

**VOLUNTARY COMPLIANCE AGREEMENT**

BETWEEN THE

STATE OF GEORGIA

AND THE

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE FOR CIVIL RIGHTS

TRANSACTION NUMBER: 01-00406

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## PREAMBLE

*WHEREAS*, Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq., and implementing regulations at 28 C.F.R. Part 35 (ADA) and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and implementing regulations at 45 C.F.R. Part 84 (Section 504) prohibit discrimination on the basis of disability and require public entities, including state governments, and recipients of Federal financial assistance to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities;

*WHEREAS*, applying the most integrated setting mandate of Title II of the ADA, see 28 C.F.R. § 35.130(d), the United States Supreme Court ruled in the case of Olmstead v. L.C., 527 U.S. 581, 597-607 (1999) (Olmstead) that the unnecessary institutionalization of individuals with disabilities can constitute discrimination under the ADA when the state's treatment professionals determine that community-based treatment is appropriate and the affected individual does not oppose such placement;

*WHEREAS*, the Supreme Court observed in Olmstead that the "state's responsibility is not boundless" and that states are allowed to weigh the needs of others with disabilities, including those who require institutional levels of care;

*WHEREAS*, the Georgia Department of Community Health (DCH) and the Georgia Department of Human Resources (DHR) recognize that they have an independent obligation under Georgia law to provide services in the community to persons who have intellectual and developmental disabilities (DD) and/or persons with a mental health disability (MH), Ga. Code Ann., § 37-2-1 (See Appendix, definition of "intellectual and development disabilities," "mental health disability," and "individuals with intellectual and developmental disabilities and/or a mental health disability");

*WHEREAS*, DHR and DCH desire State-operated facilities to adopt a treatment goal to treat qualified individuals with disabilities in the most integrated setting appropriate to their needs and consistent with the individual's choice and to ensure that the individuals' care is directed towards acquiring skills and abilities that promote as much independence, autonomy, and development as possible (See Appendix, definition of "State-operated facilities");

*WHEREAS*, in 2001, certain public interest organizations that advocate for the rights of persons with disabilities (Georgia Advocacy Office, the Atlanta Legal Aid Society, Inc., the Georgia Legal Services Program, and the Disability Law Policy Center of Georgia, Inc.) filed class complaints with the United States Department of Health and Human Services, Office for Civil Rights (OCR) alleging that DHR, DCH and other named Respondents (See Appendix, definition of "Respondents") have failed to treat qualified persons with DD and/or MH in the most integrated setting appropriate in violation of Title II of the ADA (See Appendix, definition of "Georgia class complaints") and

thereafter OCR undertook investigation of the Respondents' compliance with the mandates of the ADA and Olmstead, as well as Section 504;

*WHEREAS*, DCH, DHR and the Governor's Office through the Olmstead Coordinator (hereinafter collectively referred to as "the State") do not admit to any violation of the ADA or Section 504 by entering into this Agreement and in fact specifically deny any such violations;

*WHEREAS*, the State desires to clarify how it will organize and make available Federal, State and local resources to ensure that qualified persons with DD and/or MH receive services in the most integrated setting appropriate to their needs in full compliance with the spirit, intent, and letter of the ADA and Section 504;

*WHEREAS*, OCR will suspend its investigation of the Georgia class complaints while the State and OCR work cooperatively to increase the delivery of services in the community so that qualified individuals with DD and/or MH currently institutionalized in State-operated facilities can receive services in the most integrated setting;

*NOW THEREFORE*, in consideration of the mutual covenants and agreements contained herein, OCR and the State, the parties to this Agreement, AGREE AS FOLLOWS:

## **ARTICLE 1: GENERAL PROVISIONS**

### **SECTION I: Purpose of this Agreement**

This Agreement is intended to resolve the Georgia class complaints' allegations concerning the provision of community services for persons with DD currently institutionalized in State-operated facilities and for persons with MH currently institutionalized in State-operated facilities for longer than 60 days, who can be appropriately provided with community services in the most integrated setting appropriate to their needs and who do not oppose community services. (See Appendix, definition of "community services.")

### **SECTION II: Appointment and Role of Olmstead Coordinator**

(A) Within 14 days after the execution of this Agreement, the State will assign an individual the primary task of coordinating the State's compliance with this Agreement, hearing and addressing Olmstead-related problems, and developing and implementing Georgia's Olmstead Plan objectives (hereinafter, "Olmstead Coordinator"). The Olmstead Coordinator shall report directly to the Governor. State agencies with Olmstead obligations shall report their Olmstead activities to the Olmstead Coordinator in Monthly Progress Reports and any other reports as specified in Article 2, Section III or Article 3, Section III. The Olmstead Coordinator will review the Monthly Progress Reports and any compliance concerns brought by OCR, and whenever deadlines specified under this Agreement are not met or the Olmstead Coordinator otherwise determines progress is not sufficient and/or effective, the Olmstead Coordinator will convene within four weeks, a meeting of the affected State agencies to determine what policy, administrative, resource, and budgetary changes are necessary in the subsequent quarter to achieve the progress required under this Agreement or under the State's Olmstead Plan. For purposes of this paragraph, a deadline under this Agreement includes, but is not limited to, any instance in which an individual does not receive community services within 90 days of the discharge date specified in his or her Transition Plan, as described in Article 2, Section I (B), or Person Centered Transition Plan, as described in Article 3, Section I (B). Within one week of the meeting between the affected State agencies and the Olmstead Coordinator, the affected State agencies will report back to the Olmstead Coordinator with a Corrective Plan detailing the corrective measures each agency will take, along with corresponding target dates, to assure compliance with this Agreement. On at least a quarterly basis, the Olmstead Coordinator will send a summary of any such Corrective Plans to OCR, the Olmstead Planning Committee (defined in Article 1, Section IV), and to the independent consultants selected and hired by the State ("the State's consultants"). The summary of Corrective Plans will include updates of all corrective actions completed and all corrective actions not completed by the target dates within the Corrective Plans. If requested, the State shall allow OCR and the State's consultants access to the Corrective Plan or other underlying

information used to create the summary of Corrective Plans.

(B) In order to leverage the resources available throughout the State of Georgia to increase the opportunities for community services and to eliminate artificial barriers to community services, the Olmstead Coordinator will actively seek the participation and assistance of other State agencies in promoting the goals of Georgia's Olmstead Plan, thereby coordinating the State's efforts as a cohesive whole.

### **SECTION III: Assessing Statewide Need for Community Services**

The Olmstead Coordinator, DHR and DCH will use demographic, survey, and other reliable data to make meaningful annual estimates of the need for community services in the State for individuals with DD and/or MH currently institutionalized or otherwise at risk of institutionalization. The data will provide the number of individuals institutionalized in State institutions who have been determined appropriate for community services, as well as the numbers of individuals in the community at risk of institutionalization for lack of community services. The data will be published yearly as part of the State's Annual Olmstead Report, which will use the data developed under this section to assess the need for community services within the State of Georgia.

### **SECTION IV: Revising the State Olmstead Plan**

(A) No later than seven months after the effective date of this Agreement, the State will create a new draft of its multi-year Olmstead Plan to make it consistent with this Agreement and to set forth new, concrete and realistic annual Olmstead goals. The Olmstead Plan shall include an annual schedule of anticipated discharges (in a de-identified format) for all individuals with DD and/or MH who are institutionalized and have been determined appropriate for community services and are not opposed to same, as well as how to obtain and/or maintain necessary community services for those at risk for institutionalization. The Olmstead Plan shall also include a comprehensive and effective plan to treat all institutionalized persons having a preference for community services in the most integrated setting appropriate for each individual.

(B) The State's Olmstead Plan shall be approved by the Olmstead Planning Committee ("OPC"), which shall be created by the Governor via an executive order and housed under the auspices of the Governor's Office. The OPC shall be appointed within 90 days after the execution of this Agreement and approve the State's Olmstead Plan within seven months of the execution of this Agreement. The OPC shall have a majority membership consisting of non-State officials, including consumers and advocates. The OPC shall be chaired by the Olmstead Coordinator appointed under this Agreement and shall have the full cooperation of DHR and DCH, including access to such information as is required by this Agreement and any additional information that the Olmstead Coordinator deems necessary for the development of effective Olmstead planning. The OPC shall consist of members to be selected and appointed by the Governor, as follows:

- The Olmstead Coordinator, as Chair of the Committee;
- The Commissioner of Human Resources, or designee;
- The Commissioner of Community Health, or designee;
- The Director of the Division of Mental Health, Developmental Disabilities and Addictive Diseases of the Department of Human Resources;
- Two parents of children with disabilities, including one parent of a child with a developmental disability and one parent of a child with a mental health disability;
- One youth citizen with a mental health disability or developmental disability;
- One adult citizen with a mental health disability;
- One adult citizen with a developmental disability;
- One family member/relative of a person with a mental health disability;
- One family member/relative of a person with a developmental disability;
- One citizen associated with the advocacy community for persons with mental health disabilities;
- One citizen associated with the advocacy community for persons with developmental disabilities; and,
- One provider of community-based treatment services.

(C) The Governor shall retain the sole discretion to add, remove, or replace members of the OPC as needed to maintain the membership categories listed in paragraph (B); and may add additional members to the OPC as he deems appropriate to carry out the duties of the Committee. The Governor will ensure that adequate funding is made available for OPC to carry out its responsibilities, but retains full discretion in determining the amount of and source(s) for such funding.

(D) The OPC shall solicit and include in the Olmstead Plan the views of a cross-section of individuals who are personally and/or professionally involved in community services for institutionalized individuals, including those with disabilities and in facilities not covered by this Agreement. Such individuals could include consumers, interested members of the public, and members of advocacy organizations. The Olmstead Plan shall include annual goals for each year of the Olmstead Plan, and, if available, shall consider the community services data described in Article 1, Section III of this Agreement. The OPC shall also discuss any other issues the Committee determines are pertinent to the creation of a comprehensive and effective Olmstead Plan. Such issues could include the following: (1) data the State should collect to determine Statewide need for community services; (2) the State's resources for providing community services and determining how resources may be better utilized; (3) whether the State's policies are consistent with the State's Olmstead goals and this Agreement and what policy changes may better meet those obligations; and (4) any other issues the OPC believes pertinent to the Olmstead Plan or effort. Before its release, OCR may review the State's Olmstead Plan for consistency with this Agreement.

(E) Review of the State's Olmstead Plan Progress: The OPC shall regularly receive reports regarding the State's progress in meeting the goals of the Olmstead Plan and the State's Annual Olmstead Report, as identified in Article 1, Section IV(F), in order to

identify policies, processes, or other problems that may frustrate the State from achieving the goals of the Olmstead Plan, and recommend changes to advance the Olmstead Plan and Annual Olmstead Report objectives. The resulting recommendations shall be included in the subsequently issued Annual Olmstead Report.

(F) Regular Public Reporting of the State's Progress in its Olmstead Plan and New Goals: Each December, the OPC shall issue the Annual Olmstead Report for public distribution to consumers, potential consumers, service providers, advocates, and employees of State agencies, detailing the progress achieved pursuant to this Agreement and the Olmstead Plan, including the number of individuals leaving State-operated facilities, the census at the facilities, the numbers of persons awaiting community services, substantive and procedural policy changes made to meet Olmstead objectives, and the actions the State will take to accomplish its Olmstead goals and obligations in the year ahead. The Annual Olmstead Report shall make policy proposals and recommend specific funding for initiatives and resources during the subsequent budget development cycle to meet the State's Olmstead goals and obligations. The Annual Olmstead Report shall consider the community services data described in Article 1, Section III to assess the need for community services in the State. The OPC will also assess all items addressed in the Olmstead Plan (i.e., those items enumerated in Article 1, Section IV (D) of this Agreement) and, as appropriate, include an update of the Olmstead Plan in the Annual Olmstead Report. The Annual Olmstead Report shall solicit, include, and respond to public comments from interested members of the public and public advocacy organizations with concerns about Olmstead issues. Additionally, henceforth, the annual budget presentations made to the Board of Community Health and the Board of Human Resources shall include a section specifically addressing the respective Department's and the State's Olmstead-related goals. The presentations shall be maintained on the internet web sites of each Department, and shall be made available to all interested members of the public upon request. Such presentations shall not include any "individually identifiable health information," as defined in 45 C.F.R. § 160.103.

## **ARTICLE 2: PROVISIONS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES**

### **SECTION I: Preventing Unnecessary Institutionalization**

The State believes that all persons with DD can be successfully provided services in the community with appropriate supports, and will develop its resources in order to eliminate the institutionalization of individuals with DD, provided the individuals do not oppose such community services. Nothing in this Agreement, however, limits the State from discharging persons who may oppose community services from its institutions, so long as they have an adequate Person Centered Description and Transition Plan or Person Centered Transition Plan. Toward this end, the State will do the following:

(A) Creation of DD Olmstead List: Within 120 days after the execution of this Agreement, DHR will conduct a Person Centered Planning process for all individuals with DD who are institutionalized as of the date of execution of the Agreement and who have not already received the Person Centered Planning process. Through its "Person Centered Planning" process, DHR will utilize the Health Risk Screening Tool and Supports Intensity Scale to identify the specialized needs of persons with DD, resulting in a "Person Centered Description" ("PCD"), as discussed in Article 2, Section II (A), for each individual. Within 120 days after the execution of this Agreement, the State will provide to OCR a dated list of all individuals with DD currently residing in State institutions who do not actively oppose receiving services in the community. This list shall be known as the "DD Olmstead List." The DD Olmstead List will be attached to this Agreement in a de-identified format as Exhibit A hereto and the terms will be incorporated by reference herein. Individuals with DD subsequently admitted to a State institution will receive a PCD and will be added to an up-to-date DD Olmstead List within 90 days of being admitted, but the dated Olmstead List attached as Exhibit A will serve as the baseline for measurement of performance under Article 2, Section I (C) of this Agreement with regard to the placement of individuals with DD.

(B) Discharge of Individuals on the DD Olmstead List and DD Transition Lists: The parties recognize that DHR utilizes two sets of lists in its planning for individuals with DD – the DD Olmstead List and an annual "Transition List," which identifies by priority the specific individuals who DHR is planning to discharge to the community within a given State fiscal year. In developing the annual Transition Lists, DHR shall annually place onto the Transition List, consistent with DHR Online Directive Information System (ODIS) Policy Directive # 6805-302 (DHR Policy Directive # 6805-302), discussed in paragraph (G) of this Section and attached to this Agreement as Exhibit C, a minimum proportion of the individuals who are on the up-to-date DD Olmstead List at the time of the creation of the Transition List. That proportion shall be one-fifth in the first year of this Agreement, one-fourth in the second year, one-third in the third year, one-half in the fourth year, and the remainder in the final year of the Agreement. The State will develop

a PCD and Transition Plan for all individuals placed on the Transition List for each year. Each individual's Transition Plan shall be completed within 90 days of his/her placement on the Transition List. Each Transition Plan shall include the supports and services required to safely transition the individual, a proposed service provider, and a specified date of discharge. The discharge date determined by DHR will be reasonable and based on the assessed needs of the individual and may change if the medical needs of the individual change and require different supports and services or a different proposed provider. The State will marshal resources (see paragraph (E) of this section) needed to secure community services by the discharge date. The State will formulate its budget requests and utilize Federal funding provided to it under the "Money Follows the Person" (MFP) grant to adequately fund enough community services to ensure that institutionalized individuals on the Transition List can be placed in the community by the discharge date specified in their Transition Plan and the State will place such individuals by the discharge date specified in their Transition Plan.

(C) Discharge of Individuals on the DD Olmstead List Within Five Years: The State will expand its provider network of community services to meet the needs of all individuals on the DD Olmstead List attached as Exhibit A. In those instances where there are not currently providers capable of providing adequate services to those individuals on the DD Olmstead List, the State will expand its network of providers and services to meet the needs of those individuals. The State will formulate its budget requests and utilize, among other resources, the MFP grant over the five-year term of the MFP grant awarded to the State to develop its provider capacity such that individuals on the DD Olmstead List will be discharged and placed in community services within five years, and the State will discharge and place all individuals on the DD Olmstead List attached as Exhibit A within 5 years after the date of execution of this Agreement.

(D) Review of Transition Plans: Within six months after the execution date of this Agreement, the State's consultant will review a sample of individual Transition Plans as needed to assess the competency of assessments and the reasonableness of the discharge dates and any and all conditions related to the transition or discharge dates. If the State's consultant finds individual or systemic problems with the competency of assessments or the reasonableness of the discharge dates, the State will timely implement the corrective measures identified by the State's consultant, and continue to meet its obligations within five years of the execution of the Agreement.

(E) The Olmstead Coordinator will ascertain the level and extent of community services needed on a Statewide basis, and base all budget proposals of DHR and DCH on such projected needs in order to adequately fund enough community services so that all institutionalized individuals with DD who are on the Transition List can be placed in the community by the discharge date specified in their Transition Plans. All budget proposals submitted by any State agency with Olmstead obligations will be developed in coordination with the Olmstead Coordinator and be subject to approval by the Olmstead Coordinator. The parties to the Agreement recognize that neither the Olmstead Coordinator nor the Governor can guarantee the legislative approval of any such budgetary proposal but that they shall make all good faith efforts to seek the resources

necessary to address the service needs identified during the budgetary process.

(F) The State commits to continue to improve the delivery of community services and to eliminate the possibility of unnecessary institutionalization for those persons with developmental disabilities who do not oppose community services. Towards this objective, the State commits to providing community services to all persons on the DD Olmstead List, consistent with each individual's own choice of placement, while simultaneously maintaining efforts to minimize the number of individuals awaiting community services after the effective date of this Agreement.

(G) The State will educate institutionalized individuals, their families, and guardians regarding appropriate community-based services that may meet the individuals' needs. At least on a quarterly basis, the State will offer educational opportunities to all individuals in State institutions consistent with DHR Policy Directive # 6805-302 attached to this Agreement as Exhibit C. Individuals, their families/guardians, and advocates will be exposed to information about community life outside an institution and success stories of others who have transitioned into the community. Hospital staff, providers, individuals and parents/guardians will have opportunities to participate in ongoing training for choosing a provider and other topics such as the kinds of community services available, the safety of receiving services in the community and how people with different disabilities have integrated into their communities. Educational events will include presentations from community providers and should include visits to locations in the community where people with disabilities receive services. This Agreement does not require the State to continue to utilize DHR Policy Directive # 6805-302 attached as Exhibit C should it subsequently decide that a new policy would result in improved service or results, so long as the new policy remains consistent with this Agreement and the standards within the previous policy. In the event that the State should decide to alter DHR Policy Directive # 6805-302, DHR shall provide OCR with an opportunity for review prior to implementation.

## **SECTION II: Assessing the Preferences, Strengths, and Needs of Individuals on the DD Olmstead and Transition Lists**

(A) The State has provided OCR with copies of its "Person Centered Description," the Health Risk Screening Tool, and the Supports Intensity Scale currently used by DHR to identify an individual's preferences, strengths, capacities, needs and desired outcomes. However, this Agreement does not require the State to continue to utilize the aforementioned tools should it subsequently decide that other methodologies would result in improved service or results. In the event that the State should decide to alter or adopt new assessment tools, DHR shall provide such assessment tool to OCR for review, and OCR may provide comments to DHR regarding the tool's consistency with this Agreement. All staff involved in the assessment of individuals for community services shall be trained to competency on any assessment tool and standards prior to using the assessment tool.

(B) Regular Reassessments: The State maintains that all persons with DD can live in the community with the proper supports and services. However, in the event that DHR's treatment professionals determine that the receipt of community services is not appropriate for a given individual, the State's consultant shall review that individual's assessment and DHR shall reassess such an individual every 90 days, documenting that reassessment in the individual's medical record. Also DHR shall provide all individuals with written notice of the due process procedures as provided in Article 4, Section I of this Agreement. If the review by the State's consultant disagrees with the determination that the individual is not appropriate for community services, the consultant will confer with the individual's treatment professionals. If the consultant continues to disagree with the determination after the consultation process, the consultant will present the individual's case to the Olmstead Coordinator for review.

### **SECTION III: Monitoring Progress**

(A) Monitoring Progress and Olmstead Monthly Progress Reports: In order to closely monitor its progress, the State will implement a procedure within 14 days of the execution of this Agreement whereby the Olmstead Coordinator and the State's consultant will conduct monthly tours of State-operated facilities (one facility each month) to personally examine individual PCD's, Transition Plans and assessments of individuals determined not appropriate for community services. The State's consultant will provide corrective feedback as needed to ensure that the goals of this Agreement are met. Additionally, treatment teams from the other State facilities will participate telephonically in each monthly tour. Thereby, the State's consultant's feedback will be provided to all of the State's facilities, and each facility will have a monthly opportunity to discuss challenges or obstacles regarding placement of particular individuals. The Olmstead Coordinator retains the discretion to alter the frequency of such tours after twelve (12) months if the Olmstead Coordinator is satisfied that sustained progress is being made. In the event the Olmstead Coordinator decides to change the frequency of the tours, he or she shall develop a plan describing how discharge plans will be reviewed, how site visits will be conducted and how the State will continue monitoring system barriers to successful community placements. Such a plan will be created with input from the State's consultant and provided to OCR for review prior to implementation. In no event, however, shall the tours take place less than quarterly after the first 12 months. Further, the Olmstead Coordinator shall require DHR, and any other agency with Olmstead obligations specified by the Olmstead Coordinator, to provide the Olmstead Coordinator with a Monthly Progress Report that specifies the number of individuals with DD newly admitted or readmitted to State-operated facilities, the number of individuals who begin receiving services by the discharge date specified in their Transition Plan, the number of individuals not receiving community services by the discharge date, the length of the delays, and the number of persons awaiting community services for more than 60 days after their discharge date. For all individuals awaiting community services for 90 days or longer after the discharge date specified in their Transition Plan, the Monthly Progress Report will identify the specific barriers to that individual receiving community services, what corrective actions are to be taken to remove those barriers (including time

frames), and the total length of time the individual has been awaiting community services. The State shall also develop and implement policies for collecting after-care data to determine the efficacy of the individuals' Transition Plans within six months of execution of this Agreement and provide the policies to OCR for review prior to implementation. Additionally, all State executive agencies with Olmstead obligations will be required to report to the Olmstead Coordinator on Olmstead-related activities as often as the Olmstead Coordinator deems necessary.

(B) Form of the Monthly Progress Report: The form of the Monthly Progress Report shall be decided by the Olmstead Coordinator and may be modified based on the Olmstead Coordinator's determination of the most effective method of tracking the State's progress in meeting the requirements of this Agreement and the State's Olmstead Plan goals. However, whatever form the Monthly Progress Report takes, it shall include, at minimum, the data listed in paragraph (A) of this section for the duration of this Agreement.

#### **SECTION IV: Adequately Preparing Individuals for Community Services**

(A) Adopting community services as a treatment goal: The State shall ensure that all individuals in State-operated facilities shall receive such treatment or habilitation during their institutionalization as necessary to prepare those individuals adequately for community services.

(B) Planning for community services while in institutions: Prior to finalizing the PCD, the State shall solicit input from the intended community service providers who will likely be responsible for the individual's community supports and services and establish ongoing communication and dialogue on how to plan the transition to community services.

(C) Giving individuals and their families sufficient advance notice to prepare for discharge: All persons added to a Transition List will receive a notice from the State of their placement on the Transition List and the month of their anticipated discharge within 30 days after they are added to the Transition List. The State will provide this notice in writing. The notice should make clear that the discharge date is an estimate only, and the date of actual discharge may vary, based on the condition or choice of the individual or his/her guardian if legally required to make such decision. The notice also shall be conspicuously placed in the individual's medical records. The notice may only be provided to family members, authorized representatives, or guardians consistent with the requirements of the Privacy Rule, 45 C.F.R. §§ 160, 164, issued under the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. No. 104-191.

(D) Transition Planning: No individual shall be discharged pursuant to this Agreement without an appropriate Transition Plan that provides for the individual's receipt of appropriate community services. The process of developing each individual's Transition Plan will include collaboration with the individual and, as appropriate and as consistent

with HIPAA, the individual's family members, legal representatives, guardians, friends and any other persons designated by the individual. The Transition Plan shall address the individual's goals and choices regarding living arrangements and services needed to achieve the individual's goals. An appropriate Transition Plan under this Agreement shall memorialize the determinations of community services in a single, comprehensive document which shall include the following: (a) all areas of assessed need; (b) the specific community services that will be provided to meet the identified needs of the individual and the nature, frequency and duration of the services to be provided; and (c) transition services to prepare the individual for community services including counseling, habilitation, skill development or training, peer mentoring, site visits, or other services as appropriate. Consideration of community services shall not be limited to currently available community services. Where an individual is deemed appropriate for community-based services and desires such services but no provider currently offers the needed services, the State will issue an individualized Request for Proposal to potential providers in an effort to develop the needed community-based treatment program. Nothing in this Section relieves the State of its obligations under Article 2, Section 1(C) of this Agreement.

(E) Training on Community Services: The State will ensure that all staff with transition planning and community services placement responsibilities associated with this Agreement receive on-going and comprehensive training on all matters relevant to their duties in implementing this Agreement, including, but not limited to, the various community service programs available in the State. The training curriculum and materials will include at a minimum the scope of each such service program, the rules and procedures for such services, eligibility requirements, how to apply and access such services, and emergency procedures. Toward this end, DHR and DCH, under the supervision of the Olmstead Coordinator, will develop a community Training Plan within six months after the execution of this Agreement with standards and milestones consistent with the job duties of each individual with transition planning and community placement responsibilities. The State will provide OCR with the Training Plan and any accompanying training materials for comment within six months after the execution of this Agreement. The Olmstead Coordinator will review and assess the effectiveness of the Training Plan and, if necessary, make refinements he or she deems necessary to enhance the effectiveness of such employee training.

## **ARTICLE 3: PROVISIONS FOR INDIVIDUALS WITH A MENTAL HEALTH DISABILITY**

### **SECTION I: Preventing Unnecessary Institutionalization**

The State will develop its resources in order to eliminate the unnecessary institutionalization of individuals with MH who can be appropriately served in the community, provided the individuals do not oppose such community services. Toward this end, the State will do the following:

(A) Creation of "MH Olmstead List": Within 120 days after the execution of this Agreement, DHR will use the assessment tool described in Article 3, Section II of this Agreement to assess all individuals with MH who have been institutionalized for longer than 60 days as of the date of execution of the Agreement and who have not already been determined appropriate for community services. For any individual who has not been determined appropriate for community services, DHR will conduct ongoing and timely reassessments of the individual's need for continued hospitalization. This clinical assessment will be repeated when there are clinically relevant changes in the individual's condition or every 30 days, whichever is sooner. Within 120 days after the execution of this Agreement, the State will provide to OCR a dated list of all individuals with MH currently residing in State institutions who DHR's treatment professionals determined are appropriate for community services under the assessment process described above. This list shall be known as the "MH Olmstead List" and will be attached to this Agreement in a de-identified format as Exhibit B hereto and the terms will be incorporated by reference herein. Individuals with MH subsequently admitted to a State institution for longer than 60 days will be assessed under the assessment process described above and, if determined appropriate for community services, will be added to an up-to-date MH Olmstead List within 90 days of being admitted, but the dated Olmstead List attached as Exhibit B will serve as the baseline for measurement of performance under Article 3, Section I (C) of this Agreement with regard to the discharge of individuals with MH.

(B) Discharge of Individuals on the up-to-date MH Olmstead List: Public hospitals set anticipated discharge dates based upon the predicted improvement of the consumer. Individuals with MH may move on and off the up-to-date MH Olmstead List based upon their psychiatric condition and changes in mental status. The State will develop a Person Centered Transition Plan ("PCTP") for all individuals on the MH Olmstead List within 30 days of his/her being placed on the MH Olmstead List, consistent with DHR, Division of Mental Health, Developmental Disabilities and Addictive Diseases Policy No. 7.105 (MHDDAD Policy No. 7.105), discussed in paragraph (G) of this Section and attached to this Agreement as Exhibit D. Each PCTP shall include an anticipated date of discharge. The anticipated discharge date projected by DHR will be reasonable and based on the assessed needs of the individual, and the State will marshal resources needed to secure community services by the discharge date by formulating budget requests of DHR to adequately fund enough community services to ensure that institutionalized individuals

with MH, who are appropriate for community services and who do not oppose treatment, can be discharged to the community by the discharge date specified in their PCTP, and the State will place all such individuals by the discharge date specified in their PCTP. The parties acknowledge that the medical needs of an individual may change and the State's treatment professionals may determine that community services are no longer appropriate by the discharge date specified in an individual's PCTP, resulting in adjustment of the anticipated discharge date. In the event an individual's anticipated discharge date is changed, the hospital treatment team shall document that it has discussed this decision with the individual and has provided the individual with information regarding the right to seek review of such a decision. In consultation with the individual, the treatment team will modify the individual's PCTP to document changes in services designed to address the individual's changing treatment needs.

(C) Discharge of Individuals on the MH Olmstead List Within Five Years: The State will expand its provider network of community services to meet the needs of individuals on the MH Olmstead List attached as Exhibit B. In those instances where there are not currently providers capable of providing adequate services to those individuals on the MH Olmstead List, the State will expand its network of providers and services to meet the needs of those individuals. The State will formulate its budget requests to develop its provider capacity such that individuals on the MH Olmstead List will be discharged and placed in community services within five years, and the State will discharge and place all individuals on the MH Olmstead List attached as Exhibit B within 5 years after the date of execution of this Agreement. However, nothing in this Agreement requires the State to place an individual on the MH Olmstead List into the community whose condition changed after the creation of the MH Olmstead List and who no longer has a discharge date or whose discharge date was changed to a date after the term of this Agreement.

(D) Review of Transition Plans: Within six months after the execution date of this Agreement, the State's MH consultant will review a sample of individual PCTPs as needed to assess the competency of assessments and the reasonableness of the discharge dates and any and all conditions related to the discharge dates. If the State's MH consultant finds individual or systemic problems with the competency of assessments or the reasonableness of the discharge dates, the State will timely implement the corrective measures identified by the State's consultant, and continue to meet its obligations within five years of the execution of the Agreement.

(E) The Olmstead Coordinator will ascertain the level and extent of community services needed on a Statewide basis for persons with MH, and base all budget proposals on such projected needs in order to adequately fund enough community services so that all institutionalized individuals with MH, who are appropriate for community services and who do not oppose placement, can be placed in the community by the discharge date specified in their PCTP. All budget proposals submitted by any State agency with Olmstead obligations will be developed in coordination with the Olmstead Coordinator and be subject to approval by the Olmstead Coordinator. The parties to the Agreement recognize that neither the Olmstead Coordinator nor the Governor can guarantee the legislative approval of any such budgetary proposal but that they shall make all good

faith efforts to seek the resources necessary to address the service needs identified during the budgetary process.

(F) The State commits to continue to improve the delivery of community services and to eliminate unnecessary institutionalization for those persons with MH who have been determined appropriate for community services. Towards this objective, the State commits to providing community services to all persons on the MH Olmstead List, consistent with each individual's own choice of accepted psychiatric treatment modalities, while simultaneously maintaining efforts to minimize the number of individuals awaiting community services after the effective date of this Agreement.

(G) The State will educate institutionalized individuals, their families, and guardians regarding appropriate community-based services that may meet the individuals' needs. At least on a quarterly basis, the State will offer ongoing educational opportunities, group training, and educational events to all individuals in State institutions, their families and guardians, consistent with MHDDAD Policy No. 7.105, attached to this Agreement as Exhibit D. The training opportunities will include courses on topics such as the kinds of community services available, the safety of receiving services in the community, and how people with different disabilities have integrated into their communities. Educational events may include presentations from community providers and should include opportunities to visit locations in the community where people with MH receive services. This Agreement does not require the State to continue to utilize MHDDAD Policy No. 7.105 attached as Exhibit D should it subsequently decide that a new policy would result in improved service or results, so long as the new policy remains consistent with this Agreement and the standards within the previous policy. In the event that the State should decide to alter MHDDAD Policy No. 7.105, DHR shall provide OCR with an opportunity for review prior to implementation.

## **SECTION II: Assessing the Appropriateness of Community Placement and the Preferences, Strengths, and Needs of Individuals on the MH Olmstead List**

(A) Current DHR policy provides that all individuals with MH who are hospitalized for longer than 60 days are assessed for readiness to transition to the community on at least a monthly basis. The State has provided OCR with copies of its "Mental Health Planning List Criteria" currently used by DHR to assess whether an individual with MH can appropriately receive services in the community. However, this Agreement does not require the State to continue to utilize the aforementioned criteria should it subsequently decide that other methodologies would result in improved service or results. In the event that DHR alters its assessment tool for individuals with MH, DHR shall provide such assessment tool to OCR for review, and OCR may provide comments to DHR regarding the tool's consistency with this Agreement. All staff involved in the assessment of individuals for community services shall be trained to competency on any assessment tool and standards prior to using the assessment tool.

(B) The State's MH consultant will review a sampling of completed assessments of

individuals deemed not appropriate for community services, as well as for those persons whose transition to the community is planned. If the review by the State's consultant disagrees with the determination that the individual is not appropriate for community services, the consultant will confer with the individual's treatment professionals. If the consultant continues to disagree with the determination after the consultation process, the consultant will present the individual's case to the Olmstead Coordinator for review.

### **SECTION III: Monitoring Progress**

(A) Monitoring Progress and Olmstead Monthly Progress Reports: In order to closely monitor the State's progress, the State will implement a procedure within 14 days of execution of this Agreement whereby the Olmstead coordinator and the State's consultant will conduct monthly tours of State-operated facilities (one facility each month) to personally examine individual Person Centered Transition Plans and assessments of individuals determined not appropriate for community services. The State's consultant will provide corrective feedback as needed to ensure that the goals of the Agreement are met. Additionally, treatment teams from the other State facilities will participate telephonically in each monthly tour. Thereby, the State's consultant's feedback will be provided to all of the State's facilities, and each facility will have a monthly opportunity to discuss challenges or obstacles regarding placement of particular individuals. The Olmstead Coordinator retains the discretion to alter the frequency of such tours after twelve (12) months if the Olmstead Coordinator is satisfied that sustained progress is being made. In the event the Olmstead Coordinator decides to change the frequency of the tours, he or she shall develop a plan describing how discharge plans will be reviewed, how site visits will be conducted and how the State will continue monitoring system barriers to successful community placements. Such a plan will be created with input from the State's consultant and provided to OCR for review prior to implementation. In no event, however, shall the tours take place less than quarterly after the first 12 months. Further, the Olmstead Coordinator shall require DHR to provide him with a Monthly Progress Report that specifies the number of individuals with MH newly admitted or readmitted to State-operated facilities, the number of individuals with MH who begin receiving services by the discharge date specified in their PCTP, the number of individuals not receiving community services by the discharge date, the length of the delays, and the number of persons awaiting community services for more than 60 days after their discharge date. For all individuals awaiting community services for 90 days or longer after the discharge date specified in their PCTP, the Monthly Progress Report will identify the specific barriers to that individual receiving community services, what corrective actions are to be taken to remove those barriers (including time frames), and the total length of time the individual has been awaiting community services. The State shall also develop and implement policies for collecting after-care data within six months of execution of this Agreement to determine the efficacy of the individuals' PCTPs and provide the policies to OCR for review prior to implementation.

(B) Form of the Monthly Progress Report: The form of the Monthly Progress Report shall be decided by the Olmstead Coordinator and may be modified based on the

Olmstead Coordinator's determination of the most effective method of tracking the State's progress in meeting the requirements of this Agreement and the State's Olmstead Plan goals. However, whatever form the Monthly Progress Report takes, it shall include, at minimum, the data listed in paragraph (A) of this section for the duration of this Agreement.

#### **SECTION IV: Adequately Preparing Individuals for Community Services**

(A) Adopting community services as a treatment goal: The State shall ensure that all individuals with MH in State facilities shall receive such treatment or habilitation during their institutionalization as necessary to prepare those individuals adequately for discharge to the community.

(B) Planning for community services while in institutions: Prior to finalizing the PCTP, the State shall solicit input from the intended community service providers who will likely be responsible for the individual's community supports and services and establish ongoing communication and dialogue on how to plan the transition to community services.

(C) Giving individuals and their families sufficient advanced notice to prepare for discharge: All persons added to the MH Olmstead List after the execution of this Agreement will receive a notice from the State of their placement on the MH Olmstead List and the month of their anticipated discharge within 30 days after they are found appropriate for community services and added to the MH Olmstead List. The notice should make clear that the discharge date is an estimate only, and the date of actual discharge may vary, based on the condition or choice of the individual or his/her guardian if legally required to make such decision. The notice will be provided in writing to the individual, and also will be conspicuously placed in the medical record of the individual with MH. The notice may only be provided to family members, authorized representatives, or guardians consistent with the requirements of the Privacy Rule issued under the Health Insurance Portability and Accountability Act (HIPAA).

(D) Transition Planning: No individual shall be discharged pursuant to this Agreement without an appropriate PCTP that provides for the individual's receipt of appropriate community services, unless the individual no longer meets the criteria for lawful retention in a State facility and refuses available community services and/or transition services. The process of developing each individual's PCTP will include collaboration with the individual and, as appropriate and as consistent with HIPAA, the individual's family members, legal representatives, guardians, friends and any other persons designated by the individual. The PCTP shall address the individual's goals and choices regarding living arrangements and services needed to achieve the individual's goals. An appropriate PCTP under this Agreement shall memorialize the determinations of community services in a single, comprehensive document which shall include the following: (a) all areas of assessed need; (b) the specific community services that could be provided to meet the identified needs of the individual and the nature, frequency, and

duration of the services to be offered; and (c) transition services to prepare the individual for community services including counseling, habilitation, skill development or training, peer mentoring, site visits, or other services as appropriate. Consideration of community services shall not be limited to currently available community services. Where an individual is deemed appropriate for community-based services and desires such services but no provider currently offers the services required by the individual, the State will issue an individualized Request for Proposal to potential providers in an effort to develop the needed community-based service(s). Nothing in this Section relieves the State of its obligations under Article 3, Section 1(C) of this Agreement.

(E) Preparing and Educating Institutionalized Individuals and their Designees about Community Services: Throughout the process of preparing for the transition to community services, the State will provide ongoing education and counseling to the individual and, as appropriate and as consistent with HIPAA, the individual's family members, legal representatives, guardians, friends and any other persons designated by the individual. The education and counseling will include discussions of the resources available for community services, with special emphasis on safety and quality of life measures so that such concerns may be comprehensively addressed and, if possible, allayed. The education and counseling shall be initiated as soon as possible once community services are determined appropriate for the individual. Whenever individuals and their designees are informed of an institutionalized individual's appropriateness for community services, they shall also be advised of how they can access the State's counseling and educational services, and referred to resources where their particular questions or concerns may be addressed.

(F) Training on Community Services: The State will ensure that all staff with transition planning and community services discharge responsibilities associated with this Agreement receive on-going and comprehensive training on all matters relevant to their duties in implementing this Agreement, including, but not limited to, the various community service programs available in the State for persons with MH. The training curriculum and materials will include at a minimum the scope of each such service program, the rules and procedures for such services, eligibility requirements, how to apply and access such services, and emergency procedures. Toward this end, DHR and DCH, under the supervision of the Olmstead Coordinator, will develop a community Training Plan within six months after the execution of this Agreement with standards and milestones consistent with the job duties of each individual with transition planning and community placement responsibilities. The State will provide OCR with the Training Plan and any accompanying training materials for comment within six months after the execution of this Agreement. The Olmstead Coordinator will review and assess the effectiveness of the Training Plan and, if necessary, make refinements he deems necessary to enhance the effectiveness of such employee training.

## **ARTICLE 4: MISCELLANEOUS PROVISIONS**

### **SECTION I: Informing Individuals Found Inappropriate for Community Services of their Rights**

(A) Advising Consumers of their Rights in Writing: Whenever the State's treatment professionals determine that an institutionalized individual is not appropriate for community services, the State will document the reasons in the individual's record and provide the individual with an oral explanation of the determination, along with a document providing general notice of the determination. The document will notify the individual of the availability of a written statement containing the factual basis of the determination, along with notice of what steps may be taken if he or she disagrees with the determination, including the right to contest such determination before an impartial hearing officer or administrative law judge, and such other administrative hearing rights as set forth and described within the Rules and Regulations of the Georgia Department of Human Resources. The document will also provide contact information for legal aid organizations and the Georgia Advocacy Office. In addition to written notice, the individual and/or the individual's designated representative must also be provided, as appropriate, any other method or form of communication that would be most effective in meaningfully explaining the determination and the rights and remedies available to the individual. Additionally, DHR will post a description or summary of such rights and contact information in all treatment units and in visitation areas. These procedures are in addition to the treatment team discussions required by Articles 2 and 3, Section 1, paragraph (B).

(B) The Georgia DHR and the Georgia DCH shall offer bi-annual training to Office of State Administrative Hearing judges and other staff on the community services available in the State, including the scope of each service, the rules and procedures for such programs, eligibility requirements, and how to apply and access such services.

### **SECTION II: Modifications in Law and Practice**

(A) Georgia's Attorney General's Office will review the regulations of the Respondent agencies and determine if any regulations need to be amended to implement the terms of this Agreement. Any such amendments to existing regulations deemed necessary shall be pursued in accordance with the Georgia Administrative Procedure Act. Within 3 months after the execution of this Agreement, the Attorney General's Office will provide OCR with a written statement indicating its conclusion as to all regulations reviewed. Any regulations changed will be mailed to OCR for its general information.

(B) The Governor shall recommend and solicit legislative approval of any State statutory changes necessary to carry out the terms of this Agreement, if any.

(C) Within three months after the execution of this Agreement, the State will publish and disseminate on the internet a list of community service programs for all interested persons or individuals who work with individuals with disabilities eligible for such programs, including all persons involved in the Person Centered Planning process for persons with DD or MH. The list of community service programs will detail the primary Federal, State, and local programs that provide community services in Georgia and provide information about those services, including how to access or refer people to such services and eligibility requirements. Within two months, the State will provide OCR with a list of community service programs for comment.

### **SECTION III: OCR's Responsibilities under this Agreement**

(A) OCR shall monitor implementation of this Agreement to assure compliance with its terms, including but not limited to: (1) whether the rate of progress and procedures for discharges from State-operated facilities or private facilities operated by a vendor on behalf of the State into community services are consistent with the Agreement; (2) whether the State's self-monitoring system effectively tracks and monitors the State's compliance with the Agreement; and (3) whether the State undertakes timely and effective corrective action when the State fails to meet the terms of this Agreement, such as when an individual does not receive community services within 90 days of the discharge date specified by the Transition Plan. Towards this end, the State shall, if requested, supply such data and documents (including Transition Plans) as deemed necessary by OCR to perform its monitoring obligations. If requested, the State shall permit OCR to inspect premises, interview witnesses, and examine and copy documents as is necessary to determine the State's compliance with the Agreement.

(B) If requested by the State, OCR will provide technical assistance on matters relevant to compliance with this Agreement.

### **SECTION IV: Enactment, Confirmation, and Dissolution of this Agreement**

(A) This Agreement shall become effective on the date it is signed by all parties to the Agreement and shall remain in effect for five years from the effective date, at which point if OCR determines that the State has substantially complied with this Agreement, OCR's review and monitoring of this Agreement shall terminate. Notwithstanding the aforementioned time limitation, the State agrees that it will comply with Section 504 for so long as it continues to receive Federal financial assistance and with Title II of the ADA for so long as it is a public entity within the meaning of the ADA.

(B) In approving this Agreement, the Governor, through the Olmstead Coordinator, directs all State executive agencies to fully comply with its provisions. Where provisions and terms of this Agreement require legislative action, the Governor shall make good faith efforts to seek such legislative action.

(C) This Agreement recognizes that the Governor has no authority to speak for Georgia's legislature in areas that are within the legislature's constitutional purview. Should legislative action occur that is inconsistent with this Agreement, the parties shall confer as to the viability of this Agreement. If the State's Executive agencies cannot comply with the terms of this Agreement due to legislative action, OCR may terminate this Agreement, and revive its investigation, as if no Agreement had ever been in place.

(D) This Agreement does not cover those patients committed to a State-operated facility pursuant to Ga. Code Ann. § 15-11-149; or those committed to a State-operated facility pursuant to Ga. Code §§ 17-7-130 or 17-7-131 and for whom the statute requires a further order of the committing court prior to release.

(E) Should OCR find that the State has failed to substantially comply with this Agreement, OCR shall provide written notice to the State of the specific areas of non-compliance. Thereupon the parties shall be required to confer within 30 days and attempt to reach agreement as to what steps may be necessary to meet the goals of this Agreement, and resolve such compliance issues to both parties' satisfaction. If an agreement is not reached, thereafter, OCR may terminate this Agreement with 30 days notice. Should the agreement be terminated by OCR, OCR may revive its investigation of the Georgia Class Complaints that gave rise to this initial action, as specified in the Appendix.

(F) This Agreement does not address or resolve issues involved in any complaint investigation, compliance review, or administrative action under Federal laws by other Federal agencies, including any action or investigation under Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq., or Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, or the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997, by the United States Department of Justice (DOJ) with respect to any matter presented to DOJ before or after the date of this Agreement.

## **SECTION V: General Provisions**

(A) The State shall not intimidate, threaten, coerce, or discriminate against any person who has filed a complaint, testified, assisted, or participated in any manner in the investigation of the matters addressed in the complaints or this Agreement.

(B) OCR's failure to enforce the entire Agreement or any provision thereof with respect to any deadline or any other provision therein shall not be construed as a waiver of OCR's right to enforce other deadlines and provisions of the Agreement.

(C) This Agreement is a public agreement, and there are no restrictions on the release or publication of the Agreement or its terms. However, this Agreement is not intended to create any contractual rights enforceable by any person or entity other than the parties to this Agreement. The State and OCR shall provide a copy of this Agreement to any

person upon request except where prohibited by law.

(D) All provisions in this Agreement are severable. Should any provisions of the Agreement be held invalid by a court of competent jurisdiction, all other provisions shall be deemed to remain in force.

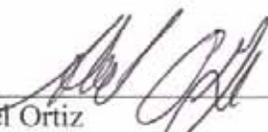
(E) This Agreement may be amended upon written consent of both OCR and the State.

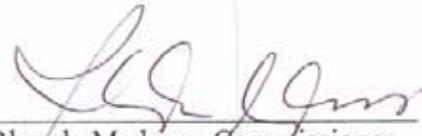
(F) OCR and the State have jointly agreed that Abel Ortiz will serve as the State's Olmstead Coordinator. OCR and the State have jointly agreed that Karen Green McGowan, R.N. will serve as the State's consultant with respect to the terms of this Agreement that involve persons with DD, and that Dr. Joseph R. Bona, MD, MBA will serve as the State's consultant with respect to the terms of this Agreement that involve persons with MH. In the event that Ms. McGowan or Dr. Bona is unable to serve or continue serving as the State's consultant for the duration of this Agreement, the parties shall meet or otherwise confer within 30 days of the vacancy to discuss and attempt to agree upon an alternate consultant. If the parties cannot agree, each party will submit three names to the Olmstead Planning Committee, which shall choose an alternate consultant from the proposed names.

(G) Authorizations. The individuals signing this Agreement on behalf of the State represent and warrant that they are authorized to execute this Agreement on behalf of the State and that the terms of this Agreement shall be legally binding on the State including all member organizations and entities that are owned or controlled by the State. The individual signing this Agreement on behalf of HHS represents and warrants that he is signing this Agreement in his official capacity and that he is authorized to execute this Agreement on behalf of HHS.

**SECTION VI: SIGNATURES**

Executed this 1 day of July, 2008.

By:   
Abel Ortiz  
On behalf of the Governor for the  
State of Georgia

By:   
Dr. Rhonda Medows, Commissioner  
Ga. Dept. of Community Health

By:   
B.J. Walker, Commissioner  
Ga. Dept. of Human Resources

By:   
Mr. Roosevelt Freeman  
United States Department Of Health and  
Human Services, Office for Civil Rights

## Appendix: Definitions

Wherever the following terms appear in this Agreement, they shall have the meaning set forth below.

“Advocate” shall mean any individual who regularly, and with no, or only nominal compensation, assists disabled individuals to maintain or secure their rights under state or Federal law. It shall also refer to the particular complainants in this case, and the employees of those organizations.

“Choice”—when used in reference to the choice of community services—shall be the choice of the individual, exclusively, as best it may be determined.

“Community Services” refers to the full range of services and supports needed to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility.

“Georgia Class Complaints” refers to the following class complaints:

- Case No: 01-00406 GAO v. Ga. Reg. Hosp. Savannah;
- Case No: 01-00407 ALAS v. Ga. Reg. Hosp. Atlanta
- Case No: 01-00408 GAO v. West Central Hospital
- Case No: 01-00409 GAO v. Pleasant View Nursing Center
- Case No: 01-00410 DLPC v. Gracewood State Hospital/School
- Case No: 01-00411 DLPC v. Central State Hospital
- Case No: 01-00412 DLPC v. NW Ga. Regional Hospital
- Case No: 02-00530 GLSP v. Ga. Reg. Hospital Augusta
- Case No: 02-00531 ALAS v. Southwestern State Hospital
- Case No: 01-00436 Georgia Compliance Review

The term “Georgia Class Complaints” does not refer to Olmstead related complaints concerning persons who have disabilities besides DD and/or MH, or persons in facilities other than State-operated facilities, as defined in this Agreement.

“Individuals with intellectual and developmental disabilities and/or a mental health disability” and “individuals with DD and/or MH” refer to individuals with intellectual and developmental disabilities, a mental health disability, or a dual diagnosis.

“Institutionalized” always refers to individuals with DD and/or MH institutionalized in State facilities unless the Agreement specifically states otherwise.

“Intellectual and developmental disabilities (DD)” has the meaning specified at 42 U.S.C. § 15002(8), which defines the term “developmental disability.” This same class of people has been referred to in past correspondence between OCR and the State of

Georgia as persons with developmental disabilities and/or individuals with mental retardation (DD/MR).

“Mental Health Disability” refers to any of various psychiatric conditions, usually characterized by impairment of an individual’s normal cognitive, emotional, or behavioral functioning, and caused by physiological or psychosocial factors.

“Public advocacy organization” refers to a non-profit entity involved in advocating or delivering services for the disabled, including the Atlanta Legal Aid Society (ALS), the Georgia Legal Services Program (GLSP), the Georgia Advocacy Office (GAO), the Disability Law and Policy Center of Georgia (DLPC) and the Council on Developmental Disabilities.

“Respondents” refers to the following entities named in the Georgia class complaints:

- Georgia Department of Community Health
- Georgia Department of Human Resources
- Gracewood State School and Hospital
- Region 12 MH/MR/SA

“State-operated facilities” refers to State owned or operated hospitals, ICF-MRs, psychiatric hospitals, and nursing facilities.

“Substantial Compliance” refers to maintenance of compliance in a subject area of the VCA for a sustained period of time. With regard to an individual Georgia institution, substantial compliance in a subject area is achieved if any violations are minor or occasional, and are not systemic. On a systemic level, substantial compliance is achieved so long as, when evaluating the State’s compliance with this Agreement as a whole, any noted deviations from specific VCA requirements do not frustrate the essential purposes of the Agreement. Noncompliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance will not constitute failure to maintain substantial compliance. At the same time, temporary compliance during a period of sustained noncompliance shall not constitute substantial compliance, but may be considered by OCR when considering overall systemic substantial compliance.