


Figure 5

[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 2016 and 2017 (Figure 4). Combined mental illness disabilities and physical disabilities accounted for the majority, 68 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, and legislative recommendations.

Total Disability Population Served	FY 2016	FY 2017	Total Cases
Physical Disability	93	37	130
Mental Illness	91	52	143
None/Not Determined/Not Available	59	32	91
Intellectual and Developmental Disability	21	10	31
Brain Injury-Mental Illness	2	1	3
Addictive Disease	1	0	1
Co-Mental Illness and Addictive Disease	1	0	1
Total Cases by Disability Type	**268**	**132**	**400**

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.

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-five percent of cases involving issues of complaint are initiated directly by individuals with disabilities and the other thirty-five percent are initiated by relatives, agency personnel, and other advocates.

O.C.G.A. § 37-2-39

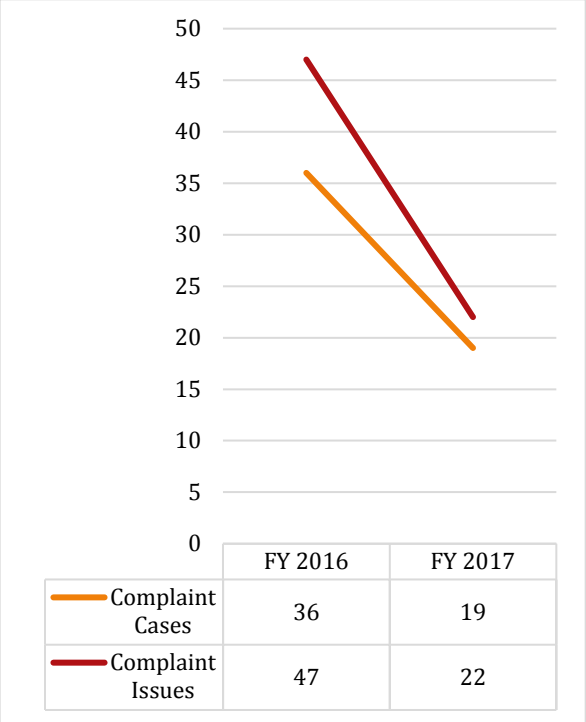
The ombudsman shall prepare and distribute to each services provider in the state a written notice describing the procedure to follow in making a complaint, including the address and telephone number of the office and the ombudsman. The administrator or person in charge of such services provider shall 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 2016 and 2017, follow.

Complaint Issues

- The percentage of complaint cases decreased by 47% from FY 2016 to FY 2017.
- The percentage of complaint issues decreased by 53% from FY 2016 to FY 2017.

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).



	FY 2016	FY 2017
Complaint Cases	36	19
Complaint Issues	47	22

Figure 7

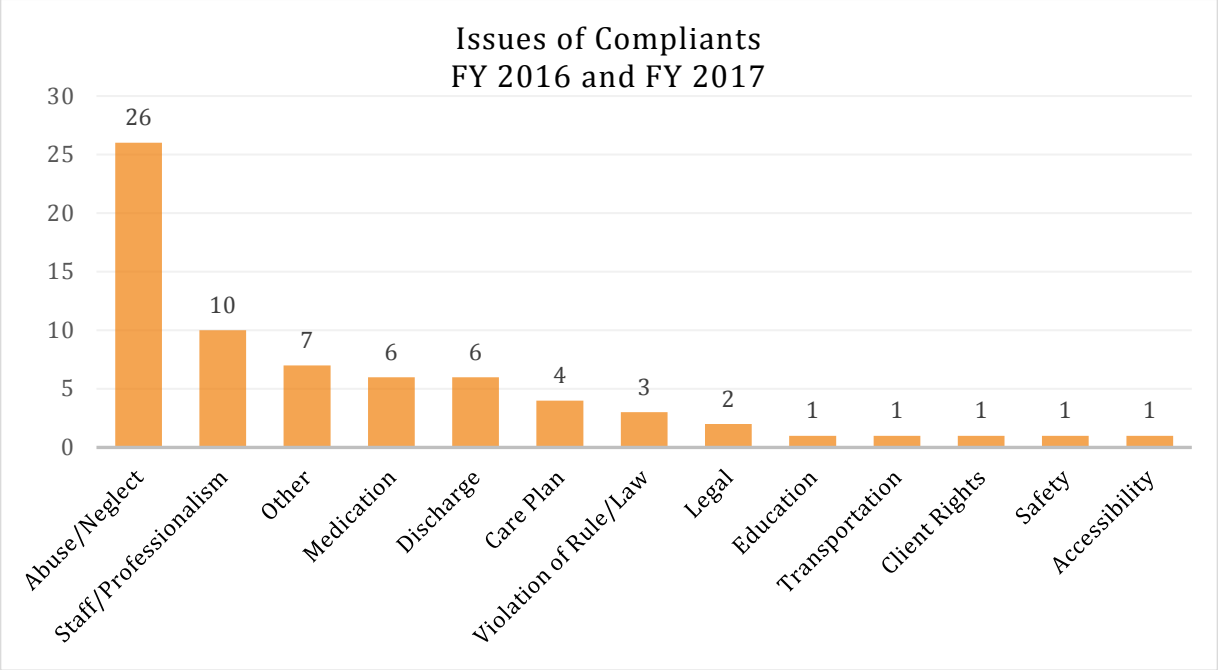


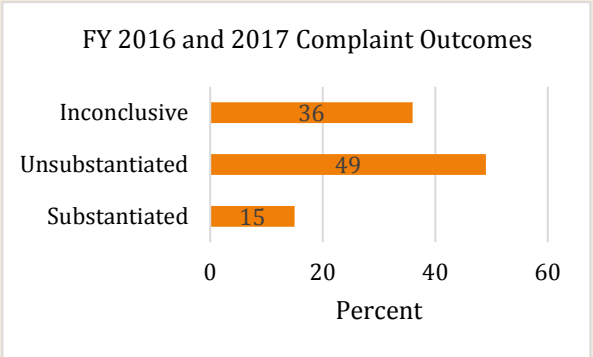
Figure 8

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 2016 and 2017 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 makes recommendations to the Department of Behavioral Health and Developmental Disabilities (DBHDD). However, not all complaints are related to DBHDD services. In fiscal year 2016, fifty percent of complaints were unrelated to services provided by DBHDD or DBHDD contracted providers, and in fiscal year 2017, forty-two percent were unrelated (Figure 10).



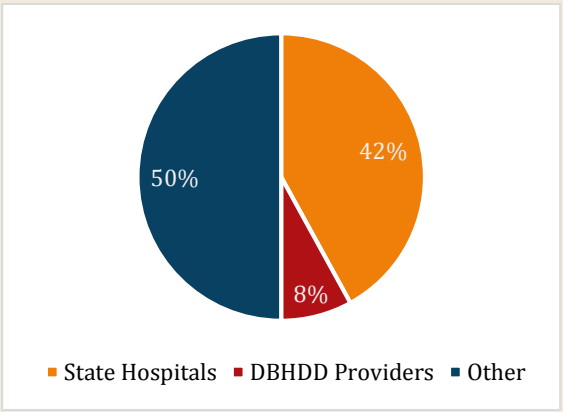


Figure 9 & 10

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 353 issues during the 2016 and 2017 fiscal years that stemmed from assistance and information requests:

- Coordinated actions between a mental health consumer, a DBHDD regional office, and a DBHDD contracted provider to address organizational inefficiencies that resulted in a negative treatment experience with the provider. The provider acknowledged the consumer's experience was unacceptable and committed to address the issues raised;

- Provided resolution to a discrimination complaint alleging a healthcare provider refused to render services to a physically disabled patient. Determined the provider was misinterpreting Healthcare Facility Regulation Division regulations related to wheelchair-bound patients and, subsequently, the patient was able to schedule the necessary procedure;

- Coordinated actions between DBHDD and a DBHDD contracted provider to address safety concerns of a consumer receiving supported housing services, resulting in the consumer being redirected to other appropriate supported housing options;

- Communicated patient's safety concerns to a state psychiatric hospital patient advocate, resulting in the patient receiving a precautionary relocation to a different unit; and

- Served as a liaison between DBHDD and a mother who requested a new review of level of need to determine if her child qualified for additional family supports while waiting to receive a Medicaid waiver.

[4] During the FY 2016-2017 biennium, only sixteen percent (16%) of intake cases involved one or more issues of complaint, whereas, eighty-four percent (84%) 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 2016 and 2017	Percentage
Housing	27	28.0%
Benefits	23	24.0%
Other	16	16.5%
Care plan	8	8.3%
Abuse and/or Neglect	6	6.2%
Discharge	6	6.2%
Subtotal (5 most frequent assistance request issues)	**86**	**89% of total**
Total (of all issues assistance requests)	**97**	**100%**

Top 5 Most Frequent **Information Request Issues**	FY 2016 and 2017	Percentage
Benefits	91	36.0%
Other	55	21.5%
Housing	32	12.5%
Legal	18	7.0%
Abuse and/or Neglect	9	3.5%
Transportation	9	3.5%
Subtotal (5 most frequent information request issues)	**214**	**84% of total**
Total (of all information requests issues)	**256**	**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 16 and three times in FY 17 to review the deaths that met the legislative guidelines. The MRG conducted 47 total reviews during the biennium, of which 38 were initial reviews.

Medical Review Statistics

FY 2016 and FY 2017 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
February 5, 2016	7	0	5	2	**7**
March 18, 2016	8	2	8	2	**10**
May 6, 2016	6	2	6	2	**8**
August 19, 2016	6	2	3	3	**8**
November 7, 2016	7	3	10	0	**10**
February 24, 2017	4	0	4	0	**4**
TOTAL	**38**	**9**	**36**	**9**	**47**

Figure 13

Policy, Regulatory, and Legislative Changes

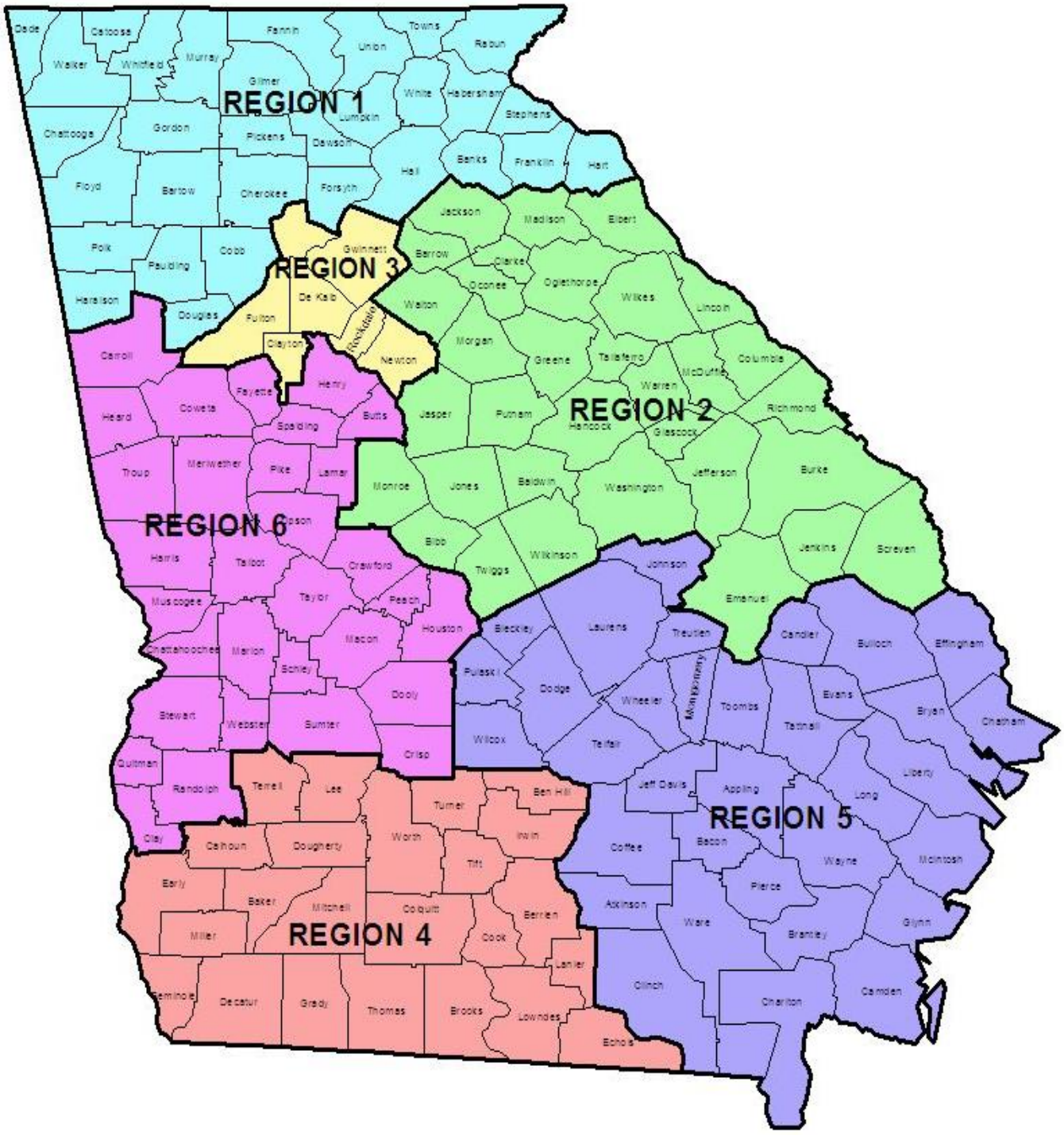
Changes Implemented During the Biennium

1) **Homelessness and Housing First Framework.** For people living with a mental illness, the road to recovery requires certain anchors of stability, and one essential anchor is stable housing. DBHDD provides supported housing to people with a severe a persistent mental illness through the Georgia Housing Voucher, a rental subsidy program administered by the department. In 2015, DBHDD shifted toward the Housing First Framework, which seeks to help the homeless population access and sustain permanent supported housing first, and then provides behavioral health services as needed. The burden is on the behavioral health provider to engage the tenant with available treatment options. Continued tenancy is not dependent on compliance with treatment. The premise behind Housing First is that the basic need of stable housing must be met before people can shift their focus from survival to treatment and sustained recovery, and thereby end the cycle of homelessness. During the biennium, the housing stability rates saw an increase from 74 percent in FY 2016 to 84 percent in FY 2017.

2) **Settlement Agreement Extension**. On May 18, 2016, the State of Georgia and the United States Department of Justice (DOJ) agreed to a settlement agreement extension modifying the original terms of the 2010 Americans with Disabilities Act Settlement. The extension agreement represents an acknowledgement by the DOJ of the state's compliance with the majority of provisions in the original ADA settlement agreement. The work outlined in the extension is a reflection of many of the existing strategic priorities of the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). One of those strategic priorities was the creation of the Office of Health and Wellness (OHW) within the Division of Developmental Disabilities. In July of 2016 in OHW began implementing the processes of High Risk Surveillance and Statewide Clinical oversight; these processes resulted in the provision of clinical oversight activities and surveillance of individuals of heightened risk due changes in condition, diagnosis, newly identified risk, and other identified qualifiers of risk and personal and environmental destabilization. Process implementation has driven systems change, inclusive but not limited to, the generation and/or revision clinical policies, standardization of clinical nursing assessments for state and provider agencies, standardization of the process of determining skilled nursing supports, the conduction of clinical symposiums for physicians, nurses, and ancillary clinical professionals, the development of healthcare plans intended for personalization to the indicated and ordered needs of the individual, and development of IDD curriculum for nurses through partnership with Emory School of nursing.

3) **DBHDD State Hospital to Community Transitions**. In early 2014, Commissioner Frank Berry suspended the transition of individuals from state hospitals to community based settings to provide the Department the opportunity to enhance health, safety, and habilitation support offered post-transition. To that end, the DBHDD Office of Transitions developed a policy that balanced standardization of the transitions process with individualization for each individual. Today, each individual's unique desires and needs are identified and planned for in such a way that health and safety are optimized. The Person-Centered Description is completed with input from each individual's transition team, focusing on a positive vision of the future and painting a picture of the skills and capacities which embody each person. The Individualized Support Plan Narrative is completed as a compilation of an individual's personal, behavioral, and clinical information, summarized to identify an individual's comprehensive needs for transitioning from a state hospital to the community. An Enhanced Supports Review of each individual's nursing and behavioral needs is also completed to further identify individualized needs in these areas. Housemate compatibility is assessed once potential housemates are identified. The individual's transition team utilizes the individualized information and recommendations from these processes to support conversations with potential providers in consideration of their ability to provide the services each individual will need. Subsequently, the transition team can make recommendations to each individual, their support persons and/or legal guardian towards the goodness of fit between a provider and an individual, relative to the individual's identified wants and needs. Since the suspension was lifted, the Department has been able to ensure safe, quality transitions for over 80 individuals.

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.

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