WASHINGTON

Medical Commission

Licensing. Accountability. Leadership.

Regular Meeting
November 19-20, 2026

Meeting Agenda – 1st Revised November 19-20, 2026

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

In accordance with the Open Public Meetings Act, this meeting notice was sent to individuals requesting notification of Washington Medical Commission (WMC) meetings. This agenda is subject to change. The WMC will accept public comments at the Business Meeting. To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

These meetings will be hybrid. Participants can attend either in person or virtually.

Commissioners and WMC Staff will attend virtually.

In-person location: Department of Health, Room 153, 111 Israel Rd SE, Tumwater, WA 98501
Virtual via Teams: Meeting and registration links can be found below.

Time	Thursday – November 19, 2026		Room
Open Sessions			
Personal Appearances			
8:30 am	Panel A – Meeting Link: 11/19/2026 Panel A	Page 7	Virtual
8:30 am	Panel B – Meeting Link: 11/19/2026 Panel B	Page 8	Virtual
Closed Sessions			
Case Disposition			
10:30 am	Panel A		Virtual
10:30 am	Panel B		Virtual
Noon	Lunch Break		
Case Disposition			
12:30 pm	Panel A		Virtual
12:30 pm	Panel B		Virtual

Time	Friday – November 20, 2026	Room
Open Sessions		
9:30 am – 11:30 am	**Business Meeting**	**Virtual**

To attend virtually, please **register** for this meeting at: WMC Business Meeting

1.0 Chair Calls the Meeting to Order

2.0 Consent Agenda

Items listed here are considered routine agency matters and are approved by a single motion without separate discussion. If separate discussion is desired, that item will be removed from the Consent Agenda and placed on the regular Business Agenda. **Action**

2.1 Agenda – Approval of the November 20, 2026, Business Meeting agenda. Pages 2-5

2.2 Minutes – Approval of the August 21, 2026, Business Meeting minutes. Pages 9-14

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3.0 WMC Fees Rulemaking Workshop

Pages 15-33

Rachel Campbell, HSQA Fee and Data Manager, will facilitate this workshop regarding fees for physicians (MD), physician assistants (PA), and Certified Anesthesiologist Assistants (CAA).

4.0 Public Comment

The public will have the opportunity to provide comments. If you wish to speak, please use the Raise Hand function, and you will be called upon. Keep your comments brief, and when the Chair opens the floor, state your name and, if applicable, the organization you represent. If you would prefer to submit written comments, send them to amelia.boyd@wmc.wa.gov by **November 18, 2026**.

Please do not use this public comment period to address disciplinary cases or issues that the WMC is currently covering in its rulemaking or policy efforts. If you wish to comment on rules currently under development, to ensure your comments are considered as part of rulemaking, visit our "Rules in Progress" page and select the specific rule from the "Current Rules in Progress" table. We also welcome you to attend and comment at our rulemaking workshops and hearings. The schedule for these meetings can be found on our "Rules in Progress page. For feedback on WMC policies, guidelines, or interpretive statements, you may email medical.policy@wmc.wa.gov or provide verbal comments at one of the upcoming Policy: Interested Parties or Policy Committee meetings. You can find the schedule for these meetings on the Policy Meetings page.

Disclaimer: The WMC accepts written comment into the record as a normal course of the Business Meeting. On a case-by-case basis, the WMC will, at its sole discretion, grant a request to verbally read a comment into the record. Comments containing profanity, discriminatory language, ad hominem attacks on Commissioners or staff, threats of violence, or discussion of active cases or litigation before or involving the WMC will not be read. The comments will still be included in the materials for consideration and awareness.

4.1 The Chair will call for comments from the public.

5.0 Chair Report

6.0 Commissioner Training

6.1 **Open Public Meetings Act (OPMA)** — Update

Heather Carter, AAG, will provide annual training on the OPMA. Pages 34-51

7.0 New Business

7.1 **Rulemaking Petition** — **Action**

Amelia Boyd, Program Manager, will present a rulemaking petition regarding opioid prescribing. Memo on page 52. Pages 53-56

7.2 **2027 Meeting Dates - Change** — **Action**

Ms. Boyd will present a suggested change to the July meeting date. Pages 57-60

7.3 **2028 Meeting Dates - Proposed** — **Action**

Ms. Boyd will present the proposed meeting dates for 2028. Pages 61-64

8.0 Old Business

8.1 **Committee/Workgroup Reports** — Update

The written reports are on page 65. The Chair will call for additional reports. See pages 66-67 for a list of committees and workgroups. Pages 65-67

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8.2 **Rulemaking Activities** — Report
Rules Progress Report provided on page 68.

8.2.1 **Executive Order 26-06: Improving Government Efficiency Through Regulatory Reform** — Informational, Pages 69-72
Ms. Boyd will present this item.

8.3 **Joint Guidance for Retail Intravenous Therapy Clinics** — **Action**, Pages 73-77
Mike Farrell, Supervising Staff Attorney, will present this item for discussion and possible action.

8.4 **Lists & Labels Request** — **Action**
The Commission will discuss the requests received for lists and labels, and possible approval or denial of these requests. Approval or denial of these applications is based on whether the requestor meets the requirements of a "professional association" or an "educational organization" as noted on the application (RCW 42.56.070(8)).

8.4.1 RussoCME — Pages 78-89

9.0 Policy Committee Report

Christine Blake, Public Member, Chair, will report on items discussed at the Policy Committee meeting held on October 29, 2026. The agenda was as follows:

9.1 **Guidance Document: A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety (GUI2014-02)** — **Action**, Pages 90-96
The Committee recommended approving the document as revised.

9.2 **Clinical Experience Assessment Tool** — **Action**, Pages 97-100
The Committee recommended approving the document as revised.

9.0 Member Reports

The Chair will call for reports from Commission members.

10.0 Staff Member Reports — Pages 101-116

The Chair will call for further reports from staff.

11.0 Assistant Attorney General Report

Heather Carter, AAG, may provide a report.

12.0 Adjournment of Business Meeting

Informational

Hearing Schedule	Page 6
2027 Meeting Schedule	Pages 57-60

Correspondence

Letter from American Board of Medical Specialties	Pages 117-118
Letter concerning "diploma mills"	Pages 119-122
Email regarding new acute low back pain guideline	Pages 123-125
Information from Nebby G. regarding SEIU-M Proposal	Pages 126-400

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Open Session

Noon **Lunch & Learn**

Register to attend this meeting virtually here: WMC Lunch & Learn

When Should a Commissioner Recuse? Understanding Conflicts, Impartiality, and the Appearance of Fairness

Jimi Bush, Director of Quality and Engagement, will present a practical overview of the Washington Medical Commission's Commissioner Recusal Procedure for Managing Conflicts of Interest, adopted January 10, 2025. The presentation will explore the legal and ethical foundations of recusal, including Washington's appearance-of-fairness doctrine, the Ethics in Public Service Act, and applicable administrative procedures governing disqualification. The presentation will distinguish situations in which a Commissioner must recuse, should recuse, or may not need to recuse.

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FORMAL HEARING SCHEDULE

WASHINGTON Medical Commission
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DISCLAIMER: THE BELOW HEARING SCHEDULE IS SUBJECT TO CHANGE.

Hearing Date	Respondent	Case No.	Location
December 2026			
No hearings scheduled for this month			
January 2027			
January 5-8	Watson, Brooks, MD	M2025-503	TBD
January 21-22	Denor, Joseph, MD	2025-16969	TBD
February 2027			
February 12	Berg, Tracy, MD	2025-15058	TBD
February 26	Bot, David D., MD	2025-17313	TBD
March 2027			
March 18-19	Shaw, David, MD	M2025-713	TBD
April 2027			
April 5-9	Mulholland, Mark, MD	M2024-199	TBD
May 2027			
May 12-14	Kirkpatrick, Richard, MD	M2024-502	TBD

Information on how to observe a hearing can be obtained from the Adjudicative Clerk Office, (206) 391-5193.

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Panel A
Personal Appearance Agenda

Thursday, November 19, 2026

Meeting Link: Personal Appearances - Panel A

Panel Members:	Sarah Lyle, MD, Panel Chair	Ziad Al Soufi Al Sukkary, MD	Daniel Cabrera, MD	Arlene Dorrough, PA-C
	Anjali D'Souza, MD	Jamie Koop, Public Member	Jennifer Lee, MD	Elisha Mvundura, MD
	Douglas Pullen, Public Member	Scott Rodgers, Public Member		
	Robert Bernstein, MD, Pro-Tem	Peter Casterella, MD, Pro-Tem	Jimmy Chung, MD, Pro-Tem	Peggy Hutchison, MD, Pro-Tem
	Penny Reck, MD, Pro-Tem			

Compliance Officer: Anthony Elders

8:30 a.m.	**Jeffrey L. Clemons, MD** Attorney: Matthew McCauley	M2025-502 (2024-12305) RCM: Peggy Hutchison, MD SA: Lisa Krynicki
9:00 a.m.	**Richard Lee-Tsong Lin, MD** Attorney: Ronald J Friedman	M2025-722 (2025-2243) RCM: Sarah Lyle, MD SA : Colleen Balatbat
9:30 a.m.	**Nneka Tamara Asiamigbe, MD** Attorney: Pro Se	M2024-503 (2023-13513) RCM: Arlene Dorrough, PA SA: Mike Farrell

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Panel B

Personal Appearance Agenda

Thursday, November 19, 2026

Meeting Link: Personal Appearances - Panel B

Panel Members:	Chair: Terry Murphy, MD	Michael Bailey, Public Member	Christine Blake, Public Member	Toni Borlas, Public Member
	Po-Shen Chang, MD	Karen Domino, MD	April Jaeger, MD	Qudsia Khan, MD
	Ed Lopez, PA-C	Satyavardhan Pulukurthy, MD		
	Eileen Ravella, PA-C, Pro-Tem	Amy Rowley, Public Member, Pro-Tem	Richard Wohns, MD, Pro-Tem	

Compliance Officer: Mike Kramer

8:30 a.m.	**Lavena Morgan, MD** Attorney: Pro Se	M2025-716 (2025-1995 et al.) RCM: Christine Blake SA: Mike Farrell
9:00 a.m.	**Anne B. Blanchette, PA** Attorney: Levi S. Larson	M2024-53 (2023-7601) RCM: April Jaeger, MD SA: Rachelle Villalobos
9:30 a.m.	**Derrick Havin, MD** Attorney: Markus W. Louvier	M2023-650 (2023-4324) RCM: Po-Shen Chang, MD SA: Lisa Krynicki

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Business Meeting Minutes
August 21, 2026

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Link to recording: https://youtu.be/dYJm5b3NNe4

Commission Members

Ziad AlSoufi, MD (V)
Michael Bailey, Public Member (V)
Christine Blake, Public Member
Toni Borlas, Public Member – Absent
Daniel Cabrera, MD – Absent
Po-Shen Chang, MD
Diana Currie, MD (V)
Karen Domino, MD
Arlene Dorrough, PA-C – Absent
Anjali D'Souza, MD – Absent
April Jaeger, MD – Absent
Qudsia Khan, MD (V)
Jamie Koop, Public Member – Absent
Jennifer Lee, MD (V)
Ed Lopez, PA-C, Vice Chair
Sarah Lyle, MD (V)
Terry Murphy, MD, Chair
Elisha Mvundura, MD, Officer-at-Large (V)
Robert Pullen, Public Member (V)
Satya Pulukurthy, MD
Scott Rodgers, JD, Public Member

WMC Staff in Attendance

Colleen Balatbat, Staff Attorney (V)
Anjali Bhatt, Bus. Practices & Productivity Mngr.
Jen Batey, Legal Support Staff Manager
Amelia Boyd, Program Manager
Carolynn Bradley, Mgmt Analyst/Contract Mgr
Kayla Bryson, Executive Assistant
Jimi Bush, Director of Quality & Engagement
Carmen Challender, Health Svcs. Consultant (V)
Marisa Courtney, Licensing Manager
Kelly Elder, Staff Attorney
Allen Esparza, Chief Investigator
Michael Farrell, Supervising Staff Attorney
Gina Fino, MD, Medical Consultant (V)
Ryan Furbush, Paralegal
Rick Glein, Director of Legal Services
Danielle Hacker, Commission Mtg. Coordinator
Mike Hively, Director of Ops. & Informatics
Ken Imes, Information Liaison
Kyle Karinen, Executive Director
Shelley Kilmer-Ready, Legal Assistant (V)
Sara Kirschenman, Staff Attorney (V)
Mike Kramer, Compliance Officer (V)
Lisa Krynicki, Staff Attorney (V)
Micah Matthews, Deputy Executive Director
Joe Mihelich, Health Services Consultant
Lynne Miller, Paralegal
Fatima Mirza, Program Case Manager
Nicholas Morris, Demographics & Informatics
Rosie Morrow-Okon, Healthcare Investigator
Freda Pace, Director of Investigations
Stormie Redden, Legal Assistant

Others in Attendance

Heather Carter, Assistant Attorney Gen. (AAG)
Haylie Kang, Department of Health (DOH)
Alex Kent-Guerra
Hillary Norris, Washington State Medical Association (WSMA) (V)
Marianne Richter, DOH

(V) indicates the participant attended virtually

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1.0 Call to Order

Terry Murphy, MD, Chair, called the meeting of the Washington Medical Commission (WMC) to order at 9:33 a.m. on August 21, 2026.

Kyle Karinen, Executive Director, shared that a former Executive Director of the Commission, Maryella Jansen, passed recently. A moment of silence was held in her honor.

2.0 Consent Agenda

The Consent Agenda contained the following items for approval:

2.1 Agenda for August 21, 2026

2.2 Minutes from May 8, 2026, Business Meeting

Motion: The Chair entertained a motion to approve the consent agenda. The motion was seconded and approved unanimously.

3.0 Public Comment

No members of the public provided comments.

4.0 Chair Report

Dr. Murphy stated she had no Chair Report.

5.0 New Business

5.1 Personal Appearances Procedure

Amelia Boyd, Program Manager, reported that the Personal Appearances Procedure had been revised and provided the document for the Commission's information.

5.2 Demographic Census and HELMS Survey Revision

Mike Hively, Director of Operations and Informatics, presented information on the physician and physician assistant demographic census, which was launched in 2016 to support workforce planning, disaster preparedness, and minimum data set requirements. He explained that while the census continues to provide valuable workforce information, the existing data largely reflects health care delivery as it existed in 2016 and does not fully account for changes such as expanded telemedicine, the transition to HELMS, and the upcoming demographic dashboard.

Mr. Hively noted that updating the census would modernize the data set, improve data quality and standardization, and increase the usefulness of the commission's demographic dashboard. He requested that the commission authorize a revision of the demographic census and identify two to three volunteers to serve as consultants to review proposed changes and provide feedback.

6.0 Old Business

6.1 Committee/Workgroup Reports

These reports were provided in writing and included in the meeting packet.

The Chair called for additional reports and none were provided.

6.2 Rulemaking Activities

The rulemaking progress report was provided in the meeting packet. In addition to the written report, Amelia Boyd, Program Manager, made the following requests:

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6.2.1 **Request for Approval to Initiate Rulemaking**
Ms. Boyd asked for Commission approval to initiate standard rulemaking for chapter 246-918 WAC Physician Assistants, to conduct the statutorily required five-year review of the chapter.

Motion: The Chair called for a motion to approve initiating standard rulemaking on chapter 246-918, Physician Assistants. The motion was seconded and passed unanimously.

6.2.2 **Request for Approval to Initiate Rulemaking**
Ms. Boyd asked for Commission approval to initiate a CR-102, Proposed Rulemaking, for the IMG Limited License rules.

Ms. Boyd stated that if approved, the rules hearing is tentatively scheduled for November 20, 2026.

Motion: The Chair called for a motion to approve initiating the CR-102 for the IMG Limited Licenses rules. The motion was seconded and passed unanimously.

6.2.3 **Request to Rescind Approval of Rulemaking – CDTAs**
Ms. Boyd recommended rescinding the 2020 CR-101 on Collaborative Drug Therapy Agreements (CDTA) because the issues and policy considerations have significantly evolved. She recommended that, if rulemaking is pursued in the future, the commission file a new CR-101 reflecting current policy objectives.

Motion: The Chair called for a motion to approve rescinding the CR-101 regarding CDTAs. The motion was seconded and passed unanimously.

6.3 Request to rescind Interpretive Statement: "Establishing the Use of Nitrous Oxide in Office-Based Settings", INS2023-02
Ms. Boyd presented a recommendation to rescind Interpretive Statement INS2023-02 regarding the use of nitrous oxide in office-based settings. The guidance in the interpretive statement has been incorporated into WAC 246-919-603, which became effective June 13, 2026, making the interpretive statement no longer necessary.

Motion: The Chair called for a motion to approve rescinding INS2023-02. The motion was seconded and passed unanimously.

6.4 Proposed New Dates for May 2027 Meeting
Ms. Boyd presented a request to reschedule the May 2027 commission meeting. The commission had previously approved holding the meeting on May 6 and 7, 2027. Due to the preferred meeting location being unavailable on those dates, she requested approval to reschedule the meeting to May 20 and 21, 2027.

Motion: The Chair called for a motion to approve changing the dates. The motion was seconded and passed unanimously.

6.5 Lists & Labels Request
The following lists and labels request was discussed for possible approval or denial. Approval or denial of this request is based on whether the entity meets the

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requirements of a "professional association" or an "educational organization" as noted on the application (RCW 42.56.070(9)).

6.5.1 Northwest Washington Medical Society

Motion: The Chair entertained a motion to approve the request. The motion was seconded and approved unanimously.

7.0 Policy Committee Report

Christine Blake, Public Member, Chair, will report on items discussed at the Policy Committee meeting held on July 22, 2026. The agenda was as follows:

Consent Agenda

Mr. Matthews presented a proposed change to remove the requirement for Policy Committee review of the Commission's internal operating procedures. He explained that internal procedures are administrative documents that address the commission's internal processes and do not establish policy or provide interpretive guidance. The change would clarify the Policy Committee's governance role and allow its review to focus on policies, guidelines, and interpretive statements. Most internal procedures will continue to be available on the WMC website.

The list of documents being requested for removal was as follows:

1. Complainant Opportunity to be Heard Through an Impact Statement
2. Complainant Request for Reconsideration--Closed Cases
3. Panel Composition
4. Panel Consent Agenda
5. Pro Tem Appointments
6. Processing Complaints of Sexual Misconduct Through the Sexual Misconduct Analysis Review Team (SMART)
7. Referral of Sexual Misconduct Cases
8. Processing CRP Certified Cases
9. Stipulation to Informal Disposition (STID)
10. Whistleblower Protection
11. Approving Accrediting Entities to Accredit or Certify the Use of Anesthesia in Office-Based Surgical Settings
12. Approving Entities to Credential Pain Management Specialists
13. Compensation and Reimbursement for Commission Duties
14. Delegation of Final Decision Making to Health Law Judges
15. Delegation of Signature Authority for Credentialing, Disciplinary and Rulemaking
16. Personal Appearances Procedure

Motion: The Committee Chair entertained a motion to approve the request. The motion was seconded and approved unanimously.

7.2 **Interpretive Statement: Clarifying Eligibility for a License to Practice Medicine (INS2025-XX)**

Ms. Blake presented this document and stated the Committee recommended approving this document for DOH Secretary Review.

Motion: The Committee Chair entertained a motion to approve the document

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for DOH Secretary review. The motion was seconded and approved unanimously.

7.3 **Policy: Licensee Use of Augmented Intelligence Tools in Patient Care (POL20206-XX)**

Ms. Blake presented this document and stated the Committee recommended approving this document for DOH Secretary Review.

Motion: The Committee Chair entertained a motion to approve the document for DOH Secretary review. The motion was seconded and approved by majority.

8.0 Member Reports

Dr. Elisha Mvundura, Dr. Karen Domino, Dr. Po-Shen Chang, and Ed Lopez, PA-C, attended the recent annual meeting of the Federation of State Medical Boards (FSMB) and shared feedback regarding their experience.

9.0 Staff Reports

Written reports were included in the meeting materials. The reports below are in addition to the written reports:

Ms. Boyd provided an update regarding the Federation of State Medical Boards (FSMB) annual meeting scheduled for next year. She noted that the meeting is typically held during the last week of April but has been moved up a couple of weeks to April 15-17, 2027.

Freda Pace, Director of Investigations, introduced new non-clinical investigator, Rosie Morrow-Okon.

Kyle Karinen, Executive Director, provided an update on the implementation of HELMS and expressed appreciation to staff who have been instrumental in supporting the transition to the new platform. He specifically recognized Jen Batey and Shelly Kilmer-Ready for their significant work supporting case review and personal appearances and helping commissioners navigate the new system. Mr. Karinen acknowledged that HELMS remains a work in progress and thanked the staff for their continued efforts to make the transition successful.

Kayla Bryson, Confidential Secretary, introduced new Commission meeting coordinator, Danielle Hacker.

10.0 AAG Report

Heather Carter, AAG, had nothing to report.

11.0 Adjournment

The Chair called the meeting adjourned at 10:10 am.

Submitted by

Amelia Boyd, Program Manager

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Terry Murphy, MD, Chair
Washington Medical Commission

Approved November 20, 2026

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November
2026

Washington Medical Commission Fee Overview and Proposal

Washington State Department of HEALTH

Presented by
Rachel Campbell,
HSQA Fee and Data
Manager

OVERVIEW

Overview of process

Overview of current state

Review fee proposal

Fee Rules Process

- 4 main steps
  - CR101 – preproposal statement of inquiry
  - Interested Party work
  - CR102 – proposal, including draft language
    - This step also includes interested party work in the form of a formal public hearing
  - CR103 – rules finalized

Current stage

Average timeline for fee rulemaking is 12-18 months from start to finish.

Laws and Regulations

- The department has a legal obligation to ensure health professions are self-supporting in accordance with state law. DOH policy requires each profession to be within its calculated reserve fund balance “standard deviance range” within a six-year period.
    - RCW 70.230.050 and 43.70.250 require fees to cover all program costs
    - OFM and Department policy recommend maintaining a reserve level of 20% or 2-3 months of annual expenditures ($600,000 in FY2026)

Licensure and Fees

The Washington Medical Commission currently licenses 45,000 practitioners across 3 professions.

- 5,360 applications and 21,107 renewals at a 94% renewal rate for physician and surgeons and a 88% renewal rate for physician assistants (2026)
- Recent fee activity:
  - 2026: Certified Anesthesiologist Assistant implemented
  - 2025: Physician health and voluntary substance use disorder monitoring program fee increase
  - 2022: Osteopathic Physician Assistant Transition (SHB 2378, 2020)
  - 2020: Fee Increase

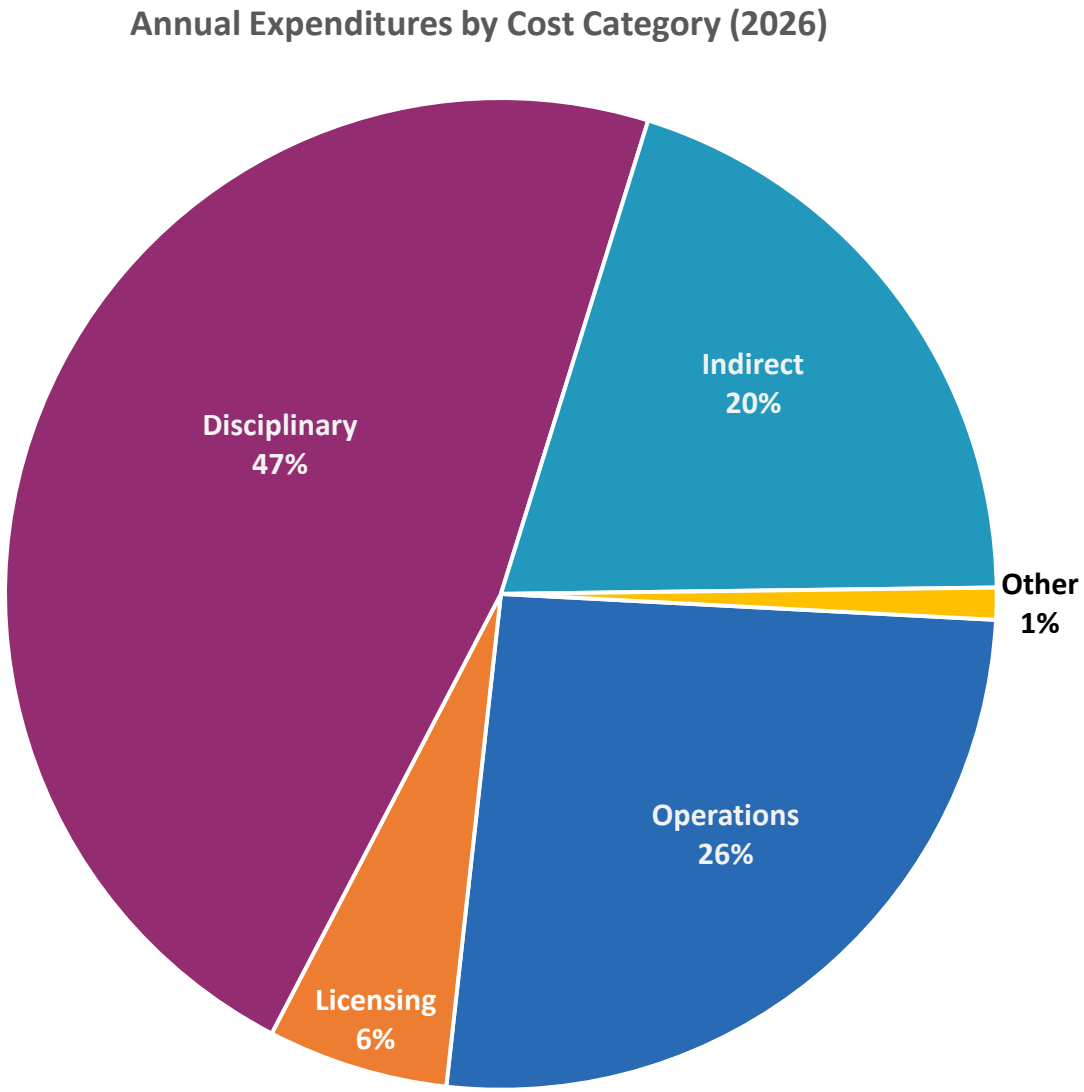
Table B: Proposed Licensure Fee Changes

License	Fee Type	Current Fee
Physician and Surgeon	Application	$425
	UW HEAL-WA Surcharge	$16
	WPHP Surcharge	$70
	Total	$511
	Two-year renewal	$824
	UW HEAL-WA Surcharge (two-year)	$32
	WPHP Surcharge (two-year)	$140
	Total	$996
	Late renewal penalty	$300
	Expired reissuance	$262.50
Physician Assistant	Application	$50
	UW HEAL-WA Surcharge	$16
	WPHP Surcharge	$70
	Total	$136
	Two-year renewal	$247
	UW HEAL-WA Surcharge (two-year)	$32
	WPHP Surcharge (two-year)	$140
	Total	$419
	Late renewal penalty	$124
	Expired reissuance	$50
Certified Anesthesiologist Assistant	Application	$50
	Two-year renewal	$247
	Late renewal penalty	$124
	Expired reissuance	$50

Financial Overview

	Program Financial Summary (8- Year)							
	FY2019	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**FY2025**	**FY2026**
Total Revenue	$ 9,255,000	$ 10,890,000	$ 14,965,000	$ 14,649,000	$ 15,954,000	$ 16,006,000	$ 16,738,000	$ 17,053,000
Total Expenditures	$ 10,724,000	$ 10,851,000	$ 11,745,000	$ 11,953,000	$ 14,120,000	$ 13,750,000	$ 14,232,000	$ 17,001,000
Ending Fund Balance	**$ 2,426,000**	**$ 2,465,000**	**$ 5,685,000**	**$ 8,382,000**	**$ 10,216,000**	**$ 12,472,000**	**$ 14,978,000**	**$ 15,030,000**
Recommended Reserve	$ 5,362,000	$ 5,426,000	$ 5,873,000	$ 5,976,000	$ 7,060,000	$ 6,875,000	$ 7,116,000	$ 8,501,000
Annual Variance	$ (1,469,000)	$ 39,000	$ 3,220,000	$ 2,696,000	$ 1,834,000	$ 2,256,000	$ 2,506,000	$ 52,000
Balance Above Reserve	$ (2,936,000)	$ (2,961,000)	$ (188,000)	$ 2,406,000	$ 3,156,000	$ 5,597,000	$ 7,862,000	$ 6,529,000

What Does the Fee Support?



Historic Drivers

- **Revenue growth from**
  - Increased licensing activity following the COVID-19 pandemic, with IMLC approvals averaging more than 1,000 annually over the past three years.
  - Growth in the licensed population, generating additional renewal revenue retained by the state.
  - Expansion of the regulatory program, including the addition of osteopathic physician assistants (2021) and certified anesthesiologist assistants (2025).
  - New revenue streams from the clinical experience license program for international medical graduates, established in 2025.
  - Higher-than-anticipated licensing activity and revenue growth beyond the original assumptions used in the 2020 fee-setting process.

- **Expenditure growth from**
  - Ongoing implementation, maintenance, and support costs associated with the Health Enforcement and Licensing Management System (HELMS).
  - Expansion of regulatory responsibilities to include additional professions and licensing pathways.
  - Increased licensing and regulatory workload associated with growth in the licensed population and IMLC participation.
  - Ongoing operational and administrative costs to support expanded licensing and regulatory activities.

Current Financial Status and Outlook

Revenue is at a surplus, creating a fund balance larger than recommended reserves.

- **Strong Financial Position:** The program ended FY2026 with a $15.0 million fund balance, including an operating surplus of $52,000 and reserves approximately $6.5 million above the recommended target of $8.5 million or 50% of annual expenditures.
- **Steady Revenue Growth:** Annual licensing revenue is projected to increase from **$17.1 million in FY2026 to $19.4 million by FY2032**, assuming current fee levels remain unchanged.
- **Increasing Expenditures:** Operating expenditures are expected to rise from ***$*17.0 million to $19.3 million** over the same period.
- **Operating Surplus Peaks in FY2029:** Annual operating surpluses are projected to reach approximately **$1.6 million in FY2029**, before gradually declining as expenditure growth outpaces revenue growth.
- **Future Operating Shortfall**: Expenditures are projected to exceed revenue beginning in **FY2034.**
- **Healthy Fund Balance:** Fund balance is projected to reach approximately **$20.9 million by FY2032**, remaining above the recommended reserve target throughout the forecast period.

Projected revenue growth and accumulated reserves provide an opportunity for a measured fee reduction while maintaining sufficient resources for financial stability.

Key Financial Risks and Uncertainties

- HELMS completion and ongoing support costs
- Potential legislative direction to redirect excess health profession fund balances to other professions, including Medical Commission funds
- Implementation of the Physician Assistant Compact
- Changes in IMLC participation and enrollment post-COVID-19
- Shifts in health care workforce patterns and professional practice
- Potential legislative changes to fee structures and review processes amid state budget constraints
- Fluctuations in complaint, investigation, and disciplinary workloads
- Evolving regulatory responsibilities, including certified anesthesiologist assistants and Executive Order 25-03

Proposed Fee Changes
Applications and Other Fees

Table B: Proposed Licensure Fee Changes			
License	**Fee Type**	**Current Fee**	**Proposed Fee**
Physician and Surgeon	Two-year renewal UW HEAL-WA Surcharge (two-year) WPHP Surcharge (two-year) **Total**	$824 $32 $140 **$996**	$749 $32 $140 **$921**
	Late renewal penalty	$300	No Change
	Expired reissuance	$262.50	No Change
Physician Assistant	Two-year renewal UW HEAL-WA Surcharge (two-year) WPHP Surcharge (two-year) **Total**	$247 $32 $140 **$419**	$172 $32 $140 **$344**
	Late renewal penalty	$124	No Change
	Expired reissuance	$50	No Change
Certified Anesthesiologist Assistant	Two-year renewal	$247	$172
	Late renewal penalty	$124	No Change
	Expired reissuance	$50	No Change

Next Steps

1. December 2026, file the proposed fee rule (CR-102)
2. Share the filed CR-102 & receive public comments
3. Winter 2026, public rule hearing
4. Consider comments and adopt final rule (CR-103)
5. Share the filed CR-103 with interested parties
6. July 1, 2027, fee becomes effective

Questions and Feedback

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Washington State Department of HEALTH

Washington Medical Commission

Fee Narrative

November 2026

The Washington State Department of Health (department) works to protect and improve the health of all people in Washington State. In partnership with the Washington Medical Commission (commission), the department accomplishes this work in part by licensing and regulating physicians and surgeons, physician assistants, and certified anesthesiologist assistants under Chapter 18.71, Chapter 18.71A, Chapter 18.71B, Chapter 18.71C, and Chapter 18.71D RCW.

Fees paid by these health care professionals support the costs of licensing and regulation, including credentialing, complaint processing, investigations, disciplinary activities, and other functions necessary to protect the public and ensure qualified health care professionals can practice in Washington.

Based on the program's current financial position and long-term forecast, the department is proposing a reduction in renewal fees to better align revenue with the cost of licensing and regulating these professions while maintaining adequate reserves to address future financial and operational needs.

FY2026 Fiscal Review

- **Revenue:** $17,053,000
- **Expenditures:** $17,001,000
- **Operating surplus:** $52,000
- **Ending fund balance:** $15,030,000
- **Recommended Reserve:** $8,501,000
  (based on 50% of annual expenses)
- **Amount above Reserve:** $6,528,000

Financial goal: Align fees with the cost of licensing and regulation while maintaining sufficient reserves to manage financial uncertainty and support ongoing program responsibilities.

Current assumptions are based on an effective date of **July 1, 2027.**

All projections are approximate and subject to change.

Questions?

Program Contact
Amelia.Boyd@wmc.wa.gov

Funding the Profession

RCW 43.70.250 requires that the costs of each profession, occupation, or business be borne by its members through fees. Accordingly, the department considers projected revenue, expenditures, and fund balances when setting licensing fees to ensure that revenue appropriately supports the cost of licensing and regulating each profession.

The current fees for physicians and surgeons and physician assistants took effect in February 2020. At that time, a fee increase was necessary to address a declining fund balance, with projections indicating that the program could reach a negative balance within two years. The increase also accounted for anticipated ongoing costs associated with the department's new Health Enforcement and Licensing Management System (HELMS), as well as uncertainty about future licensing activity and regulatory costs.

Since the 2020 fee-setting process, several developments have changed the program's financial outlook. Osteopathic physician assistants entered the commission's physician assistant regulatory framework in 2021. Certified anesthesiologist assistants became a newly regulated profession following enactment of SB 5184, with fees established in October 2025 in alignment with physician assistant fees. In addition, HB 2189 established the clinical experience license program for international medical graduates in 2025, creating a revenue stream that had not been anticipated when the current fees were established.

Licensing activity also increased following the COVID-19 pandemic, including participation in the Interstate Medical Licensure Compact (IMLC). The commission has reported averaging more than 1,000 IMLC license approvals annually over the past three years, exceeding pre-pandemic projections. Because renewal fees are retained by the state, growth in the licensed population has contributed additional revenue to the program.

Together, higher-than-anticipated licensing activity, the addition of professions and licensing programs, and revenue growth beyond the costs of administering the program have contributed to the program's current financial position. These developments differ from the assumptions underlying the 2020 fee-setting decision and have resulted in accumulated reserves above the department's recommended target.

The following financial forecast evaluates how these trends are expected to affect future revenue, expenditures, and fund balances, and considers the level of reserves needed to maintain financial stability.

Financial Forecast

Under current fee levels and forecast assumptions, the program is projected to continue accumulating fund balances, with the balance remaining above the recommended reserve target through FY2032. The following projections illustrate the program's expected financial trajectory if fees remain unchanged.

In FY2026, the program generated approximately $17.1 million in licensing revenue while supporting approximately 45,000 licenses across three professions. The licensed population is expected to continue growing, supported by an 89% renewal rate and continued licensing activity. Based on current licensure trends and forecast assumptions, annual revenue is projected to increase to approximately $17.2 million in FY2027 and $19.4 million by FY2032.

FY2026 expenditures totaled approximately $17.0 million, including approximately $800,000 in final contract payments to the University of Washington and a $645,000 transfer to cover the program's share of HELMS implementation costs. These one-time expenditures and funding adjustments contributed to the relatively modest FY2026 operating surplus of approximately $52,000.

With the conclusion of these one-time expenses, expenditures are projected to decrease slightly to approximately $16.3 million in FY2027, resulting in an anticipated operating surplus of approximately $920,000. Annual operating surpluses are expected to increase over the next several years, reaching approximately $1.6 million in FY2029. Thereafter, surpluses are projected to gradually decline as expenditure growth begins to outpace revenue growth. Total expenditures are forecast to increase to approximately $19.3 million by FY2032, with expenditures anticipated to exceed revenue beginning in FY2034.

The program's ending fund balance is projected to increase from approximately $15.0 million in FY2026 to $16.0 million in FY2027 and $20.9 million by FY2032, assuming current fee levels remain unchanged. Although annual operating surpluses are expected to diminish toward the end of the forecast period, accumulated surpluses are projected to maintain the fund balance above the department's recommended reserve target. This financial trajectory supports a measured fee reduction to bring revenues more closely into alignment with anticipated costs while maintaining sufficient reserves to address future financial and operational uncertainty.

Fund Balance and Reserve Adequacy

The program ended FY2026 with a fund balance of approximately $15.0 million. The department’s recommended reserve for the commission is $8.5 million, equivalent to approximately 50% of FY2026 actual expenditures, or six months of operating costs. The ending fund balance therefore exceeded the recommended reserve by approximately $6.5 million.

The Office of Financial Management (OFM) recommends a reserve equivalent to 25% of expenditures for the overall fund. Within that framework, the department establishes reserve targets for individual programs based on factors such as financial and operational risk, program size, and anticipated funding needs. For commissions, the department works with commission leadership to determine an appropriate reserve level that reflects these considerations and the commission’s risk tolerance. The 50% recommended reserve target reflects the department’s collaboration with the commission.

The reserve target will be adjusted in future projections to reflect anticipated expenditures. Maintaining an adequate reserve allows the commission to respond to fluctuations in licensing activity, regulatory workload, technology costs, and other unforeseen needs without requiring abrupt fee increases. Under current fee levels, the fund balance is projected to continue growing above the program-specific reserve target through FY2032. This creates an opportunity to moderate revenue through a measured fee reduction while retaining sufficient resources to maintain financial stability.

Key Financial Risks and Uncertainties

The forecast remains subject to uncertainty. Key factors that could affect future expenditures, workload, revenue, and fund balance availability include:

- Completion and ongoing support costs associated with HELMS.
- Continued or additional legislative direction, similar to budget proviso Section 922(4)(a) of the final 2026 operating budget, to use excess health profession fund balances, including the Medical Commission's fund balances, for other professions.
- Implementation of the Physician Assistant Compact.
- Changes in IMLC participation and enrollment following the COVID-19 pandemic.
- Changes in health care workforce patterns and professional practice.
- Potential legislative changes to how fees are structured or reviewed due to the current state budget environment.
- Fluctuations in complaint, investigation, and disciplinary workloads.
- Evolving regulatory responsibilities, including those associated with certified anesthesiologist assistants and implementation of Executive Order 25-03.

These uncertainties reinforce the importance of maintaining adequate reserves while aligning fee revenue with projected program costs. The proposed fee adjustment balances these considerations by moderating fund balance growth while preserving the financial flexibility needed to respond to future costs and workload changes.

Fee Proposal

Based on the program's financial forecast, the department proposes reducing two-year renewal fees by $75 for physicians and surgeons, physician assistants, and certified anesthesiologist assistants, effective July 1, 2027.

The proposal follows a request from the Washington Medical Commission for the department to reduce fees for physicians and surgeons and physician assistants. In its request, the commission recognized the program's financial stability and recommended a measured reduction to help avoid a cycle of reducing fees and subsequently needing to increase them.

The department considered the commission's request alongside projected revenue and expenditures, the recommended reserve target, and uncertainties that may affect future estimates. Maintaining adequate reserves remains important to managing financial volatility and unforeseen regulatory needs. However, continued accumulation of fund balances above the recommended reserve target may indicate that current fees exceed the level needed to support program operations and maintain reserves. Excessive balances may also increase exposure to legislative fund sweeps, through which fee revenue may be redirected for other purposes.

The proposed $75 fee reduction is intended to moderate future fund balance growth while maintaining sufficient resources to support ongoing licensing and regulatory responsibilities. Compared with current fee levels, the reduction is projected to decrease annual revenue by an average of approximately $1.7 million and result in an ending fund balance of approximately $12.6 million by FY2032.

Table B: Proposed Licensure Fee Changes

License	Fee Type	Current Fee	Proposed Fee
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Certified Anesthesiologist Assistant	Two-year renewal	$247	$172
	Late renewal penalty	$124	No Change
	Expired reissuance	$50	No Change

The department will continue to monitor the program's financial position and consider future fee changes as necessary to maintain alignment with statutory requirements.

Washington State Department of HEALTH

November 2026

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Open Public Meetings Act

Presented by the Office of the Attorney General

Washington's Open Public Meetings Act (OPMA)

- Passed in 1971
- Requires meetings to be open to the public, gavel to gavel
- RCW 42.30

Open Government Laws Like the OPMA are Often Called "Transparency Laws" or "**Sunshine Laws**" because they "shine light" on government.

Transparency builds public confidence in government.

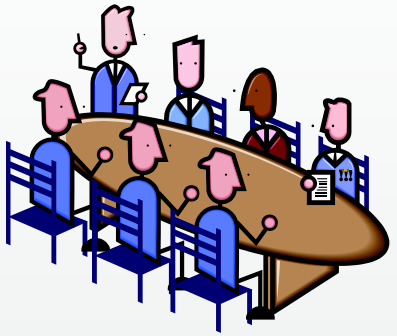
"*Sunlight is the best disinfectant.*"

U.S. Supreme Court Justice Louis Brandeis

The OPMA Applies To

All meetings of the **GOVERNING BODY** of a **PUBLIC AGENCY** shall be open and public and all persons shall be permitted to attend any meeting of the governing body of a public agency, except as otherwise provided in RCW 42.30.

RCW 42.30.030



What is a Governing Body?

The multimember board or other policy or rule-making body of a public agency.

RCW 42.30.020

OR

Any committee of such public agency *when:*

- ❑ the committee acts on behalf of the governing body,
- ❑ conducts hearings, or
- ❑ takes testimony or public comment.

The OPMA Does Not Apply To

These entities:

- Courts
- Legislature
- Agencies not defined as “public agency” in OPMA, such as agencies governed by a single individual
- Private organizations

These activities:

- Licensing/permitting for businesses, occupations or professions or their disciplinary proceedings (or proceedings to receive a license for a sports activity, or to operate a mechanical device or motor vehicle)
- Quasi-judicial matters
- Matters governed by the WA Administrative Procedure Act, RCW 34.05
- Collective bargaining

RCW 42.30.020(1), RCW 42.30.140

What is a Meeting?

- "Meeting" means meetings at which the public agency takes "action."
- "Action" means the transaction of the official business of the public agency and includes but is not limited to:

- Public testimony
- Discussions
- Reviews
- Final actions*
- All deliberations
- Considerations
- Evaluations

* The requirements of the OPMA are triggered whether or not "final" action is taken.

RCW 42.30.020

“Meeting” (Continued)

- A “meeting” of a governing body occurs when a majority of its members (quorum) gathers with the collective intent of transacting the governing body’s business.
  - Physical presence not required – a meeting can occur by phone or e-mail.
  - An exchange of e-mail could constitute a meeting if, for example, a quorum of the members participate in the e-mail exchange & discuss agency business.
  - Does not need to be titled “meeting” – OPMA also applies to “retreats,” “workshops,” “study sessions,” etc.
- Simply receiving information without comment is not a meeting.

Final Action

- "**Final action**" is a collective positive or negative decision, or an actual vote, by a majority of the governing body, or by the "committee thereof".
- Must be taken in public, even if deliberations were in closed session.
- Secret ballots are not allowed.

RCW 42.30.060, RCW 42.30.020

OPMA MEETING TYPES

Regular

Special

Emergency

Notice and agenda requirements vary based on the type of meeting.

Regular Meetings

"Regular meetings" are recurring meetings held in accordance with a periodic schedule by ordinance, resolution, bylaws or other rule.

- A state public agency must:
  - Yearly, file with Code Reviser a schedule of regular meetings, including time and place
  - Publish changes to regular meeting schedule in state register at least 20 days prior to the rescheduled date

RCW 42.30.077 requires governing bodies to make the agenda of each regular meeting of the governing body available online no later than 24 hours in advance of the published start time of the meeting.

RCW 42.30.070; RCW 42.30.075; RCW 42.30.077

Special Meetings

A "**special meeting**" is a meeting that is not a regular meeting (not a regularly scheduled meeting).

Called by presiding officer or majority of the members.

Notice - timing: 24 hours before the special meeting, written notice must be:

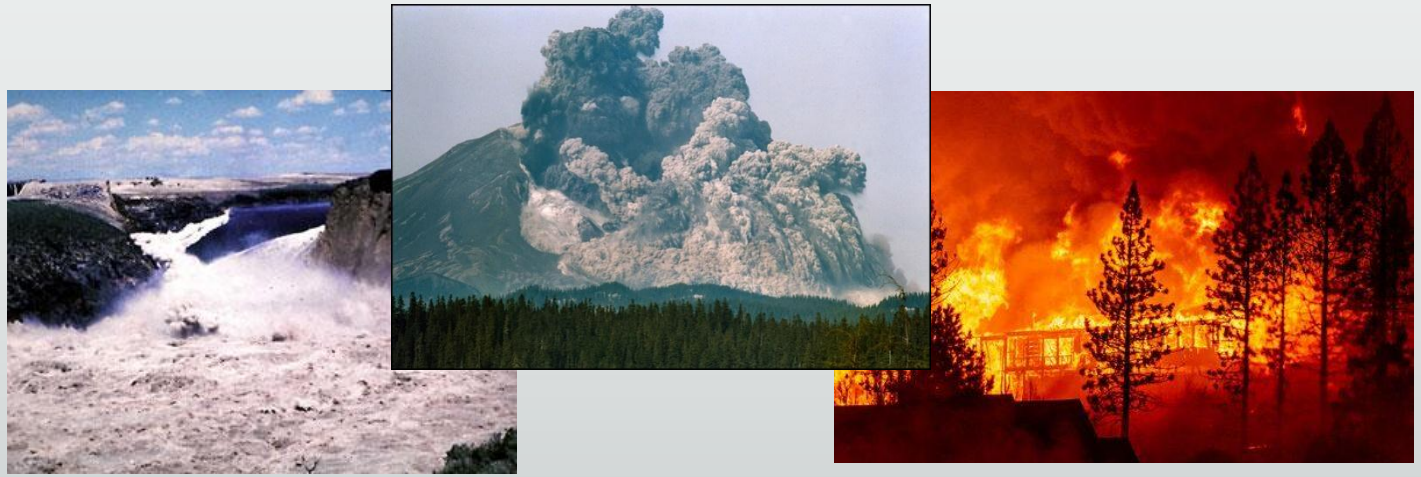
- Given to each **member** of the governing body (unless waived)
- Given to each **local newspaper of general circulation, radio, and TV station** which has a notice request on file
- Posted on the **agency's website** [with certain exceptions in RCW 42.30.080(2)(b), for example, if the agency does not have a website]
- Prominently **displayed at the main entrance** of the agency's principal location and the meeting site (if not that same location)

RCW 42.30.080

Emergency Special Meetings

- Notice is not required when special meeting called to deal with an emergency
  - Emergency involves injury or damage to persons or property or the likelihood of such injury or damage
  - Where time requirements of notice make notice impractical and increase likelihood of such injury or damage

~ RCW 42.30.080(4)



Executive Session

- Part of a regular or special meeting that is closed to the public.
- Limited to specific purposes set out in the OPMA.
- Purpose of the executive session and the time it will end must be announced by the presiding officer before it begins.
- Time may be extended by further announcement.

Executive Session

Specified purposes set out in OPMA. Includes, for example:

- **Discuss Agency Enforcement Actions, Litigation or Potential Litigation with Legal Counsel**

Three Requirements:

1. Purpose is to discuss agency enforcement action, litigation or potential litigation to which the agency, governing body, or a member acting in official capacity is, or is likely to become, a party.
2. Public knowledge regarding discussion likely to result in an adverse legal or financial consequence to the agency.
3. Legal counsel representing the agency is present. An executive session is not permitted just because legal counsel is present.

- **Real estate sale or lease**
- **Publicly bid contracts**
- **Evaluate qualifications of applicant for public employment or review performance of a public employee**
- **National security**

Other purposes listed in RCW 42.30.110

Travel and Gathering

- A majority of the members of a governing body may travel together or gather for purposes other than a regular meeting or a special meeting, so long as no action is taken.

- Discussion or consideration of official business would be action, triggering the requirements of the OPMA.

RCW 42.30.070

Public Attendance and Comment

A public agency can't place conditions on public to **attend** meeting subject to OPMA:

- For proceedings governed by OPMA, **cannot** require people to:
  - Register their names or other information,
  - Complete a questionnaire, or
  - Otherwise fulfill any condition precedent to attendance

Reasonable rules of conduct can be set (see upcoming slide on disruptive conduct).

Cameras and tape recorders are permitted unless disruptive

Public must have the opportunity to **comment** at or before every regular meeting at which final action is taken.

Interruptions and Disruptions

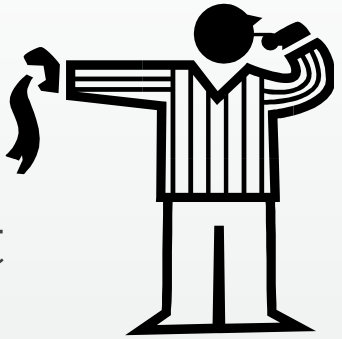
- The OPMA provides a procedure for dealing with situations where a meeting is being interrupted so the orderly conduct of the meeting is unfeasible, and order cannot be restored by removal of the disruptive persons.

- Meeting room can be cleared and meeting can continue, or meeting can be moved to another location, but final disposition can occur only on matters appearing on the agenda. More details set out in the OPMA.

RCW 42.30.050

Penalties for Violating the OPMA

- A court can impose a $500 civil penalty against each member (personal liability) who knowingly attends a meeting in violation of OPMA; and $1000 for a subsequent knowing violation.



- Court will award costs and attorney fees to a successful party seeking the remedy.
- Action taken at meeting can be declared null and void.

OPMA Training

- The "Open Government Trainings Act" requires OPMA training for every member of a governing body within 90 days of taking their oath or assuming their duties. Refresher training occurs no later than every 4 years.
- Training can be taken online, in person, or by other means.
- Training resources, videos, and more information about the Act (a "Q & A") are available on the Attorney General's Office Open Government Training Web Page: http://www.atg.wa.gov/OpenGovernmentTraining.aspx

RCW 42.30.205.

Memo

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

To: **WMC Commissioners**

From: **Amelia Boyd, Program Manager**

Subject: **Petition requesting a new rulemaking to review and revise WAC 246-919-850 through 246-919-985**

On October 22, 2026, the WMC received a petition requesting a new rulemaking to review and revise WAC 246-919-850 through 246-919-985, which address opioid prescribing for pain management.

The petition asks the WMC to simplify and clarify the rules by distinguishing legally required professional standards from clinical recommendations, best practices, and explanatory information that may be more appropriate for separate guidance.

The petition states that the current rules are complex and may contribute to confusion, administrative burden, and barriers to patient access to pain care. It also states that the requested changes are not intended to reduce patient protections or minimum professional standards.

The WMC is already in the process of updating its opioid prescribing rules and anticipates completing that rulemaking by next summer. Until the current rulemaking is complete, the WMC will not be able to open the same WAC sections identified in the petition for a separate rulemaking.

Executive Order 26-06 also establishes a six-month pause, beginning December 4, 2026, on initiating new rulemaking that imposes new or additional regulatory requirements. The executive order directs agencies to review existing regulations and identify opportunities to reduce unnecessary regulatory burdens. Although the petition describes its goals as primarily intended to simplify and reduce regulatory burdens, it does not provide enough detail to determine the specific regulatory changes that would be needed or whether the resulting rulemaking could impose new or additional requirements.

ATTACHMENT TO PETITION FOR AMENDMENT OF STATE ADMINISTRATIVE RULES

Washington Medical Commission – WAC 246-919-850 – WAC 246-919-985

2. Amend Rule – I am requesting the agency to change an existing rule

List rule number (WAC), if known: WAC 246-919-850 – WAC 246-919-985

I am requesting the following change:

Review and amend WAC 246-919-850 through WAC 246-919-985 to create a concise, clearly written regulatory framework that identifies the actions physicians and physician assistants are legally required to take when prescribing opioids.

The amended rules should retain appropriate patient-safety protections and minimum standards of professional practice. Clinical recommendations, best practices, explanatory information, and examples that are not intended to have the force of law should instead be placed in separate Washington Medical Commission guidance.

This structure would allow the Commission to maintain strong safeguards while giving physicians clearer legal requirements and greater ability to exercise appropriate clinical judgment, ultimately improving patient access to safe, appropriate, and evidence-based pain care.

This change is needed because:

The existing opioid prescribing rules have created a regulatory framework that is complex, difficult to navigate, and administratively burdensome. This cumulative regulatory burden can make it difficult for physicians to distinguish mandatory legal requirements from recommended clinical practices and, in some cases, has contributed to hesitation to prescribe opioids when clinically appropriate.

The Washington State Medical Association's 2024 multidisciplinary work group, which engaged physicians across specialties and patients, identified recurring review of the opioid prescribing rules as an important means of improving pain management and access to care. As part of its review, WSMA identified 85 occurrences of mandatory “shall” or “must” language, 20 occurrences of advisory “should” provisions, and 33 references to documentation – related terms. The cumulative effect of these requirements creates a regulatory framework that can be difficult to operationalize and may encourage defensive practice rather than individualized clinical decision-making.

This complexity can have consequences for patients. When physicians are uncertain about regulatory requirements or concerned that appropriate clinical decisions may expose them to regulatory or disciplinary consequences, patients may experience unnecessary barriers or delays in accessing appropriate pain management. Improving access to safe, appropriate, and evidence-based pain care should therefore be a central consideration in the Commission's regulatory framework.

ATTACHMENT TO PETITION FOR AMENDMENT OF STATE ADMINISTRATIVE RULES

Washington Medical Commission – WAC 246-919-850 – WAC 246-919-985

The Commission has the authority to simplify and clarify the regulatory framework while maintaining appropriate patient protections. Separating enforceable legal requirements from clinical recommendations would make regulatory expectations clearer, improve compliance, reduce uncertainty for physicians, and allow clinical recommendations to evolve with medical evidence without requiring repeated administrative rulemaking.

This approach is also consistent with the Legislature's direction. The Legislature has directed the Commission, in consultation with WSMA and other specific stakeholders, to adopt opioid prescribing rules for physicians, while providing broad authority regarding the content of those rules at RCW 18.71.800. We believe the Commission can fully satisfy its statutory responsibilities while presenting physicians with a clearer, more accessible regulatory framework that distinguishes enforceable legal requirements from clinical recommendations.

The requested amendments are not intended to deregulate opioid prescribing or reduce patient protections. Rather, they would simplify and clarify the regulatory framework while preserving core safeguards and appropriate physician clinical judgment. A regulatory framework that is clear, proportionate, and workable for physicians can better support both patient safety and timely access to appropriate pain management.

The effect of this rule change will be:

The rule change would create a clearer and more accessible regulatory framework for opioid prescribing while maintaining appropriate patient protections.

Physicians and physician assistants would be better able to identify and consistently comply with enforceable legal requirements. Separating those requirements from clinical recommendations would reduce regulatory complexity and uncertainty, improve physician confidence in appropriately treating patients with pain, and reduce unnecessary hesitation to prescribe opioids when clinically appropriate.

A separate Commission guideline would allow clinical recommendations and best practices to be updated more efficiently as medical evidence and standards of care evolve, without requiring repeated amendments to administrative rules.

For patients, the intended effect would be improved access to safe, appropriate, and evidence-based pain management. By reducing regulatory complexity and distinguishing legal requirements from clinical recommendations, the amended rules would help minimize unnecessary barriers, delays, and disruptions in care while preserving appropriate safeguards against unsafe prescribing.

The rule is not clearly or simply stated:

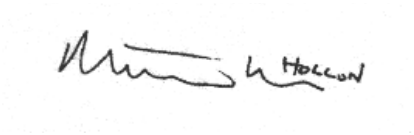
ATTACHMENT TO PETITION FOR AMENDMENT OF STATE ADMINISTRATIVE RULES

Washington Medical Commission – WAC 246-919-850 – WAC 246-919-985

The current regulatory framework does not clearly distinguish enforceable legal requirements from clinical recommendations and best practices. The resulting complexity requires physicians to navigate numerous provisions and exceptions to determine their legal obligations. A more concise rule, paired with separate clinical guidance, would make the Commission's requirements substantially clearer and simpler.

The goal of a regulatory framework governing opioid prescribing that balances improving patient access to appropriate pain management while maintaining critical safeguards could be established through legislation. However, we believe that a rulemaking approach led by the Commission would provide a venue for more thoughtful and deliberate consideration of this complex and important topic. We implore the Commission to initiate a new rulemaking through which we can work toward what we believe are shared goals.

The undersigned physician leaders and medical associations support this petition:



Matthew Hollon, MD, MPH, MACP
President
Washington State Medical Association

Timothy H. Dellit, M.D.
CEO, UW Medicine
Executive Vice President for Medical Affairs
Paul G. Ramsey Endowed Dean of the School of Medicine
University of Washington

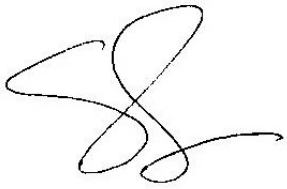
Nathan Schlicher, MD, JD, MBA
Chief Clinical Officer
Better Prescribing Better Treatment

David J. Tauben, MD, FACP
Clinical Professor Emeritus
Medicine and Anesthesia & Pain Medicine
University of Washington

Victoria Fang, MD
Medical Director
UW Medicine Primary Care

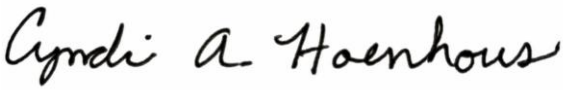
Chelene Whiteaker
Senior Vice President, Government Affairs
Washington State Hospital Association

ATTACHMENT TO PETITION FOR AMENDMENT OF STATE ADMINISTRATIVE RULES
Washington Medical Commission – WAC 246-919-850 – WAC 246-919-985



Steven Stanos, DO
Medical Director, Swedish Pain Services
Medical Director, Swedish Health System
Pain Medicine and Services

Rose Bigham
Co-Chair
Washington Patients in Intractable Pain



Cyndi A. Hoenhous
Co-Chair
Washington Patients in Intractable Pain

Supportive state medical societies:

- Washington Academy of Family Physicians
- American Academy of Emergency Physicians, Washington Chapter
- Washington Academy of Eye Physicians and Surgeons
- Washington State Psychiatry Association
- Washington State Medical Oncology Society

2027 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

January

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

1	New Years Day	Holiday – Offices Closed	
7	Policy Committee	4 pm	Virtual
14	Personal Appearances	8:30 am	Virtual
14	Case Disposition	10:45 am	Virtual
15	Committees/Workgroups	8:30 am	Virtual
15	Business	9:30 am	Virtual
15	Lunch & Learn	Noon	Virtual
18	Martin Luther King Day	Holiday – Offices Closed	
28	Policy: Interested Parties	10 am	Virtual

February

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

15	President's Day	Holiday – Offices Closed	
25	Policy Committee	4 pm	Virtual

March

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

11	Personal Appearances	8:30 am	Hybrid Capital Events Center Tumwater
11	Case Disposition	10:45 am	
12	Committees/Workgroups	8:30 am	
12	Business	9:30 am	
12	Lunch & Learn	Noon	
25	Policy: Interested Parties	10 am	Virtual

Approved: August 21, 2026

2027 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

April

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

13-17	FSMB Annual Meeting	Oklahoma City, OK	
22	Policy Committee	4 pm	Virtual

May

S	M	T	W	T	F	S
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9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

20	Personal Appearances	8:30 am	Hybrid Davenport Grand Spokane
20	Case Disposition	10:45 am	
21	Committees/Workgroups	8:30 am	
21	Business	9:30 am	
21	Lunch & Learn	Noon	
31	Memorial Day	Holiday – Offices Closed	

June

S	M	T	W	T	F	S
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6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

11	SMART Training	8:30 am	In person DOH Tumwater
18	Juneteenth (observed)	Holiday – Offices Closed	
24	Policy: Interested Parties	10 am	Virtual

July

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

5	Independence Day (observed)	Holiday – Offices Closed	
15	Personal Appearances	8:30 am	Hybrid DOH Tumwater
15	Case Disposition	10:45 am	
22	Policy Committee	4 pm	Virtual
29	Commissioner Retreat	8:30 am	In Person – TBD

2027 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

August

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
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22	23	24	25	26	27	28
29	30	31				

26	Personal Appearances	8:30 am	Hybrid DOH Tumwater
26	Case Disposition	10:45 am	
27	Committees/Workgroups	8:30 am	
27	Business	9:30 am	
27	Lunch & Learn	Noon	

September

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12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

6	Labor Day	Holiday – Offices Closed	
23	Policy: Interested Parties	10 am	Virtual

October

S	M	T	W	T	F	S
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24	25	26	27	28	29	30
31						

7	Personal Appearances	8:30 am	Hybrid Location: TBD
7	Case Disposition	10:45 am	
28	Policy Committee	4 pm	Virtual

November

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
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21	22	23	24	25	26	27
28	29	30				

11	Veterans Day	Holiday – Offices Closed	
18	Personal Appearances	8:30 am	Virtual
18	Case Disposition	10:30 am	
19	Committees/Workgroups	8:30 am	
19	Business	9:30 am	
19	Lunch & Learn	Noon	
25	Thanksgiving Day	Holiday – Offices Closed	
26	Native American Heritage Day	Holiday – Offices Closed	

2027 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

December

S	M	T	W	T	F	S
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12	13	14	15	16	17	18
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2	Policy: Interested Parties	10 am	Virtual
24	Christmas (observed)	Holiday – Offices Closed	
31	New Year's Day (observed)	Holiday – Offices Closed	

Association Meetings

Association	Date(s)	Location
Washington Academy of Physician Assistants (WAPA) & Oregon Society of Physician Associates (OSPA) Joint Spring Conference	March 14-16	Seaside, OR
Washington State Medical Association (WSMA) Annual Meeting	September 25-26	Bellevue, WA
WAPA Fall Conference	September 30-October 3	TBA

Other Meetings

Entity	Date(s)	Location
Council on Licensure, Enforcement and Regulation (CLEAR) Winter Symposium	January 6	New Orleans, LA
Federation of State Medical Boards (FSMB) Annual Conference	April 15-17	Oklahoma City, OK
Interstate Medical Licensure Compact Commission (IMLCC) Mid-Year Meeting	May 18	Virtual
FSMB International Conference	TBA	TBA
CLEAR Annual Conference	September 20-23	Vancouver, BC
FSMB Board Attorneys Workshop	TBA	TBA
IMLCC Annual Meeting	November 15-16	Wyoming

2028 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

January

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

6	Policy Committee	4 pm	Virtual
13	Personal Appearances	8:30 am	Virtual
13	Case Disposition	10:45 am	Virtual
14	Committees/Workgroups	8:30 am	Virtual
14	Business	9:30 am	Virtual
17	Martin Luther King Day	Holiday – Offices Closed	
27	Policy: Interested Parties	10 am	Virtual

February

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		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29				

21	President's Day	Holiday – Offices Closed	
25	Policy Committee	4 pm	Virtual

March

S	M	T	W	T	F	S
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12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

9	Personal Appearances	8:30 am	Hybrid Location: TBD
9	Case Disposition	10:45 am	
10	Committees/Workgroups	8:30 am	
10	Business	9:30 am	
23	Policy: Interested Parties	10 am	Virtual

April

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20	Policy Committee	4 pm	Virtual
26-29	FSMB Annual Meeting	Las Vegas, NV	

Proposed: November 20, 2026

2028 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

May

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
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21	22	23	24	25	26	27
28	29	30	31			

18	Personal Appearances	8:30 am	Hybrid Location: TBD
18	Case Disposition	10:45 am	
19	Committees/Workgroups	8:30 am	
19	Business	9:30 am	
29	Memorial Day	Holiday – Offices Closed	

June

S	M	T	W	T	F	S
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11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

9	SMART Training	8:30 am	In person Location: TBD
19	Juneteenth (observed)	Holiday – Offices Closed	
22	Policy: Interested Parties	10 am	Virtual

July

S	M	T	W	T	F	S
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23	24	25	26	27	28	29
30	31					

4	Independence Day	Holiday – Offices Closed	
13	Personal Appearances	8:30 am	Hybrid Location: TBD
13	Case Disposition	10:45 am	
20	Policy Committee	4 pm	Virtual
28	Commissioner Retreat	8:30 am	In Person – TBD

August

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

24	Personal Appearances	8:30 am	Hybrid Location: TBD
24	Case Disposition	10:45 am	
25	Committees/Workgroups	8:30 am	
25	Business	9:30 am	

2028 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

September

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

4	Labor Day	Holiday – Offices Closed	
21	Policy: Interested Parties	10 am	Virtual

October

S	M	T	W	T	F	S
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15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

12	Personal Appearances	8:30 am	Hybrid Location: TBD
12	Case Disposition	10:45 am	
26	Policy Committee	4 pm	Virtual

November

S	M	T	W	T	F	S
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5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

10	Veterans Day (observed)	Holiday – Offices Closed	
16	Personal Appearances	8:30 am	Virtual
16	Case Disposition	10:30 am	
17	Committees/Workgroups	8:30 am	
17	Business	9:30 am	
23	Thanksgiving Day	Holiday – Offices Closed	
24	Native American Heritage Day	Holiday – Offices Closed	

2028 Meeting Schedule

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

December

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

7	Policy: Interested Parties	10 am	Virtual
25	Christmas	Holiday – Offices Closed	

Association Meetings

Association	Date(s)	Location
Washington Academy of Physician Assistants (WAPA) & Oregon Society of Physician Associates (OSPA) Joint Spring Conference	TBA	TBA
Washington State Medical Association (WSMA) Annual Meeting	TBA	TBA
WAPA Fall Conference	TBA	TBA

Other Meetings

Entity	Date(s)	Location
Council on Licensure, Enforcement and Regulation (CLEAR) Winter Symposium	TBA	TBA
Federation of State Medical Boards (FSMB) Annual Conference	TBA	TBA
FSMB International Conference	TBA	TBA
CLEAR Annual Conference	TBA	TBA
FSMB Board Attorneys Workshop	TBA	TBA

Committee/Workgroup Reports
November 20, 2026

High Reliability Organizations Workgroup – Chair: Dr. Chung Staff: Mike Farrell
Nothing to report.

Healthcare Disparities Workgroup – Chair: Dr. Currie Staff: Kyle Karinen
Nothing to report.

IV Hydration Treatment Workgroup – Chair: Dr. Murphy Staff: Mike Farrell/Jimi Bush
Nothing to report.

Finance Workgroup – Chair: Dr. Murphy Staff: Kyle Karinen
Nothing to report.

Psychedelics in Behavioral Health Treatment Workgroup – Chair: Dr. Domino Staff: Kyle Karinen
Adriann Jones, the Commissions new policy manager, has graciously agreed to join the workgroup and spearhead the completion of the ketamine treatment in behavior health guidance document. She reviewed the work to date, researched current studies, and summarized the available data. Her skills and enthusiasm have provided a much-needed boost to this workgroup.

Committees & Workgroups

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

Executive Committee
Chair: Dr. Murphy
Vice Chair: Ed Lopez, PA-C
Officer-at-Large: Dr. Mvundura
Policy Chair: Chris Blake, PM
Immediate Past Chair: Dr. Domino
Kyle Karinen
Micah Matthews
Heather Carter, AAG

Policy Committee
Chris Blake, PM, Chair (B)
Dr. Domino (B)
Ed Lopez, PA-C (B)
Dr. Lyle (A)
Scott Rodgers, PM (A)
Heather Carter, AAG
Adriann Jones
Fatima Mirza
Kyle Karinen
Micah Matthews
Amelia Boyd

Newsletter Editorial Board
Dr. Chung
Dr. Wohns, Pro Tem Commissioner
Jimi Bush, Managing Editor
Micah Matthews

Legislative Subcommittee
Chris Blake, PM
Dr. Jaeger
Dr. D'Souza
Dr. Chang
Scott Rodgers
Micah Matthews
Stephanie Mason

Finance Workgroup
Dr. Murphy, WMC Chair, Workgroup Chair
Mr. Lopez, WMC Vice Chair
Kyle Karinen
Micah Matthews
Jimi Bush

Health Equity Advisory Committee
Dr. Jaeger
Chris Blake, PM
Douglas Pullen, PM
Kyle Karinen
Mahi Zeru

Panel L
Dr. Chung, Pro Tem Commissioner, Chair
Chris Blake, PM
Arlene Dorrough, PA-C
Dr. Lyle
Dr. Wohns, Pro Tem Commissioner
Marisa Courtney, Licensing Manager
Micah Matthews

High Reliability Workgroup
Dr. Chung, Pro Tem Commissioner, Chair
Dr. Domino
Chris Blake, PM
Dr. Jaeger
Scott Rodgers, PM
Dr. Chang
Ed Lopez, PA-C
Dr. Lyle
Kyle Karinen
Micah Matthews
Mike Farrell
Jimi Bush
Amelia Boyd

Updated: November 17, 2026

Committees & Workgroups

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

IV Hydration Treatment Workgroup
Dr. Murphy, Workgroup Chair
Dr. Jaeger
Kyle Karinen
Freda Pace
Dr. Fino
Mike Farrell
Jimi Bush

Psychedelics in Behavioral Health Treatment Workgroup
Dr. Domino, Workgroup Chair
Kyle Karinen
Rick Glein
Dr. Fino
Mike Farrell
Jimi Bush
Marne Nelson
Adriann Jones
Ex Officio Member: Dr. Chris Bundy, WPHP

CDTA Workgroup
Dr. Chung, Pro Tem Commissioner
Dr. Lyle
Ed Lopez. PA-C
Kyle Karinen
Micah Matthews
Dr. Fino
Amelia Boyd

Chapter 246-919 WAC – MDs Rules
Dr. Domino, Presiding Officer
Dr. Chang
Chris Blake, PM
Kyle Karinen
Micah Matthews
Marisa Courtney, Licensing Manager
Amelia Boyd
Heather Carter, AAG
Marlon Basco-Rodillas, DOH Policy Analyst

Opioid Prescribing General Provisions for MDs and PAs Rules
Dr. Domino, Presiding Officer
Ed Lopez, PA-C
Dr. Chang
Chris Blake, PM
Kyle Karinen
Micah Matthews
Amelia Boyd
Heather Carter, AAG
Marlon Basco-Rodillas, DOH Policy Analyst

WAC 246-921-125 CAA CME Rules
Dr. Domino, Presiding Officer
Dr. Khan
Dr. Lee
Ed Lopez, PA-C
Kyle Karinen
Micah Matthews
Marisa Courtney
Amelia Boyd
Heather Carter, AAG
Marlon Basco-Rodillas, DOH Policy Analyst

SB 5185 – IMG Pilot Project Rules
Chris Blake, PM, Presiding Officer
Dr. AlSoufi
Michael Bailey, PM
Dr. Chang
Dr. Khan
Dr. Mvundura
Kyle Karinen
Micah Matthews
Marisa Courtney
Amelia Boyd
Heather Carter, AAG
Marlon Basco-Rodillas, DOH Policy Analyst

Any committee or workgroup engaging with interested parties or gathering public input must conduct open public meetings.

PM = Public Member

WPHP = Washington Physicians Health Program

Updated: November 17, 2026

WMC Rules Progress Report						CR Doc Filing Status			
Rule	**Status**	**Date**	**Next step**	**Complete By**	**Notes**	**CR-101**	**CR-102**	**CR-103**	**CR-105**
Opioid prescribing--General Provisions for MDs and PAs	CR-101 filed	4/30/2025	Workshops are in progress	January 2027	Keep BoMS updated.	Complete	TBD	TBD	NA
chapter 246-919 WAC MD Physicians WAC 246-919-010 through WAC 246-919-520 WAC 246-919-602 through WAC 246-919-700	CR-101 filed	5/22/2025	Workshops are in progress	11/30/2026		Complete	TBD	TBD	NA
WAC 246-921-125 AA CME	Request to initiate CR-102	11/20/2026	File CR-102	ON HOLD	EO 26-06	Complete	TBD	TBD	NA
SB 5185 - IMG Pilot Project	CR-102 approved	8/21/2026	File CR-102	November 2026		Complete	TBD	TBD	NA
chapter 246-918 PAs WAC 246-918-005 through WAC 246-918-420	CR-101 approved	8/21/2026	File CR-101	ON HOLD	EO 26-06	TBD	TBD	TBD	NA
MD & PA fees (WAC 246-919-990 & 246-918-990)	CR-101 filed	7/30/2026	Workshop	11/20/2026	DOH-led process	Complete	TBD	TBD	NA

Possible upcoming rulemaking
Suicide prevention training sections in CAA - once MD rules have been finalized
Sexual misconduct section in CAA rules - once MD rules have been finalized.

Executive Order: EO 26-06

Updated: 11/13/2026

STATE OF WASHINGTON
OFFICE OF GOVERNOR BOB FERGUSON

EXECUTIVE ORDER 26-06

IMPROVING GOVERNMENT EFFICIENCY THROUGH REGULATORY REFORM

WHEREAS, Washington state is committed to protecting the health, safety, welfare, and quality of life of its residents while fostering a strong economy, creating jobs, and ensuring that government operates effectively and efficiently; and

WHEREAS, state regulations play an essential role in protecting the public, workers, consumers, and the environment, but must be regularly reviewed to ensure they remain necessary, effective, and appropriate; and

WHEREAS, outdated, duplicative, overly complex, and unnecessary regulations can increase costs for businesses and residents, delay important projects, discourage investment, and create barriers to economic opportunity; and

WHEREAS, advances in technology and changes in business practices create opportunities to modernize regulatory requirements, reduce paperwork, streamline permitting and licensing, and improve government services; and

WHEREAS, a coordinated statewide review of existing rules and statutes can identify opportunities to reduce unnecessary burdens, improve regulatory predictability, and strengthen Washington's economic competitiveness;

NOW, THEREFORE, I, Bob Ferguson, Governor of the state of Washington, by the power vested in me by the Constitution and the statutes of the state of Washington, do hereby order and direct the following:

Scope and purpose

This Order applies to all cabinet agencies and other executive agencies that report to the Governor, referred to in this Order as agencies. Other state entities with regulatory authority are encouraged to undertake similar reviews. The purpose of this initiative is to reduce unnecessary regulatory burdens and improve government services while preserving protections for public health, safety, workers, consumers, and the environment.

Agency review and reporting

The Governor's Office for Regulatory Innovation and Assistance (ORIA), in coordination with the Governor's Office and the Office of Financial Management (OFM), shall lead this initiative. Within sixty days of the effective date of this Order, ORIA shall issue implementation guidance to agencies, including a standardized reporting template.

Within sixty days of the effective date of this Order, each agency head shall designate an executive lead responsible for the agency's implementation of this Order. Each agency shall undertake a process to review its existing rules and statutes. The purpose of this review is to identify opportunities to:

a. Eliminate outdated, duplicative, or unnecessary requirements;

b. Simplify rules and statutes to improve clarity, consistency, and ease of compliance;

c. Reduce administrative burdens on businesses, individuals, nonprofit organizations, and local governments;

d. Streamline permitting, licensing, and other approval processes, including reducing unnecessary procedural steps;

e. Modernize administrative requirements and improve coordination across agencies to reduce duplication and inconsistent requirements; and

f. Identify statutory changes that would reduce unnecessary regulatory burdens or enable more efficient government operations.

Agencies may prioritize their reviews based on opportunities for meaningful regulatory improvements and build upon existing regulatory review initiatives and processes. Agencies are not expected to complete a comprehensive review of all existing rules and statutes before submitting their initial report.

This initiative is complementary to Executive Order 25-03 on permitting and licensing efficiency and Executive Order 25-06 on improving customer experience. Agencies may leverage existing work and reporting under these executive orders, where appropriate, to satisfy the requirements of this Order.

Within eight months of the effective date of this Order, each agency shall submit an initial report to ORIA, OFM, and the Governor's Office. This initial report shall provide a status update on its efforts, including any barriers to its work, and identify specific regulatory

reforms the agency recommends pursuing, including:

a. Administrative rules the agency recommends amending, repealing, or consolidating; and

b. Recommended statutory changes, including potential agency request legislation for future legislative sessions.

Within sixty days after the agency reports are due, ORIA shall submit consolidated recommendations to the Governor's Office, including opportunities for cross-agency reforms. Agencies shall submit subsequent reports to ORIA annually, beginning July 1, 2028, documenting progress in implementing regulatory reforms and identifying new opportunities. Within sixty days after the annual agency reports are due, ORIA shall submit an annual consolidated report to the Governor's Office summarizing agency progress and recommending additional regulatory reforms.

Rulemaking pause

For six months beginning 30 days after the effective date of this Order, agencies shall not initiate new rulemaking that would impose new or additional regulatory requirements on businesses, individuals, or other regulated entities, except when necessary to:

a. Comply with state or federal law, court orders, or other binding legal requirements;

b. Respond to imminent threats to public health, safety, or the environment, including emergency response;

c. Maintain federal funding; or

d. Address other circumstances approved by the Governor’s Office in consultation with ORIA.

For purposes of this section, “initiate” means filing the first notice under chapter 34.05 RCW to commence a new rulemaking proceeding. ORIA will publish additional guidance for agencies on compliance with the rulemaking pause. This restriction does not apply to rulemaking proceedings initiated before the beginning of the six-month period.

This Order shall be implemented consistent with applicable law. Provisions of this Order are not intended to alter any existing collective bargaining agreements. This Order is not intended to confer and does not confer any legal right or entitlement and shall not be used as a basis for legal challenges to any rule or any other action or inaction of the governmental entities and employees subject to it.

This Order takes effect immediately.

Signed and sealed with the official seal of the state of Washington on this 4th day of November, AD, Two Thousand and Twenty-Six, at Redmond, Washington.

By:

/s/
Bob Ferguson
Governor

BY THE GOVERNOR:

/s/
Secretary of State

Joint Guidance for Retail Intravenous Therapy Clinics

WASHINGTON MEDICAL COMMISSION
WASHINGTON BOARD OF OSTEOPATHIC MEDICINE AND SURGERY
WASHINGTON STATE BOARD OF NURSING
WASHINGTON STATE PHARMACY QUALITY ASSURANCE COMMISSION

Purpose

The Washington State Department of Health has received reports that intravenous (IV) therapy clinics in our state are operating in contravention of Washington law and established standards of care and creating a risk of harm to the residents of the state of Washington. The Washington Medical Commission, the Board of Osteopathic Medicine and Surgery, the Washington State Board of Nursing, and the Washington State Pharmacy Quality Assurance Commission, issue this Joint Guidance to advise practitioners on the requirements for the safe and legal operation of IV therapy clinics in the state of Washington.

This guidance is based upon the existing laws and regulations of Washington and sets forth the relevant scopes of practice and standards of care implicated by retail IV therapy businesses.[1] We offer no opinion or evaluation concerning the efficacy of IV therapy offered by retail IV therapy businesses. As with all matters concerning the regulation of medical, nursing and pharmacy practice, we encourage and expect every licensee to practice within the applicable standard of care, the legal scope of practice, and with reasonable skill and safety for patients.

For the purpose of this document, the term "practitioner" refers to allopathic physicians, osteopathic physicians, physician assistants, advanced practice registered nurses, and pharmacists operating under a collaborative drug therapy agreement. These licensees have the legal authority to prescribe IV therapy.

Legal Requirements and Best Practices

All practitioners should be aware of the legal requirements and best practices when offering IV therapy to patients in Washington, as follows:

1. The services provided in an IV therapy clinic—the diagnosis of the patient's condition and the recommendation of IV therapy--constitute the practice of medicine.[2]

[1] We acknowledge and appreciate the work done by other boards who have issued statements on this topic, in particular the West Virginia Boards of Medicine, Osteopathic Medicine, Pharmacy, and Registered Nurses; the Alabama Board of Medical Examiners; the South Carolina State Boards of Medical Examiners, Pharmacy, and Nursing; and the Mississippi State Board of Medical Licensure.

[2] Under RCW 18.71.011, one engages in the practice of medicine when one "offers or undertakes to diagnose, cure, advise, or prescribe for any human disease…or other condition"…or "administers or prescribes drugs or medicinal preparations…" Likewise, under RCW 18.57.001(4) defines "osteopathic medicine and surgery" as "the use of any and all methods in the treatment of disease…and all other physical and mental conditions." Advanced practice registered nurses may diagnose patients and recommend IV therapy. See RCW 18.79.050.

2. IV therapy requires the insertion of a needle into a patient's vein for the intravenous administration of fluid into a patient's bloodstream, monitoring the patient during and at the conclusion of treatment, and removal of the IV catheter thereafter. This is a medical procedure that requires supervision by appropriately licensed health professionals.

3. A person who receives IV therapy is a patient, and an appropriate health care record for the patient must be created and maintained. The record should be available to the patient and other treating practitioners and should be maintained in a manner that fully complies with the health care record retention and confidentiality requirements of Washington law[3] and the HIPAA Privacy and Security Rules.[4]

4. To provide IV therapy, a practitioner must first establish a practitioner-patient relationship with the patient. A practitioner-patient relationship is formed when the practitioner agrees to advise, diagnose, or treat a patient and the patient agrees that the practitioner will advise, diagnose or treat the patient.[5] A practitioner-patient relationship may be established via telehealth, but not established through email, instant messaging, text messaging, or fax. Practitioners should be aware that the standard of care for telehealth care is the same as for in-person care.[6]

5. Practitioners may assess patients for IV therapy.[7] The practitioner assessment requires the practitioner to personally evaluate the patient, take an appropriate history, diagnose the patient, and make treatment recommendations. IV therapy may not be appropriate for certain age groups, including children and the elderly.

6. A practitioner should obtain and document informed consent in the medical record prior to the delivery of care.[8]

7. IV saline and any after-market additives are drugs that require a prescription or order to administer. IV therapy cannot be administered without a valid prescription or order.

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[3] Chapter 70.02 RCW. See also Washington Medical Commission Guidance Document: "Medical Records: Documentation, Access, Retention, Storage, Disposal, and Closing a Practice." GUI2024-02. Adopted April 26, 2024.

[4] See HIPAA Privacy Rule; HIPAA Security Rule.

[5] See Washington Medical Commission Policy Statement: Terminating the Practitioner-Patient Relationship, POL2022-03, adopted March 4, 2022.

[6] The newly enacted Uniform Telehealth Act provides, in part: "A health care practitioner may provide telehealth services to a patient located in this state if the services are consistent with the health care practitioner's scope of practice in this state, applicable professional practice standards in this state, and requirements and limitations of federal law and law of this state….A practitioner-patient relationship may be established through telehealth. A practitioner-patient relationship may not be established through email, instant messaging, text messaging, or fax. RCW 18.134.030. In addition, certain professions are required to take telemedicine training. See the Washington Department of Health website on telemedicine for additional information and resources.

[7] Physician assistants may assess patients for IV therapy if it is within their education, training, and experience, and is consistent with their collaboration agreement. RCW 18.71.A.030, WAC 246-918. Nurse practitioners may assess patients for IV therapy if they are practicing within their education, training, and experience. RCW 18.79.050, WAC 246-840-300.

[8] Washington Medical Commission Guidance Document: Informed Consent and Shared Decision-Making, GUI2022-01, adopted May 27, 2022.

8. Practitioners should only order IV therapy if they, as the assessing practitioner, determine it would be beneficial to the patient. The prescription or order must be part of a medically prescribed plan of care that includes a personal examination and a bona fide practitioner-patient relationship.
9. Practitioners should not issue "standing orders" for a retail IV therapy business, or its employees, to provide IV therapy to patients. A standing order does not create an independent practitioner-patient relationship between individual persons and the practitioner or the IV therapy business. IV therapy should not be administered based upon a standing order.[9]
10. The administering of IV therapy requires a professional license. A licensed person other than the physician (MD or DO), physician assistant, or nurse practitioner may administer IV therapy only if the administration of IVs is within that practitioner's scope of practice.
11. Registered nurses and licensed practical nurses may participate as part of the care team at an IV therapy clinic.[10]
12. Registered nurses and licensed practical nurses may insert and remove IV catheters and monitor patients before, during and after IV therapy is administered. The on-site presence of a physician, physician assistant, or nurse practitioner is not required for a nurse to administer the prescribed or ordered IV therapy; however, the nurse must have the knowledge, skill, and competency necessary to carry out the administration procedures and monitor the patient in a safe manner. The nurse should perform a nursing evaluation and monitor the patient for such things as side effects, toxic effects, allergic reactions, unusual and unexpected effects, changes in a patient's condition that contraindicate continued administration of the pharmaceutical or treatment regimen, and effects that may rapidly endanger a client's life or well-being. A nurse should be prepared to make judgments and decisions concerning actions to take in the event such effects occur and should document all nursing acts performed by the nurse in carrying out the IV administration and noted during the monitoring of the patient during administration.
13. Registered nurses and licensed practical nurses may not:
    a. Prescribe or order IV therapy.
    b. Independently recommend or approve the patient's "selection" of a specific IV therapy cocktail.
    c. Administer IV therapy without a valid prescription order for a prescribing practitioner who has established a practitioner-patient relationship with the patient and determined that a specific IV therapy would be beneficial to the patient.[11]

[9] See Washington State Board of Nursing Advisory Opinion NCAO 28.00: Standing Orders, adopted November 12, 2021.
[10] See Washington State Board of Nursing Advisory Opinion, *Infusion Therapy Management,* NCAO 24.00, adopted September 11, 2020.
[11] Id.

14. The term "compounding" means "the act of combining two or more ingredients in the preparation of a prescription."[12] The FDA has cautioned that patients can be significantly harmed when drugs are compounded in a way that does not assure sterility and quality.[13]

15. IV therapy cocktails are compounded drugs. Adding vitamins, minerals, or prescription drugs to a bag of saline solution is compounding.

16. Drug compounding must follow specific safety and sterility guidelines, and may only be undertaken by licensed pharmacists and, in certain circumstances, legally qualified practitioners of medicine.[14]

17. Practitioners who order IV therapy and who do not receive compounded end-use cocktails from a licensed pharmacy may only compound IV therapy cocktails if they have the education, training, and experience to ensure the safety and sterility of the final product. Pharmacies compound IV therapy cocktails following the receipt of valid patient-specific orders or prescriptions written by licensed prescribers.

18. Properly trained nurses may compound medication only for a specific patient and under the direction of an authorized health care practitioner with prescriptive authority.[15]

19. Practitioners should consider having an annual review by a pharmacist to ensure compliance with regulations and adherence to best practices.

20. Certain practitioners may themselves compound the IV therapy cocktails they have ordered or prescribed. Practitioners may also prescribe the IV therapy cocktails for licensed pharmacy personnel, operating within their scope of practice, to compound.~~These practitioners may also delegate compounding to licensed pharmacists under their supervision. However, they should~~ Practitioners may not delegate compounding responsibilities to professionals who are not authorized or legally permitted to compound.

21. Treatment provided to a patient pursuant to a practitioner's order for IV therapy falls within the supervision and professional responsibility of the ordering practitioner. A physician who serves as a medical director for an IV therapy clinic is responsible for supervising all personnel in the clinic and is ultimately responsible for the safety of patients.[16]

[12] RCW 18.64.011(6). The FDA website states "Compounding is generally a practice in which a licensed physician or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist, combines, mixes or alters ingredients of a drug to create a medication tailored to the needs of an individual patient.

[13] FDA reminds compounders to use ingredients suitable for sterile compounding.

[14] RCW 18.64.270; WAC 246-945-100. All practitioners who compound must comply with the standards set forth in the United States Pharmacopeia-National Formulary See Compounding and the FDA: Questions and Answers; Federation of State Medical Boards White Paper on Compounding of Medications by Physicians.

[15] See Washington State Board of Nursing Advisory Opinion, *Registered Nurse and Licensed Practical Nurse: Compounding and Reconstituting Medications,* NCAO 11.01, adopted November 12, 2021.

[16] Washington Medical Commission Guidance Document: Medical Directors: Roles, Duties, and Responsibilities, GUI2020-02, adopted August 21, 2020.

For questions concerning any of the guidelines set forth herein, please contact the appropriate licensing board for additional information.

DRAFT

Washington State Department of Health
Health Professions Quality Assurance

Application for Approval to Receive Lists

This is an application for approval to receive lists, not a request for lists. You may request lists after you are approved. Approval can take up to three months.

RCW 42.56.070(8) limits access to lists. Lists of credential holders may be released only to professional associations and educational organizations approved by the disciplining authority.

- A "professional association" is a group of individuals or entities organized to:
  - Represent the interests of a profession or professions;
  - Develop criteria or standards for competent practice; or
  - Advance causes seen as important to its members that will improve quality of care rendered to the public.
- An "educational organization" is an accredited or approved institution or entity which either
  - Prepares professionals for initial licensure in a health care field or
  - Provides continuing education for health care professionals.

☐ We are a "professional association" x☐ We are an "educational organization."

Melissa Neigbhors	509-431-0718	russocme@gmail.com
Primary Contact Name ⮥	Phone ⮥	Email ⮥

Eliza McNelly - russocme2@gmail.com	Russocme.com
Additional Contact Names (Lists are only sent to approved individuals) ⮥	Website URL ⮥

RussoCME	30-0598736
Professional Assoc. or Educational Organization ⮥	Federal Tax ID or Uniform Business ID number ⮥

935 SE High St	Pullman, WA 99163
Street Address ⮥	City, State, Zip Code ⮥

Mail Continuing Medical Education brochure to regional providers

1. How will the lists be used? ⮥

MD, DO, PA, ARNP, RN, CRNA, LPN, PT, PTA, PH, NT, CH, EMS, PY

2. What profession(s) are you seeking approval for? ⮥

Please attach information that demonstrates that you are a "professional association" or an "educational organization" and a sample of your proposed mailing materials.
Attach completed application to your recent list request using the public portal:
https://www.doh.wa.gov/aboutus/publicrecords

Alternate options: Email to: PDRC@DOH.WA.Gov Mail to: PDRC - PO Box 47865 - Olympia WA 98504-7865

Melissa Neighbors	11-16-2026
Signature ⮥	Date ⮥

If you have questions, please call (360) 236-4836.

For Official Use Only

Approved: _____ (5-year) _____ (one-time)
Denied: _____

Authorizing Signature: _____
Printed Name: _____
Title: _____ Date: _____

Venue

In person in Spokane, live streamed on Zoom and or accredited recording available

November 20 & 21, 2026

Spokane Valley Event Center
10514 E Sprague Ave
Spokane Valley, WA 99206

Questions:

Eliza McNelly | 509-592-5506 | info@russocme.com
Melissa Neighbors | 509-431-0718 | russocme@gmail.com

Accommadation

Comfort Inn and Suites - $99 per night call 509.926.7432

Accreditation

ABIM CME MOC ACCREDITED

- *14 AMA PRA Category 1 Credits*™
- 14 MOC points for the ABIM MOC Program
- Application for prescribed credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.
- Approved for a total of 3 NP Pharmacology hours. (Fri. - 2 Sat. - 1)
- Washington State accepts AMA PRA Category 1 Credits for NP's & PA's
- 14 equivalent CE credits for ANCC recertification
- 14 CE contact hours for the Washington State Board of Nursing.
- Recorded Conference - 14 AMA Category 1 Credits

RussoCME.com

Faculty Speakers

David Bragin-Sanchez, MD
Board Cert. - Adv. Heart Failure, Cardiovascular Disease
Multicare Pulse Heart Institute
Spokane, WA

Anna Gardella, MD
Board Cert. - Cardiology, Interventional Cardiology
Multicare Pulse Heart Institute
Spokane, WA

Zachary Gilbert, MD
Multicare Pulse Heart Institute
Spokane, WA

Maeve Jones-O'Connor, MD
Board Cert. - Interventional Cardiology
Multicare Pulse Heart Institute
Spokane, WA

Cooper Kersey, MD
Board Cert.- Echocardiography
UW Medicine
Seattle, WA

Matthew Low, MD
Board Cert.- Vascular Surgery
Kootenai Health
Coeur d'Alene, ID

Jonathan Medina-Beckwith, DNP
Virginia Mason Franciscan Health
Seattle, WA

Pablo Michel-Sanchez, MD
Board Cert. – Cardiology
Kootenai Health
Coeur d'Alene, ID

James Mudd, MD
Board Cert. - Adv. Heart Failure and Transplant Cardiology
Providence Heart Institute
Spokane, WA

Gautam Nayak, MD
Board Cert. - Cardiovascular Disease
Lake Chelan Health
Lake Chelan, WA

David S. Owens, MD
Board Cert. - Cardiovascular Disease
UW Medicine
Seattle, WA

Matthew Subramani, MD
Board Cert.- Cardiovascular Medicine
Virginia Mason Franciscan Health
Seattle, WA

Eric Wallace, DO
Board Cert.- Cardiovascular Disease
Kootenai Health
Coeur d'Alene, ID

Mrinal Yadava, MD
Board Cert.- Echocardiography
UW Medicine
Seattle, WA

* This live activity has been planned and implemented in accordance with the accreditation requirements and policies of the Colorado State Medical Society through the joint providership of Gritman Medical Center and RussoCME. Gritman Medical Center is accredited by the Colorado State Medical Society to provide continuing medical education for physicians. This educational activity is designated for a maximum of 14 hours of AMA PRA Category 1 Credit(s).

Upcoming Conferences

Olympic Peninsula Medical Conference - Nov. 6 & 7
NW Primary Care Medical Conference - Dec. 4 & 5
Wenatchee Medical Conference - Jan. 29 & 30, 2027
Yakima Valley Medical Conference - Mar. 19 & 20, 2027

Registration - RussoCME.com

Cancellations: All cancellations need to be emailed to Eliza at info@russocme.com on or before November 15th. There will be a $50 administration fee withheld. Cancellations after Nov. 16 you can send someone in your place or switch to view as a recording.

Non Profit Org
US Postage Paid
Spokane, WA
Permit 28

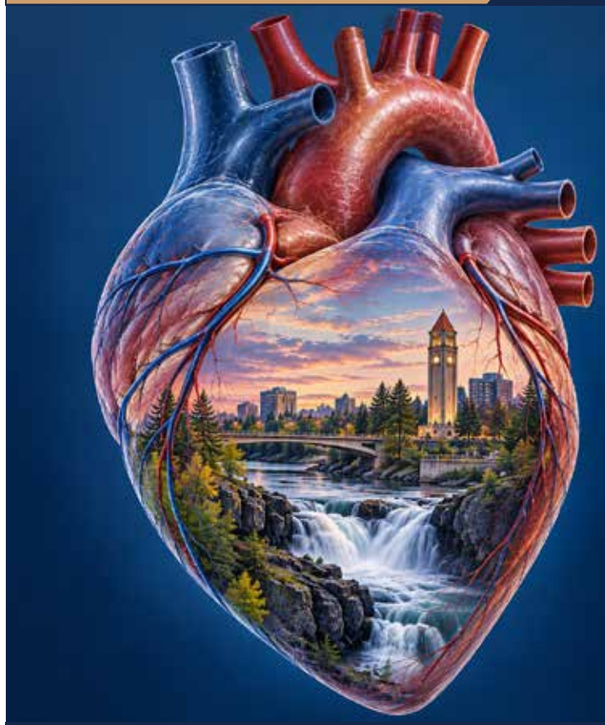
Gritman MEDICAL CENTER
700 S Main St
Moscow, ID 83843

Early Registration: October 23, 2026
Regular Registration: November 11, 2026

Early Registration Discount: October 23, 2026

Spokane Cardiac Symposium

14 *AMA PRA Category 1 Credits*™



November 20 & 21, 2026

Spokane Valley, Washington

In Person | Live Stream | Recording
www.RussoCME.com

Friday, November 20,2026

7:30AM Registration/Exhibits

7:50AM Introduction

8:00AM **TAVR in 2026: Updates and State of the Art | Maeve Jones-O'Connor, MD**
- Review current indications, care determinations and patient selection criteria for TAVR.
- Techniques, imaging, and key considerations for optimizing outcomes
- Changing landscape of short & long term complications and future challenges.

9:00AM **Stroke Prevention in Atrial fibrillation Eric Wallace, DO**
- Understand temporal trends in Afib incidence and ablation success rates.
- Current limitations in Afib guidelines and changing landscape in stroke management and prevention

10:00 AM Break/Exhibits

10:20AM **Hypertrophic Cardiomyopathy Jonathan Medina Beckwith, DNP, ARNP**
- Diagnostic definition of HCM and its phenocopies
- Role of genetic testing in HCM treatment
- Novel treatment options from drug therapy to procedures for HCM

11:20AM **Navigating the 2026 Dyslipidemia Guidelines | Matthew Subramani, MD**
- Key updates to the 2026 Dyslipidemia Guidelines
- Understand the PREVENT equations and patient management groups
- Utilize CAC, Lp(a) and ApoB in clinical practice

12:20PM Lunch Break

12:50PM New Data on ATTR-CM for Health Care Providers From CARDIO-TTRansform [NON-CME]

1:10 PM Exhibit Break

1:40 PM **Left Atrial Appendage Occlusion Zachary Gilbert, MD**
- Indications and patient selection criteria
- Discuss procedural techniques and imaging
- Approaches to post-procedure management

2:40 PM Afternoon Break/Exhibits

3:00 PM **Peripherial Artery Disease: Don't Let That Leg Get Away! | Matthew Low, MD**
- Recognize risk factors and symptoms
- Indications for referral and revascularization
- Prevention of cardiovascular and limb complications

4:00 PM **Syncope: Evaluation and Management Gautam Nayak, MD**
- Recognize the most common causes of syncope
- Employ the appropriate evaluation to optimally risk stratify and determine the cause of syncope
- Therapeutic options for different causes

5:00 PM Non-CME Dinner

Saturday, November 21, 2026

7:30AM Registration/Exhibits

7:50AM Introduction

8:00AM **Cardiomyopathy in Primary Care David Bragin-Sanchez, MD**
- Recognize the major types and clinical presentations of cardiomyopathy
- Evaluation strategies for patients with suspected cardiomyopathy

9:00AM **Murmurs for the PCP | Mrinal Yadava, MD**
- Differentiating pathologic & physiologic murmurs
- Identifying various kinds murmurs
- Workup for a when a murmur is discovered

10:00 AM Break/Exhibits

10:20AM **Coronary Artery Disease Pablo Michel-Sanchez, MD**
- Clinical assessment of angina
- Multimodality imaging for risk stratification
- Prevention of progression of atherosclerotic cardiovascular disease (ASCVD)

11:20AM **Complex Cardiovascular Care Anna Gardella, MD**
- Identify key challenges in managing complex cardiovascular patients
- Develop individualized treatment plans for high-risk patients

12:20PM Lunch Break

12:50PM Lunch Lecture [NON-CME]

1:10 PM Exhibit Break

1:40 PM **Echocardiograms | Cooper Kersey, MD**
- Diagnostic strengths of transthoracic echocardiography
- Limitations of echocardiography and when alternative testing is preferred
- Practical framework for ordering and interpreting echocardiograms in primary care

2:40 PM Afternoon Break/Exhibits

3:00 PM **Heart Failure with Reduced Ejection Fraction | James Mudd, MD**
- Review the diagnosis, staging, and contemporary management of HFrEF
- Discuss guideline-directed medical therapy and strategies to optimize treatment

4:00 PM **The Care of an Athletes Heart David S. Owens, MD**
- Physiologic adaptations of the athlete's heart and distinguish them from pathologic cardiac conditions
- Apply evidence-based strategies for cardiovascular evaluation, risk stratification, and safe participation

5:00 PM Conference Ends

Registration Information

Complete and mail in the attached registration form or

Register online at www.russocme.com

- **Early Registration** must be submitted or post marked by October 23, 2026
- **Regular Registration** must be submitted or post marked by November 11, 2026
- **Day of Registration** available. Additional $20 for registering day of or postmarked after Nov 11th.

Educational Support

MultiCare Pulse Heart Institute

KootenaiHealth

Providence

UW Medicine Heart Institute

Virginia Mason Franciscan Health

RUSSOCME.COM

Registration Form

Spokane Cardiac Symposium 2026

Please print legibly. Receipts will be e-mailed.

Name:_____

Degree:_____Specialty:_____

Address:_____

City/State/Zip:_____

Phone:_____

E-mail_____

Clinic Name:_____

Clinic City:_____

How do you plan on attending?

○ Attending in Person ○ Attending Virtually

○ Recording -14 AMA Category 1 Credits

Day of registration available. An Additional $20 will be charged if post marked after November 11th.

Regular Registration Due: November 11

Circle Selection	MD / DO	NP/PA	RN/Allied Health*
Complete Conference	$430	$405	$280
Friday Only	$285	$255	$185
Saturday Only	$285	$255	$185

*PT, DC, OD, PharmD, ND, Other **Students $75 a day

Early Registration Due: October 23, 2026

Circle Selection	MD / DO	NP/PA	RN/Allied Health*
Complete Conference	$415	$390	$265
Friday Only	$270	$240	$170
Saturday Only	$270	$240	$170

Please make checks payable to RussoCME
Mail completed form with your check to:

Melissa Neighbors
935 SE High St
Pullman, WA 99163

Cut here

Melissa Neighbors (Public Records Request #N020542-110126)

Public Records Request Details

Division OR Board:	HSQA|
HSQA - Type of Record(s):	Other/Unknown (Provide description below)|
Are you requesting a list of individuals?:	Yes
Describe the Record(s) Requested:	Request records for MD, DO, ARNP, PA, RN, CH, NT, PT, PTA, RN, CNA, CRNA
From Date:	10/1/2026
To Date:	11/2/2026

Other Request Information

Preferred Method to Receive Records:		Electronic via Request Center
Modified Request Description:		Summary of the public record desired that will be visible in the public archive if the request is published.
Internal Status:	List	This status is not visible to the requester.
Extend RCD by:		Select length of extension (Business Days). Selecting 70, 100, and 120 will also update Estimated Completion Date.
Extension Action:		Select 'APPLY EXTENSION' and Save to extend dates.

Special Details

Tribal:	No	Check this box if the request contains Tribal information.
High Profile Media Request:	No	Check if this request is considered a high profile media request.
Law Enforcement Proviso (Federal, State or Local):	No	Check this box if this request is form a federal, state or local law enforcement.
PDM ONLY - Law Enforcement Proviso Submitted:		
Multi-Divisional Request:	No	Check if this request has records from multiple divisions
Request Complexity:	1	**View Complexity Criteria below...**

Show/Hide Complexity Criteria

Clarifications

Appeal Information

State Reporting Bill

Changed Response Time:	No
Clarification Sought:	No

Installments:	No
Records Provided:	Yes
Scanned Docs:	No
Physical Records Provided:	No
Actual Completion Date:	11/3/2026
Type of Requester:	Other

You have requested access to a list or lists of individuals. RCW 42.56.070(8) prohibits agencies from providing access to lists of individuals requested for commercial purposes (with the exception of recognized professional associations or educational organizations).

To receive the requested list, you must complete the declaration contained in Section 1 that you will not use the list for a commercial purpose. At a minimum, "commercial purposes" means that such lists are utilized to contact or affect such individuals to facilitate, in any manner, profit-expecting activity.

Select the boxes below to acknowledge:

I understand that “commercial purposes” means that the person/entity requesting the records intends to use them to facilitate profit-expecting business activity.:	Yes
I understand that the use for commercial purposes of said records may also violate the rights of the individuals named herein and may subject me to liability for such commercial use.:	Yes
I declare that I and/or the entity I represent will not use the requested records for commercial purposes. I also acknowledge it is my affirmative duty to prevent others from using the records for commercial purposes.:	Yes

---

The Public Records Act at RCW 42.56.080 authorizes agencies to require a requester to provide information as to the purpose of a request “to establish whether inspection and copying would violate RCW 42.56.070(8).”

1. I am requesting the list of individuals on behalf of:	Organization or Business
Name of organization or business:	RussoCME
Website address:	russocme.com
Purpose of organization or business:	Continuing Medical Education
The organization or business is a professional association or educational organization recognized by the professional licensing or examination board:	Yes

The request is for a list of applicants for professional licenses and of professional licensees of the subject area of the association or organization:	Yes
2. The purpose in making this request for the list of individuals is:	To send Continuing Medical Education brochure - we do have a registration fee which covers the cost of the conference itself, All content is Accredited with American Medical Association credits - AMA Category 1.
3. I or the organization/business intend to generate revenue or financial benefit from using the list of individuals:	Yes
4. I or the organization/business intend to solicit money or financial support from any of the individuals on the list:	No
5. I or the organization/business intend to make individuals on the list aware of business commercial entities, business/financial enterprises or business/financial opportunities:	No
I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct:	Yes

Internal Fields

5 Day Letter Date**:	11/3/2026
5 Day Letter Sent*:	Yes ***** Please select **Yes** once you have sent the 5 Day letter. ****** If you are not closing this request at the same time the 5 day letter is being sent, you **MUST** update the **Required Completion Date** at the right with an estimated completion date.
Estimated Completion Date:	11/9/2026

Days in Status (Internal - Updated Overnight)

Public Archives Summary

Notes

Note	Created	Modified
Received direct communication from requester. Uploaded and responded via GovQA.	11/12/2026 10:30:00 AM by KAITLIN NIELSEN	11/12/2026 10:30:00 AM by KAITLIN NIELSEN

Message History

Date

On 11/16/2026 10:06:10 AM, Melissa Neighbors wrote:
TO: "WA State DOH Records Center"[washingtondoh@govqa.us]
Hello Kaitlin,
Can I send in my new application to you? Please see attached application with a copy of a educational brochure as an example.
Thanks,
Melissa
On Thu, Nov 12, 2026 at 10:45 AM Melissa Neighbors wrote:
Hello Kaitlin,
We were on the approved list - I was thinking it expired spring of 2027 because I think they last 5 years. Did our approval just expire?
Thanks!Melissa
On Thu, Nov 12, 2026 at 10:30 AM WA State DOH Records Center wrote:

Attachments:
List_Request_Application.doc

On 11/12/2026 12:11:01 PM, SACHIKA HIRAIDE wrote:
Subject: DOH Public Records Center :: N020542-110126
Body:
Reference # N020542-110126.

Dear Melissa Neighbors,

The Washington State Department of Health received a communication from you on 11/12/2026. The communication states:

" We were on the approved list - I was thinking it expired spring of 2027 because I think they last 5 years. Did our approval just expire? "

Your approval for the following credentials have expired: NP on 9/12/2018; PH on 10/16/2020; EMS on 12/11/2023; DO, DOA on 3/29/2026; PT, PTA on 4/4/2026; MD, PA on 4/8/2026; NT on 4/29/2026; CH on 5/24/2026; RN, LPN, ARNP, NS on 6/28/2026.

If you have any questions or need additional information, please feel free to respond directly to this email.

Sincerely,

SACHIKA HIRAIDE
Public Disclosure Office
Washington State Department of Health
www.doh.wa.gov/about-us/public-records

On 11/12/2026 10:48:04 AM, Melissa Neighbors wrote:
TO: "WA State DOH Records Center"[washingtondoh@govqa.us]
Hello Kaitlin,
We were on the approved list - I was thinking it expired spring of 2027 because I think they last 5 years. Did our approval just expire?
Thanks!Melissa
On Thu, Nov 12, 2026 at 10:30 AM WA State DOH Records Center wrote:

Attachments:
List_Request_Application.doc

Date

On 11/12/2026 10:29:50 AM, KAITLIN NIELSEN wrote:
Subject: DOH Public Records Center :: N020542-110126
Body:
Reference # N020542-110126

Dear Melissa Neighbors,

The Washington State Department of Health received a communication from you on 11/11/26. The communication states:

"We requested a list from DOH from several boards (MD, DO, PA, NP etc) all of the lists don't have a physical mailing address but only an email. We were hoping to send out a education brochure this week but the addresses are missing. Can you check this and resend the updated lists Reference # N020542-110126."

On 11/3/26 we released a list of available information to the DOH Public Records Center for your review. Please note this information is limited to what the law allows.

RCW 42.56.070(8) prohibits disclosure of lists of individuals requested for commercial purposes. However, lists of applicants for professional licenses and of professional licensees may be made available to professional associations or educational organizations approved by the applicable licensing board.
You are currently NOT an approved professional association or educational organization with the Washington State Department of Health. Therefore, the requested information cannot be provided to you at this time, and this request was considered closed on 11/3/26. This means that the Department of Health will not further address the request, and as of the date of the 11/3/26 communication, the PRA' s one-year statute of limitations to seek judicial review starts to run.

List requests are approved by the specific licensing board and approval can take up to three months.

You may apply for approval to receive lists from the applicable licensing board by completing and submitting an Application for Approval to Receive Lists. The application and additional information can be found here or on the customer public records portal under 'See All FAQs' in the left navigation pane. The completed application can be uploaded directly to this request via the online portal.

If you receive approval from the licensing board you will need to submit a new list request and upload the approval letter.

If you have any questions or need additional information, please feel free to respond directly to this email or reach out to the approving licensing board.

Sincerely,

KAITLIN NIELSEN
Public Disclosure Office
Washington State Department of Health
www.doh.wa.gov

Date

On 11/3/2026 10:37:00 AM, SACHIKA HIRAIDE wrote:

Date

Subject: DOH Public Records Center :: N020542-110126
Body:

Reference # N020542-110126.

Dear Melissa Neighbors,

The Department of Health received a public records request from you on November 01, 2026. Your request mentioned:

" Request records for MD, DO, ARNP, PA, RN, CH, NT, PT, PTA, RN, CNA, CRNA"

Records identified as responsive to your public records request have been uploaded to the DOH Public Records Center. Since all identified records have been provided to you, this request is considered closed. The Department of Health does not intend to further address the request, and the PRA's one-year statute of limitations to seek judicial review has started to run as of the date of this communication.

Please contact me within 30 days 12/3/2026 9:23:35 AM by e-mail at publicdisclosure@doh.wa.gov or by postal mail at: Public Records Officer, Washington State Department of Health, P.O. Box 47808, Olympia, WA 98504-7808, if you have any questions.

NOTE: Pop-up Blockers on your web browser will need to be disabled to download files from this site.

Some information within your requested records may have been withheld. Please see the Redaction Summary located at the end of each document for a list of redactions that were applied. If any records were withheld in their entirety, please refer to the Exemption Log provided to you.

Under RCW 42.56.520 you may appeal the decision to withhold information contained in the records via a request for review by the Department of Health' s Public Records Officer. When filing an appeal for Public Records, please include your Public Records Request reference number so the correct request can be reviewed. The request must be submitted in writing by one of the following methods:

1. Send an email request to PRRappeals@doh.wa.gov
   OR
2. Mail your request to:
   Public Records Officer
   Washington State Department of Health
   P.O. Box 47808
   Olympia, WA 98504-7808

If you wish to file for review or reconsideration of a complaint case file decision, please follow the "Complaint and Disciplinary Process" on our DOH web site. You may contact our HSQA Complaint Intake team at HSQAComplaintIntake@DOH.WA.GOV or by calling (360) 236-4700 to get more information on how to complete the case reconsideration process.

Sincerely,

SACHIKA HIRAIDE
Public Disclosure Office
Washington State Department of Health
www.doh.wa.gov

Date

On 11/1/2026 12:18:18 AM, System Generated Message:
Subject: Public Records Request :: N020542-110126
Body:

Dear Melissa Neighbors:

Thank you for submitting a public records request to the Washington State Department of Health. Your request has been received and is being processed in accordance with the State of Washington Public Records Act, Chapter 42.56 RCW. Your request was received in this office on 11/1/2026 and given the reference number N020542-110126 for tracking purposes. You will receive an official acknowledgement letter within 5 business days from this date.

Not all public documents are available in electronic format. If the document(s) requested are not available electronically, we will make them available for inspection or by paper copy in accordance with the Public Records Act, Chapter 42.56 RCW.

Sincerely,

Washington State Department of Health
Public Records Request
Public Records

To monitor the progress or update this request please log into the DOH Online Public Records Center

Powered by GovQA

Track the issue status and respond at: https://washingtondoh.govqa.us/WEBAPP//_rs/RequestEdit.aspx?rid=184396

On 11/1/2026 12:18:16 AM, Melissa Neighbors wrote:
Request Created on Public Portal

Request Details

Reference No:	N020542-110126
Create Date:	11/1/2026 12:18 AM
Update Date:	11/16/2026 10:06 AM
Completed/Closed:	Yes
Close Date:	11/3/2026 10:27 AM

Status:	Closed - Full Release
Priority:	Low
Assigned Dept:	Health Systems Quality Assurance
Assigned Staff:	SACHIKA HIRAIDE

Customer Name:	Melissa Neighbors
Email Address:	russocme@gmail.com
Phone:	5094310718
Group:	(Not Specified)

Source:	Web

Guidance Document

WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety

"We need to quit blaming and punishing people when they make mistakes and recognize that errors are symptoms of a system that's not working right, and go figure out and change the system so no one will make that error again, hopefully. We have to change the culture, so everyone feels safety is his or her responsibility, and identifies hazards before someone gets hurt."

Commented [AJ1]: Edit with date and title off

-Lucian Leape, MD
Adjunct Professor of health policy, Harvard School of Public Health
Co-Founder, National Patient Safety Foundation

Purpose

The Washington Medical Commission (Commission) adopts this Guidance Document to collaborate with the health care system to reduce medical error[1] and enhance patient safety.

Background

Commented [AJ2]: Define DMV (regulatory body)

In its seminal report, *To Err is Human: Building a Safer Health System,* the Institute of Medicine (Now the National Academy of Medicine) studied high-risk industries that have taken a systems approach to improving safety, and concluded that the most effective way to reduce error and improve patient safety is not by blaming individuals, but by creating an environment that encourages organizations to identify errors, evaluate causes, and take appropriate actions to prevent future errors from occurring.[3,2,3] The IOM detailed the efforts of other high-risk industries, most notably aviation, in applying these principles with remarkable success.[Error! Bookmark not defined.,4] The report called for applying these principles to health care, observing that health care remains decades behind other high-risk industries in its approach to ensuring safety and creating safer systems.**Error! Bookmark not defined.**

Leading national patient safety expert Lucian Leape, MD, among others, advocates for embracing the IOM's recommendations by implementing a systems approach involving a "just culture" in medicine-- a culture that is open, transparent, supportive and committed to learning; a culture centered on teamwork and mutual respect, where every voice is heard and every worker is empowered to prevent system breakdowns and correct them before they occur; where patients and families are fully engaged in their care; and where caregivers share information openly about hazards, errors and adverse events.[5,6,7,8,9]

Since the IOM report, many organizations have adopted a "just culture" model in their health care systems and have experienced increases in event reporting with corresponding decreases in medical

errors.[10,11,12] A just culture has no tolerance for reckless or intentional disregard of safe practices, which continues to require a traditional process of discipline. A just culture in healthcare recognizes that medical errors often involve competent providers in flawed systems. A just culture encourages voluntary event reporting, open communication, and fair handling, which contributes to ongoing education and improvements of systems, to reduce medical errors and improve patient safety. [18,21,13]

The Commission has responded to the IOM's report and to Dr. Leape's call to become a force for error reduction, rather than concealment, with the following:

- *Endorsing just culture principles.* The Commission encourages institutions, hospitals, clinics and the health care system to adopt a just culture model to reduce medical error and make systems safer. Likewise, the Commission will use just culture principles in reviewing cases of medical error.
- Entering into Patient Safety Collaborations with the Foundation for Health Care Quality, to develop and support Communication and Resolution Programs throughout the state of Washington, and to develop a process to handle such cases.

By implementing the above activities, the Commission seeks to become a more effective regulator, and to better meet its mandate to protect the public.

The Commission Endorses a Just Culture Model for Health Care Systems

"Just culture" is a term describing an approach to reducing errors in high-risk and complex industries by recognizing that errors are often due to flaws in systems, such that blaming individuals for human error while failing to address contributing systemic issues, does not make systems safer. In *Just Culture Restoring Trust and Accountability in Your Organization*,[14] expert Sidney Dekker explains, "The primary purpose of a just culture, to most, is to give people the confidence to report safety issues. Because then people know that the organization will respond fairly. A just culture should enable your organization to learn from an incident, yet also hold people 'accountable' for undesirable performance." Also, "The main argument for building a just culture is that *not* having one is bad for both justice and safety." A just culture encourages open communication so that near misses can serve as learning tools to prevent future problems, and adverse events can be used to identify and correct root causes.

Despite the efforts of many organizations across the country to develop initiatives to enhance patient safety, progress has been slow and insufficient.[7,8] Medical errors remain vastly underreported.[15,16,17] Traditional malpractice and disciplinary systems are thought to impede progress by discouraging the reporting of errors, contributing to a culture of blame and a "wall of silence" in health care that inhibits learning and prevents systems change that is critical to reducing error.[14,18,19] As a result, Dr. Leape calls on regulators to become a force for error reduction rather than a force for error concealment. [15]

As the regulator of allopathic physicians, physician assistants, and anesthesiology assistants, the Commission encourages healthcare entities to address the root causes of medical errors using the just culture model, to improve patient safety in the state of Washington. As our healthcare delivery system becomes more patient-centered, team-based, and transparent, a just culture model is timely. A just culture embraces open communication (transparency) and a systemic approach (team based), to improve patient safety (a truly patient-centered end result). The **The Patient Safety Collaboration to Support Communication and Resolution Programs**

In 2013, the Commission and the Foundation for Health Care Quality (Foundation) signed a Statement of Understanding to form a Patient Safety Collaboration (Attachment A). The purpose of the agreement is for the Commission and the Foundation to work together to help the medical profession to do better in reducing medical errors by promoting and supporting communication and resolution programs (CRPs).

Communication and Resolution Programs

CRPs are based on just culture principles which recognize that most medical errors are caused, not by incompetent providers, but rather, by the interaction between competent providers who have made a simple human error in a system with processes or conditions that failed to stop that human error from injuring a patient. CRPs are a stark departure from the long-standing tradition of denying and defending unanticipated outcomes,**Error! Bookmark not defined.**,[20,21] and CRPs promote a patient-centered response to unanticipated outcomes.

To support that response, CRPs require open and prompt communication to address the root cause of medical errors. For example, when a patient is harmed, providers are empowered to communicate to the patient what happened, what steps will be taken to address the event, and how similar outcomes will be prevented in the future. This approach provides numerous benefits: (1) support for involved patients, families, and care providers; (2) rapid investigation and closure of gaps which contributed to unanticipated outcomes; (3) proactive resolutions; and (4) collaboration across all involved stakeholders.

The CRP process involves the following steps:

- Immediate reporting of unanticipated outcomes, both to the patient and family and to the institution;
- Immediate investigating to determine the factors that led to the event;
- Communicating the findings of the investigation to the patient and the patient's family;
- Apologizing to the patient and, when appropriate, an offer of compensation or non-financial resolution;
- Changing the system to prevent the event from re-occurring; and
- Sharing lessons learned with the medical community to help prevent systemic recurrences.

CRPs promote provider accountability to address systemic issues that mal aligned to allow the error to harm a patient. Providers must report unanticipated outcomes as soon as they occur, participate in efforts to understand whether the unanticipated outcome was due to medical error or system failure, and participate in efforts to prevent recurrences. CRPs do not tolerate reckless or intentional disregard of safe practices. CRPs have been used in a number of health care institutions and systems across the country with success and have the support of the Joint Commission and the Agency for Health Care Quality and Research. [14,30,31,22]

The Foundation for Health Care Quality

The Foundation is a nonprofit organization that administers quality improvement programs. The Foundation uses clinical performance data as a tool and works with providers and hospitals to adopt

evidence-based practices to improve patient safety.[23] The Foundation also houses the Washington Patient Safety Coalition, a collaboration of patient safety leaders who share best practices to reduce medical errors and improve patient safety.[24]

The CRP Certification Process

The collaboration between the Commission and the Foundation led to the creation of an additional step in the standard CRP process: the formation of a CRP Event Review Board. This Board serves as a neutral panel to review and certify CRP events. The Board is composed of individuals from across the health care spectrum, including patient safety advocates, risk managers, insurers, and physicians.

When an unanticipated outcome occurs and an institution completes a CRP process, the institution may request an independent review by submitting an application for certification to the Board. The Board reviews the application and all relevant records and documents, and determines whether all key elements of the CRP process have been satisfied, particularly that the systems changes are appropriate and effective. If all the elements are fully satisfied, and patient safety has improved as a result, the Board will send a report back to the institution stating that the event is certified. This step provides an additional level of objective quality review of the CRP process.

The Commission's Coordination with the CRP Process

When the Commission receives a complaint against a provider and learns that the provider is participating in a CRP process, the Commission will exercise its discretion to decide whether to place the case on hold pending timely completion of the CRP process. However, the Commission will not place a case on hold if the provider's continued practice presents a risk to patients or if the Commission is concerned that patient safety will not be adequately addressed by the CRP. In those cases, the Commission will conduct a prompt investigation and take appropriate action to protect the public.

If the Commission places a CRP case on hold and then receives a report that the event has been certified, the Commission will exercise its discretion to determine whether to investigate the matter or to close the case. If the Commission determines that the CRP process has timely and effectively enhanced patient safety, including individual and system-level improvements, the Commission may close the case as satisfactorily resolved. If not, the Commission will promptly investigate the case and take appropriate action, if warranted.

The CRP process is limited to cases of human error. The CRP Event Review Board will not certify cases involving reckless or intentional conduct, gross negligence, sexual misconduct, boundary violations, patient abuse, drug diversion, criminal activity, and other unethical or unprofessional behavior.

CRPs Benefit Patients and their Families, Providers, and the Commission

The use of CRPs is a drastically different approach to addressing medical errors than the traditional system of secrecy, denial, and defensiveness. CRPs provide patients with what they need after an

unanticipated outcome: open and honest communication about what occurred, emotional first aid, accountability, an apology, remediation and compensation. Ultimately, CRPs are also likely to reduce medical errors and improve patient safety in the future.

CRPs benefit providers by reducing barriers to reporting medical errors. CRPs offer a safe environment for providers to disclose unanticipated outcomes, have an honest discussion with the patient and the patient's family, and work to improve systems, without undue fear of malpractice suits, professional discipline, or personal embarrassment.[25] CRPs promote a non-punitive, learning culture to improve patient safety.

For the Commission, CRPs help to remove limitations inherent in the traditional disciplinary process:

- Reports of medical errors to the Commission are often delayed for years by the malpractice system, which limits the effectiveness of the Commission's response to complaints.[Error! Bookmark not defined.] The CRP process requires prompt reporting and patient-centered action, which allows early resolution of medical errors. This expedited process will allow the Commission to address errors much sooner than under the current system.
- When a medical error occurs, the Commission can discipline the individual provider but is unable to directly influence the institution to make system changes to ensure the error is not repeated. Currently, the Commission's jurisdiction is limited to providers; and the Commission has no jurisdiction over institutions, such as hospitals or clinics. The CPR process requires the individual provider and the institution to collaborate, which is an intentional change from our current system, to prevent future patient harm.
- The Commission lacks an efficient mechanism for sharing lessons learned to other licensees and institutions to prevent similar errors from reoccurring. The CRP process requires collaboration across and among institutions, to share lessons learned to prevent future patient harm. C ollaboration allows the Commission to have a greater effect on patient safety than the traditional disciplinary process and thereby improve its ability to protect the public.

Furthermore, medical errors that do not cause harm –otherwise known as "near misses"-- seldom come to the attention of the Commission. This collaboration strongly encourages reporting of near misses to help identify potential system problems and implement system fixes before patients are harmed. By promoting early reporting of all unanticipated outcomes, as well as near misses, a wider range of errors will be identified and corrected. [26]

The Commission encourages all institutions, clinics, and practices in the state of Washington to develop a CRP program, to make it available to all physicians and physician assistants, to have events certified by the CRP Event Review Board, and to join in the effort to foster open communication, reduce medical errors, and improve patient safety in our state.[27]

Conclusion

Medical errors continue to pose a serious threat to patient safety. The Commission is firmly committed to its mandate to protect the public but recognizes limitations of the current disciplinary process in an evolving health care delivery system. The Commission believes that a more effective approach is to

collaborate with health care systems to develop a more patient-centered response to medical errors to improve patient safety moving forward.

The Commission believes that by endorsing just culture principles and collaborating with the Foundation for Healthcare Quality to support and develop CRPs, the Commission will help to reduce medical errors, become a more effective regulator, and better meet its mandate to protect the public.

Number:	GUI2014-02
Date of Adoption:	January 29, 2014
Reaffirmed / Updated:	March 2, 2018
Revised:	xxxxx
Supersedes:	None.

[1] Medical Error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Institute of Medicine 2000. Committee on Quality of Health Care in America. *To Err is Human: Building a Safer Health System*. Washington DC: National Academy Press; 2000.
[2] Institute of Medicine 2001. Committee on Quality of Health Care in America. *Crossing the Quality Chasm*. Washington DC: National Academy Press; 2001.
[3] Sentinel Event Statistics Released for 2014, the Joint Commission. April 2015: "In 2014 the leading root causes and contributory factors are examples of cognitive failures. Cognitive failure is preventable and safety-critical industries take a systems view. Health care organizations must focus on factors that influence errors and operationalize strong corrective actions aimed at improving working conditions and eliminating all preventable injury, harm and death." Ronald Wyatt, M.D., M.H.A., medical director, The Joint Commission. Accessed at http://www.jointcommission.org/assets/1/23/jconline_April_29_15.pdf
[4] The success of the Aviation Safety Reporting System is attributed to three factors: reporting is safe (pilots are not disciplined if they report promptly), simple (a one-page report is made), and worthwhile (experts analyze the reports and disseminate recommendations to the pilots and the FAA). Leape L, , Reporting of Adverse Events, *N Eng J Med.* 2002;347:1633.
[5] Leape L, Berwick D, et al., Transforming Healthcare: a Safety Imperative, *Qual. Saf. Health Care*, 2009; 18:424-428. Waterson P, *Patient Safety Culture*. Ashgate 2014.
[6] Safe Practices for Better Healthcare—2010 Update, National Quality Forum, page 7. http://www.qualityforum.org/Publications/2010/04/Safe_Practices_for_Better_Healthcare_%E2%80%93_2010_Update.aspx accessed 3-9-15.
[7] Marx D. *Whack a Mole: The Price We Pay for Perfection*. By Your Side Studios: 2009.
[8] Marx D. *Patient Safety and the "Just Culture": A Primer for Health Care Executive.* New York, NY: Columbia University: 2001.
[9] Waterson P, *Patient Safety Culture*. Ashgate 2014.
[10] Petschonek S, Burlison J, Development of the Just Culture Assessment Tool: Measuring the Perceptions of Health-Care Professionals in Hospitals, *J Patient Safety* 9(4): 190-197.
[11] Wachter RM, Pronovost PJ Balancing "no blame" with accountability in patient safety. *N Eng J Med.* 2009;361:1401-1406.
[12] The National Quality Forum endorsed a just culture approach as part of a patient safety program. See Safe Practices for Better Healthcare—2010 Update. https://www.qualityforum.org/Publications/2010/04/Safe_Practices_for_Better_Healthcare_%E2%80%93_2010_Update.aspx
[13] Boysen PG, Just Culture: A Foundation for Balanced Accountability and Patient Safety, *The Ochsner J.* 2013;13:400-406.
[14] S. Dekker, *Just Culture Restoring Trust and Accountability in Your Organization:* 3rd edition 2017.
[15] Studies show that disclosure of medical errors occurs in approximately 30% of cases. Wu A, Boyle D, Wallace G, Mazor K, Disclosure of Adverse Events in the United States and Canada: an Update and a Proposed Framework for Improvement, *J. Public Health Research,* 2013; 2:e32:186-193.
[16] James J., A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care. *J. Patient Saf.* 2013;9(3) 122-128.

[17] Bell SK, Smulowitz P, Woodward A, Mello M, Duva A, Boothman R, Sands K, Disclosure, Apology, and Offer Programs: Stakeholders' Views of Barriers to and Strategies for Broad Implementation. *Millbank Quarterly* 2012;90(4): 682-705.
[18] The Commonwealth Fund, Q&A with Lucian Leape, http://www.commonwealthfund.org/publications/newsletters/states-in-action/2010/jan/january-february-2010/ask-the-expert/ask-the-expert accessed 4-28-15.
[19] Sage WM, Medical Liability and Patient Safety, *Health Law*. 2003;22(4):26-36.
[20] Mello M, Senecal S, Kuznetsov Y, Cohn J, Implementing Hospital-Based Communication-and-Resolution Programs: Lessons Learned in New York City. Health Affairs 2014; 33(1): 30-38.
[21] Mello M, Boothman R, McDonald T, Driver J, Lembriz A, Bouwmeester D, et al., Communication-and-Resolution Programs: the Challenges and Lessons Learned from Early Adopters. Health Affairs. 2014; 33(1): 20-29.
[22] Mello M, Gallagher T, Malpractice Reform—Opportunities for Leadership by Health Care Institutions and Liability Insurers. *N. Eng. J. Med.* 2010;362(15):1353-1356.
[23] The Foundation has the following programs: 1. Clinical Outcomes Assessment Program (COAP), which collects data submitted by all 35 hospitals in the state where cardiac interventions are performed, then producing a quarterly report to the hospitals, and documenting statistically significant improvements in quality, as well as establishing standards by peer consensus and holds institutions accountable for performing to those standards. 2. Surgical Care and Outcomes Assessment program (SCOAP), which involves the surgical community working with stakeholders to create a framework which defines metrics, tracks hospital performance, and reduces variability and errors in surgical care. 3. Obstetrics Clinical Outcomes Assessment Program (OB COAP), the obstetrics version of COAP. 4. The Washington Patient Safety Coalition, which consists of diverse groups working together to improve patient safety through the sharing of best practices related to patient safety. 5. HealthPact, which seeks to transform communication in healthcare, recognizing that poor communication is a fundamental cause of most preventable injuries. 6. The Bree Collaborative, established by the Washington State Legislature, consist of stakeholders appointed by the Governor and is tasked with annually identifying three health care services with high variation in the way care is delivered, that are frequently used, and do not lead to better care or patient health, or have patient safety issues. The group then develops evidence-based recommendations to send to the Health Care Authority to guide the care provided to Medicaid enrollees, state employees and other groups. http://www.qualityhealth.org/
[24] In 2011, the Foundation received a grant from the Agency for Healthcare Research and Quality to form HealthPact. HealthPact is a program designed to improve communication in health care by (1) training healthcare providers to communicate better with each other and with patients, (2) working with stakeholders to create an ongoing learning community and implement best practices in their respective institutions, and (3) developing CRPs.
[25] Statement on Medical Liability Reform, Bulletin of the American College of Surgeons, March 1, 2015 (CRPs "show the most promise for promoting a culture of safety, quality and accountability; restoring financial stability to the liability system; and requiring the least political capital for implementation.") Available at http://bulletin.facs.org/2015/03/statement-on-medical-liability-reform/
[26]Krause Ph.D., Thomas R and Hidley, M.D., John, *Taking the Lead in Patient Safety,* John Wiley & Sons, Inc. *,* 2009 Near-miss reporting is recognized as one of several leading indicators for healthcare safety (p. 42) "Virtually every patient injury is preceded by lower-level decisions and outcomes that increase the likelihood of a safety failure. The catastrophic outcome – a sentinel event, serious injury, or death—can be seen as the tip of an iceberg embedded in a larger architecture of behaviors, practices, and outcomes that made the greater loss predictable." (p. 189) ". . . the companies setting the benchmark for industry safety often have the highest rates of reported near misses because they do not penalize the reporting of near misses and do not directly reward the reduction of incident rates. Instead, they welcome the information stemming from near misses, quickly digest its implications, and act immediately to reduce the likelihood of repeated exposures to hazard." (p. 221) "When a single serious event occurs, it can be inferred with high probability that many related but less severe events have occurred previously. To prevent medical errors and adverse events, small events and their precursors must be taken as seriously as large ones." P. 38
[27] The AHRQ has provided grants to other sites around the country to implement CRPs. The Collaborative for Accountability After Patient Injury consists of leading experts on medical error to exchange ideas and support the growth and spread of CRPs.

Clinical Experience Assessment

Name: _____ Date: _____

Ranking Guidelines	
1. ~~"I did it."~~	The licensee required complete guidance or was unprepared or not competent; I had to do most of the work myself.
2. ~~"I talked them through it."~~	The licensee was able to perform some tasks competently but required repeated directions.
3. ~~"I directed them from time to time."~~	The licensee demonstrated some independence and competence and only required intermittent prompting.
4. ~~"I was available just in case."~~	The licensee functioned independently and competently and only needed assistance with nuances or complex situations.
5. ~~"They did it."~~	The licensee functioned autonomously without need for oversight or supervision.
6. ~~"Not Observed"~~	The licensee was not seen or observed completing this task.

1. Gather a History and Perform a Physical Examination						
1	2	3	4	5	6	Task
						Obtain a complete and accurate history in an organized fashion.
						Demonstrate patient-centered interview skills.
						Demonstrate clinical reasoning in gathering focused information relevant to a patient's care.
						Perform a clinically relevant, appropriately thorough physical exam

2. Prioritize a Differential Diagnosis Following a Clinical Encounter						
1	2	3	4	5	6	Task
						Synthesize essential information from previous records, history, physical exam, and initial diagnostic evaluations to propose a scientifically supported differential diagnosis.
						Prioritize and continue to integrate information as it emerges to update differential diagnosis, while managing ambiguity.
						Engage and communicate with team members for endorsement and verification of the working diagnosis that will inform management plans.

3. Recommend and Interpret Common Diagnostic and Screening Tests						
1	2	3	4	5	6	Task
						Recommend first-line cost-effective screening and diagnostic tests for routine health maintenance and common disorders.
						Interpret results of basic studies and understand the implication and urgency of the results.

4. Enter and Discuss Orders and Prescriptions						
1	2	3	4	5	6	Task
						Compose orders efficiently and effectively verbally, on paper, and electronically.
						Demonstrate an understanding of the patient's condition that underpins the provided orders.
						Recognize and avoid errors by attending to patient-specific factors, using resources, and appropriately responding to safety alerts.
						Discuss planned orders and prescriptions with team, patients, and families.

5. Document a Clinical Encounter in the Patient Record						
1	2	3	4	5	6	Task
						Prioritize and synthesize information into a cogent narrative for a variety of clinical encounters (admission, progress, pre- and post-op, and procedure notes; informed consent; discharge summary).
						Follow documentation requirements to meet regulations and professional expectations.
						Document a problem list, differential diagnosis, and plan supported through clinical reasoning that reflects patient's preferences.

6. Provide an Oral Presentation of a Clinical Encounter						
1	2	3	4	5	6	Task
						Present personally gathered and verified information, acknowledging areas of uncertainty.
						Provide an accurate, concise, well-organized oral presentation.
						Adjust the oral presentation to meet the needs of the receiver.
						Demonstrate respect for patient's privacy and autonomy.

7. Form Clinical Questions and Retrieve Evidence to Advance Patient Care (*only level 3 required)						
1	2	3	4	5	6	Task
						Combine curiosity, objectivity, and scientific reasoning to develop a well-formed, focused, pertinent clinical question (ASK).
						Demonstrate awareness and skill in using information technology to access accurate and reliable medical information (ACQUIRE).
						*Demonstrate skill in appraising sources, content, and applicability of evidence (APPRAISE).
						*Apply findings to individuals and/or patient panels; communicate findings to the patient and team, reflecting on process and outcomes (ADVISE).

8. Give or Receive a Patient Handover to Transition Care Responsibility						
1	2	3	4	5	6	Task
						Document and update an electronic handover tool and apply this to deliver a structured verbal handover, using communication strategies known to minimize threats to transition of care
						Provide succinct verbal communication conveying illness severity, situational awareness, action planning, and contingency planning.

9. Collaborate as a Member of an Interprofessional Team						
1	2	3	4	5	6	Task
						Identify team members' roles and responsibilities and seek help from other members of the team to optimize health care delivery.
						Include team members, listen attentively, and adjust communication content and style to align with team-member needs.
						Establish and maintain a climate of mutual respect, dignity, integrity, and trust; prioritize team needs over personal needs to optimize delivery

10. Recognize a Patient Requiring Urgent or Emergent Care and Initiate Evaluation and Management (*only level 3 required)						
1	2	3	4	5	6	Task
						Recognize normal and abnormal vital signs as they relate to patient- and disease-specific factors as potential etiologies of a patient's decompensation.
						Recognize severity of a patient's illness and indications for escalating care.
						Initiate and participate in a code response and apply basic and advanced life support.

						Upon recognition of a patient's deterioration, communicates situation to attending physician.

11. Obtain Informed Consent for Tests and/or Procedures						
1	2	3	4	5	6	Task
						Describe the key elements of informed consent: indications, contraindications, risks, benefits, alternatives, and potential complications of the intervention.
						Communicate with the patient and family to ensure that they understand the intervention including pre/post procedure activities.

12. Perform General Procedures of a Physician (*only level 3 required)						
1	2	3	4	5	6	Task
						*Demonstrate technical skills required for the procedure.
						Understand and explain the anatomy, physiology, indications, contraindications, risks, benefits, alternatives, and potential complications of the procedure.
						Completes expected procedures and keeps log book signed by mentor

13. Identify System Failures and Contribute to a Culture of Safety and Improvement (*only level 3 required)						
1	2	3	4	5	6	Task
						Identify and report actual and potential ("near miss") errors in care using system reporting structure (event reporting systems, chain of command policies).
						Participate in system improvement activities in the context of learning experiences (rapid-cycle change using plan–do–study–act cycles, root cause analyses, morbidity and mortality conference, failure modes and effects analyses, improvement projects).
						Engage in daily safety habits (accurate and complete documentation, including allergies and adverse reactions, medicine reconciliation, patient education, universal precautions, hand washing, isolation protocols, falls and other risk assessments, standard prophylaxis, time-outs).
						Admit one's own errors, reflect on one's contribution, and develop an individual improvement plan.

Staff Reports - November 20, 2026

Kyle Karinen, Executive Director

Dr. Diana Currie

I sent out an email in October, but I want to take the opportunity to again thank Dr. Currie for her service over seven years. From that email:

Diana is one of my favorite Commission members I've ever worked with. When she handled cases, you never got anything less a thoughtful answer. Even when if saw things differently on a particular issue, it was always with an eye toward making healthcare better. She always sought out your opinion. It was a collaborative experience through and through. She is a delight and the Commission will greatly miss her.

We have reached out to the Governor's Office for guidance on whether to begin the recruiting process early but have not heard back. In the meantime, on the obstetrics front, the Commission remains in excellent hands with Dr. Mvundura and Dr. Hutchison handling Reviewing Commission Member duties.

IMLC

By the time you read this staff report, I will have returned from the Interstate Medical Licensure Compact Commission's annual meeting in Savannah, Georgia. As the Executive Director, I am a member of the commission that oversees the operation of IMLC. The meeting agenda this year is a typical one. Of note, the IMLC is reaching the point of nationwide participation. Two of our neighboring states are notable holdouts – California and Oregon. It seems far more likely California will join before Oregon. If California does join the Compact, we can expect to see a spike in licensees similar to when other large states (Texas) came on line.

The IMLC annual meeting agenda can be found on the Compact Commission's website here:

Commission Meetings | Interstate Medical Licensure Compact

Caseloads

As you may have noticed and as mentioned elsewhere in staff reports, complaint volume remains high. While the Commission will not set a new record for complaints received in a year, it is not far off the (unfortunately) record-setting pace set in 2025. We have compared notes with our colleagues in the Department and Board of Nursing and they are seeing similar trends. Projecting disciplinary caseloads is a notoriously difficult proposition, but I am concerned that we may have simply reached a new normal and it's a challenging one. More to come on this, but we are talking with our colleagues as well as the others in state government about possible ways of addressing this. The UDA is an excellent system for professional licensing and regulation, but it is a resource-intense endeavor at almost every level. We may be reaching a point where greater efficiency

Kyle Karinen, Executive Director continued

must be wrung from a system that is not designed for efficiency. Jimi Bush provided a recent report on the rise in complaints and is working on a follow-up. One set of numbers in particular demonstrates the trend:

Annual Totals of complaints by Fiscal Year:

FY 2016 1600
FY 2017 1182
FY 2018 1664
FY 2019 1398
FY 2020 1544
FY 2021 1661
FY 2022 1958
FY 2023 1667
FY 2024 1982
FY 2025 2127
FY 2026 2443

I have a feeling this is a topic that may be re-visited in 2027, but I do want it to be on your collective radar as we tackle many other issues in the upcoming session. (See below for more notes on that.)

Micah Matthews, Deputy Executive Director

Recurring: Please submit all Payroll and Travel Reimbursements within 30 days of the time worked or travelled to allow for processing. Request for reimbursement items older than 90 days will be denied. Per Department of Health policy, requests submitted after the cutoff cannot be paid out. For specific guidance on Commissioner compensation, please refer to the WMC guideline: Compensation and Reimbursement for Commission Duties (wa.gov)

Staffing Update

We are pleased to welcome to the WMC Adriann Jones as our new Policy Manager effective October 1. Adriann comes to us from the DOH Office of Immunizations where she was a Policy Analyst. She has a deep knowledge of vaccines and vaccine policy from her time with DOH and in the private sector. She participated in her first Policy Meeting in October and is taking on some much needed projects to move that high profile work forward for the WMC. Please welcome her if you see her at a meeting or event.

Legislative Session

The 2027 session is fast approaching and there are several items to share.

- We have not yet had our Certified Anesthesiologist Assistant surcharge request legislation approved, but it does seem likely based on feedback from Governor's office policy reviewers.
- This will be a long session focusing on writing the biennial budget. As of this writing (11/10/26) we are awaiting the final case load and budget forecasts, which

will determine approaches the Governor's office and the Legislature will take in session.

- Policy Manager Adriann Jones and I will give a legislative session overview and training at the January 2027 WMC Business Meeting.
- There is a sizable budget gap to fill (billions) and much of this can be attributed to multiple causes. Chief among them are increased caseloads, increasing lawsuit settlements against certain state institutions, federal cuts, and now lawsuits from school districts (Lake Washington, Tacoma, Yakima) alleging the state is in violation of the McCleary decision regarding fulling funding basic education.
- On the policy side, we understand that bills addressing issues related to Assistive Intelligence, MDMA and psylocibin administration, and studying how to fund primary care as a public good or commodity.
- In anticipation of a difficult and potentially extended session, I am providing notice that I will be taking leave for the latter part of December into the new year. My out of office will provide direction to key staff based on issue area.

Federal Updates

The HHS issued enforcement discretion guidance for comment on several peptides for consumer use. FSMB is coordinating feedback, but several state boards have existing regulations and discipline in process to include several deaths from compounded peptides that are on the FDA guidance list.

Meetings and Conferences

- September 2: FSMB Board Executive Advisory Committee met to finalize updates to the model medical practice act. Completed updates should be published by the end of the year.
- September 14: FSMB/AMA joint summit on AI. This was a refocus of the AI working group based on the debate that occurred at the Baltimore Annual Meeting that was not supposed to be solely AI focused. Based on a November 10 conversation with Dr. Chaudry the President of FSMB, the revised 37-page draft guidance will be available to member boards for comment, the week of November 16.
- I presented at the CLEAR Annual Conference September 16 on a panel related to international physicians and mobility. The WMC MD CE program is one that is being watched closely in the United States and internationally due to its success and sheer size of the licensee population.
- September 24: I attended the WA Health Workforce Council Meeting by request to discuss the WMC MD CE program and its specifics. This is one of many groups, to include Washington FQHCs and free clinics, that are considering the benefits of our CE program to expand access to primary care in Washington.
- October 4: Program Case Manager Fatima Mirza and I attended the NCQA summit in Atlanta, GA to learn about their accreditation programs and meet with senior leadership to engage on their standards as they relate to our MD CE licensees and their ability to work in NCQA accredited clinics and facilities.
- November 4: I attended one of several Office of Insurance Commissioner roundtables in Olympia on primary care in preparation for a request legislation ask to study changing the funding delivery model for primary care in Washington.

Micah Matthews, Deputy Executive Director continued

- November 9: Chair Murphy, Policy Chair Blake, Policy Manager Adriann Jones, Program Case Manager Fatima Mirza, and Legislative and Communications Analyst Corey Painter attended the National Digital Health Forum presented by Center for Telemedicine and e-Health Law. I presented on two panels: one relating to AI sandboxes with the executive directors of the Oklahoma Medical Board and IMLCC. The second discussed the concept of licensing AI agents with another state medical board, academics, and a representative of the Cicero institute. For reference, the Cicero institute is the same group promoting legislation that would create a new regulatory body to regulate the practice of medicine by agentic AI tools separate from medical board oversight. The two-day forum also served as training and orientation for the Policy Team on telemedicine and AI issues at the state and national level.
- December 8: I will present at the American Telemedicine Association EDGE conference on AI policy trends, statutory changes, oversight, and potential payment models.

Amelia Boyd, Program Manager

Recruitment

We are seeking MDs in the following specialties to serve as Pro Tem Members:

- Urology
- Radiology
- Neurosurgery/Neurology
- General surgery
- Psychiatry
- Orthopedic surgery

If you know anyone who might be interested in serving as a Pro Tem, please have them email me directly at amelia.boyd@wmc.wa.gov.

For additional details about WMC membership, visit our website: Medical Commission Members. We also have an informational video on our YouTube channel that outlines the roles and responsibilities of Commissioners.

The following position expired as of June 30, 2022, and we are awaiting word from the Governor's office staff on the new appointee:

- Public Member – Toni Borlas – not eligible for reappointment

The following position expired as of June 30, 2023, and we are awaiting word from the Governor's office staff:

- Public Member – Scott Rodgers – eligible for reappointment

Amelia Boyd, Program Manager continued

We have completed recruiting for the following positions whose terms ended on June 30, 2026:

- One physician representing Congressional District 3 – Dr. Po-Shen Chang, eligible for reappointment
- One physician representing Congressional District 5 – Dr. April Jaeger, not eligible for reappointment
- One physician representing Congressional District 9 – Dr. Daniel Cabrera, eligible for reappointment
- One Physician-at-Large – Dr. Mvundura, eligible for reappointment
- One Physician Assistant – Ed Lopez, PA-C, eligible for reappointment
- Two Public Members
    - Jamie Koop, eligible for reappointment
    - Douglas Pullen, eligible for reappointment

The applications along with our recommendations were sent to the Boards and Commissions office in early June.

If you have questions about serving as a member of the WMC, please contact me at amelia.boyd@wmc.wa.gov.

Mike Hively, Director of Operations and Informatics

Operations and Informatics

Between August 11 and November 2, 2026, the team continued tracking eleven active litigation holds, added one new hold, and is currently processing two holds involving approximately 14,000 documents and completed one electronic search for records. Also, the team processed four inquiries from the Department's Public Disclosure Office. Five compulsory requests were received with four completed and one in progress. The combined pages reviewed were approximately 18,000 with over 1,000 redactions applied and 21 pages withheld.

Digital Archiving

The team completed the following records processing:

- 179 case files totaling 7,255 pages scanned for digital archiving
- 212 paper-based PA applications scanned and processed to PDF/A format
- 493 MD licenses processed to PDF/A format
- 513 licenses uploaded to the HELMS database
- 9 complaints closed below threshold (BT) processed to PDF/A format
- 46 duplicate records deleted from HELMS

Data Requests and Demographic Work

The team handled six external email inquiries regarding providers' open and closed complaints and processed over 700 address changes.

Mike Hively, Director of Operations and Informatics continued

Demographic activities included:

- Adding approximately 100 anonymous census submissions to individual licensee applications
- Removing approximately 70 duplicate surveys from HELMS
- Correcting approximately 40 survey data entry errors
- Entering approximately 140 hard-copy and PDF census surveys into HELMS

The Power BI Demographics Dashboard was launched and updated. Staff also organized and cleaned census data for the quarterly dashboard update and continued reviewing census information for an upcoming revision. Additional static and customized census reports were prepared upon request.

IT Support and Administrative Activities

Ongoing support included technology assistance, equipment research and procurement, inventory preparation, software and hardware troubleshooting, VPN connectivity, and technology training for staff, commissioners, and pro tem personnel. Support was also provided during hybrid and in-person WMC meetings.

Lastly, activities also included mail processing, MFT folder creation, ILRS-to-HELMS meetings, and completion of five DOH training courses and all required Learning Center courses.

Gina Fino, MD, Medical Consultant, Director of Compliance

As most respondents began their compliance journey before the use of HELMS as our case management system, a compiled compliance file is still available and accessible in your HELMS portal for your compliance cases. As new respondents enter compliance using HELMS to track completed requirements, the compliance files will be available as separate deliverables in HELMS. We will keep the Commission informed about how to access these materials in preparation for personal appearances. Please provide feedback as we continue to use HELMS for compliance records and tracking.

At the conclusion of the November meeting, thirty-eight respondents will have appeared before the Commission in 2026. Many thanks to everyone for helping us make that happen. We look forward to having more respondents appear in 2027.

Rick Glein, Director of Legal Services

Legal Unit Staff Update

On September 2, Legal welcomed our newest staff attorney, Rachelle Villalobos. Rachelle most recently served at the King County Prosecuting Attorney's Office, collaborating with prosecutors and law enforcement on complex financial crime cases. Prior to that role, she spent more than a decade as a financial legal examiner with the Washington State Department of Financial Institutions Consumer Services Enforcement Unit. Rachelle graduated from the Golden Gate University School of Law.

Summary Actions:

In re Marnie L. Boyer, PA, Case No. M2026-68. In October 2026, the Commission issued an Ex Parte Order of Summary Suspension which ordered Ms. Boyer's physician assistant license be suspended pending further disciplinary proceedings by the Commission. A Statement of Charges (SOC) concurrently served on Ms. Boyer alleges that she was negligent in her prescribing of controlled substances and management of opioid prescribing to five patients, and also failed to appropriately examine and document two pediatric patients who presented with signs or symptoms consistent with non-accidental trauma or abuse. As of the writing of this staff report, the Commission has not received an Answer to the SOC. Ms. Boyer is required to respond to the SOC by November 16, 2026.*

In re Ray Fortner Smith, MD, Case No. 2026-8488. In November 2026, the Commission issued an Ex Parte Order of Summary Restriction which prohibits Dr. Smith from prescribing controlled substances pending further disciplinary proceedings by the Commission. A SOC concurrently served on Dr. Smith alleges that he negligently overprescribed methadone while working as the medical director of an opioid treatment program, failed to appropriately monitor and manage adverse effects of methadone, and failed to keep proper documentation. The Commission alleges that Dr. Smith's prescribing practices placed patients at risk of harm and created an unreasonable risk of methadone diversion into the community. As of the writing of this staff report, the Commission has not received an Answer to the SOC. Dr. Smith is required to respond to the SOC by November 23, 2026.*

*The license holder must file a request for hearing with the disciplining authority within twenty days after being served the statement of charges. RCW 18.130.090.

Orders Resulting from SOCs:

In re Yasser El-Wahidy Farrag, MD, Case No. M2026-272. Default Order (Failure to Respond).** In June 2026, a Health Law Judge (HLJ), on delegation from and authorized by the Commission, issued an Ex Parte Order of Summary Suspension which ordered Dr. Farrag's medical license be suspended pending further disciplinary proceedings by the Commission. A SOC concurrently served on Dr. Farrag alleges the Medical Board of California issued an Accusation alleging gross negligence, repeated negligent acts, failure to maintain adequate and accurate records, and dishonesty, which resulted in Dr. Farrag surrendering his California medical license. The Commission further alleges that the Maine Board of Licensure in Medicine issued a complaint regarding fraudulent activity taken by Dr. Farrag in response to his temporary privileges at St. Jospeh Hospital being revoked. The SOC alleges that Dr. Farrag let his Maine medical license expire while under investigation for the alleged unprofessional misconduct. In August 2026, upon delegation to a HLJ, a Final Order of Default was issued which concluded sufficient grounds exist to take disciplinary action and ordered Dr. Farrag's medical license be indefinitely suspended.***

In re Frederick Scott Dattel, MD, Case No. M2025-738. Agreed Order. In June 2026, a HLJ, on delegation from and authorized by the Commission, issued an Ex Parte Order of

Summary Suspension which ordered Dr. Dattel's medical license be suspended pending further disciplinary proceedings by the Commission. A SOC concurrently served on Dr. Dattel alleges Dr. Dattel surrendered his license in California after being convicted of a felony (false statements relating to health care matters in violation of 18 U.S.C. §§ 1035(a)(2) and 2), and the state of Florida suspended Dr. Dattel's medical license due to the California violation. In August 2026, the Commission accepted an Agreed Order in which Dr. Dattel agreed to permanently surrender his Washington medical license.

In re Barb H. Bailey, PA, Case No. M2025-1028. Final Order (Waiver of Hearing).** In December 2025, the Commission issued a SOC alleging that Ms. Bailey failed to comply with a March 2023 Stipulation to Informal Disposition (2023 STID) requirement that she submit a paper regarding the dangers of lapses of documentation, with a focus on time management techniques, and the potential impact poor documentation could have on patients. In January 2026, Ms. Bailey responded to the SOC and waived her opportunity for a hearing. In August 2026, the Commission issued a Final Order which reprimands Ms. Bailey for her willful and knowing refusal to comply with the 2023 STID requirement and ordered her to complete the requirement within 90 days of the Final Waiver Order. But for Ms. Bailey's retirement from the active practice of medicine, the Commission would have imposed a greater sanction.

In re Fernando D. Vega, MD, Case No. M2025-1193. Final Order.** In January 2026, the Commission issued an Ex Parte Order of Summary Suspension which ordered Dr. Vega's medical license be suspended pending further disciplinary proceedings before the Commission. The summary suspension order allowed for a brief period where Dr. Vega was able to issue prescriptions to established patients to mitigate the disruption in care. A SOC concurrently served on Dr. Vega alleges that he knowingly prescribed ibogaine, a psychedelic Schedule 1 controlled substance, despite an active practice restriction under a July 2025 Stipulation to Informal Disposition restricting Dr. Vega "from treating patients with MDMA, psilocybin, or any Schedule 1 psychedelic or hallucinogenic substance … unless they are approved by the FDA, DEA, or are otherwise legalized for a legitimate medical or therapeutic purpose". A hearing on the merits of the SOC was held on September 18, 2026. A HLJ, on delegation from and authorized by the Commission, issued a Final Order in September 2026 which permanently revoked Dr. Vega's medical license.

In re Harrison G. Frank, MD, Case No. 2025-15600. Default Order (Failure to Respond).** In July 2026, a HLJ, on delegation from and authorized by the Commission, issued an Ex Parte Order of Summary Suspension which ordered Dr. Frank's medical license be suspended pending further disciplinary proceedings by the Commission. A SOC concurrently served on Dr. Frank alleges that Dr. Frank voluntarily surrendered his medical license in North Carolina while under investigation for failing to conform to the standards of acceptable and prevailing medical practice relating to hormone prescribing for two patients and practicing in states in which he was not licensed. Dr. Frank did not file a response to the SOC within the time allowed. In October 2026, upon delegation to a HLJ, a Final Order of Default was issued which concluded sufficient grounds exist to take

disciplinary action and ordered Dr. Frank's medical license be indefinitely suspended.***

In re Brian Earl Goody, PA, Case No. M2026-75. Agreed Order. In March 2026, the Commission issued a SOC alleging Mr. Goody provided patient care to an elderly patient with dementia and contacted the patient by personal cell phone without a legitimate reason, violating professional boundaries. The Commission further alleged that Mr. Goody continued messaging the patient, violating professional boundaries over several days which occurred while a 2022 Stipulation to Informal Disposition was in place for a boundary violation towards a coworker. In October 2026, the Commission accepted an Agreed Order which requires Mr. Goody to undergo a fitness to practice evaluation, complete a professional boundaries course, write a reflective paper, maintain appropriate boundaries, attend personal appearances, and pay a fine of $5,000. Mr. Goody may petition to terminate the Agreed Order in two years.

In re Jonathan W. Hemmert, MD, Case No. M2025-870. Agreed Order. In November 2025, the Commission issued a SOC, with Amended SOCs filed in February and March 2026, alleging that Dr. Hemmert failed to supervise patient treatment, failed to ensure devices were FDA approved and had patients sign deceptive and dishonest waivers. In October 2026, the Commission accepted an Agreed Order in which Dr. Hemmert agreed to a Practice Agreement to not serve as a medical director of any clinic or facility in Washington state in which the Cryoskin device, Neveskin device, or substantially similar device is being used on patients until the device has been approved or cleared by the FDA. Dr. Hemmert also agreed, when serving as a medical director in Washington state, he will ensure a patient or customer is not asked to sign a release of liability document connected in any way with the patient's or customer's receipt of services in the clinic. The Agreed Order requires Dr. Hemmert to complete an ethics course, permit compliance audits of any clinic where he is a medical director, and pay a fine of $1,000. Dr. Hemmert may petition to terminate the Agreed Order in three years.

In re James P. Bossmann, MD, Case No. M2025-496. Agreed Order. On March 2, 2026, the Commission issued an Ex Parte Order of Summary Suspension which ordered Dr. Bossmann's medical license be suspended pending further disciplinary proceedings. A SOC concurrently served on Dr. Bossmann alleges that Dr. Bossmann failed to maintain appropriate boundaries with a patient. The Commission further alleges that Dr. Bossmann underwent two comprehensive evaluations, and each team of evaluators opined that Dr. Bossmann is not safe to practice medicine with reasonable skill and safety due to ongoing symptoms of an impairing health condition. In October 2026, the Commission accepted an Agreed Order which continued the suspension of Dr. Bossmann's medical license.*** Dr. Bossmann may petition for reinstatement after he submits proof he has completed the following requirements: 1.) psychiatric-specific treatment; 2.) professionals-specific treatment; 3.) enrollment in the Washington Physician Health Program (WPHP); 4.) boundaries and ethics CME; and 5.) submission of a paper reflecting on his treatment and the completed CME, stating how he intends to apply what he learned to his practice. Dr. Bossmann also agreed to pay a $5,000 fine.

The period of suspension during which Dr. Bossmann receives the treatment needed will be followed by an indefinite period of monitoring.

In re Patrick J. D'Abbracci, MD, Case No. M2026-66. Final Order (Waiver of Hearing.)** In May 2026, a HLJ, on delegation from and authorized by the Commission, issued an Ex Parte Order of Summary Suspension which ordered Dr. D'Abbracci's medical license be suspended pending further disciplinary proceedings by the Commission. A SOC concurrently served on Dr. D'Abbracci alleges Dr. D'Abbracci enrolled in a five-year health support agreement with the Washington Physicians Health Program (WPHP), but WPHP reported that Dr. D'Abbracci was administratively discharged due to incarceration. In August 2026, Dr. D'Abbracci responded to the SOC and waived his opportunity for a hearing. In October 2026, the Commission issued a Final Order finding that Dr. Bossmann was administratively discharged from WPHP due to WPHP's inability to monitor his health condition while he is incarcerated and ordered that Dr. D'Abbracci's medical license be indefinitely suspended.***

In re Robert Jarczak, PA, Case No. M2025-832. Final Order.** In May 2025, Mr. Jarczak submitted an application to the Commission for a Physician Assistant license. A Notice of Decision on Application denying the application was issued in December 2025 based on criminal convictions and licensing action in Texas and Washington. Mr. Jarczak requested a hearing which was held in September 2026. The Commission issued a Final Order in October 2026 which granted Mr. Jarczak's application upon meeting the minimum regulatory requirements for credentialing. Mr. Jarczak's credential was issued on October 30, 2026, and immediately placed on probation for at least 48 months. The Final Order requires Mr. Jarczak to complete a CME; prepare and submit a written paper, providing insight into his past behavior and decision-making; obtain an assessment from WPHP; submit personal progress reports; provide a copy of the Final Order to current and future health care employers; and cause his health care employer to submit 16 quarterly performance evaluation reports. Mr. Jarczak may petition to modify the terms and conditions of the Final Order no sooner than 12 months.

**Either party may file a petition for reconsideration within ten days of service of the order. RCW 34.05.461(3); 34.05.470. A petition for judicial review must be filed and served within 30 days after service of the order. If a petition for reconsideration is filed, the 30-day period does not start until the petition is resolved. RCW 34.05.542; 34.05.470(3).
***A person whose license has been suspended under chapter 18.130 RCW may petition the disciplining authority for reinstatement. RCW 18.130.150.

Interstate Medical Licensure Compact (IMLC) Automatic Discipline:
In re Charles E. Chandler, II, MD, Case No. 2026-15926. Order of Automatic Suspension of IMLC License.**** Dr. Chandler was first issued his Washington state medical license in June 2025 through the Interstate Medical Licensure Compact (IMLC). Dr. Chandler's state of principal licensure is Georgia. The Commission found that the Texas Medical Board suspended Dr. Chandler's license to practice as a physician in June 2026.

Accordingly, in September 2026, the Commission ordered Dr. Chandler's Washington state medical license also be suspended.*****

In re Jason S. Finkelstein, MD, Case No. 2026-19120. Order of Automatic Suspension of IMLC License.**** Dr. Finkelstein was first issued his Washington state medical license in March 2022 through the IMLC. Dr. Finkelstein's state of principal licensure is Texas. The Commission found that Dr. Finkelstein's licenses to practice medicine were suspended by the Kentucky Board of Medical Licensure (August 2026), the Kansas State Board of Healing Arts (September 2026), the West Virginia Board of Medicine (October 2026), and the North Dakota Board of Medicine (October 2026). Accordingly, in October 2026, the Commission ordered Dr. Finkelstein's Washington state medical license also be suspended.*****

In re William Asa Seeds, MD, Case No. 2026-16127. Order of Reciprocal Action Imposing Sanctions on IMLC License.**** Dr. Seeds was first issued his Washington state medical license in August 2023 through the IMLC. Dr. Seeds' state of principal licensure is Ohio. The Commission found that the State Medical Board of Ohio (Ohio Board) suspended Dr. Seeds' medical license in July 2026. A stay of the suspension was granted in August 2026. During the pendency of the appeal to the Ohio Board, Dr. Seeds shall not provide infusion clinic services or ketamine clinic services in the State of Ohio and shall complete the CME course designated in the suspension order within nine months. Accordingly, in October 2026, the Commission imposed reciprocal conditions on Dr. Seeds' Washington state medical license.*****

****If a license granted to a physician by the member board in the state of principal license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status. If the member board in the state of principal license subsequently reinstates the physician's license, a license issued to the physician by any other member board shall remain encumbered until that respective member board takes action to reinstate the license in a manner consistent with the medical practice act of that state. RCW 18.71B.100(2).
*****Upon receipt of notice from the Interstate Commission that a license granted to a physician by a member board other than the state of principal license is revoked, surrendered, suspended or relinquished in lieu of discipline, then any license(s) issued by any member board(s), including the state of principal license, shall be automatically and immediately suspended by the other member board(s) for 90 calendar days on entry of the order of the disciplining board to permit the member board to investigate under the Medical Practice Act of that state. ILMC Rule 6.5g.

Items of Interest:
On September 17, the Legal-Compliance Unit met in person at the Harbor House in Olympia for a day of camaraderie and collaboration. Carmen and Sara guided us through several team-building activities to begin our day. Rick, Mike F., and Gina treated the team to pizza from Vic's, a favorite pizzeria among the locals. Legal & Compliance is

Rick Glein, Director of Legal Services continued

grateful to Kyle for carving out time from his packed schedule to stop by, lend his support, and engage in an exchange of insights and wisdom. To round out the afternoon, Mike F. and Kristin Brewer led us through an intriguing presentation on Tales from the Trenches. A huge thank you to our planning committee this year – Carmen, Sara, and Carolynn.

In November, the Legal Unit commenced coordinating file and pleading exchanges with the Attorney General's Office via HELMS. We appreciate the support and collaboration we have received from the Assistant Attorneys General and AGO paralegals as the Legal team implements another component of the HELMS database.

On November 6, the Legal Unit facilitated the Inaugural Quarterly Interactive Lunchtime Q&A with the Commissioners. Rick started us out with a short presentation to clarify the differences between disciplinary actions. Unit leadership from Investigations, Legal, and Compliance were available to answer questions about unit-specific processes as we work together on disciplinary cases. We appreciated the insightful questions and enjoyed the opportunity to delve into various topics together. We will be reaching out again in a few months to find a date for the next meeting that accommodates more Commissioners.

Freda Pace, Director of Investigations

Complaint Intake

There has been a significant increase in complaint volume for October and November. Additional CMT dates may be needed to accommodate reviews of pending complaints to avoid a backlog.

CMT panels are filled for the remainder of 2026. January 2027 has a few vacancies for both public and clinical commissioners. Visit our SharePoint for available dates or contact Chris Waterman.

We appreciate your continued participation in this very important process. We would not be able to do this work without you and your support!

Remember, if you sign up for a CMT slot and you have a last-minute scheduling conflict, please reach out to Chris Waterman as soon as you are able to ensure that we have adequate staffing needs.

Jimi Bush, Director of Quality and Engagement

Call for Speakers

I am starting to populate the 2027 CME webinar schedule. I am looking for speakers with expertise in the following areas:

- How to talk to your doctor about your healthcare needs as an LGBTQ individual.
- "Webside" Manner

Jimi Bush, Director of Quality and Engagement continued

- Infections Disease in the aftermath of COVID
- Non-surgical cosmetic procedures

Please send any recommendations to Jimi

Staffing Update
Anjali, our performance and productivity manager recently gave birth to a healthy baby girl. She will be on leave as a result. Any issue that you would normally direct to her, please send to Jimi. I have been appointed as a member of the healthcare policy group with the Washington State Women's Commission. I am very excited to intersect the work of the Commission with the WSWC.

HELMS Update
The HELMS business team has stressed to us that their unit is understaffed at the moment. As a result, our request for updates to the commissioner portal and meeting structures are caught in a backlog. There is no timeframe for when these fixes will be addressed. If you are struggling with HELMS or uploading your materials, please contact Jimi.

Fiscal Year 2026
The FY26 Performance report is now available on our website.

Newsletter
The most read newsletter article in the fall edition was Oversight Challenges of Medical Spas:

What Washington Physicians Need to Know with over 2100 views. If you have a topic you would like to write about for the upcoming newsletter, please let Jimi know.

Mahi Zeru, Strategy Manager

Reasonable Accommodation Update
2026 – **50** fulfilled requests and 1 request for request for reconsideration

Upcoming FGM/C Awareness Training
Date & Time: January 20, 11:00 AM – 12:00 PM

Overview: A specialized training session for WMC staff and commissioners covering cultural nuances, trauma-informed perspectives and survivor experiences. Trainers will also review specialized interviewing techniques, evidence collection, and statutory enforcement. Calendar invitation with virtual meeting link will be sent soon!

Adriann Jones, Policy Manager

A brief introduction of myself, I've worked in public policy for about 10 years, primarily in vaccines. I live in Redmond with my partner and three animals who will likely make appearances in our meeting spaces. When I'm not analyzing RCWs and WACs or the current policy landscape, I'm curled up with a good book or spending time with my

Adriann Jones, Policy Manager continued

family. I'm eager to support the Commission's policy needs and help sustain our mission.

Right now, I'm focused on two main areas. First, I'm analyzing emerging research and policy approaches to psychedelics in behavioral health, with the goal of drafting guidance that is grounded in evidence and attentive to safety. Second, I'm preparing for the 2027 legislative session, which includes tracking relevant bills, anticipating stakeholder questions, and making sure the Commission has the analysis and materials it needs to engage effectively.

Marisa Courtney, Licensing Manager

Total licenses issued from 08/12/2026-11/10/2026= 1,194 Licenses

Credential Type	Total Workflow Count
Certified Anesthesiologist Assistant License	4
Physician And Surgeon Clinical Experience License	21
Physician And Surgeon Fellowship License	1
Physician And Surgeon Institution License	0
Physician And Surgeon License	507
Physician and Surgeon License Interstate Medical Licensure Compact	368
Physician And Surgeon Residency License	14
Physician And Surgeon Teaching Research License	2
Physician And Surgeon Temporary Permit	0
Physician Assistant Interim Permit	14
Physician Assistant License	263
Physician Assistant Temporary Permit	0
Totals:	**1194**

Information on Renewals: Aug- Oct Renewal Count Total

Credential Type	Total # of Renewals
CAA	1
IMLC	459
MD	3902
MDCE	3
MDRE	10

Marisa Courtney, Licensing Manager continued	
Credential Type	**Total # of Renewals**
MDFE	1
MDTR	17
MDIN	1
PA	721
Total:	**5115**

Licensing Unit Update

The Licensing Unit continues to experience a steady volume of applications; however, we are pleased to report that our licensing processing timelines are beginning to decrease. Following an exceptionally busy and impactful peak season, this is an encouraging improvement and a reflection of the continued hard work and dedication of our Licensing team. We are hopeful that this positive momentum will continue as we move into the final months of the year.

As we navigate a season of change within the Licensing Unit, we will also be saying a bittersweet goodbye to our Interstate Medical Licensure Compact (IMLC) Specialist, Sylke Dixon. Sylke has been with the Commission for 6.5 years and was instrumental in piloting and developing the IMLC Licensing Specialist position into what it is today. Her dedication, expertise, and contributions have been invaluable to the success of the program and our team.

While we are incredibly sad to see her leave, we are equally excited for her next chapter with the Prison Pet Partnership Program, where she will have the opportunity to pursue her passion for working with animals and make a meaningful difference. Her last day with the Commission will be November 13, 2026, and we wish her nothing but success and happiness in this new adventure.

With Sylke's departure, we approached Zachary Santos, our current PA Compact Specialist, about transitioning into the IMLC Specialist position, and we are pleased that he has accepted this opportunity. Over the coming weeks, we will focus on providing Zach with the training and resources necessary to ensure a successful transition. Once he is fully trained and comfortable working independently, we anticipate beginning the process of filling the PA Compact Specialist position within the next few months.

PA Compact Update

The PA Compact continues to make exciting progress toward implementation, with several important developments underway.

On November 18, 2026, the Technology Committee will participate in its third sprint demonstration, providing another opportunity to review the progress being made in developing the Compact's data system. These demonstrations continue to be an important part of ensuring the system is moving forward and meeting the operational needs of the Compact.

Additionally, more proposed rules have been drafted and submitted for public comment, with plans to present them to the Executive Committee for consideration and adoption.

Marisa Courtney, Licensing Manager continued

We are also excited to share that Pennsylvania has officially joined the PA Compact as its 30th member state! This milestone reflects the continued growth and support for the Compact as we work toward implementation.

For those interested in following the technology development process, recordings of the sprint demonstrations are being made available on the PA Compact's website. Additional recordings will continue to be posted as development progresses.

PA Compact News and Updates: https://www.pacompact.org/news/

We look forward to sharing additional updates as the Compact continues to move closer to becoming operational.

American Board of Medical Specialties
Higher standards. Better care.™

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(312) 436-2600
abms.org

BY ELECTRONIC MAIL

September 14, 2026

Kyle Karinen, JD
Executive Director
Washington Medical Commission
111 Israel Road SE
Tumwater, WA 98501

Re: American Board of Medical Specialties (ABMS) Statement on the Florida Board of Medicine's Decision To Add a Recognizing Agency to Its Advertising Administrative Rule

Dear Mr. Karinen and members of the Washington Medical Commission,

We would like to bring to your attention a recent action by the Florida Board of Medicine that will result in Florida's patients receiving misleading medical information regarding how a physician has been formally recognized as a specialist. Both ABMS and state medical boards share a commitment to ensuring that patients, the public, and other users of a board certification credential are provided with accurate information regarding a specialty physician's qualifications and how those qualifications are assessed. Unfortunately, the Florida Board of Medicine failed to honor this commitment

Specifically, ABMS is disappointed in the Florida Board of Medicine's decision to approve the National Board of Physicians and Surgeons (NBPAS) as a "recognizing agency" under its "truth in advertising" rule, which was only possible by exempting NBPAS from a critical requirement in the existing rule. As a result of this decision, NBPAS' members in Florida are now permitted to represent to the public that they are "specialists" even though NBPAS has not administered its own initial comprehensive examination to assess its members' clinical knowledge and skills, which is a requirement that applies to all other recognizing agencies. By disregarding the law in this manner, the Florida Board of Medicine has failed to follow its longstanding precedent of only approving recognizing agencies with rigorous physician specialty certification programs—such as ABMS and the additional seven certifying bodies identified in the rule—which in fact administer their own initial and ongoing examinations to assess the clinical knowledge and skills of their diplomates.

We all care deeply about our independent roles and work to improve the delivery of quality medical care and patient safety. ABMS staff would like the opportunity to meet with you and/or your staff to share more about how ABMS Member Boards have worked to make certification programs relevant, flexible, and meaningful for today's physicians. To schedule a time to meet, I encourage you to contact Amy Gibson, Senior Vice President, Policy and External Relations, at agibson@abms.org.

Sincerely,

Richard E. Hawkins, MD

President and Chief Executive Officer

cc: Amelia Boyd (Program Manager) and Washington Medical Commission staff

August 24, 2026

Executive Director Michael Meotti
Washington Student Achievement Council
917 Lakeridge Way SW
Olympia, WA 98502

Submitted via Email

Re: Concerns Regarding "Diploma Mills"

Dear Executive Director Meotti:

On behalf of the American Osteopathic Association (AOA) and the 43 undersigned osteopathic specialty and state associations, collectively representing over 207,000 osteopathic physicians (DOs) and osteopathic medical students (OMSs) nationwide, we write today to bring your attention to a concerning issue which has implications for the integrity of higher education, state and federal consumer protections, and public trust in the medical professions.

In recent months, our organizations have become aware of an increase in third-party entities marketing so-called "degree conversion" services (also known as diploma mills) to licensed physicians. These organizations claim, often through unsolicited outreach and online advertising, that a Doctor of Osteopathic Medicine (DO) degree may be "converted" into a Doctor of Medicine (MD) degree, or vice versa, by simply paying a fee to the organization, without the recipient completing the standardized and accredited educational pathway leading to the other degree.

Unfortunately, many state laws do not actually prevent a physician of one educational background from claiming the other degree (i.e. "John Smith, MD, DO" or "John Smith, DO, MD"). The law may state, for example, "a person who is licensed by the state medical board and who holds a doctor of medicine degree shall use 'physician and surgeon,' 'MD,' etc.," without prohibiting them from *additionally* using the DO degree, and vice versa. Unscrupulous individuals have taken note and are now exploiting these ambiguities for their own financial gain, raising serious concerns within the medical community about higher education oversight, healthcare truth in advertising, and public transparency.

By way of additional background, DO and MD physicians do complete similar education and training (as outlined below) – *which is equivalently rigorous but contains several important differences* – before they become eligible for unlimited medical licensure as *either* a DO *or* an MD in all 50 states:

- Four years of medical school, comprised of two years of didactic study followed by two years of clinical rotations done in community hospitals, major medical centers, and doctors' offices;
    - *NOTE: MD-granting medical schools are accredited by the Liaison Committee on Medical Education (LCME), and DO-granting schools are accredited by the Commission on Osteopathic College Accreditation (COCA). Both organizations are recognized as setting the standards necessary for competent practice as either an MD or as a DO, respectively, by the US Department of Education.*

    - *As part of their COCA-accredited education, DOs complete 200+ hours of training in osteopathic principles and practice that MD students do not complete, which enables DOs to safely treat patients using hands-on modalities (osteopathic manipulative treatment), in addition to options such as medication or surgery;*
- 12,000 – 16,000 hours of supervised postgraduate education (residency) over the course of three to seven years to develop advanced knowledge and clinical skills relating to a wide variety of conditions;
- A comprehensive, three-part medical licensing examination series (either the Comprehensive Osteopathic Medical Licensing Examination, which *specifically tests fitness for osteopathic medical practice*, or the US Medical Licensing Examination);
- Many physicians also choose to sit for certifying board exams in their chosen specialty, either through the AOA Bureau of Osteopathic Specialists or through the American Board of Medical Specialties; and
- They also complete osteopathic and/or allopathic (MD) continuing medical education hours throughout the tenure of their practice.

In recognition of the fact that there are two distinct medical educational pathways and two medical degree types in the US, every state has established laws and regulations which allow physicians who graduated from a COCA-accredited medical school to apply for licensure as a "doctor of osteopathic medicine" (sometimes referred to as a "doctor of osteopathy"), and physicians who graduated from an LCME-accredited medical school to apply for licensure as a "doctor of medicine." State laws also prohibit non-physicians from using either title.

There is *no* recognized academic or regulatory process in the US that permits the conversion of one primary medical degree into another. MD and DO degrees are awarded only upon completion of separate, fully accredited medical education programs, each governed by distinct accrediting bodies recognized by the US Department of Education. Credentials marketed by diploma mills—often described as "certificates of equivalence" or "supplemental diplomas"—do not constitute degrees from accredited institutions and do not carry validity for licensing, employment/insurance, or clinical practice. They exist solely to mislead.[1, 2, 3]

The federal Higher Education Act of 1965 recognizes the problem of diploma mills and directs the US Department of Education to provide information to the public and to coordinate with federal enforcement agencies to deter and address such practices. Federal statute defines a diploma mill as an entity that offers academic credentials for a fee while requiring little or no legitimate educational coursework and lacking accreditation from an agency recognized by the Secretary of Education.[4] Federal law establishes clear standards for the recognition of accrediting bodies, ensuring that only those meeting rigorous criteria (such as COCA and LCME) may serve as authorities on educational quality. Programs or institutions that rely on

[1] "Getting a secondary MD degree as a DO – is it possible, and what could be the harm?" https://thedo.osteopathic.org/2026/04/getting-a-secondary-md-degree-as-a-do-is-it-possible-and-what-could-be-the-harm/
[2] Diploma Mills and Accreditation. https://www.ed.gov/laws-and-policy/higher-education-laws-and-policy/college-accreditation/diploma-mills-and-accreditation
[3] College Degree Scams. https://consumer.ftc.gov/articles/college-degree-scams
[4] Higher Education Act of 1965, As Amended Through P.L. 119-21, Enacted July 4, 2025. p. 19, 33. https://www.govinfo.gov/content/pkg/COMPS-765/pdf/COMPS-765.pdf

unrecognized or self-created accreditation frameworks fall outside these standards and may mislead or cause harm to consumers.[5]

In addition to violating the Higher Education Act, diploma mills also contravene federal consumer protection principles. The Federal Trade Commission has long held that misleading claims regarding educational credentials, accreditation status, or professional outcomes may constitute deceptive practices under federal law. Representations suggesting that an individual may lawfully advertise an additional medical degree designation—without having completed the accredited degree program associated with that designation—risk misleading not only physicians, but also employers, licensing bodies, and the public.[6]

From the perspective of occupational licensing and regulation, the downstream consequences of diploma mill practices are substantial. Physicians who rely on unearned credentials could be subject to disciplinary scrutiny, employment consequences, or reputational harm. More broadly, the existence of these entities risks confusing the public and undermining confidence in the systems that safeguard educational quality and professional licensure—systems in which state agencies play an essential role.

For this reason, we believe collaboration with state higher education agencies is critical. While educational accreditation is primarily a federal responsibility, state agencies remain key partners in identifying problematic actors, informing the public, and coordinating with state licensing authorities and attorneys general. Clear and consistent messaging from education regulators can help deter misleading practices before they gain further traction.

We respectfully urge the Washington Student Achievement Council to:

1. **Consider issuing general guidance** clarifying that primary medical degrees cannot be converted and holders must complete separately accredited medical education programs recognized under federal law.
2. **Evaluate whether entities promoting medical degree "conversion" services violate state education or consumer protection laws**, particularly where degree-granting authority or equivalency is implied.
3. **Coordinate, as appropriate, with the state attorney general's office and relevant professional licensing boards** to ensure shared awareness and consistent regulatory responses.
4. **Refer interested parties to established federal resources** maintained by the US Department of Education and the Council for Higher Education Accreditation regarding diploma mills and recognized accreditation entities.

We appreciate your longstanding commitment to preserving academic integrity and protecting the public from misleading claims. The AOA, our state and specialty affiliates, and our members stand ready to assist you in your endeavors. Should you have any questions or if we can be a resource, please contact Raine Richards, JD, AOA Vice President of State and International Affairs at rrichards@osteopathic.org.

Sincerely,

[5] Higher Education Act of 1965, As Amended Through P.L. 119-21, Enacted July 4, 2025. p. 698 - 706. https://www.govinfo.gov/content/pkg/COMPS-765/pdf/COMPS-765.pdf
[6] Avoid Fake-Degree Burns By Researching Academic Credentials. https://www.ftc.gov/node/60304

American Osteopathic Association
Arkansas Osteopathic Medical Association
Arizona Osteopathic Medical Association
Florida Osteopathic Medical Association
Georgia Osteopathic Medical Association
Hawaii Association of Osteopathic Physicians & Surgeons
Idaho Osteopathic Physicians Association
Illinois Osteopathic Medical Society
Indiana Osteopathic Association
Kentucky Osteopathic Medical Association
Maine Osteopathic Association
Michigan Osteopathic Association
Mississippi Osteopathic Medical Association
Missouri Association of Osteopathic Physicians and Surgeons
Montana Osteopathic Medical Association
North Carolina Osteopathic Medical Association
New Hampshire Osteopathic Association
New Jersey Association of Osteopathic Physicians and Surgeons
New York State Osteopathic Medicine Society
Ohio Osteopathic Association
Oklahoma Osteopathic Association
Osteopathic Physicians & Surgeons of California
Osteopathic Physicians & Surgeons of Oregon
Pennsylvania Osteopathic Medical Association
Tennessee Osteopathic Medical Association
Texas Osteopathic Medical Association
Virginia Osteopathic Medical Association
Wisconsin Association of Osteopathic Physicians and Surgeons

American Academy of Osteopathy
American College of Osteopathic Emergency Physicians
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Obstetricians and Gynecologists
American College of Osteopathic Pediatricians
American College of Osteopathic Surgeons
American Osteopathic Academy of Orthopedics
American Osteopathic College of Anesthesiology
American Osteopathic College of Occupational and Preventative Medicine
American Osteopathic College of Ophthalmology and Otolaryngology – Head and Neck Surgery
American Osteopathic College of Pathologists
American Osteopathic College of Physical Medicine and Rehabilitation
American Osteopathic College of Radiology
Florida Society of the American College of Osteopathic Family Physicians
Student Osteopathic Medical Association

Outlook

Fw: New AAPM Acute Low Back Pain Guideline + Free CME Resources

From Boyd, Amelia (WMC) <Amelia.Boyd@wmc.wa.gov>
Date Thu 10/29/2026 5:29 PM
To Boyd, Amelia (WMC) <Amelia.Boyd@wmc.wa.gov>

From: Sabrina Kidwai <kidwaicollective@gmail.com>
Sent: Thursday, October 1, 2026 6:40 AM
To: Karinen, Kyle S (WMC) <kyle.karinen@wmc.wa.gov>
Subject: New AAPM Acute Low Back Pain Guideline + Free CME Resources

External Email

Dear Mr. Karinen:

I wanted to share a new resource from the American Academy of Pain Medicine (AAPM) that may be helpful to health care professionals in your state.

Today, AAPM released a new clinical practice guideline on the assessment and treatment of acute low back pain, along with several free resources for health care professionals and patients.

Resources include an on-demand 1.5-credit CME activity available at no cost, as well as a dedicated health care professional website with clinical and implementation tools and a separate patient website with information and resources.

I've pasted the press release below with additional information and links to the new resources. We hope you'll consider sharing these free resources with physicians and other health care professionals in your state who may benefit from them.

Thank you for helping us spread the word. If you have any questions, please let us know.

Sincerely,
Sabrina Kidwai

--
Sabrina Kidwai
CEO
Kidwai Collective
https://kidwaicollective.com/
Instagram:@Kidwaicollective
Threads: @Kidwaicollective

Media Contact: Sharon Kneebone, IOM FASAE, CAE | skneebone@painmed.org | +1 443 399 1465

Sabrina Kidwai, APR, CAE | kidwaicollective@gmail.com | 703-801-1107

New Acute Low Back Pain Guideline Emphasizes Early Self-Care, Selective Imaging and Limited Opioid Use

[Columbia, MD] — [October 1, 2026] — The American Academy of Pain Medicine (AAPM), the Pacific Northwest Evidence-based Practice Center at Oregon Health & Science University, and Aggregate Analytics, Inc. today announced the publication of a new clinical practice guideline and accompanying systematic review in *Pain Medicine*.

Assessment and Treatment of Acute Low Back Pain: A Multidisciplinary Clinical Guideline provides evidence-based recommendations for outpatient care of adults with atraumatic acute low back pain lasting six weeks or fewer, with or without radiculopathy. The recommendations are intended to support individualized clinical judgment and shared decision-making.

Key findings from the guidelines

- **Avoid routine early imaging.** Do not routinely obtain imaging unless signs, symptoms or risk factors suggest serious spine pathology.

- **Begin with Education and self-management.** Explain the usual course, reassure patients that movement is generally safe, encourage continued low-impact activity, and consider appropriate self-management options.

- **Add evidence-based options when needed.** If symptoms do not improve after one or two weeks, consider nonopioid and nonpharmacologic options based on the patient's health, preferences, or prior response, safety, access, and cost.

- **Avoid routine initial opioid use.** Consider a short course of short-acting opioids only in selected circumstances when pain remains severe despite optimized alternatives and the anticipated benefits outweigh the risks.

"Many patients with acute low back pain can improve without intensive intervention," said Devan Kansagara, MD. "This guideline gives clinicians a practical framework to identify serious conditions, help patients remain active, and add treatment selectively while respecting individual needs and preferences."

The guideline is designed to inform, not replace, clinical judgment. Its recommendations are not intended to restrict, limit, delay or deny access to clinically appropriate care.

AAPM has also developed multiple implementation resources for clinicians and patients, including a point-of-care reference, patient discussion tools, and a free 1.5-credit clinician education activity.

Access the guideline and resources*

- **Guideline and systematic review:** www.painmed.org/acute-low-back-pain-guideline
- **Clinician education and implementation tools:** www.painmed.org/acute-low-back-pain-clinicians
- **Patient information and resources:** www.painmed.org/acute-low-back-pain-patients

**Contact AAPM for permissions to preview the embargoed URLs.*

Funding and collaboration

This project is supported by the Food and Drug Administration (FDA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award (FAIN) totaling $1,999,980, with 100 percent funded by FDA/HHS. The content is that of the authors and does not necessarily represent the official views of, nor any endorsement by, FDA/HHS or the U.S. Government.

###

The **American Academy of Pain Medicine** advances evidence-based, patient-centered pain care through clinical guidance, education, advocacy, research, and professional collaboration. AAPM brings together physicians and other pain professionals committed to improving function, quality of life, and outcomes for people living with pain. Learn more at painmed.org.

The **Pacific Northwest Evidence-based Practice Center at Oregon Health & Science University** conducts systematic reviews that help clinicians, policymakers, researchers, and other decision-makers evaluate healthcare evidence. Its work informs clinical practice guidelines, reimbursement and coverage policies, and future research. Learn more at ohsu.edu/evidence-based-practice-center

Aggregate Analytics, Inc. is a healthcare research firm specializing in systematic reviews, comparative-effectiveness reviews, health technology assessments, and evidence synthesis. Its interdisciplinary team evaluates clinical research to help public and private organizations make evidence-informed decisions about healthcare practice, policy, and clinical guidance. Aggregate Analytics is a partner in the Pacific Northwest Evidence-based Practice Center.

Dear Washington State Medical Commission and Leadership,

I pray this message finds you well.

Please thoroughly review this. I truly believe it's the one thing needed to add value to the Joel's law petition and make it more effective.

A specialized unit is desperately needed within the attorney general's office.

Below and attached is just for information. Completely separate from my filings for my sister. I thought this might be helpful in your advocacy for the great state of Washington.

Before anything else, I want to express my sincere respect and gratitude for the life you've all chosen to lead.

Whether or not people always see it, your work has created opportunities, solved problems and positively impacted countless lives. I can only imagine the weight of the responsibility that comes with stewarding such influence and making decisions that affect others.

Thank you for your willingness to serve through your faith, leadership, kindness and commitment to making a meaningful difference.

I hope you know that your efforts are seen, valued and deeply appreciated.

God bless you.

I am a passionate advocate for mental health and for improving the systems, resources and compassionate support available to those who need them most.

I am also deeply passionate about caregiving, elder care and women's health, particularly raising awareness about postpartum depression and postpartum psychosis, conditions that can profoundly affect mothers and their families.

I am also a guardian, caregiver and advocate for [redacted] That experience has given me an intimate understanding of how difficult and overwhelming it can be for families to navigate healthcare, mental health services, caregiving systems and elder care, especially when the systems designed to help can sometimes feel fragmented, difficult to navigate or inadequate to meet the needs of vulnerable individuals and their families.

[redacted]

These experiences have profoundly shaped my sense of purpose and priorities. They have given me a deep commitment to advocating for vulnerable individuals and families, raising awareness and helping create better systems of care, systems rooted in compassion, dignity, understanding, early intervention and genuine support.

Not just preventative care but primarily crisis management and intervention.

I believe that no mother, child, elderly person, caregiver or family should have to navigate these challenges alone.

This past 6 years for many have been painful, traumatic and life altering, including for myself.

But instead of drowning in pain.

I choose to turn a very painful moment and turn it into purpose.

I created this system for Ohio due to [redacted] being there at the time and guardianship was there as well but I pray you can see the benefit for Washington state as well and to build and duplicate nationally (maybe one day globally) to bring awareness that impacts us all. This lived experience is what inspired me to build a better caregiver system and supportive app to pour into building stronger family foundations.

With that in mind, I wanted to reach out and take a big leap of faith…

I am writing to share attached with you because I know you care.

My goal is to encourage an Executive, Legislative and Interagency review of the attached SEIU-M proposal, distribution to relevant Statewide, Federal and Worldwide Leadership and an opportunity to meet with the right personnels to discuss it. In addition to a proposal I created for better legislative laws and guidance for woman's health.

My background is technical, not political, legal or medical. I analyze problems from a systems perspective and that lens is what led me here. [redacted]. It revealed large gaps.

Huge gaps in how our systems coordinate care, communicate across agencies and respond when vulnerable and elderly people are at their most fragile.

[redacted].

However, I know many families have not been so fortunate and that is what compelled me to act.

That experience, that truthful pain, shaped the attached proposal for a Specialized Emergency Intervention Unit, Medical Stabilization (SEIU-M), an interdisciplinary framework designed to strengthen crisis response, continuity of care and protections for vulnerable populations across Ohio, Florida, New York, nationwide and worldwide.

Attached for your review:

1. SEIU-M Fact Sheet
2. SEIU-M Executive Action Memo
3. SEIU-M Executive Briefing Summary
4. SEIU-M Proposal
    - The Systems Modernization Proposal and Operational Implementation Framework
5. SEIU-M White Paper
6. SEIU-M Case Study and Systems Impact Analysis
7. SEIU-M Ownership Diagram (Pyramid)
8. SEIU-M Distribution List
9. Interagency Letters - Attached Zip Folder contains 22 Distributed Letters.

I would be grateful if you could forward it to relevant leadership that you believe would be impelled to support this proposal and effective in doing so.

Please reference attached Distribution List as a guide.

My hope is simple. That this proposal can serve as a starting point for constructive dialogue and better coordination between the systems families depend on during a crisis. I would welcome the chance to meet with you or your designated representatives to walk through it, answer questions and explore whether any part of it might be useful for future evaluation or pilot consideration.

I recognize the extraordinary demands on you all and on your agencies and I share this in good faith and with deep respect for the work you and your teams do every day.

If you feel compelled to do so, I humbly ask that you support, share and elevate this proposal as widely as possible. My sincere hope is that it reaches the policymakers, institutional leaders, healthcare professionals, legal advocates and community stakeholders capable of advancing meaningful reform, strengthening interagency

coordination and protecting the dignity, continuity of care, civil rights and well-being of vulnerable individuals and families facing complex systemic challenges.

Permission is freely granted for these concepts to be reviewed, adapted or further developed in the public interest.

I hope it helps you in your continued service and advocacy for so many.

It's not perfect but it addresses a larger system problem, it's something I've sent multiple government agencies, legislative representatives and the Ohio attorney general's office to bring awareness.

I pray it's useful in your impact and improving our healthcare system and bringing more awareness where people and families need more care and support.

I recognize one person can't change the world. My mission is to just bring awareness and pray those with a platform continue to use their voice for good.

Thank you for your time and your service.

God bless you and God bless all those entrusted to protect us all.

With gratitude, appreciation, respect and unwavering faith,

Nebby

Nebiat Gebreziabher

[redacted] NebbyG@Outlook.com

I don't want any problems. I want to solve them.

Subject: Complete SEIU-M Proposal Package

Dear Ohio Interagency and Legislative Leadership,

I hope this message finds you well.

I am writing to humbly request an Executive, Legislative and Interagency review of the attached SEIU-M proposal, distribution to relevant Federal and Statewide Leadership and an opportunity to meet and discuss it.

My background is technical, not political, legal or medical. I analyze problems from a systems perspective and that lens is what led me here. What my father and our family went through during his medical crisis revealed something larger than one case. It revealed large gaps.

Huge gaps in how our systems coordinate care, communicate across agencies and respond when vulnerable and elderly people are at their most fragile.

By the grace of God, my father will be okay. I have strong faith in that.

However, I know many families have not been so fortunate and that is what compelled me to act.

That experience, that truthful pain, shaped the attached proposal for a Specialized Emergency Intervention Unit, Medical Stabilization (SEIU-M), an interdisciplinary framework designed to strengthen crisis response, continuity of care and protections for vulnerable populations across Ohio and nationwide.

Attached for your review:

1. SEIU-M Fact Sheet
2. SEIU-M Executive Action Memo
3. SEIU-M Executive Briefing Summary
4. SEIU-M Proposal
    - The Systems Modernization Proposal and Operational Implementation Framework
5. SEIU-M White Paper
6. SEIU-M Case Study and Systems Impact Analysis
7. SEIU-M Ownership Diagram (Pyramid)
8. SEIU-M Distribution List
9. Guardian Testimony
10. Interagency Letters - Attached Zip Folder contains 22 Distributed Letters.

If this has reached you outside the appropriate channel, I would be grateful if you could forward it to relevant leadership that you believe would be impelled to support this proposal and effective in doing so.

Please reference attached Distribution List.

My hope is simple. That this proposal can serve as a starting point for constructive dialogue and better coordination between the systems families depend on during a crisis. I would welcome the chance to meet with you or your designated representatives to walk through it, answer questions and explore whether any part of it might be useful for future evaluation or pilot consideration.

I recognize the extraordinary demands on you all and on your agencies and I share this in good faith and with deep respect for the work you and your teams do every day.

If you feel compelled to do so, I humbly ask that you support, share and elevate this proposal as widely as possible. My sincere hope is that it reaches the policymakers, institutional leaders, healthcare professionals, legal advocates and community stakeholders capable of advancing meaningful reform, strengthening interagency coordination and protecting the dignity, continuity of care, civil rights and well-being of vulnerable individuals and families facing complex systemic challenges.

Permission is freely granted for these concepts to be reviewed, adapted or further developed in the public interest.

Thank you for your time and your service.

God bless you and God bless all those entrusted to protect us all.

With gratitude, appreciation, respect and unwavering faith,

Nebby

Nebiat Gebru Gebreziabher
Court-Appointed Guardian, under Ohio Probate Court Jurisdiction
206-753-7910 · NebbyG@Outlook.com

I don’t want any problems. I want to solve them.

CASE STUDY
and Systems Impact Analysis

SEIU-M / CIU-M Proposal

Specialized Emergency Intervention Unit: Medical Stabilization ***- SEIU-M (See-U)***
Crisis Intervention Unit: Medical Stabilization ***- CIU-M (CI U)***

A Documentary Foundation for Closing the Resolution Gap: The Working Demonstration of How One Patient, One Family and One Set of Public Systems Became an Argument for Coordinated National Reform

Prepared for Deep Context Review by:
Judicial, Constitutional Analysts and Interagency Reviewers

Offered in the spirit of collaborative and Coordinated modernization
And in deep respect for the difficulty of the work performed by every person and system this document touches.

A Note from the Guardian

- The weight of Aging, an accident or an illness will impact us all one day if not already.
- A parent who ages. A child who is hurt. Your spouse, a family member, a friend or someone you love falls ill. Or you, in a moment you never saw coming. None of us is more than one phone call away from needing someone to fight for us or our loved ones and from discovering whether anyone will.
- I write this on behalf of every person and every family who lived this reality and was never heard.
- For every vulnerable and voiceless person who was abandoned.
- For every family member who felt confused, helpless and alone.
- For every guardian forced to fight a system they were never trained to fight.
- For every elder whose dignity was reduced to a case number.
- For every patient sent back, again and again, to the place that harmed them, with no solution offered.
- For every caregiver who carried the weight long after everyone else looked away.
- For every family that could not afford to keep fighting and lost someone to the gap.
- For the ones still inside it tonight, waiting for a pathway that does not yet exist.
- I write this so that the next person and the next family will be heard.
- So, they know they are not alone, to never give up and that their sacrifices were seen.
- And I write this for all of us. Because the protection we could not always find should not depend on chance, on money, or on whether you happen to have someone willing and able to fight for you. It should be built into the system itself waiting for you before you ever need it.

Why This Document Is Before You

This Case Study is offered as evidentiary documentation of the constitutional condition identified in Jackson v. Indiana, 406 U.S. 715 (1972). The Jackson holding rests on both due process and equal protection grounds under the Fourteenth Amendment. Defendants found incompetent and unrestorable are subjected to more prolonged institutional confinement and fewer procedural protections than defendants proceeding through civil commitment pathways. That asymmetry is not theoretical in this record. It is the documented operational reality of six years of a single case. The equal protection violation the Court identified in 1972 is present here in every year of the chronology that follows. The Sixth Amendment speedy trial right under Barker v. Wingo, 407 U.S. 514 (1972) is also implicated. The four factors are met: the delay is years long, the reason is systemic rather than clinical, the guardian has asserted the right at every stage and the prejudice is documented and severe. The framework this Case Study supports exists to make the constitutional standard Jackson established operationally functional at the point of crisis contact rather than enforceable only through federal litigation after years of harm.

Somewhere in America, an elderly woman with early dementia missed her evening medication for the third night in a row at the long-term care facility where her family placed her. She became confused, frightened, agitated. She struck an aide. The police were called. She was arrested. By morning, she was a defendant in a criminal case. By afternoon, the court had ordered a competency evaluation. By the time her daughter could get there, her mother had been entered into a system that has a clear pathway for people who can be restored to competency and almost no pathway at all for people who cannot.

This is not hypothetical. Variations of this story unfold every day in Ohio and across the country. The names change. The diagnosis changes. The crisis is different. Unintentional accidents and human errors happen. The facilities change. The structure does not.

This Case Study documents one such story in detail. It is offered not as a complaint, but as evidence. Behind the chronology that follows is a single patient, a single family, a single set of institutions and a single set of public systems. Behind the framework the chronology supports is a population that includes, eventually, almost everyone reading this document. The aging parent. The grandparent with dementia. The veteran with a traumatic brain injury. The neighbor who had a stroke and never fully came back. The colleague whose mother is in a memory-care unit two states away. The future version of the reader.

One in three American adults will, at some point, provide unpaid care for an aging family member. One in nine adults over 65 live with Alzheimer's disease or related dementia. The population aged 65 and older will exceed 80 million by 2040. The systems that exist to protect them, healthcare, long-term care, behavioral health, the courts, guardianship, adult protective services, were built in different decades, under different assumptions, for a country with a different demographic shape. They were not designed to coordinate with one another. They do not consistently do so now.

The SEIU-M / CIU-M framework is the missing implementation piece for the national behavioral health crisis strategy. The framework this Case Study supports does not ask any of those systems to do something they were not built to do. It asks them to do, together and in the correct order, the work each of them is already authorized to do alone. It proposes coordination, not coercion. It proposes a sequence, not a new authority. It proposes that medical stabilization happen before behavioral interpretation, that causation be investigated before charges are filed, that the Probate Court be at the table before the criminal court is asked to decide and that families be received as partners rather than treated as obstacles.

What follows is the documentary foundation for that proposal. It is presented with respect for every professional and every institution whose work this chronology touches. It is also presented with the recognition that the human cost of inaction is real, ongoing and measurable in lives. The reviewer is asked to read this document with both of those recognitions held simultaneously.

There is a clear pathway for the legally incompetent person who can be restored.
There is no clear pathway for the legally incompetent person who cannot.

The space between those two facts is where this Case Study lives
and where policy reform must be reached.

The first pathway is law. The second is silence. We have clear protections for prevention but what happens when a crisis actually strikes? The SEIU-M / CIU-M framework exists to end that silence. Behind that silence is a person who cannot speak for themselves: elderly, disabled, medically vulnerable, often already declared legally incompetent. They cannot tell you which medication was withheld. They cannot explain why they were rushed to the ER or arrested for behavior the right medication would have prevented. And now they are trapped inside a system with no clear way out or worse, dead from the negligence and abuse that poisoned their care.

These are the people this framework exists to protect.

The SEIU-M / CIU-M Document Package

This Case Study is one of six documents in a coordinated institutional submission. Each document serves a different reader at a different level of review. They are meant to be read together. A reviewer can enter the package through whichever document best matches their role and the time they have available.

Document	What It Does	Who It Is For
Fact Sheet	One page. The framework at a glance.	Initial transmittal, scanning, public affairs.
Executive Action Memo	Single-page memo. Finding, anchoring, ask, authorities requested.	Cabinet secretaries, agency heads, White House review.
Executive Briefing	The case for rapid leadership review: problem, solution, implementation, request.	Executive, legislative and federal decision-makers.
Operational Implementation Framework (Proposal)	The full operational blueprint: architecture, workflow, training, funding, phased rollout.	Implementing agencies, operational leadership, interagency coordinators.
White Paper	Policy theory and evidence base. Constitutional, statutory, clinical and comparative context.	Policy researchers, legislative counsel, federal policy staff, academic reviewers.
Case Study and Systems-Impact Analysis (this document)	The chronology, the medical record, the regulatory findings, the working demonstration of the Resolution Gap.	Deep-context reviewers, judicial and constitutional analysts, federal civil-rights authorities.

How This Case Study Connects to the Other Five

This document is the evidentiary backbone of the six-document submission package. The other five documents make the institutional argument; this one preserves the record that argument rests on. Every claim in the Executive Briefing, the Proposal, the White Paper, the Executive Action Memo and the Fact Sheet that depends on the underlying case traces back to a section here.

To make that tracing easy, every section and appendix in this Case Study carries a citation anchor tag in the right margin, in the form [CS sec.N] or [CS App-X]. A reviewer who encounters a reference to, for example, CS sec.23.5 in another document can come directly to the corresponding section in this one. The Table of Contents that follows lists every anchor.

How to Read This Document

Accountability, not accusation.

This Case Study examines what the architecture did. It does not examine what any individual did. Accountability, as the document uses the term, means looking at the structure: how decisions get made, how information flows, how evaluations are designed, how transitions are governed, what evidence is allowed to enter review. Accusation, by contrast, names a person and blames them. The two are not the same exercise and this document does not undertake the second.

The chronology that follows identifies structural gaps and proposes structural remedies. The professionals inside the chronology are doing difficult work in frameworks they did not design. The emergency physicians making boarding decisions at three in the morning. The prosecutors weighing charges against medically complex defendants. The public defenders carrying caseloads measured in the hundreds. The corrections officers managing competency timelines without clinical resources. The social workers and protective-services investigators absorbing case complexity their statutory authority does not match. The judges asked to make permanent decisions on incomplete medical records. The clinicians attempting to coordinate across systems that do not share information well. The facility staff working inside survey frameworks not always equipped for the medical complexity of the residents they serve. The legislators appropriating against demands that exceed any single budget cycle. Where the record reflects an outcome that deserves institutional concern, this document names the framework that produced it, not the people inside it.

That is not a softening of the analysis. It is what makes the analysis useful. A framework can be redesigned. A person identified for criticism becomes defensive and defensiveness produces no reform. The SEIU-M / CIU-M proposal is oriented toward redesign.

Many of the professionals reflected in this chronology have themselves expressed concern about the frameworks they work inside. Their longitudinal observations are part of the record this document rests on. Their contribution is honored by proposing the structural infrastructure that would make their work easier, for them and for every comparable case that will follow.

Table of Contents

Sections and appendices, with citation anchor tags. The anchors shown in the right margin correspond to the in-document headings and provide stable citation references for the other five documents in the package.

Front Matter
Why This Document Is Before You
The SEIU-M / CIU-M Document Package
How to Read This Document
Table of Contents
Part I. Foundational Frame
1. Scope of This Case Study [CS sec.1]
2. Name-Use Protocol [CS sec.2]
3. What This Case Study Argues [CS sec.3]
4. Why This Matters Beyond One Family [CS sec.4]
Part II. Chronology
5. The Six-Year Record [CS sec.5]
Part III. Medical, Clinical and Forensic Context
6. Medical and Rehabilitation Context [CS sec.6]
7. Functional Neurological Disorder and How It Is Misread [CS sec.7]
8. When the Treating Record and the Forensic Record Do Not Meet [CS sec.8]
9. Least Restrictive Stabilization and Public Safety [CS sec.9]
10. What Stabilization Actually Means [CS sec.10]
Part IV. Systems Analysis
11. Equity, Access and Who Gets the Better Pathway [CS sec.11]
12. Guardianship, Communication and Care Coordination [CS sec.12]
13. The Gaps This Case Reveals [CS sec.13]
14. The Questions This Case Asks of Policy [CS sec.14]
15. Elder Justice and the Protection of the Vulnerable [CS sec.15]
Part V. Systems Impact
16. Detailed Systems-Impact Analysis [CS sec.16]
17. What the Record Shows About Stabilization [CS sec.17]
18. Where Forensic Evaluation Currently Falls Short [CS sec.18]
19. Evidence to Preserve in Comparable Cases [CS sec.19]
Part VI. Lessons and Connection to the Framework
20. What This Case Study Teaches [CS sec.20]
21. How Each Lesson Maps to the Framework [CS sec.21]
22. Records, Testimony and Evaluation Considerations [CS sec.22]
Part VII. The Resolution Gap
23. The Resolution Gap: Two Pathways, One Missing [CS sec.23]
23.1 The Asymmetry of Pathways [CS sec.23.1]

23.2 What This Case Demonstrates [CS sec.23.2]
23.3 The Already-Adjudicated Incompetent Person [CS sec.23.3]
23.4 The Constitutional Architecture That Already Exists [CS sec.23.4]
23.5 The Constitutional Impossibility of Restoration [CS sec.23.5]
23.6 The Ohio Statutory Matrix Where No Title Owns the Resolution [CS sec.23.6]
23.7 The Administrative Blackhole [CS sec.23.7]
23.8 How the Gap Shows Up in Practice [CS sec.23.8]
23.9 Compounding Harms in the Medically Vulnerable Elder [CS sec.23.9]
23.10 The Human Experience of Indefinite Suspension [CS sec.23.10]
23.11 Prevention and Crisis Response Together [CS sec.23.11]
23.12 The Federal Frameworks Already in Place [CS sec.23.12]
23.13 The Structural Remedies Required [CS sec.23.13]
23.14 The Case Before the Reviewer [CS sec.23.14]
Part VIII. Closing
24. A Closing Word [CS sec.24]
Appendix A. The Framework at a Glance [CS App-A]
Appendix B. Authorities and References [CS App-B]

Part I. Foundational Frame

Sections 1 through 4 establish the foundation that governs the chronology, the medical and forensic analysis and the systems-impact discussion that follow. Read these four sections first and the rest of the document will read in the right key.

1. Scope of This Case Study [CS sec.1]

This Case Study sits apart from the other five documents in the package by design. The Fact Sheet, the Executive Action Memo, the Executive Briefing, the Operational Implementation Framework and the White Paper make the institutional argument. This document holds the record that argument rests on. Its purpose is to preserve the full human, medical, rehabilitative, custodial, legal and operational context of one real case at the intersection of healthcare, long-term care, behavioral health, neurology, guardianship, the courts and continuity of care.

This is not a grievance narrative. It is a working example. It is presented because the chronology that follows is not unique. It is operationally representative of what happens, across this country, every time medical complexity, age-related vulnerability, neurological symptoms and institutional escalation meet inside systems that were not built to coordinate. The names change. The diagnoses change. The cities change. The shape of what unfolds does not.

The Case Study does not assign blame to any professional, evaluator, provider, agency, court or institution. It identifies the procedural and structural gaps that recur when medically complex people experience crises that cross neurological, psychiatric, endocrine, rehabilitative, custodial and legal lines. The reviewer is asked to read it as a structural diagnostic, not as an indictment.

It does not seek to replace clinical judgment, lawful judicial authority, prosecutorial discretion, emergency response protocols or public-safety decision-making. It seeks to strengthen the coordination, communication and stabilization infrastructure those systems can call on when medically vulnerable people are involved in complex crisis events. It does this by demonstrating, through one extensively documented case, why integrated multidisciplinary coordination would have produced better outcomes, for the patient, for the family, for the institutions involved and for the public systems carrying the cost.

It is also offered with awareness that the audiences receiving it operate under their own constraints, their own workforce realities, their own fiscal pressures and their own legal frameworks. The recommendations are intended to be implementable inside those constraints, not abstracted from them.

2. Name-Use Protocol [CS sec.2]

This document avoids naming unapproved individuals. It refers generally to evaluators, institutional personnel and facility staff unless names were specifically approved for medical, judicial or systems-review context. Named individuals and entities appear only where the documentary record makes naming unavoidable for evidentiary clarity or where the named party is a treating professional whose involvement supports the longitudinal record.

The patient at the center of this chronology is referred to throughout as the patient. The patient's daughter, appointed Guardian of Person by the Franklin County Probate Court on April 13, 2022, is referred to as the court-appointed guardian or the guardian. The family is referred to functionally rather than by name. This protects the dignity of the individuals at the center of the chronology and aligns this document with the broader SEIU-M / CIU-M institutional submission, which is presented anonymously as The Guardian, under Ohio Probate Court jurisdiction.

The treating providers identified below participated in the longitudinal record that underpins this analysis. Their identification is preserved because their observations are evidentiary. The integrity of a treating-provider record depends on knowing whose observations it contains. Each is named in the form in which the underlying clinical, rehabilitation, judicial or institutional record reflects them.

Affiliation	Role / Specialty	Provider
OhioHealth Neuroscience	Treating Neurologist - iSchemic Stroke Aftercare & FND Diagnosis	Dr. Aniket Natekar
OhioHealth	Treating Psychiatrist - FND Diagnosis Referral to Trauma Therapy	Dr. Kristen Kilbarger
Ohio-DBH / Ohio-MHAS, COBH	Attending Psychiatrist	Dr. Prabhavathy Mannava
Ohio-DBH / Ohio-MHAS, COBH	Attending Psychiatrist	Dr. Neil Patel
OhioHealth	Endocrinology, Type II Diabetes	Dr. Derek Lapp
OhioHealth	Endocrinology, Type II Diabetes	Dr. Jay Patel
OhioHealth	Primary Care Physician	Dr. Ruth Egwakhe
Ohio-DBH / Ohio-MHAS, COBH	Primary Care	Dr. Ellis Opusunju
OhioHealth Neuroscience Rehabilitation Services	Multidisciplinary Neuro Rehabilitation, Neuro PT, OT and SLP Therapy	Treating Rehabilitation Team
NovaCare Rehabilitation	Physical Therapy	Treating Physical Therapist
Ohio State University Medical Center	Nephrology, Stage 3 CKD Management	Treating Nephrologist
Ohio State University Medical Center	Ophthalmology, Three Retinal Surgical Procedures	Treating Ophthalmologist
Outpatient Behavioral Health	Trauma-Informed Therapy	Treating Trauma Therapist
OhioHealth	Cardiology, Medical Clearance	Treating Cardiologist
OhioHealth	Urology, Medical Clearance	Treating Urologist
OhioHealth	Clinical Dietetics	Treating Registered Dietitian
ABD Podiatry	Podiatric Care	Dr. Richard Schilling
Ohio Dentist	Dental Care & Dentures	Treating and Surgical Dentist
Acupuncture	Acupuncture Care	Ohio
Delaware County Court of Common Pleas	Judicial Decision-Maker, April 2023 Least-Restrictive Release Order	Honorable Judge David Gormley
Ethiopian Orthodox Tewahedo Church and Community	Pastoral and Community Support	Ethiopian Community, Pastors and Religion Leaders

3. What This Case Study Argues [CS sec.3]

This Case Study argues one thing, in many ways.

Medically vulnerable people can move through emergency rooms, hospitals, rehabilitation facilities, behavioral-health systems, forensic evaluations, jails, courts, guardianship proceedings and long-term care environments without a single coordinated process responsible for holding the picture together. No one is in charge of integration. Each system does its own work, by its own rules, against its own evidentiary standards, on its own timeline. Each system performs well within its lane. The lanes do not connect.

The result is decision-making that drifts. Rehabilitation evidence gets discounted because the system reviewing it is not a rehabilitation system. Treating-provider observations get treated as supplementary because the forum receiving them is structured around forensic reports. Outpatient stabilization progress gets overshadowed by acute presentation because the evaluation window is short. Longitudinal functional data gets underweighted against institutional snapshots because the institutional snapshot is what the court has in front of it.

The framework this Case Study supports asks for the integration that does not currently happen. It asks for medical, neurological, behavioral-health, rehabilitation, legal, judicial, guardianship and continuity-of-care evidence to come into the same room before the high-consequence decision is made. It asks for the following to be considered together, not separately:

- Medical stabilization.
- Medication continuity and reconciliation.
- Neurological review and post-stroke assessment.
- Rehabilitation progress and outpatient stabilization evidence.
- Functional Neurological Disorder (FND) differentiation.
- Endocrine and metabolic stability.
- Trauma-informed assessment.
- Guardianship participation and longitudinal caregiver observation.
- Public-safety balancing.
- Least-restrictive treatment planning.
- Cultural, linguistic and faith-based continuity.
- Continuity of care across transitions.
- Mobility and functional independence supported by home-based adaptive infrastructure.

A broader policy question runs through every section that follows. Are modern forensic, custodial and emergency behavioral-health systems sufficiently integrated with rehabilitation medicine, neurological assessment, endocrinology, outpatient stabilization and multidisciplinary medical review to make sound, least-restrictive, evidence-based decisions when medical complexity and behavioral presentation overlap? The chronology demonstrates that even when every individual professional acts in good faith within their own discipline, the absence of a unifying coordination structure can produce a cumulative result that none of those professionals, reviewed individually, would have endorsed.

This argument is not theoretical. It is grounded in six years of context and documentation, with the medical chronology proper spanning March 2021 through May 2026. It includes multiple care environments, two custodial transitions, one judicial release order, six months of demonstrated community stabilization, ongoing neurorehabilitation, a formal diagnosis of Functional Neurological Disorder, a determination of incompetency and unrestorability, regulatory findings from the Ohio Department of Health against two of the involved care facilities and an active case in the Delaware County Court of Common Pleas under Case Nos. 22 CR I 10 0600, 23 CAA 07 0038 and 24 CV C 04 0380.

4. Why This Matters Beyond One Family [CS sec.4]

This Case Study is one family's documentation. The framework it supports is not.

The operational scale of this gap is documented in state-level data. Forensic patients occupy approximately 93 percent of available Ohio state psychiatric hospital beds, displacing civil patients and constraining system capacity statewide (Office of the Governor of Ohio, Governor's Work Group on Competency Restoration and Diversion, 2024). State forensic bed operational cost is approximately $790 per bed per day. A single multi-year forensic placement of an unrestorable defendant exceeds $280,000 per year before associated clinical, judicial and administrative costs (Texas HHSC State Hospital Cost Study, 2024, used as representative reference).

Across the United States, an estimated 53 million adults provide unpaid care to a family member or friend. Approximately 11 million of them are caring for someone with Alzheimer's disease or another dementia. The population aged 65 and older will reach 80 million by 2040. The number of adults under guardianship in Ohio alone has grown from roughly 42,000 in 2011 to approximately 49,000 in 2020, with 6,000 to 7,000 new guardianship applications filed each year. Behind each of those numbers is a person, a family, a sequence of decisions that did not have to go the way they went.

The reviewer of this document, whatever their institutional role, is statistically likely to face some version of this situation in their own family. A parent's diagnosis. A grandparent's decline. A sibling's stroke. A spouse's slow forgetting. The question is not whether this will reach them. The question is what public infrastructure will exist when it does.

Consider a few of the people the current architecture leaves exposed.

Every one of these people had a medical event. Not one of them met a system built to recognize it. The thread that connects them is not their diagnosis, it is the moment their illness was read as a choice.

1. **The retired teacher with early dementia.** Forty years in the same house. One confused afternoon she walks into a neighbor's home believing it is hers, and is arrested for trespassing. Her son, two states away, learns of it from a phone call at midnight. The disease that took her bearings is nowhere in the report; only the trespass is.
2. **The teenager with epilepsy.** He has a seizure in a school hallway, and in the disoriented minutes afterward, a state called postictal confusion, he shoves a teacher's aide who grabs his arm. He has no memory of it. The school resource officer files a charge. A sixteen-year-old now has an assault on his record for the few automatic minutes after his own brain misfired.
3. **The veteran with traumatic brain injury.** Stable for a decade on a careful medication regimen. He has a behavioral episode at his residential facility and is taken to jail, where the intake nurse has no medication list, no history, no number to call. The thing that kept him stable for ten years stops at the booking desk. By morning he is in crisis.
4. **The young man having a diabetic emergency.** His blood sugar craters on the drive home. Hypoglycemia looks, to anyone who doesn't know, exactly like drunkenness, slurred, sweating, combative, confused. He is pulled from the car. By the time anyone checks a glucose level, he has been restrained as a hostile drunk rather than treated as a man minutes from a coma.
5. **The grandmother in skilled nursing.** Her evening insulin is missed for the third night running. Or her Ozempic is missed 2 weeks in a row. Her blood sugar climbs, she grows agitated, and she strikes the aide trying to redirect her. The aide presses charges. The system now has jurisdiction over a woman whose conduct was, in plain medical reality, the downstream result of a medication failure no one is investigating.

6. **The autistic young adult in a meltdown.** Overwhelmed in a crowded store, he drops to the floor, rocking, hands over his ears, unable to answer the questions being shouted at him. To the officers called by the manager, silence and non-compliance read as defiance. He is hands-on the floor within ninety seconds. Nothing about how he communicates, or doesn't, ever reaches the people deciding how much force to use.
7. **The mother of three during COVID.** Diagnosed with multiple sclerosis at thirty-five, a new mother with a two-year-old and infant twins. MS is a relapsing disease, long stretches of normal life broken by flares that arrive without warning. In ordinary times she has in-person neurology visits, a nurse who knows her, family who drop in. The pandemic took all of it: appointments became phone calls or vanished, the people who would have noticed her slipping were kept behind closed doors and she was alone in a house with three children under three. So when a flare hits on a bad morning, disoriented, frightened, speech slurred, balance gone, no one is positioned to see it. She drives. She is pulled over. To the officer it reads as impairment, and she fails the roadside test because her legs will not do what she asks. Her three small children spend the night with a neighbor while she sits in a cell, and the system holding her has no idea it has taken a sick, isolated mother, not a dangerous one.
8. **The new mother with postpartum psychosis.** Six days after delivery, she stops sleeping and her thoughts come loose. This is a true psychiatric emergency, treatable and time-sensitive, but it presents as a frightening, irrational woman, not a patient. The 911 call describes a disturbance. Officers arrive before clinicians. She is taken into custody instead of into care and the seventy-two-hour window in which she most needed a hospital is spent in a holding cell.
9. **The faith leader who immigrated decades ago.** In his later years his health cascades, a stroke, then a TIA, then a functional neurological disorder that produces symptoms no first responder is trained to read. He is a father, a grandfather, the founder of a congregation that gave him an honorific name meaning he who brings life to others. When his FND triggers a non-epileptic seizure in public, the people around him see a man behaving erratically, not a patient in distress. The responding system has no record of who he is and no way to tell a neurological event from a threat. A community pillar becomes, in an instant, a body to be controlled.

None of these people needed punishment. Each needed someone, somewhere in the chain, to recognize illness as illness. The architecture gave them an officer instead of a clinician, a charge instead of a chart, a cell instead of care and it did this not out of malice, but because it was never built to see them at all.

Nine people. Nine different paths into the same gap. Nine different families now carrying labor those families were never equipped to carry, fighting institutions they were never trained to fight, learning a vocabulary, guardianship, competency, restoration, least-restrictive, Olmstead, that no one should have to learn the hard way.

The framework this Case Study supports does not pretend to prevent every crisis. Crises will continue to happen. What the framework proposes is that when they happen, the public systems that respond do so in coordination rather than in isolation. That medical stabilization come before behavioral interpretation. That medication safety be checked before the patient is criminalized. That the Probate Court be informed before the trial court is asked to decide. That families be received as partners. That least-restrictive options be considered. That stabilization, when it succeeds, be allowed to lead to resolution rather than to indefinite suspension.

This is not a partisan request. The medically vulnerable do not divide along party lines. The architecture this framework strengthens protects people across every demographic, every region, every faith, every income level. The protection it offers is, in the most literal sense, for everyone. Including, eventually, the reviewer.

Every reviewer of this document will, at some point in their life, be a caregiver, a guardian or the person needing one. The protective architecture proposed here is not for them. It is for us. All of us.

The Case Study is therefore offered not as accusation but as architectural diagnosis. A working example, presented with humility about the difficulty of the work each system performs, of the modernization gap that the SEIU-M / CIU-M framework is designed to close. It is also offered with urgency. The demographic transition is happening now. Every year that the gap remains operationally open is a year in which more families will learn what this one has learned, in the way this one had to learn it.

Part II. Chronology

A six-year longitudinal record of medical, custodial, judicial and rehabilitation events.

5. The Six-Year Record [CS sec.5]

The chronology that follows is reconstructed from medical records, treating-provider notes, regulatory findings issued by the Ohio Department of Health, court records from the Delaware County Court of Common Pleas, notarized affidavits, guardian-prepared documentation and a sustained body of treatment-team correspondence maintained from October 2022 through the present.

It is presented as one continuous record, not as isolated events. Read in sequence, it shows a recurring pattern. The patient stabilizes when continuity of care is preserved, when his medications are administered correctly, when he is in a trauma-informed environment and when his guardian is present. He destabilizes when those conditions break down. The pattern is consistent enough across six years and across multiple care environments to function as evidence in its own right.

The chronology is divided into phases for ease of review.

Before 2021. The Baseline

The patient is a man born in 1956. He immigrated from Ethiopia, became a naturalized United States citizen, raised five children and was, for decades before this story begins, a working member of his community. He held longstanding family, church and community relationships. He lived with manageable chronic conditions, mild Type 2 diabetes, hypertension, mild anxiety and sciatica, that required periodic medical supervision but did not impair his functioning.

He was a founding member of an Ethiopian Orthodox Tewahedo Church in Seattle. The Patriarch of the Ethiopian Orthodox Tewahedo Church conferred on him the honorific title Megabi Gebru. In Ge'ez, the liturgical language of the church, the title means he who brings life to others. He held the leadership title Aleca within the community. The cultural, linguistic and faith-based foundations of his life become operationally important later in the chronology because they are the same foundations that supported his most stable period of outpatient rehabilitation.

The patient at the center of this Case Study is an Ethiopian Orthodox Tewahedo immigrant whose primary languages are Tigrinya and Amharic. Ge’ez serves as his liturgical language. He held a senior spiritual leadership role within the Ethiopian Orthodox Tewahedo community. His cultural identity and access to interpreter services in Tigrinya and Amharic were clinical and legal requirements at every stage of his forensic evaluation and court proceedings. The absence of culturally competent evaluation and the absence of Tigrinya and Amharic interpreter services at critical junctures in his forensic evaluation and competency proceedings are documented gaps in the record. These gaps are not peripheral. In a population whose behavioral expression may be shaped by cultural frameworks that differ from those assumed in standard forensic evaluation instruments language access and cultural competency are clinical requirements not administrative accommodations. The SEIU-M framework designates interpreter services in the patient’s primary language including Tigrinya and Amharic as mandatory components of the medical stabilization and evaluation protocol.

The record does not reflect violent behavior, severe psychiatric instability or chronic behavioral-health deterioration before the neurological decline that begins in 2021. He had no criminal history. He had no prior psychiatric diagnosis. He had no documented history of suicidal ideation, self-harm or aggression. The baseline is described, uniformly, as gentle, community-oriented, faith-centered and nonviolent.

This baseline is not offered as character defense. It is offered as clinical data. Late-onset primary psychiatric illness beginning at age 65 or later, without prior history, is clinically uncommon. When a previously well-functioning, faith-engaged elder presents with sudden behavioral change after a documented neurological event and during a documented period of medication mismanagement, the diagnostic question is not whether psychiatric illness has emerged. The question is what medical, neurological, endocrine, traumatic and pharmacological variables are producing the presentation and what sequence of stabilization will most reliably restore baseline functioning. The Case Study returns to this distinction repeatedly because it sits at the center of every decision that follows.

March 2021. Vaccination and the Onset of Severe Medical Destabilization

In March 2021, during the height of the COVID-19 pandemic, the patient received the Pfizer COVID-19 vaccination series. Following the second dose in late March, his medical baseline shifted in a way that is documented in his clinical record. He became severely ill. He was hospitalized. He experienced a period of temporary blindness. After the acute episode resolved, he developed an expanding set of new neurological and medical symptoms: seizures, frequent falls, memory loss, uncontrolled diabetes, uncontrolled hypertension, impaired mobility, essential tremors, headaches and dental complications.

The chronology reflects repeated emergency intervention and a rapidly expanding circle of specialists: neurology, endocrinology, primary care, rehabilitation medicine. Many healthcare systems were under extraordinary workforce strain during this period and that strain contributed to fragmented communication, delayed stabilization and inconsistent coordination across providers. This was the operational environment in which his trajectory shifted from manageable chronic conditions to compound neurological vulnerability. In retrospect, that shift defined the next five years of his life.

The temporal proximity between the vaccination series and the onset of severe destabilization is in the medical record. This Case Study does not draw a causal conclusion from that proximity. It preserves the chronology as the treating team and family experienced it, because that chronology is operationally relevant to how subsequent providers, evaluators and institutional reviewers should interpret the rapidity and pattern of his decline.

June 2021. Relocation and a Search for Coordinated Care

The patient regained partial vision in June 2021 and relocated from Seattle to Columbus to be closer to the Ethiopian Orthodox community and to seek improved medical coordination. The move produced modest improvement. Seizure frequency declined. Diabetes management stabilized somewhat. But establishing new primary care in central Ohio proved difficult, consistent with the broader post-pandemic workforce strain affecting healthcare systems across the state.

July 2021. The Fall That Changed What Was Required

In July 2021, the patient collapsed and lost consciousness. He presented to the emergency department with seizures, severe headaches, uncontrollable tremors, mobility instability, memory loss, uncontrolled blood sugar, uncontrolled blood pressure and the loss of four anterior teeth from the fall. The episode crossed a threshold. Home-based care without coordinated specialty involvement was no longer sufficient. He had no established Ohio primary care physician at the time of the fall and was still following up remotely with his Seattle-based primary care provider.

August through November 2021. Enrollment, Specialty Care and a Care Plan

Between August and November 2021, the patient enrolled in Ohio Medicaid and Medicare, turned 65 and began searching for a senior living environment that could provide twenty-four-hour medical supervision, medication administration support, grooming assistance, supervised meals and continuity oversight. During this period he established care with Dr. Ruth Egwakhe as his treating primary care

physician and with Dr. Derek Lapp as endocrinologist for diabetes management. He was referred to neurology and to optometry. Home health aide services were arranged for medication support. Physical therapy began for mobility rehabilitation. The neurology referral was delayed by ongoing pandemic-related access constraints.

December 1 to 13, 2021. Stroke and the First Long-Term Care Transition

On December 1, 2021, the patient presented to Grant Medical Center with severe disorientation and communication impairment. He was diagnosed with a stroke and admitted. He remained hospitalized through December 13, 2021, when he was discharged to The Grand of Dublin, a long-term care environment intended to provide rehabilitation support, twenty-four-hour medical supervision, medication management and therapeutic care.

The medication reconciliation between Grant Medical Center and The Grand of Dublin did not transfer correctly. The court-appointed guardian alerted the receiving facility immediately and provided the complete prescription list at the point of transfer. The corrected medication regimen was not consistently implemented. This is the first operational example of a pattern that would repeat across every subsequent transition. The patient's continuity, his neurological stability and his rehabilitation trajectory depended on reconciliation processes between systems that had no structural owner. Without an owner, the reconciliation depended on the guardian. Without the guardian, it would not have happened at all.

December 2021 through April 2022. The Grand of Dublin

During his residence at The Grand of Dublin from December 2021 through early April 2022, the record reflects sustained difficulty with continuity of care, medication reconciliation, diabetes management and infection-control coordination. The Ohio Department of Health subsequently investigated the facility and issued regulatory findings against it relating to this patient's care. The survey is preserved in the record under ODH Survey Number OH00131063 (The Grand of Dublin).

Family observations during this period describe escalating concerns: incorrect medication administration, a falsely documented COVID-19 status that resulted in the patient being placed in isolation for over a month while not actually positive for the virus and a corresponding decline in his trust, his mood and his stabilization. This period is the origin point of the patient's later trauma response to institutional care environments. Subsequent FND symptom amplification under conditions of institutional fear traces directly to events documented here.

March 2022. The Guardianship Petition

In March 2022, following the documented experience at The Grand of Dublin, a formal petition for appointment as Guardian of Person was filed with the Franklin County Probate Court. This filing is the institutional inflection point at which the family moved from informal advocacy to formal legal authority for medical decision-making and continuity coordination.

April 13, 2022. Court Appointment of Guardian of Person

On April 13, 2022, the Franklin County Probate Court appointed the court-appointed guardian as Guardian of Person under Ohio Revised Code Chapter 2111. The Letter of Guardianship is part of the supporting record. It was subsequently provided to every facility, custodial environment and treatment team thereafter involved in the patient's care.

The Case Study returns to this point repeatedly because it is one of the most important facts in the entire chronology. By April 13, 2022, this patient had been adjudicated legally incompetent by a sitting court of competent jurisdiction. The Probate Court had already done the work. The question that recurs

across every subsequent system encounter is whether that prior adjudication was honored, recognized and integrated into care decisions in the manner Ohio guardianship law contemplates. Often, it was not.

April through October 2022. Abbington of Powell

On April 7, 2022, the patient was admitted as a resident of Abbington of Powell, an assisted-living environment, at a Tier 3 designation, the highest level of medical and supervisory care the facility offered. Tier 3 meant the patient was not responsible for self-administration of medications, was dependent on facility staff for medication delivery and required structured supervisory oversight.

The initial weeks went well. He engaged with the resident community. He participated in activities. Staff described him as warm and socially engaged.

Then the medications began to fail. The patient's prescribed Ozempic (semaglutide) injections were repeatedly missed or unaccounted for across multiple months. The medication-administration failures are documented in the Ohio Department of Health survey findings issued against the facility, preserved in the record under ODH Survey Numbers OH00136991, OH00137240 and OH00139261 (Abbington of Powell).

In July 2022, after continued medication failures and an emergency-department admission for medication-related instability, the Ohio Department of Health began formal review of the facility. The Aetna MyCare case manager filed a report. A safety plan designated a single nurse as the only authorized administrator of the patient's medication. The patient was placed on suicide watch following the emergency-department admission, based on a facility-staff account that the same staff member subsequently corrected. The Case Study returns to this episode because it illustrates a recurring problem: how quickly an institutional narrative about a medically vulnerable patient can form, how durable that narrative becomes once it enters the medical record and how difficult it remains to correct, even when the person who originated it walks it back.

In August 2022, the patient's A1C measured 7.3, reflecting partial stabilization. In September 2022, the Franklin County Probate Court granted an expedited order authorizing transfer of guardianship to Florida in preparation for the patient's planned relocation to live with the guardian. Hurricane Ian disrupted that relocation. Through October 2022, the chronology reflects intensifying environmental destabilization within the facility: recurring reports of mistreatment, harassment and retaliation against the patient by other residents and by staff and continued medication-administration failures.

October 26, 2022. The Index Event

Some context bears directly on what happened on October 26, 2022 and it is in the supporting record.

The Florida relocation that the Probate Court had authorized in September and that Hurricane Ian had disrupted was, by mid-October, back on track. The guardian was scheduled to fly to Ohio on October 26, 2022 to complete the permanent transfer. The operational preparation supporting that transfer is documented. Florida-based neurology, endocrinology, cardiology and primary care had been identified and confirmed. Medication access and pharmacy continuity had been coordinated for the receiving state. A residential environment had been prepared. Emergency-response planning had been established. The patient was within hours of leaving facility-based care for long-term guardian-supervised community care.

That trajectory was interrupted on the morning of October 26 by the events that followed.

The patient was arrested in connection with an alleged incident at Abbington of Powell. The same day, prior to or immediately following the alleged incident, emergency medical services transported him to the hospital. The responding paramedics recorded a blood-glucose reading of 422 mg/dL. The receiving hospital recorded a corresponding reading of 331 mg/dL. He was admitted for crisis-level

hyperglycemia (field glucose 422 mg/dL, hospital glucose 331 mg/dL), crisis-level hypertension (blood pressure documented as high as 191/79 mmHg) and elevated cholesterol. The consulting neurologist diagnosed a Transient Ischemic Attack (TIA, a mini-stroke) corresponding to the morning of October 26.

The patient has no recollection of the alleged incident. A memory gap in a medically fragile, post-stroke elderly patient is clinically consistent with altered mental status, delirium or metabolic encephalopathy at the time of the event. He has no prior history of violence either before or after this event. The supporting record documents that on the morning in question he presented with the full clinical profile of TIA: complete disorientation, retrograde amnesia for the event, left-sided weakness, slurred speech, numbness, visual disturbance, balance impairment, severe headache, paranoia, hallucinatory experience, impaired swallowing and complete loss of motor coordination. The paramedic record, the hospital admission record and the neurology evaluation together form the medical evidentiary basis for understanding October 26, 2022 not as a behavioral event in isolation, but as a medical event of substantial clinical severity that occurred in the same hours as the alleged conduct.

This Case Study does not adjudicate the criminal allegations. It takes no position on the lawful prosecutorial discretion exercised by the Delaware County Prosecutor's Office. It raises one structural question. Was the complete medical, neurological, endocrine, rehabilitation and trauma-related context of October 26, 2022 integrated, contemporaneously, into the criminal-legal proceedings that followed? Were the discovery and the causation analysis conducted before charges were filed and indictment was pursued? Was the Probate Court, which had already adjudicated this patient legally incompetent six months earlier, notified and brought into coordination before the trial court was asked to decide anything?

These questions are not rhetorical. They are the structural questions the framework is built to answer. They are also the questions that, in this case, were not answered in the order the framework proposes.

The case is currently active in the Delaware County Court of Common Pleas under Case Nos. 22 CR I 10 0600, 23 CAA 07 0038 and 24 CV C 04 0380.

October 2022 through April 2023. The Delaware County Jail

Following arrest, the patient was held in the Delaware County Jail. The chronology of this six-month custodial period reflects sustained continuity-of-care disruption, delayed specialist involvement, denial of access to his established outpatient providers and inconsistent medication administration, particularly regarding his Ozempic prescription, which was discontinued during the early weeks of his incarceration. He was held in solitary confinement from approximately late October 2022 through late January 2023. Multiple falls occurred during this period. The guardian's requests for medical furlough to permit specialist evaluation, primarily Neurologist, however, were repeatedly denied. The Letter of Guardianship was not initially honored at the operational level.

In December 2022, after sustained advocacy, the guardian was finally permitted to visit. By then the patient's A1C had risen to 8.5. In January 2023, while the regular jail physician was on leave, the substitute physician restarted the patient on Ozempic and his condition began to stabilize. He was moved from solitary confinement to general population on January 29, 2023. Specialist evaluation continued to be denied through the rest of the custodial period. He used a wheelchair for much of the second half of this period as a result of accumulated falls and deconditioning.

The falls during this custodial period matter. The Centers for Disease Control and Prevention have established that more than one in four older adults experience a fall annually in the general population. Falls in this population produce millions of emergency-department visits and approximately one million fall-related hospitalizations nationwide each year. The CDC framework recognizes falls in elderly patients as serious clinical events with documented downstream consequences: cognitive decline,

mobility loss, deconditioning, elevated mortality risk. In a medically vulnerable elderly post-stroke patient held under prolonged isolation, with disrupted medication and without specialist neurological access, the documented falls are not isolated incidents. They are part of a recognized epidemiological pattern. They are one further operational manifestation of the continuity-of-care failure that defined this period.

This custodial period illustrates several of the framework's core concerns at once. The difficulty of preserving complex outpatient medication regimens through custodial intake is important. The structural absence of any mechanism by which a Probate Court guardianship order is automatically reconciled with custodial medical decision-making. The deterioration that follows when neurologically vulnerable individuals are held in prolonged isolation. The way trauma responses then amplify into functional neurological symptoms after release.

February 2023. ODRC -> BAD Investigation

The Custodial Oversight Record and the Limits of Jurisdiction

The custodial phase of this chronology was not without state oversight. On February 16, 2023, the Ohio Department of Rehabilitation and Correction, Bureau of Adult Detention (BAD), issued its response to a formal jail complaint the guardian had filed regarding the patient's care at the Delaware County Jail (OHJMS# COM-2023-Delaware County Jail-00017). A State Jail Inspector, accompanied by a Clinical Healthcare Specialist, conducted a site visit, met with the patient, the jail's medical staff and its administrative staff, and reviewed the patient's medical file with jail officials.

The Bureau reviewed three allegations, inadequate medical care, denial of access to the patient's established personal physicians and retaliation and found each unfounded under the Minimum Standards for Jails in Ohio. The record is preserved here in full and this Case Study represents its conclusions accurately: the Bureau determined that the care provided was consistent with the applicable jail standards, that the credentialing requirement under Ohio Administrative Code 5120:1-8-09(I) governed which outside physicians could treat the patient, and that the contested property matter fell within the jail's lawful safety and security authority.

This Case Study does not contest those findings. It presents them because their reasoning, read closely, is itself one of the clearest demonstrations of the structural problem the framework addresses. Three features of the Bureau's response are worth naming.

First, the disagreement over the patient's "personal physicians" was, at its root, a coordination failure rather than a contest of bad actors. The guardian vested by the Franklin County Probate Court with authority over the ward's medical care was arranging continuity with the physicians who had treated the patient before incarceration. The jail, operating under its own Health Authority and its own credentialing standard, could not simply absorb those external arrangements without verification. Both sides were acting within their respective mandates. What did not exist was any mechanism by which a Probate Court guardianship and a custodial Health Authority could be reconciled into a single continuity-of-care plan. The guardian's authority and the jail's standards were both legitimate and there was no interface between them. That absence, not anyone's bad faith, is the gap.

Second, and most directly on point, the Bureau expressly acknowledged the boundary of its own jurisdiction. It wrote that the guardian had raised "numerous other issues that fall outside of the Bureau's jurisdiction," referred the guardian to other agencies, and, citing Ohio Revised Code Section 5120.10(A)(2), made "no finding regarding those issues." This is the Resolution Gap stated by a state oversight body in its own words. The patient's situation generated concerns that no single authority's jurisdiction was built to encompass. The Bureau's mandate reached the minimum standards for jails; it

did not reach the medical, neurological, guardianship, continuity-of-care and elder-justice dimensions that defined the patient's actual circumstance. Each authority the case touched performed its own function correctly within its own lane. No authority held the whole.

Third, the custodial oversight framework, like the long-term-care survey framework that produced the Ohio Department of Health findings, operated after the events it reviewed and within a single domain. It was not designed to coordinate contemporaneously with the Probate Court, the treating physicians, the endocrine and neurological record, or the medication-administration history that the framework places at the center of any qualifying intake event. A jail-standards inspection answers a jail-standards question. It is not built to ask whether the conduct that produced a criminal-legal contact was the downstream consequence of a withheld medication because that question belongs to no single agency's jurisdiction at all.

The Bureau of Adult Detention did its job. It applied the standards it is charged with enforcing and it reached the conclusions those standards supported. That is precisely the point. The architecture is composed of capable bodies, each doing its own work correctly, none of them positioned or authorized to hold the patient's situation as a whole. The framework this Case Study supports does not ask the Bureau, or any single agency, to expand its jurisdiction. It asks that the separate jurisdictions be coordinated, at the qualifying event, so that the questions falling between them are owned by someone before harm compounds rather than referred elsewhere after it.

April 21, 2023. The Least-Restrictive Release

On April 21, 2023, the Honorable Judge David Gormley of the Delaware County Court of Common Pleas determined that the patient was not competent to stand trial at that time and ordered his release on his own recognizance into the care of his guardian, subject to GPS monitoring.

This is one of the most operationally significant moments in the chronology. It created a real-world, judicially supervised opportunity to test whether community-based, multidisciplinary outpatient stabilization could safely succeed for a medically vulnerable elderly patient previously held in custodial isolation. The test was set up. The patient was released. He went home with the guardian.

His A1C at release was 7.5. He was discharged in a wheelchair.

April 21 through October 26, 2023. Six Months of Community Stability

This six-month period is the empirical center of the Case Study. Read what the record shows.

- No violent incidents.
- No police interactions.
- No emergency behavioral episodes.
- No threats toward self or others.
- No safety concerns reported by neighbors, providers, faith community or family.

This was not a passive period. It was intensive, coordinated outpatient care. Under direct guardian supervision, the patient engaged with a multidisciplinary outpatient team that included his treating neurologist, Dr. Aniket Natekar of OhioHealth Neuroscience; his treating psychiatrist, Dr. Kristen Kilbarger of OhioHealth; his treating endocrinologists, Dr. Derek Lapp and Dr. Jay Patel of OhioHealth; his treating primary care physician, Dr. Ruth Egwakhe of OhioHealth; OhioHealth Cardiology, which conducted cardiac evaluation and issued medical clearance; OhioHealth Urology, which conducted urological evaluation and issued medical clearance; an OhioHealth registered dietitian for nutritional coordination; podiatric care; multidisciplinary Neuro rehabilitation through OhioHealth Neuroscience Rehabilitation Services, including neuro physical therapy, neuro occupational therapy and neuro

speech therapy; physical therapy through NovaCare Rehabilitation; outpatient trauma-informed therapy, dental care (denture process), aqua therapy, chiropractor and acupuncture therapy.

He attended every appointment. He participated actively in physical therapy, occupational therapy and speech therapy. His mobility improved week by week. He used a wheelchair from April through June 2023. He moved to a Rollator from June through August. He moved to a cane from August through November. He walked without assistance after that.

In May 2023, his treating neurologist, Dr. Aniket Natekar, formally diagnosed him with Functional Neurological Disorder (FND), in consultation with his treating psychiatrist, Dr. Kristen Kilbarger. This diagnosis is central to everything that follows. It allowed earlier symptom presentations, including the cognitive and motor manifestations observed during custodial confinement, to be reframed within a modern Neuro rehabilitation paradigm rather than a primary psychiatric or correctional framework. His treating psychiatrist discontinued psychiatric medications and referred him to trauma-informed therapy.

By the end of this six-month period, he was ambulating without assistance. He was attending online church. He was walking around entire residence complex on his own. He was sleeping in his own bed in the guardian's home. He was taking his medications reliably under guardian supervision. He was engaging actively with the multidisciplinary outpatient team. His A1C across this period stabilized in the 7.1 to 6.9 range. He was, by every measure the record contains, a man returning to his life.

This period demonstrates something the framework asks reviewers to take seriously. Medically supervised community-based rehabilitation, organized around continuity, trust, faith and family infrastructure, can produce measurable stabilization in a medically complex elderly patient previously held in custodial confinement. The absence of violence, emergency events and safety concerns across a sustained, judicially supervised period is itself substantive evidence in any least-restrictive-placement analysis that follows.

October 13, 2023. Court-Ordered Transfer to Twin Valley Behavioral Healthcare

On October 13, 2023, the patient was transferred to Twin Valley Behavioral Healthcare (TVBH) pursuant to a court order issued June 16, 2023. The record describes his initial experience of TVBH as one of partial relief. Trauma symptoms reduced compared to the prior custodial environment. Mobility and confidence continued to improve. By November 2023 he was ambulating without a cane and reported feeling closer to his baseline personality. His A1C in this period stabilized in the 6.9 range.

Inside the Ohio Department of Behavioral Health (Ohio-DBH), previously known as Ohio Mental Health and Addiction Services (Ohio-MHAS), Central Ohio Behavioral Healthcare (COBH) treatment environment, he came under the attending psychiatric care of Dr. Prabhavathy Mannava and Dr. Neil Patel, with primary care provided by Dr. Ellis Opusunju. The Ohio-DBH / Ohio-MHAS, COBH treatment team became the longitudinal clinical environment for day-to-day care. Continuity with his prior outpatient OhioHealth specialists, neurology, endocrinology, primary care, cardiology, urology, dietetics and his Ohio State University Medical Center specialists, nephrology and ophthalmology, was maintained through coordinated referral and consultation.

December 2023 through 2024. Court Evaluations and the Appeal

A renewed court-ordered evaluation was conducted at TVBH in December 2023. The patient remained at TVBH through 2024 without a primary psychiatric diagnosis warranting psychiatric institutionalization and without psychiatric medication. The systems-analysis question the framework was developed to address arises directly here. Did continued behavioral-health institutional placement, in the absence of a primary psychiatric diagnosis and in light of the six-month community period that showed no documented threat to public safety, represent the least restrictive treatment environment available?

In April 2024 a court hearing addressed level-of-privileges adjustment. In May 2024 the Fifth District Court of Appeals denied an appeal regarding Delaware County's retention of permanent jurisdiction. Throughout this period, the guardian's engagement remained constant. Daily two-way communication. In-person visits two to three times weekly. Attendance at all medical appointments. Continuous documentation of stabilization, presentation and functional baseline.

2024 through 2025. Specialty Medical Care During Institutional Placement

During the 2024 to 2025 period, the patient continued to receive specialty medical care through his established outpatient providers, coordinated alongside the Ohio-DBH / Ohio-MHAS, COBH treatment team. Ophthalmology care was provided through Ohio State University Medical Center, where he underwent three surgical procedures between 2024 and 2025 to address ophthalmological conditions affecting vision and balance. He was cleared post-operatively, with documented benefit to both. This is clinically relevant: balance is a recognized component of post-stroke and FND-related stabilization. Nephrology care continued through Ohio State University Medical Center for Stage 3 chronic kidney disease. Endocrinology coordination continued through Dr. Lapp and Dr. Jay Patel. Cardiology and urology consultation continued through OhioHealth and resulted in continued medical clearance across both specialties. The continuity of this outpatient specialty network, across multiple academic medical centers, multiple specialty disciplines and the institutional placement environment, is itself part of the documentary record on which the multidisciplinary review framework proposed by SEIU-M / CIU-M is intended to rely.

2025 through Early 2026. Sustained Placement and Continuing Advocacy

Through 2025 and into early 2026, the chronology reflects continued institutional placement at the COBH / TVBH treatment environment, sustained guardian engagement, ongoing rehabilitation, an emergency department visit in January 2026 for COVID-19 diagnosis and the subsequent restoration of expanded guardian visitation privileges. The record from this period includes a sustained body of treatment-team correspondence, formal communications addressed to the COBH treatment team and administration, addressing continuity of care, medication coordination, public-safety analysis, FND interpretation, elder-abuse concerns, trauma-informed treatment, record-integrity issues, court-preparation requests and the measurable clinical impact of structured family presence.

2026. Continuing Rehabilitation and the Systems-Modernization Initiative

The chronology continues through 2026 with sustained rehabilitation, ongoing coordination requests, continuing legal advocacy and the parallel development of the broader SEIU-M / CIU-M systems-modernization framework. The supporting record from this period includes formal outreach to the Office of the Ohio Attorney General, the Ohio Elder Justice Unit, Pro Seniors, the Office of the Governor, the Ohio Department of Aging, all members of the Ohio House of Representatives, the United States Department of Justice, federal civil-rights counsel and the Centers for Medicare and Medicaid Services. The earliest articulated version of what subsequently became the SEIU-M / CIU-M operational framework appears in the April 10, 2026 Letter to the Ohio House of Representatives. That letter establishes something important about the framework itself: it originated in case-specific advocacy chronicled in this document, not in disconnected theory.

That origin chain, from case study to policy framework, is itself part of what the reviewer holds in hand. It is a working example of how a single sustained advocacy effort, conducted across nearly six years and across every available institutional channel, can be translated from individual circumstance into systems-modernization architecture. That translation is precisely what the SEIU-M / CIU-M proposal asks the State of Ohio and federal partners to formalize at scale.

As of the day this document is submitted, the patient remains in institutional placement.

The chronology has not closed. The framework asks why?

Part III. Medical, Clinical and Forensic Context

How the diagnostic profile, the FND interpretation, the difference between treating and forensic frameworks and the question of least-restrictive stabilization all fit together.

6. Medical and Rehabilitation Context [CS sec.6]

The medical themes that recur across this Case Study are recognizable, individually, to anyone who practices internal medicine or geriatrics: diabetes management, endocrine instability, post-stroke neurological vulnerability, transient ischemic attack history, Functional Neurological Disorder, trauma exposure, rehabilitation participation, medication continuity and environmental stabilization. What makes this case operationally complex is not the individual diagnoses. It is the combination.

Each diagnosis, considered alone, is well understood. Together, in an elderly post-stroke patient with FND and trauma exposure, they produce a clinical picture that resists single-discipline characterization. Diabetes management cannot be separated from cognitive presentation when blood glucose levels reach crisis range. Hypertension management cannot be separated from neurological vulnerability when blood pressure correlates with TIA risk. Trauma exposure cannot be separated from FND symptomatology because trauma is a recognized FND precipitant. Continuity of care cannot be separated from rehabilitation participation because rehabilitation requires sustained therapeutic relationships.

Rehabilitation participation is not a footnote in this case. It is the centerpiece of the empirical demonstration that the patient stabilized under coordinated outpatient conditions. The multidisciplinary neurorehabilitation through OhioHealth Neuroscience Rehabilitation Services, including neuro physical therapy, neuro occupational therapy and neuro speech therapy, paired with physical therapy through NovaCare Rehabilitation and outpatient trauma-informed therapy, demonstrates what coordinated outpatient rehabilitation can produce for a medically complex elderly post-stroke patient. The mobility trajectory across April through October 2023, wheelchair to rollator to cane to unassisted walking, is one of the cleanest empirical demonstrations in the entire chronology.

7. Functional Neurological Disorder and How It Is Misread [CS sec.7]

Functional Neurological Disorder, often abbreviated FND, is a legitimate neurological condition. Modern neurology, neuropsychiatry and rehabilitation medicine recognize it as a real diagnosis with established clinical features, defined diagnostic criteria, evidence-based treatment pathways and substantial rehabilitation potential. It is recognized in the International Classification of Diseases. Major neurological centers, including OhioHealth Neuroscience Rehabilitation Services, run established treatment programs for it. It is not a diagnosis of exclusion. It is not a diagnosis of last resort. It is the diagnosis the patient's treating neurologist made, in consultation with his treating psychiatrist, after months of observation.

FND can present with motor symptoms (weakness, tremor, gait disturbance), sensory symptoms (numbness, vision changes), cognitive symptoms (memory impairment, dissociative experience), seizure-like episodes that are not epileptic and combinations of these. What defines the condition clinically is that symptoms fluctuate based on identifiable variables: stress, fear, trauma exposure, environmental instability, psychological overwhelm, medical destabilization, cognitive overload, autonomic dysregulation. The underlying neurological function is not permanently lost. It is functionally interrupted in ways that respond to coordinated rehabilitation, trauma-informed environment design and continuity of care.

FND is also a condition that can be misread by systems that were not trained in it.

Inside correctional, forensic and emergency behavioral-health systems, the diagnostic frameworks in use are often older. Symptoms that fluctuate under stress can be misread as inconsistent, malingered or performative. Symptoms that improve in trusted environments and worsen in fearful ones can be misread as voluntary control, as if the patient could simply choose not to be unwell. The patient cannot. The fluctuation is the disease. The condition itself is the pattern. Without modern FND literature in the evaluative framework, the framework will misclassify the patient. This is not a criticism of any individual evaluator. It is a structural observation about what the operational framework currently does and does not consistently include.

The records associated with this Case Study repeatedly raise the need for evaluative frameworks capable of reliably distinguishing among:

- Neurological destabilization from stroke, TIA or post-stroke vulnerability.
- Trauma responses arising from documented adverse care experiences.
- Endocrine complications, including hyperglycemic confusion and hypertensive crisis.
- Medication-related effects from missed, incorrect or withheld prescriptions.
- Cognitive decline associated with age, vascular disease or post-stroke change.
- Functional neurological symptoms consistent with the established FND pattern.
- Primary psychiatric illness arising from a true underlying psychiatric disorder.

A specific clinical pattern is worth identifying directly. In medically vulnerable elderly post-stroke patients with FND and documented trauma history, fluctuating paranoid presentation, statements of unusual temperature sensation and reports of breathlessness or cannot-breathe sensations may reflect fear response, autonomic activation, trauma reactivation, sensory misprocessing, environmental disorientation or neurological stress response, rather than primary psychotic pathology. Brief observation of these symptoms, without longitudinal context and without integration of the patient's neurological, trauma, endocrine and environmental variables, can produce a diagnostic conclusion narrower than the actual presentation warrants.

There is corroborating evidence in this Case Study's record. The patient's fluctuating fears and trauma-related presentations have been documented as responsive to environmental and relational conditions. They decrease measurably under conditions of guardian and family presence, environmental safety and predictable routine. They intensify under conditions of isolation, environmental displacement and perceived loss of safety. Symptoms whose intensity tracks with environmental variables are clinically distinguishable from symptoms produced by fixed primary psychotic pathology. That distinction belongs in the framework within which forensic conclusions are drawn.

Misclassification matters because the framework selected determines the trajectory available to the patient. A patient classified primarily within a psychiatric framework gets a placement pathway designed for psychiatric stabilization. The same patient classified primarily within a neurological-rehabilitation framework gets a substantially different pathway, one designed for functional restoration. Which framework the system uses is, in this respect, not a technical question. It is the question.

This Case Study supports the development of integrated neurobehavioral review pathways inside future SEIU-M / CIU-M operational models. Pathways in which neurology, neurorehabilitation, psychiatry, endocrinology, trauma-informed assessment and longitudinal treating-provider observation are structurally part of evaluation, not left to the discretion of individual evaluators working in isolation.

8. When the Treating Record and the Forensic Record Do Not Meet[CS sec.8]

One of the central structural themes in this record is the gap between treating-provider frameworks and forensic-evaluation frameworks. Both are legitimate. Both are necessary. They serve different purposes, work under different evidentiary standards and produce different outputs. The question is not whether one is right and the other is wrong. The question is whether the architecture now in place ensures that the longitudinal evidentiary record produced by treating providers and the legal-standard analysis produced by forensic evaluators consistently meet, before the high-consequence decision is made.

Treating physicians, by training and by professional obligation, generally prioritize accurate diagnosis, medical stabilization, rehabilitation and functional restoration, quality of life, functional improvement, community integration, recovery potential, least-restrictive care and long-term continuity.

Forensic evaluators, by training and by professional obligation, generally prioritize competency analysis under applicable legal standards, risk assessment, public-safety considerations, institutional liability, legal standards for restoration, future decompensation risk and capacity to understand and participate in legal proceedings.

Both sets of priorities are legitimate. Each performs essential work the other is not structured to perform. The structural concern this Case Study raises is that courts and forensic systems do not consistently receive integrated multidisciplinary context before high-consequence placement decisions are made. A forensic evaluation conducted at a single point in time, often during a period of acute presentation, may not reliably capture rehabilitation progress, community stabilization evidence, longitudinal functioning, caregiver support, treatment compliance, outpatient success and neurorehabilitation outcomes that have accumulated across the months and years preceding the evaluation.

The records in this Case Study repeatedly raise concerns that brief evaluations or short-window institutional observations may fail to capture:

- Rehabilitation progress demonstrated over weeks or months of outpatient care.
- Community stabilization demonstrated over sustained periods of supervised placement.
- Longitudinal functioning across time periods longer than the evaluation window.
- Caregiver support, family infrastructure and faith-community continuity.
- Treatment compliance under continuity-of-care conditions.
- Outpatient success and rehabilitation participation rates.
- Neurorehabilitation outcomes and FND treatment response.
- Cultural, linguistic and religious continuity as stabilization factors.
- The relationship between symptom presentation and environmental stress.

The framework therefore supports an integrated medical-legal review pathway capable of balancing rehabilitation evidence, public safety, neurological findings and continuity-of-care considerations simultaneously. The pathway does not displace forensic evaluation. It surrounds forensic evaluation with the longitudinal medical context that allows the legal-standard analysis to occur against a complete evidentiary record rather than a snapshot.

There is a further observation worth making about how multidisciplinary medical evidence currently enters legal decision-making. Forensic evaluations, by virtue of their structured relationship with the court, are received as primary evidence within competency and restoration proceedings. Treating-provider observations, by contrast, often reach the court through indirect channels, guardian-submitted records, attorney-introduced exhibits, occasional subpoena. They may not receive comparable

evidentiary weight even when the longitudinal observation period is substantially longer. This is not a criticism of any judge. It is a structural observation about how the architecture currently routes evidence and about how the framework is designed to formalize the integration of longitudinal treating-provider observation into the record on which courts rely.

9. Least Restrictive Stabilization and Public Safety [CS sec.9]

The principle of least-restrictive treatment, embedded within disability law, the Americans with Disabilities Act, the Olmstead decision, mental-health law and Ohio guardianship law, holds that individuals subject to public or institutional authority should be placed in the least restrictive environment consistent with public safety and clinical necessity. The principle is not optional. It is the operational standard against which placement decisions are measured.

This Case Study respectfully raises a policy question. Are successful outpatient stabilization, rehabilitation participation and guardian-supported care consistently weighed within institutional review against the full range of placement alternatives the least-restrictive principle requires? The April through October 2023 community period provides a structured, judicially supervised, six-month real-world test of community-based stabilization for a medically complex elderly patient previously held in custodial isolation. The record for that period reflects:

- No violent incidents.
- No police interactions.
- No emergency behavioral episodes.
- No threats to self or others.
- No safety concerns reported by neighbors, providers, faith community or family.
- Active participation in multidisciplinary outpatient care.
- Measurable progress in physical, occupational, speech and neurorehabilitation therapies.
- Reliable medication compliance under guardian supervision.
- Sustained engagement with faith community, family and cultural infrastructure.
- A1C stabilization in the clinically meaningful 7.1 to 6.9 range.

The structural question is whether the subsequent return to institutional placement was supported by an integrated multidisciplinary review of this empirical stabilization record. The framework takes no position on the lawful judicial discretion exercised in this case. The structural observation is that systems architecture would benefit from coordinated infrastructure that integrates the longitudinal stabilization record into the placement analysis whenever such a record exists.

10. What Stabilization Actually Means [CS sec.10]

Stabilization is not a single number on a chart. It is a multidimensional condition and any framework that measures only one dimension produces an incomplete picture.

A complete definition of stabilization includes medical stabilization (vital signs, glycemic control, blood pressure, neurological status, medication levels); functional stabilization (mobility, daily living activities, cognitive performance, communication); psychiatric stabilization (mood, behavior, sleep, baseline orientation); rehabilitation stabilization (sustained engagement with therapeutic relationships, measurable functional progress); social and communal stabilization (relationships with family, faith community, neighbors); cultural and linguistic continuity (engagement within the framework that supports the patient's identity); environmental stabilization (consistent, safe, predictable physical environment); and continuity-of-care stabilization (sustained treating-provider relationships across care transitions).

Each dimension matters. Each contributes to the clinical reality the placement analysis is intended to measure. A framework that measures one dimension while ignoring the others produces a placement analysis that is empirically incomplete. The SEIU-M / CIU-M framework is designed, in part, to make this expanded definition of stabilization operationally measurable, documented and integrated into the multidisciplinary review on which placement decisions rest.

Part IV. Systems Analysis

11. Equity, Access and Who Gets the Better Pathway [CS sec.11]

This Case Study makes a structural observation that deserves to be named plainly. Access to integrated multidisciplinary care correlates with private resources. Families with means can retain consultants. They can get second opinions. They can fund specialist evaluations. They can hire private counsel. They can commission independent medical advocacy. Families without means cannot.

The result is that two patients with identical clinical profiles can experience substantially different institutional trajectories, for reasons that have nothing to do with their clinical condition or their actual risk and everything to do with what their family can afford to pay for in the meantime. This is not framed as accusation against any institution. It is a structural fact about how the current architecture works. The framework's coordination architecture is organized through public infrastructure for the express purpose of making coordinated multidisciplinary review available regardless of private resources. Constitutional protections and equity considerations align in that design.

Inside the specific Case Study, the longitudinal coordination effort required to maintain continuity of care across multiple specialists, neurology, endocrinology, psychiatry, primary care, cardiology, urology, dietetics, neurorehabilitation, physical therapy, trauma-informed therapy, nephrology, ophthalmology, podiatry, across multiple institutions, OhioHealth, Ohio State University Medical Center, NovaCare, COBH / TVBH and across multiple care transitions, was sustained only through intensive guardian engagement. A guardian without the time, the education, the technical infrastructure or the financial reserves to perform that coordination would have been substantially disadvantaged. The framework is designed to take that coordination burden off the guardian and put it inside public infrastructure available to every comparable case, regardless of resources.

12. Guardianship, Communication and Care Coordination [CS sec.12]

Ohio guardianship under Revised Code Chapter 2111 vests in the court-appointed guardian formal legal authority over the ward's medical, residential, financial and personal decisions, subject to continuing Probate Court supervision. The statutory framework is strong. The operational recognition of the framework, across the institutions a ward subsequently encounters, is uneven.

This Case Study documents several recurring patterns in how the Letter of Guardianship is treated at the operational level:

- Hospital and emergency-department admissions in which the guardian's authority required repeated assertion before being recognized in the medical record.
- Custodial intake in which the Letter of Guardianship was not honored at the operational level for an extended period, producing the corresponding continuity-of-care disruption.
- Forensic evaluation contexts in which the guardian's longitudinal observations were received as supplementary rather than as primary evidence.
- Behavioral-health institutional placement in which guardian standing in placement decisions was not operationally formalized.
- Treatment-team correspondence in which the guardian's written communications addressing continuity, medication coordination, public-safety analysis and trauma-informed treatment received variable response.

The structural observation is not that any individual institution violated the guardian's legal authority. It is that the operational infrastructure for systematic recognition and integration of Probate Court guardianship into subsequent institutional decision-making is not consistently developed. The SEIU-M / CIU-M framework's Probate Court coordination interface is designed to address that gap.

When the Probate Court has already adjudicated a person legally incompetent, every system that subsequently engages with that person should be operationally aware of the adjudication. The guardian should not have to assert it. The system should already know.

13. The Gaps This Case Reveals [CS sec.13]

The Case Study reveals a defined set of systems gaps that recur across the chronology. They are not unique to the institutions in this particular case. They are operational gaps documented in comparable cases across the state and the country. Naming them at the structural level supports structural remedy.

- **Medication-reconciliation gaps at transitions.** Across the December 2021 stroke hospitalization, the April 2022 facility admission, the October 2022 custodial intake and the October 2023 institutional transfer, medication reconciliation between sending and receiving systems did not function as a structured process. It depended on guardian intervention.
- **Continuity-of-care preservation gaps.** Established treating-provider relationships were repeatedly disrupted by transitions. Specialist consultation was repeatedly delayed at receiving institutions. Outpatient rehabilitation regimens established at one care environment were not consistently sustained at subsequent ones.
- **Elder-abuse and facility-accountability investigation gaps.** The Ohio Department of Health regulatory findings against The Grand of Dublin (Survey OH00131063) and Abbington of Powell (Surveys OH00136991, OH00137240, OH00139261) came after the events they document. The framework's elder-abuse causation investigation protocol is designed to trigger this kind of review contemporaneously, not retrospectively.
- **Guardianship-recognition gaps.** Multiple operational episodes documented in the chronology required sustained advocacy before the Letter of Guardianship was honored at the institutional level.
- **Forensic-clinical integration gaps.** Brief evaluations did not consistently incorporate the longitudinal medical, rehabilitation and continuity-of-care evidence developed across the months and years preceding evaluation.
- **Least-restrictive analysis gaps.** The six-month outpatient stabilization period was not, in the structural review that followed, evidently weighed against the full range of placement alternatives the Olmstead standard contemplates.
- **Resolution-pathway gaps.** Following the unrestorability finding, no defined pathway was operationally available to transition the patient from institutional placement to guardianship-supported community placement. This is the Resolution Gap that Section 23 analyzes in full.

14. The Questions This Case Asks of Policy [CS sec.14]

The Case Study raises a defined set of policy questions for institutional review. They are not framed as conclusions. They are framed as questions the framework's coordination architecture is designed to make operationally answerable in any future comparable case.

1. **Coordination.** No single actor in the existing architecture holds the authority and the information simultaneously. Medical evaluation proceeds without legal context. Legal proceedings advance without clinical context. Guardianship is consulted after rather than before. What institutional architecture would ensure that medical, neurological, behavioral-health, rehabilitation, legal, judicial, guardianship and continuity-of-care information is integrated, in real time, at the point of a qualifying crisis event?
2. **Resolution.** What statutory or administrative pathway is operationally available for defendants found incompetent and unrestorable, particularly those already adjudicated incompetent by Probate Court under R.C. Ch. 2111?
3. **Probate Court coordination.** What formal mechanism contemporaneously notices the Probate Court of subsequent criminal-legal contact involving its already-adjudicated incompetent wards? How is the Probate Court brought into the discovery, causation and charging discussion before, not after, indictment?
4. **Medication safety.** The question that no system in the existing architecture asks first is the one that most often holds the answer. Before the behavioral interpretation. Before the incident report. Before the call to law enforcement. What protocol triggers medication-safety review as the predicate step in behavioral interpretation for medically vulnerable patients?
5. **Elder-abuse causation.** What protocol triggers Adult Protective Services, Long-Term Care Ombudsman, Medicaid Fraud Control Unit and state survey agency review at qualifying intake events involving care-facility residents?
6. **Continuity of care.** What mechanism preserves established treating-provider relationships, medication regimens and rehabilitation plans through periods of crisis transition?
7. **Least-restrictive placement.** What analytical framework ensures that the full continuum of medically appropriate settings is considered in placement decisions, consistent with the Olmstead integration mandate?
8. **Family and guardian integration.** In this case the guardian had six years of longitudinal observation, multiple treating providers, a documented medication history and a Probate Court adjudication already on record. None of that information was formally integrated into the institutional decision-making record at the point of crisis contact. What formal mechanism ensures that it is?
9. **Outcome measurement.** What structured measurement infrastructure supports continuous improvement, audit and outcome demonstration for the populations the framework addresses?
10. **Federal coordination.** What coordination with federal authorities, HHS, CMS, SAMHSA, DOJ Civil Rights, the Administration for Community Living, supports state-level implementation and cross-state learning?

15. Elder Justice and the Protection of the Vulnerable [CS sec.15]

The federal Elder Justice Act of 2010, Title XX of the Social Security Act (42 U.S.C. sec. 1397j et seq.), establishes federal authority for elder-abuse prevention, investigation and coordination. State Adult Protective Services frameworks, in Ohio under R.C. Ch. 5101, Long-Term Care Ombudsman programs under federal authority of the Older Americans Act and Medicaid Fraud Control Units operating under federal authority for patient abuse and neglect investigation in Medicaid-certified facilities, together constitute the existing federal-state elder-justice architecture.

Inside this Case Study, the Ohio Department of Health regulatory findings against The Grand of Dublin and Abbington of Powell document facility-level deficiencies relevant to the patient's care during the December 2021 to April 2022 and April 2022 to October 2022 periods. Those findings came after the events they document. The structural question is whether contemporaneous activation of the elder-justice framework, at the qualifying intake event itself, would have produced a different operational trajectory for the patient and for the facility-accountability record.

The framework's elder-abuse causation investigation protocol is designed to address that gap. When a care-facility patient under guardianship presents at a qualifying intake event, APS, the Long-Term Care Ombudsman, MFCU and the state survey agency are notified contemporaneously, not after the fact. Staffing, supervision, medication-administration practices, restraint use, prior complaints and prior survey findings are reviewed in coordination with the patient's clinical stabilization. The criminal-legal proceeding does not advance until that review is completed.

This is not a substitute for prosecutorial discretion or judicial authority. It is a coordination layer that ensures the elder-justice context is available to the prosecutor and the trial court at the point at which their authority is being exercised. The substantive decisions remain with the constitutional decision-makers. What changes is the breadth of the information available to them at the point of decision.

The deeper concern this raises is structural. Institutional elder abuse and medication mismanagement can produce behavioral manifestations that then enter the criminal-legal system, with the proceeding advancing on the institutional narrative before any contemporaneous investigation of the institutional context that may have caused the behavior. That is the operational core of the second of the framework's four principles: causation before prosecution.

The diversion dimension of this structural concern deserves specific attention. A long-term care facility presents conditions that create distinctive vulnerability to medication diversion by staff: paper-based or low-audit medication records, pre-dispensed medications without electronic access trails and a patient population that cannot reliably detect or report what was withheld or substituted. A resident with adjudicated legal incompetence is, by definition, a resident whose report of their own experience carries no independent legal weight. When that resident is also prescribed a high-value medication with a substantial secondary market, the conditions for undetected diversion are complete. No existing system within the criminal-legal, clinical or regulatory architecture is designed to investigate whether the conduct that preceded a criminal-legal contact was causally linked to the absence of a prescribed medication. That investigation does not happen. The SEIU-M causation investigation step is designed to make it happen.

Part V. Systems Impact

16. Detailed Systems Impact Analysis [CS sec.16]

This section synthesizes what the documented gaps have produced. The synthesis is presented at the systems level. It does not address individual conduct.

What the Patient Carried

Continuity disruption across multiple transitions. Medication mismanagement at multiple institutional contexts. Preventable medical destabilization at multiple points. Cognitive decline associated with prolonged institutional placement. Rehabilitation gains lost during periods of disrupted access. Trauma layered upon trauma. Loss of established treating-provider relationships. Loss of community, faith and family continuity during prolonged placement. Prolonged procedural suspension with no defined resolution pathway. Years of his life he will not get back.

What the Family Carried

Sustained institutional labor performed by a guardian without institutional support. Financial cost associated with sustained advocacy across multiple institutions. Psychological burden of serving as the integration mechanism for systems that did not coordinate. Loss of professional and personal time across approximately six years. The recurring experience of being received as an external observer rather than as a stabilization partner. Years of work that the architecture should have done.

What the Institutions Carried

Regulatory findings against two of the involved care facilities. Sustained operational expenditure on prolonged institutional placement. Sustained court calendar engagement with an unresolved case. Sustained Medicaid expenditure across multiple care environments. Sustained healthcare workforce time spent on coordination work that institutional infrastructure should have supported. The operational reputational cost of an unresolved case that no institution is structurally positioned to close.

What the Public Systems Carried

Continued utilization of state forensic-system capacity for a case that may not require it. Continued utilization of court and prosecutorial resources for a case that no party has been able to advance. Continued Medicaid expenditure that lacks therapeutic justification. Sustained constitutional exposure under Jackson v. Indiana for the time-bounded review the standard requires. Continued accumulation of the kind of operational cost the framework's coordination architecture is designed to reduce.

None of this is sustainable. None of this is necessary. Every dollar of it, every hour of it, every year of it represents work the architecture is doing because the architecture is not coordinated. The framework asks for coordination so the work can stop.

17. What the Record Shows About Stabilization [CS sec.17]

Across the longitudinal record, several stabilization themes recur with enough frequency to support institutional generalization. They are not unique to this patient. They are clinical patterns the framework's coordination architecture is designed to honor in every comparable case.

- **Continuity correlates with stabilization.** Periods of preserved treating-provider continuity, preserved medication regimens and preserved rehabilitation participation correlate with measurable stabilization across medical, neurological, functional, behavioral and rehabilitation domains. The April through October 2023 community period is the cleanest empirical demonstration.
- **Disruption correlates with destabilization.** Periods of disrupted continuity, disrupted medication and disrupted rehabilitation correlate with measurable destabilization across the same domains. The December 2021 to April 2022 facility period and the October 2022 to April 2023 custodial period are the cleanest demonstrations.
- **Environment correlates with FND presentation.** FND symptoms intensified under isolation, environmental displacement and perceived loss of safety. They attenuated under guardian and family presence, environmental safety and predictable routine. The pattern is consistent with the established FND literature.
- **Medication safety correlates with behavior.** The documented Ozempic administration failures at Abbington of Powell and the discontinuation of Ozempic during the early custodial period, correlate with documented behavioral and metabolic destabilization. Restoration of the appropriate regimen correlated with stabilization.
- **Multidisciplinary review produces clinical clarity.** The May 2023 FND diagnosis, rendered through coordination between treating neurology and treating psychiatry, allowed earlier symptom presentations to be reframed within a modern neurorehabilitation paradigm. The clarity that emerged through multidisciplinary review was not available within any single-discipline framework.
- **Cultural and faith continuity supports stabilization.** The patient's engagement with the Ethiopian Orthodox Tewahedo community in Columbus is a documented stabilization factor in the April through October 2023 period. Cultural, linguistic and faith continuity is not peripheral to stabilization for the populations the framework addresses. In many cases, it is central.

18. Where Forensic Evaluation Currently Falls Short [CS sec.18]

The Case Study raises a defined set of structural concerns about forensic-evaluation integration with the broader medical and rehabilitation record. These are not criticisms of individual evaluators. They are systems observations.

- Brief evaluation windows may not capture longitudinal functional baselines developed over months or years.
- Acute presentation observed during the evaluation window may not represent the patient's baseline functioning under continuity-of-care conditions.
- Treating-provider longitudinal observation may not be consistently integrated into the evaluation record.
- Rehabilitation participation and outpatient stabilization evidence may not receive evidentiary weight comparable to forensic-evaluation conclusions.

- FND symptomatology may be interpreted through traditional psychiatric or forensic frameworks rather than modern neurorehabilitation frameworks.
- Medication-mismanagement context may not be integrated into the differential framework against which behavioral observations are interpreted.
- Environmental and relational variables that influence symptom presentation may not be documented within the evaluation framework.
- Cultural, linguistic and faith-based stabilization factors may not be incorporated into the placement analysis.
- Guardian standing in the evaluation and review process may not be formally established.

The framework's integrated medical-legal review pathway is designed to address these gaps. It surrounds forensic evaluation with the longitudinal medical, rehabilitation, trauma-informed, guardianship and continuity-of-care context that supports a more complete evaluation foundation. It does not displace forensic evaluation. It strengthens what forensic evaluation has to work with.

19. Evidence to Preserve in Comparable Cases [CS sec.19]

The Case Study identifies the following evidence categories as essential to preserve in any comparable case. The list is not exhaustive. It is a starting framework for institutional review.

- Complete medical record across all treating institutions and specialties.
- Complete medication record, prescription, dispensing and administration, across all care environments.
- Complete rehabilitation record, including physical, occupational, speech, neurorehabilitation and trauma-informed therapy notes.
- Complete treating-provider correspondence relevant to longitudinal observation.
- Complete guardian-prepared documentation, including notarized affidavits, treatment-team correspondence and longitudinal observation records.
- Complete court record across all proceedings.
- Complete regulatory findings from the Ohio Department of Health and any other state survey agencies.
- Complete Adult Protective Services, Long-Term Care Ombudsman and Medicaid Fraud Control Unit records where applicable.
- Complete custodial intake, medical and incident records from any custodial period.
- Complete EMS, emergency-department and hospital admission records.
- Complete facility records, including survey findings, complaint history, medication-administration records, supervision records and restraint records.
- Complete behavioral-health institutional treatment records.
- Cultural, faith-community and family correspondence relevant to stabilization documentation.

Part VI. Lessons and Connection to the Framework

The Pattern Beneath the Chronology

Read as a whole, the chronology in this Case Study is not a series of separate incidents. It is a single pattern repeating. At each transition between care environments, the corrected medication regimen failed to carry forward. At each new institution, established treating-provider relationships were interrupted and had to be rebuilt. At each system encounter, the prior adjudication of incompetency and the authority of the guardian required fresh assertion before they were recognized. The same failure recurred not because any one actor intended it but because no part of the system was responsible for carrying the patient's stabilization across the gap between contacts.

For this patient, repetition was not a return to a neutral starting point. Each destabilization cost ground that had been gained. In a patient whose neurological function fluctuates with environmental stability, as Functional Neurological Disorder does, every uncoordinated transition was not merely an administrative lapse but a clinical setback that erased rehabilitation progress and deepened vulnerability. The damage compounded in the record as well as in the body. Once a crisis snapshot entered the medical and institutional narrative, it shaped the next encounter and the one after that, even after the account that produced it had been corrected. Repetition thickened the file with acute presentations while the longitudinal evidence of stabilization remained underweighted.

The six-month community stabilization period, from April to October 2023, is the clearest demonstration that the cycle was never inevitable. Given a coordinated, guardian-supported, judicially supervised environment, the patient stabilized. That period is the counterfactual the rest of the chronology lacks. Its loss on the return to institutional placement is the single most direct illustration in this record of what happens when no structural owner exists to carry a demonstrated stabilization forward into the next placement decision.

Every turn of this cycle was carried by someone. The patient carried the lost progress and the repeated return to instability. The guardian and family carried the endurance of asserting the same authority, transmitting the same medication list and reconstructing the same continuity again and again. The institutions carried duplicated effort. The public systems carried duplicated cost. None of it resolved the underlying cause, because nothing in the existing architecture was designed to find and correct that cause at the moment it first appeared. This is the repetition the framework is built to interrupt. The causation-investigation step identifies the system error once, at the qualifying event, rather than absorbing its consequence across years. The continuity-of-care preservation mechanism gives the stabilization an owner so that progress made in one setting is not surrendered at the threshold of the next. The measure of the framework is simple. It is whether the next patient's chronology is shorter than this one.

20. What This Case Study Teaches [CS sec.20]

The Case Study yields a defined set of lessons for the design of the SEIU-M / CIU-M framework. These lessons are not retrospective. They are forward-looking design principles. They tell the framework what to be.

- **Lesson 1. Multidisciplinary integration must be structural, not optional.** Single-discipline review of medically complex cases consistently underweights variables outside the reviewing discipline. The framework's coordination architecture puts multidisciplinary integration inside institutional infrastructure rather than leaving it to ad hoc clinical relationships.
- **Lesson 2. Medication-safety review must precede behavioral interpretation.** Medication mismanagement produces behavioral presentations that, read without medication context, look indistinguishable from primary psychiatric or behavioral pathology. The framework's seven-step protocol places medication-safety review as the predicate step.
- **Lesson 3. Probate Court coordination must happen contemporaneously, not after.** Recognition of the Letter of Guardianship at the operational level should not require sustained advocacy by the guardian. When a patient already adjudicated incompetent enters another system, that system should already know. The framework's Probate Court coordination interface formalizes contemporaneous integration.
- **Lesson 4. Continuity of care must be preserved through transitions.** Established treating-provider relationships are clinical resources. They should not be lost when institutional placement changes. The framework's continuity-of-care preservation mechanism formalizes their protection.
- **Lesson 5. Elder-abuse causation must be investigated contemporaneously.** Investigation that comes after the events at issue does not protect the patient at the point of harm. The framework's elder-abuse causation investigation protocol triggers contemporaneous review.
- **Lesson 6. The least-restrictive analysis must consider the full care continuum.** Placement decisions should weigh the full range of medically appropriate settings rather than default to the most restrictive available. The framework's risk-stratification logic supports full-continuum analysis.
- **Lesson 7. Guardian and family integration is operational, not optional.** Guardians and families hold longitudinal observational data that institutional review cannot replicate. The framework formalizes their participation as stabilization partners.
- **Lesson 8. The Resolution Gap requires a defined pathway.** The absence of an operational pathway for defendants found incompetent and unrestorable produces measurable harm. The framework's seven-step protocol and the Resolution Gap analysis in Section 23 are designed to close that gap.
- **Lesson 9. Outcome measurement supports continuous improvement.** The framework's measurement architecture is designed to produce the institutional evidence required to support continuous improvement, demonstrate value to funders and sustain institutional confidence.
- **Lesson 10. The framework supports, not replaces, existing authorities.** Every operational element of the framework operates within existing federal and state authority. No new agency is created. No new statutory authority is requested during the pilot phase.

21. How Each Lesson Maps to the Framework [CS sec.21]

The connection between this Case Study and the SEIU-M / CIU-M framework is direct. Each lesson above maps to a specific element of the framework's architecture. The framework is not theoretical. It is the institutional response to a documented record of structural insufficiency.

Case Study Lesson	Framework Element
Multidisciplinary integration must be structural.	Multidisciplinary review pathway (Proposal sec.5, sec.9).
Medication-safety review must precede behavioral interpretation.	Seven-step protocol, Step 2 (Proposal sec.20).
Probate Court guardianship must be integrated contemporaneously.	Probate Court coordination interface (Proposal sec.6).
Continuity of care must be preserved through transitions.	Continuity-of-care preservation mechanism (Proposal sec.9).
Elder-abuse causation must be investigated contemporaneously.	Elder-abuse causation investigation protocol (Proposal sec.8).
Least-restrictive analysis must consider the full care continuum.	Risk stratification and placement logic (Proposal sec.5, App-F).
Guardian and family integration is operational.	Family integration and caregiver partnership (Proposal sec.9).
Resolution Gap requires a defined pathway.	Resolution Gap protocol (Proposal sec.20).
Outcome measurement supports continuous improvement.	Performance metrics and KPIs (Proposal sec.12).
Framework supports rather than replaces existing authorities.	No new statutory authority during pilot phase (throughout).

This Case Study is therefore the evidentiary foundation on which the framework's operational architecture rests. Each operational element of the framework can be traced, through the mapping above, to a specific recurring pattern documented in this chronology.

22. Records, Testimony and Evaluation Considerations [CS sec.22]

Reviewers undertaking deep-context analysis of the package may consider, where appropriate to their institutional role, the following records, testimony and evaluation considerations:

- Ohio Department of Health regulatory findings: ODH Survey OH00131063 (The Grand of Dublin); ODH Surveys OH00136991, OH00137240 and OH00139261 (Abbington of Powell).
- Delaware County Court of Common Pleas records: Case Nos. 22 CR I 10 0600, 23 CAA 07 0038 and 24 CV C 04 0380.
- Franklin County Probate Court records: Letter of Guardianship issued April 13, 2022; expedited transfer order issued September 2022.
- Fifth District Court of Appeals records: May 2024 denial of appeal regarding Delaware County retention of permanent jurisdiction.
- OhioHealth treating-provider records: neurology (Dr. Aniket Natekar), psychiatry (Dr. Kristen Kilbarger), endocrinology (Dr. Derek Lapp, Dr. Jay Patel), primary care (Dr. Ruth Egwakhe), cardiology, urology, dietetics, podiatry.
- Ohio State University Medical Center records: nephrology (Stage 3 CKD management) and ophthalmology (three surgical procedures, 2024 to 2025).
- OhioHealth Neuroscience Rehabilitation Services records: multidisciplinary neurorehabilitation across neuro PT, OT and SLP.
- NovaCare Rehabilitation records: physical therapy.
- Outpatient trauma-informed therapy records.
- Ohio-DBH / Ohio-MHAS, COBH / TVBH treatment records: attending psychiatry (Dr. Prabhavathy Mannava, Dr. Neil Patel), primary care (Dr. Ellis Opusunju).
- Delaware County Jail medical records covering the October 2022 to April 2023 custodial period.
- EMS and hospital admission records for October 26, 2022.
- Pharmacy records covering the patient's complete medication history, including Ozempic prescription and administration.
- Guardian-prepared treatment-team correspondence: a sustained body of formal communications addressed to the COBH treatment team and administration.
- Notarized affidavits documenting longitudinal observation and stabilization.
- Faith-community and pastoral records documenting cultural, linguistic and community continuity.
- Federal advocacy correspondence: outreach to the Office of the Ohio Attorney General, Ohio Elder Justice Unit, Pro Seniors, Office of the Governor, Ohio Department of Aging, Ohio House of Representatives, U.S. Department of Justice, federal civil-rights counsel and the Centers for Medicare and Medicaid Services.

These records are preserved in the supporting documentary record. They remain subject to applicable confidentiality, HIPAA and judicial-record-access frameworks.

Part VII. The Resolution Gap

23. The Resolution Gap: Two Pathways, One Missing [CS sec.23]

This section is the analytical center of the entire package. It develops the structural condition the Case Study most directly demonstrates and the framework most directly addresses. Read carefully, because every other document in the submission depends on what this section establishes.

The Resolution Gap is not an artifact of any individual case. It is a structural absence in the architecture of criminal-legal, civil-commitment, guardianship, behavioral-health and Medicaid coordination. The sections that follow develop the gap analytically, place it inside constitutional doctrine, identify the Ohio statutory matrix where it persists and propose the structural remedies the framework's coordination architecture is designed to implement.

23.1 The Asymmetry of Pathways

Here is the structural injustice at the center of this Case Study, stated as plainly as it can be stated.

There is a clear pathway for the person found legally incompetent and restorable.

There is no clear pathway for the person found legally incompetent and unrestorable.

Once a court finds that a defendant lacks the present capacity to understand the proceedings or assist in their own defense under the Dusky v. United States standard, the legal process formally branches.

The defendant found incompetent and restorable enters a well-developed procedural channel. Restoration treatment is initiated under time-limited standards. Periodic competency reviews are conducted. If restoration succeeds, the case resumes. If restoration fails within the constitutionally permitted period, proceedings transition toward civil-commitment evaluation or charge resolution. The pathway is imperfect, but it exists. It functions. Every actor inside the system understands its sequence. The defendant moves through it. The case moves toward conclusion.

The defendant found incompetent and unrestorable enters a pathway that has no comparable architecture.

The clinical finding that restoration is not possible, typically grounded in dementia, traumatic brain injury, advanced cognitive decline, progressive neurological disease, severe developmental disability or stable post-acute medical conditions, is one of the most clinically definitive determinations a competency evaluator can render. Yet the procedural consequence of that determination is, in many jurisdictions, indeterminate. There is no equivalent statutory timeline. No clearly assigned coordinating authority. No defined transition mechanism. No consistent endpoint. The case enters legal limbo. It does not move forward. It does not close. It does not transition. It continues.

This is the asymmetry. It is the structural fact this Case Study documents. It is the structural fact every document in the package returns to. It is also, in plain moral terms, a kind of system failure that deserves to be named for what it is. To build a careful pathway for the people the system can restore and to leave the people the system cannot restore in indefinite procedural suspension, is not a neutral architectural decision. It is the choice to make a population disappear inside a process that no one can advance and no one is responsible for closing.

23.2 What This Case Demonstrates

The Case Study at the center of this document is a working demonstration of the Resolution Gap. The patient was determined to be incompetent. Following six months of documented community stabilization under guardian supervision, he was returned to institutional placement. He has remained in institutional placement since October 13, 2023. He has not been restored to competency. He has not been transitioned to civil commitment, because he does not consistently meet the criteria. He has not been released to guardianship-supported community placement, because no defined pathway operationally supports that transition. The case has not closed. The Probate Court has not assumed coordinated jurisdiction. The criminal court has not dismissed. He remains in the gap.

The Case Study demonstrates the gap in five operational dimensions.

- **Clinical.** The patient has been clinically stable for sustained periods under conditions of continuity-of-care preservation. The clinical case for institutional placement has not strengthened over time. It has, if anything, weakened.
- **Constitutional.** The Jackson v. Indiana standard requires that continued procedural status bear a reasonable relationship to the purpose of restoration. Where restoration is not possible, the procedural status warrants time-bounded review. The operational implementation of that review has been uneven.
- **Fiscal.** Continued institutional placement consumes state-facility capacity, court calendar capacity and Medicaid expenditure across multiple years. The fiscal load is recurring.
- **Humanitarian.** The patient is in his late sixties, elderly, post-stroke, with documented cognitive vulnerability and a documented six-month period of community stability. Each year of continued institutional placement compounds vulnerability he may not have time to recover.
- **Familial.** The guardian has carried sustained institutional labor for nearly six years. The family has been disrupted across years that cannot be returned to them.

23.3 The Already-Adjudicated Incompetent Person

The most overlooked population inside the Resolution Gap is not the criminally accused individual whose competency is being evaluated for the first time. It is the person whose legal incompetence has already been adjudicated, often years earlier, by the Probate Court.

Under Ohio Revised Code Chapter 2111 governing guardianship of persons and estates, these wards have already been determined by a court of competent jurisdiction to lack the capacity to manage their own medical care, their medications, their residential placement, their financial affairs, their legal decisions, their daily routines, their communication with institutions and their participation in administrative or judicial proceedings. A sitting court has done this work. The Probate Court's adjudication is on the record.

In this Case Study, the Franklin County Probate Court appointed the guardian on April 13, 2022, six months before the events of October 26, 2022. The patient's legal incapacity was, on the date of the events at issue, an existing judicial finding. The criminal-legal system that engaged with him on and after October 26, 2022 was not engaging with a free legal actor of intact capacity. It was engaging with an adjudicated incapacitated person whose authority over his own medical care, residence and participation in proceedings had been vested in his court-appointed guardian six months earlier, by another sitting court.

The structural question this raises is whether the criminal-legal architecture has the operational mechanisms to recognize, in real time, that the defendant brought into the system is already adjudicated incompetent under R.C. Ch. 2111 and to integrate the Probate Court's prior adjudication

into the criminal proceedings from the moment of intake. In this case, that integration was not operationally automatic. It required sustained advocacy. It was intermittent rather than structural.

A justice system judge cannot make a fair decision about a defendant whose legal incompetence has already been adjudicated by a sitting court without that adjudication being formally integrated into the proceedings. Coordination with the Probate Court is not a courtesy. It is a prerequisite to fair adjudication.

The framework asks for that coordination to happen by structural design, not by guardian heroics. The sequence the framework proposes is straightforward. Discovery before charges. Causation before indictment. Coordination with the Probate Court before the trial court is asked to decide. None of that requires new authority. All of it requires that existing authority be exercised in the right order.

23.4 The Constitutional Architecture That Already Exists

The constitutional architecture governing the Resolution Gap is well-developed in doctrine. It is operationally underdeveloped in practice. The governing framework is this:

- **Dusky v. United States, 362 U.S. 402 (1960).** The competency-to-stand-trial standard. A defendant must have sufficient present ability to consult with counsel with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings.
- **Jackson v. Indiana, 406 U.S. 715 (1972).** A defendant committed solely on the basis of incompetency to stand trial cannot be held indefinitely. The Court held that commitment cannot exceed the reasonable period necessary to determine whether there is a substantial probability that the defendant will attain competency in the foreseeable future. Where no substantial probability of restoration exists the state must civilly commit or release. Continued confinement must bear a reasonable relationship to the purpose of restoration. If restoration is not possible within a reasonable period, the State must either initiate the customary civil-commitment proceedings or release the individual.
- **Sell v. United States, 539 U.S. 166 (2003).** The standard for involuntary medication for the purpose of restoring competency.
- **Olmstead v. L.C., 527 U.S. 581 (1999).** The integration mandate under Title II of the ADA. Public entities must provide services in the most integrated setting appropriate to the needs of the individual.
- **Title II of the Americans with Disabilities Act, 42 U.S.C. sec. 12131 to 12134.** The prohibition on disability-based discrimination by public entities.
- **Section 504 of the Rehabilitation Act, 29 U.S.C. sec. 794.** The prohibition on disability-based discrimination in federally funded programs.

Each of these authorities supports a coordinated, time-bounded, least-restrictive approach to the unrestorable defendant. None of them is altered by the framework. The framework's contribution is the institutional infrastructure required to make the existing constitutional architecture operationally functional at the point of a crisis event.

23.5 The Constitutional Impossibility of Restoration in Already-Adjudicated Patients

A particular constitutional concern arises in the case of patients who have already been adjudicated incompetent by the Probate Court before their entry into the criminal-legal system. For these patients, the competency analysis is, in a meaningful operational sense, conducted twice. Once by the Probate Court under R.C. Ch. 2111. Again by the criminal court under R.C. Ch. 2945.

The two analyses do not produce the same output. The Probate Court's analysis produces a finding of legal incapacity sufficient to support guardianship. The criminal court's analysis produces a finding of competency to stand trial under the Dusky standard. The two findings, while related, are not interchangeable.

But where the Probate Court has already determined that a patient lacks the capacity to manage his own medical care, his medications, his residential placement and his participation in administrative or judicial proceedings, the question of whether that patient can be restored to competency for purposes of standing trial under the Dusky standard is a question with a strong constitutional default. The default should be that restoration to competency for a patient already adjudicated globally incompetent is, in many cases, not clinically plausible. The framework's coordination architecture is designed to bring that default into the operational analysis the criminal court conducts, contemporaneously with the patient's initial engagement with the criminal-legal system, not three or four years later.

23.6 The Ohio Statutory Matrix Where No Title Owns the Resolution

The Resolution Gap persists because no single statutory title was written to govern it. The Ohio statutory matrix at the intersection of which the gap lives is summarized below. Each chapter addresses part of the situation. None owns the resolution.

- **Ohio Revised Code Chapter 2945, Criminal Procedure.** Competency to stand trial and restoration. No operational disposition pathway for the patient who cannot be restored and does not meet civil-commitment criteria.
- **Ohio Revised Code Chapter 5122, Civil Commitment.** Does not address what happens when a stabilized patient simultaneously has open criminal charges that Chapter 2945 has not resolved. The stabilized unrestorable defendant frequently does not meet civil-commitment criteria.
- **Ohio Revised Code Chapter 2111, Guardianship.** Contains no mechanism for transferring jurisdiction over a criminal matter from the trial court to the Probate Court.
- **Ohio Revised Code Chapter 5119, Behavioral Health.** Delegates restoration treatment to Ohio-DBH / Ohio-MHAS-designated forensic centers but does not delegate to any administrative entity the authority to resolve unrestorability cases the criminal court has not disposed of.
- **Ohio Revised Code Chapter 5160, Medicaid.** Contains no defined category for the continued placement of a stabilized, unrestorable patient with open criminal charges.

23.7 The Administrative Blackhole

The structural reason this gap persists is that no single agency owns the resolution. Courts await competency evaluations. Evaluators await placement availability. Placement authorities await court orders. Prosecutors await guidance. Defense counsel await the orders prosecutors are awaiting. Hospitals and behavioral-health systems await discharge authorization that cannot be issued because charges are open. Probate Courts and guardianship systems await coordination with criminal courts that lack defined coordination protocols. Each actor performs their role correctly. Each actor lacks

authority to advance the case beyond their role. No actor possesses the authority to close the gap unilaterally.

The Case Study is an empirical demonstration of this administrative blackhole. Multiple constitutional decision-makers have engaged with the case. None has been operationally positioned to close it. The framework's coordination architecture is designed to be the infrastructure that supports these decision-makers in advancing cases through to resolution, rather than leaving cases suspended in the space between their respective authorities.

23.8 How the Gap Shows Up in Practice

The gap manifests, in practical terms, as:

- Continued forensic-bed occupancy by stabilized unrestorable patients.
- Continued court-calendar engagement with cases that no party can advance.
- Continued Medicaid expenditure across institutional environments without therapeutic justification.
- Continued Probate Court guardianship over patients whose criminal-legal status remains procedurally unresolved.
- Continued institutional placement that may exceed Olmstead least-restrictive standards.
- Continued constitutional exposure under Jackson v. Indiana for time-bounded review.
- Continued continuity-of-care disruption for patients whose treating relationships erode under prolonged institutional placement.
- Continued family separation across years that cannot be recovered.
- Continued accumulation of operational costs across multiple state systems.

23.9 Compounding Harms in the Medically Vulnerable Elder

For medically vulnerable elderly patients, the Resolution Gap produces compounding harms that exceed those produced for younger, less medically complex populations. The compounding harms include:

- Accelerating cognitive decline associated with prolonged institutional placement.
- Sustained disruption of treating-provider relationships.
- Sustained disruption of established medication regimens.
- Sustained risk of medication mismanagement within institutional contexts.

The commercial emergence of GLP-1 receptor agonists, specifically semaglutide marketed as Ozempic and Wegovy, has introduced a specific and previously nonexistent diversion risk for elderly diabetic patients in care facilities. At list prices of approximately $1,000 per month before insurance, semaglutide carries one of the highest secondary market values of any medication routinely prescribed to nursing home and rehabilitation facility residents. It is not a controlled substance. It is not tracked by DEA diversion monitoring. There is no federal system designed to detect its theft from a resident. For a facility staff member, a cognitively impaired resident on semaglutide presents as the lowest-risk, highest-value diversion target in the building. The resident whose semaglutide is diverted will develop uncontrolled blood glucose. In a patient with dementia, uncontrolled blood glucose produces behavioral presentations including agitation, confusion and apparent aggression that are clinically indistinguishable from primary psychiatric pathology. That behavioral presentation enters the incident report. The incident report enters the criminal-legal system. The medication record that would reveal the causation chain is not reviewed. It may not exist in a form that would reveal it. The SEIU-M framework is the first coordination architecture specifically designed to require that review before escalation proceeds.

- Sustained loss of rehabilitation gains.
- Sustained loss of cultural, linguistic, faith and community continuity.
- Sustained family separation during years that cannot be returned.
- Sustained trauma exposure within institutional environments.
- Increased mortality risk associated with elder institutional placement under conditions of disrupted continuity.

In a meaningful number of cases, elderly defendants do not survive the resolution process. The fiscal, constitutional and humanitarian case for closing the gap is, in this respect, time-sensitive in a way that the gap's current administrative architecture does not acknowledge. People are dying inside this gap before resolution reaches them. That fact deserves to be stated.

23.10 The Human Experience of Indefinite Suspension

Behind every procedural description of this gap is a human experience. The defendant is stuck. Present inside a system that cannot proceed. Helpless. Capable neither of advancing nor of withdrawing from the process. Confronted with the recognition that no path forward exists. Abandoned inside a process that no actor can independently resolve. Confused. Required to navigate procedural complexity that cognitive impairment precludes. Misunderstood. Interpreted through legal categories that do not align with clinical reality. Forgotten by systems whose calendars no longer prioritize the case. Procedurally invisible to administrative structures that lack metrics for unresolved unrestorability. Deprived of the dignity of resolution.

For families, the experience parallels and compounds the experience of the defendant. The guardian's sustained advocacy across nearly six years in this Case Study is one expression of what the gap requires of families who refuse to let their loved ones be lost inside it. Most families cannot sustain that level of advocacy. Most families do not have the time, the education, the technical infrastructure or the financial reserves it requires. Most families lose their loved ones to the gap not because they care less but because they do not have what this guardian had to give. The framework is, in significant part, designed for the families who cannot do what this family has done.

23.11 Prevention and Crisis Response Together

Closing the Resolution Gap is both a preventative and a crisis-response undertaking. Preventatively, the framework's coordination architecture identifies medically vulnerable patients at the qualifying intake event before the gap can begin to form. At the crisis-response level, the framework's seven-step protocol intervenes at the point at which a care-facility patient under guardianship would otherwise enter the gap. The protocol stabilizes the patient medically. It reviews the medication context. It investigates the institutional context. It coordinates with the Probate Court to support a coordinated disposition outside the gap.

Both functions are essential. Prevention reduces the rate at which patients enter the gap. Crisis response reduces the harm produced by entry when it occurs. Together they constitute the operational architecture the framework proposes.

23.12 The Federal Frameworks Already in Place

The federal frameworks supporting closure of the Resolution Gap are already in place. They include the Elder Justice Act of 2010, Title XX of the Social Security Act, supporting elder-abuse prevention, investigation and coordination; Title II of the Americans with Disabilities Act, supporting the integration mandate; Section 504 of the Rehabilitation Act, supporting reasonable accommodations; Medicaid 1115 demonstration and 1915(c) HCBS waiver authority, supporting funding architecture; SAMHSA crisis-response grant authority, supporting crisis-response coordination; HRSA workforce development

authority, supporting interdisciplinary workforce capacity; the Older Americans Act, supporting aging-population infrastructure; HIPAA and 42 C.F.R. Part 2, supporting information exchange consistent with privacy protection; and EMTALA, supporting medical screening obligations.

Each of these authorities supports an element of the framework's operational architecture. The federal architecture is, in the aggregate, sufficient to support implementation at the state level. The framework's federal alignment is documented in detail in the White Paper.

23.13 The Structural Remedies Required

The structural remedies required to close the Resolution Gap are identified throughout the broader SEIU-M / CIU-M institutional submission package. In summary:

- **A designated coordinating authority** with assigned responsibility for advancing unrestorability cases from finding to resolution.
- **A defined timeline** within which unrestorability findings must trigger a formal disposition pathway.
- **A structured transition protocol** for moving stabilized defendants from criminal-legal custody to guardianship-supported, continuity-of-care-aligned placement.
- **A medication-safety and continuity-of-care preservation mechanism** ensuring that long-term treating providers, established medication regimens and rehabilitation plans are preserved through transition.
- **A constitutional review safeguard** ensuring that continued procedural status remains justified by current necessity.
- **A standardized dismissal-with-protection protocol** permitting case closure where unrestorability is established and conditions for safe community-supported placement are met.
- **A coordination interface with Probate Court and guardianship systems** by which criminal courts can transfer or coordinate matters with Probate Court jurisdiction where guardianship is the appropriate long-term framework.
- **A data, metrics and reporting infrastructure** supporting administrative measurement of unrestorability case duration, resolution rates, transition outcomes and continuity-of-care preservation.
- **A workforce-support and training pathway** coordinating education across judicial, prosecutorial, defense, evaluator, clinical and guardianship roles.

23.14 The Case Before the Reviewer

The Case Study presented in this document is the case before the reviewer. It is the working demonstration of the Resolution Gap. It is the empirical foundation on which the framework's coordination architecture rests. It is the chronology that translates structural analysis into operational reality.

The framework humbly requests the reviewer to receive this Case Study not as personal grievance but as institutional evidence. The patient at the center of this chronology is one patient among many. The chronology that documents his experience is one chronology among many. The framework's coordination architecture is designed to ensure that no comparable patient and no comparable family encounters the architecture this chronology documents in the form in which they encountered it.

The institutional request is straightforward. Receive the Case Study as the foundational evidence supporting the broader package. Review the operational architecture proposed in the Operational Implementation Framework, the White Paper, the Executive Briefing, the Executive Action Memo and

the Fact Sheet. Engage with the framework's authors and partner institutions to develop the coordinated pilot the package proposes. Support the institutional construction of the coordination infrastructure that closes the gap this chronology documents.

And ask the harder question. If this chronology is operationally representative and the framework's empirical anchoring shows that it is, how many other families are inside some version of this story right now? How many of them lack the resources that this family had? How many of them will run out of time before the resolution they deserve arrives?

Part VIII. Closing

In Humility

This Case Study and the companion documents submitted with it are offered humbly to every authority that receives them. The framework is presented in deference to the institutional expertise, statutory authority and operational responsibility the receiving institutions hold. It is a humble request for coordination, not a prescription. Every professional named in this distribution list is trusted to exercise the full authority and judgment their role requires. What is asked is only this: that the evidentiary record preserved here be given the serious and good-faith institutional review it is designed to merit, so that the families who cannot wait and the defendants who have already waited too long do not have to wait any longer.

Our Country. Our Constitution. Every reviewer of this Case Study will, at some point, be a caregiver, a guardian or the person needing one. This country was founded on a promise that grows only when each generation chooses to honor it. Compassion. Integrity. Dignity. Due process. Protection of those who cannot protect themselves. These are not new values. They are the values our Constitution was built to protect and the values we are asked, in our time, to extend to the Americans this country's promise has not yet reached. The work before us is to stand united in building the protection they deserve, to honor what we all deserve as Americans and to keep faith with our values not by intention alone but by what we are willing to build, uphold and honor.

24. A Closing Word [CS sec.24]

This Case Study is offered in the spirit of collaborative institutional modernization. The chronology it documents is not unique. It is operationally representative of conditions that recur across this country every time medical complexity, age-related vulnerability and institutional fragmentation meet. One patient stands at the center of this document. Behind him stand many.

The framework respectfully submits that the institutional response to this Case Study should not be sympathy. It should be construction. The construction of the coordination infrastructure that closes the gap. The construction of the operational architecture that prevents comparable chronologies. The construction of the public-systems modernization that protects medically vulnerable populations during periods of crisis as a matter of structural design rather than of family heroism.

The framework recognizes the difficulty of the work performed by every professional, every institution and every system this chronology touches. The framework is offered as institutional support for that work, not as institutional criticism of it. The construction the framework proposes is intended to make every professional's work easier, more effective and more sustainable. The construction is intended to put inside public infrastructure the integration labor that families currently perform without support. The construction is intended to operationalize the constitutional standards that already govern but are not yet reliably realized in practice.

Read the chronology again, in your mind, with one question. If this had been you or your loved one, what would you have wanted to be different?

That is the question the framework is built to answer. Medical stabilization before behavioral interpretation. Causation investigated before charges are filed. The Probate Court in the room before the trial court is asked to decide. Continuity of care preserved through transition. Families received as partners. Least-restrictive options on the table. Stabilization, when it succeeds, allowed to lead to resolution rather than to indefinite suspension.

None of this is radical. None of this is partisan. None of this requires new authority. All of it requires that existing authority be exercised, in the correct sequence, by institutions willing to coordinate.

The patient at the center of this chronology remains in institutional placement as of the day this document is submitted. Each day the Resolution Gap remains operationally open is a day during which other patients comparable to him remain at risk of entering it. Other families remain at risk of carrying what this family has carried. Other communities remain at risk of losing members who could have come home.

The package is offered with the patience institutional change requires and with the urgency the chronology documents. The framework's authors recognize that careful institutional review takes time. They also recognize that time is the one resource the populations the framework protects do not have to spare.

Behind every operational principle in this framework is a person whose protection depends on whether the principle is operationalized. Behind every section of this Case Study is a family who could not afford to wait. The reform this package proposes is not abstract. It is the architecture of a country that protects its most vulnerable as a matter of structural design rather than of accident, of resources or of who happens to have a guardian willing to spend six years fighting for them.

Appendix A. The Framework at a Glance

Reviewers seeking the operational architecture in summary form may use this appendix. The complete architecture is in the Operational Implementation Framework (Proposal).

[CS App-A]

Five Operational Phases

11. **Phase I. Crisis Identification and Immediate Safety Stabilization.** Qualifying event identification, safety stabilization, parallel SEIU-M / CIU-M activation, baseline documentation.
12. **Phase II. Interdisciplinary Activation Review.** Multidisciplinary review convening, history assembly, integrated review preparation.
13. **Phase III. Integrated Medical, Neurological and Rehabilitation Review.** Comprehensive medical workup, medication reconciliation, neurological evaluation, rehabilitation assessment.
14. **Phase IV. Stabilization and Placement Analysis.** Risk stratification, least-restrictive placement selection across the full care continuum.
15. **Phase V. Reintegration and Continuity Restoration.** Discharge planning, continuity-of-care preservation, guardianship integration, outcome measurement.

Seven-Step Resolution Gap Protocol

16. **Step 1. Medical Stabilization.** The patient is stabilized medically and neurologically before any other step proceeds.
17. **Step 2. Medication-Management Review.** Medication safety is reviewed as the predicate step in behavioral interpretation.
18. **Step 3. Structured Observation Upon Return to a Corrected Regimen.** Observation of the patient on the appropriate regimen establishes a baseline that the prior presentation can be measured against.
19. **Step 4. Elder Abuse Causation Investigation.** Adult Protective Services, the Long-Term Care Ombudsman, the Medicaid Fraud Control Unit and the state survey agency are notified contemporaneously.
20. **Step 5. Coordination with Probate Court Guardian.** The Probate Court is informed and the appointed guardian is brought into the proceedings.
21. **Step 6. Multidisciplinary Review and Recommendation.** The multidisciplinary team produces an integrated review for the prosecutor, defense counsel and trial court.
22. **Step 7. Deferred or Declined Escalation When Indicated.** Where the record establishes stabilization, medication causation and guardianship-supported placement availability, escalation is deferred, declined, diverted or dismissed in coordination with the trial court, prosecutor and Probate Court.

Four Operational Principles

- Stabilization before escalation.
- Causation before prosecution. This framework saves taxpayer money. A single resolved case at six months rather than three years produces over $560,000 in direct taxpayer savings in bed costs alone. A full fiscal analysis is developed in Section 38 of the companion White Paper. Where the multidisciplinary record establishes that the conduct was the downstream

consequence of institutional failure, medication mismanagement or elder abuse, the prosecutor has a documented basis for nolle prosequi or dismissal without prejudice. The framework does not constrain prosecutorial discretion. It informs it.

- Coordination before adjudication.
- Stewardship before continuation.

Six Training Modules

- **Module I.** Crisis Recognition and Medical Complexity.
- **Module II.** Legal and Constitutional Interface.
- **Module III.** ED and EMS Coordination.
- **Module IV.** Court and Forensic Integration.
- **Module V.** Rehabilitation and Reintegration.
- **Module VI.** Facility Accountability and Good-Faith Review.

Appendix B. Authorities and References

[CS App-B]

United States Supreme Court Decisions

- Dusky v. United States, 362 U.S. 402 (1960).
- Jackson v. Indiana, 406 U.S. 715 (1972).
- Olmstead v. L.C., 527 U.S. 581 (1999).
- Sell v. United States, 539 U.S. 166 (2003).

Federal Court Decisions

- Trueblood v. Washington State Department of Social and Health Services, 101 F. Supp. 3d 1010 (W.D. Wash. 2015).

Federal Statutes

- Americans with Disabilities Act of 1990, 42 U.S.C. sec. 12101 et seq.
- Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. sec. 794.
- Older Americans Act of 1965, 42 U.S.C. sec. 3001 et seq.
- Elder Justice Act of 2010, Title XX of the Social Security Act, 42 U.S.C. sec. 1397j et seq.
- Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. sec. 1320d et seq.
- Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2.
- Nursing Home Reform Act (OBRA 1987), 42 U.S.C. sec. 1395i-3 and 1396r.
- Emergency Medical Treatment and Active Labor Act, 42 U.S.C. sec. 1395dd.
- Medicaid statutes: 42 U.S.C. sec. 1396 et seq., including sec. 1115 demonstration authority and sec. 1915(c) HCBS waiver authority.
- Federal criminal-procedure competency provisions: 18 U.S.C. sec. 4241 to 4247.

Ohio Revised Code

- Ohio Revised Code Chapter 2111, Guardianship of Persons and Estates.
- Ohio Revised Code Chapter 2945, Criminal Procedure including competency to stand trial.
- Ohio Revised Code Chapter 5119, Department of Behavioral Health, formerly Mental Health and Addiction Services.
- Ohio Revised Code Chapter 5122, Civil Commitment for Mental Illness.
- Ohio Revised Code Chapter 5160, Department of Medicaid.
- Ohio Revised Code Chapter 5101, Adult Protective Services and aging-related authorities.
- Ohio Revised Code Chapter 5165, Nursing Facilities.
- Am. Sub. H.B. 96 of the Ohio 136th General Assembly, effective October 1, 2025.

Court Records

- Delaware County Court of Common Pleas, Case No. 22 CR I 10 0600.
- Delaware County Court of Common Pleas, Case No. 23 CAA 07 0038.
- Delaware County Court of Common Pleas, Case No. 24 CV C 04 0380.

- Franklin County Probate Court, Letter of Guardianship issued April 13, 2022.
- Franklin County Probate Court, expedited transfer order issued September 2022.
- Fifth District Court of Appeals, May 2024 denial of appeal regarding Delaware County retention of permanent jurisdiction.

Regulatory Findings

- Ohio Department of Health, Survey OH00131063 (The Grand of Dublin).
- Ohio Department of Health, Survey OH00136991 (Abbington of Powell).
- Ohio Department of Health, Survey OH00137240 (Abbington of Powell).
- Ohio Department of Health, Survey OH00139261 (Abbington of Powell).

Clinical References

- Shehab N, Lovegrove MC, Geller AI, et al. US Emergency Department Visits for Outpatient Adverse Drug Events, 2013 to 2014. JAMA, 2016;316(20):2115-2125.
- Budnitz DS, Lovegrove MC, Shehab N, Richards CL. Emergency Hospitalizations for Adverse Drug Events in Older Americans. New England Journal of Medicine, 2011;365:2002-2012.
- Centers for Disease Control and Prevention, STEADI Initiative, Older Adult Falls Prevention.
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, 2013, including Conversion Disorder (Functional Neurological Symptom Disorder).
- International Classification of Diseases, 11th Revision (ICD-11), World Health Organization.

State and National Authorities

- Office of the Governor of Ohio, Governor's Work Group on Competency Restoration and Diversion (2024).
- Supreme Court of Ohio, Case Management Section, Guardianship Caseload Data.
- Texas Health and Human Services Commission, State Hospital Cost Study (2024).
- National Center on Elder Abuse, Research Brief on Prevalence and Reporting.
- SAMHSA, Forensic and Competency-to-Stand-Trial Trends Analysis (2023).
- Alzheimer's Association, 2024 Alzheimer's Disease Facts and Figures.
- AARP and National Alliance for Caregiving, Caregiving in the United States 2020.

THE SEIU-M / CIU-M SUBMISSION

Distribution List

This framework is presented to the institutions below as a coordinated submission. Each participates in the role indicated, within the authority it already holds. The list is shared with every recipient so that all may see the full structure of coordination this proposal contemplates: a single, unified effort rather than a series of separate appeals. Clinical participation in the pilot, including OhioHealth's, is to be selected and approved through a contract process, should all parties be in agreement.

#	Tier	Recipient	Role in the Framework
1	Ownership	OhioHealth	Proposed clinical partner for the pilot (by contract process)
2	Ownership	Office of the Ohio Attorney General (OAG), with the Elder Justice Unit (EJU) and Medicaid Fraud Control Unit (MFCU)	Primary owner and coordinating authority
3	Ownership	Ohio Department of Behavioral Health (OhioDBH/OhioMHAS)	Operational host
4	Coordinating	Ohio Department of Aging (ODA), including Adult Protective Services (APS)	Elder-justice and protective-services coordination
5	Coordinating	Ohio Department of Developmental Disabilities (DODD)	Cognitive-disability expertise and integration
6	Coordinating	Ohio Department of Health (ODH)	Facility survey and certification
7	Coordinating	Ohio Department of Medicaid (ODM)	Waiver authority and least-restrictive-placement financing
8	Coordinating	Long-Term Care Ombudsman (LTCO)	Independent resident advocacy
9	Coordinating	Office of the Governor	Convening executive leadership
10	Coordinating	Ohio Department of Rehabilitation and Correction (ODRC), Bureau of Adult Detention (BAD)	Custodial-phase coordination and jail-standards authority
11	Coordinating	Ohio Association of Health Plans (OAHP)	Payer coordination, outcomes and cost stewardship
12	Independent	Disability Rights Ohio (DRO)	Federally designated Protection and Advocacy (P&A)
13	Independent	Pro Seniors	Independent elder-law and advocacy
14	Federal	U.S. Department of Justice, Civil Rights Division (DOJ CRD)	ADA Title II and Olmstead enforcement
15	Federal	HHS Administration for Community Living (ACL)	Elder Justice Act, Ombudsman and P&A
16	Federal	Centers for Medicare and Medicaid Services (CMS)	Survey, certification and waiver authority
17	Federal	Substance Abuse and Mental Health Services Administration (SAMHSA)	Behavioral health crisis-system alignment
18	Legislative	Ohio General Assembly (GA)	Enabling legislation and statewide scaling
19	Judicial Policy	The Honorable Probate Courts of Ohio, via the Ohio Probate Judges Association (OPJA)	Court-coordination principle (awareness)
20	Defense	Office of the Ohio Public Defender (OPD) and the Ohio Public Defender's Association (OPDA)	Constitutional interests of vulnerable defendants
21	Prosecution	Ohio Prosecuting Attorneys Association (OPAA)	Informed, just charging decisions on the full record
22	Professional Education	Ohio State Bar Association (OSBA)	Continuing legal education and practice guidance (awareness)

Our Country. Our Constitution.

Compassion. Dignity. Due process. The protection of those who cannot protect themselves.
One unified stand, to protect the public and the best interest of us all.

Presented by: The Guardian, Nebiat (Nebby) Gebru Gebreziabher, under Ohio Probate Court Jurisdiction
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EXECUTIVE ACTION MEMO

SEIU-M / CIU-M Proposal
Specialized Emergency Intervention Unit: Medical Stabilization ***- SEIU-M (See-U)***
Crisis Intervention Unit: Medical Stabilization ***- CIU-M (CI U)***

FOR:	Federal and State Interagency, Legislative and Judicial Review
RE:	The Resolution Gap for defendants found incompetent and unrestorable and the proposed Specialized Emergency Intervention Unit: Medical Stabilization (SEIU-M / CIU-M) framework for coordinated response.

Bottom Line

The Legal System has a clear pathway for the person found incompetent and restorable. However, there is no clear pathway for a person found incompetent and unrestorable.

The constitutional standard in Jackson v. Indiana (1972) is defeated in operational fact by the absence of an implementation pathway. The Jackson holding rests on both due process and equal protection grounds under the Fourteenth Amendment. The Sixth Amendment speedy trial right under Barker v. Wingo, 407 U.S. 514 (1972), is separately implicated: a defendant whose charges are neither tried nor dismissed for years has a documented Sixth Amendment claim. The disparity between what restorable and unrestorable defendants receive is the constitutional asymmetry Jackson identified in 1972 and the basis for federal enforcement authority today.

The Resolution Gap is a national structural condition. Ohio is the proposed pilot venue.

Behind every procedural description of this gap is an elderly person who cannot tell you what medication was withheld from them, who was arrested for behavior that medication should have prevented and who is now inside a system with no exit. That person is who this framework exists for.

The harm is most acute for elderly patients already adjudicated incompetent by the Probate Court under Ohio Revised Code Chapter 2111.

The SEIU-M / CIU-M framework proposes a coordinated, court-integrated medical-stabilization pathway operating within existing federal and state authority. No new agency is created. No new statutory authority is requested during the pilot phase. This framework saves taxpayer money: a single resolved case at six months rather than three years produces over $560,000 in direct taxpayer savings before associated judicial and administrative costs.

Population

Elderly, cognitively impaired, medically vulnerable and rehabilitation-dependent individuals, particularly those whose legal incompetence has been adjudicated by a Probate Court under guardianship authority and who are subsequently subjected to criminal-legal contact through conduct that may itself be the consequence of institutional elder abuse, prescription medication mismanagement, including non-psychiatric agents such as GLP-1 receptor agonists, anticoagulants, insulin and anticholinergic agents or related clinical conditions.

Core Finding

The criminal legal system contains a developed pathway for defendants found incompetent and restorable. It contains no functional resolution pathway for defendants found incompetent and unrestorable. Cases enter procedural limbo. Charges remain open. Civil commitment is unavailable because the patient has stabilized. No statutory mechanism transfers the matter to Probate Court guardianship oversight. No agency owns the resolution. The population most affected is the population least able to advocate for change.

A justice system judge cannot make a fair decision about a defendant whose legal incompetence has already been adjudicated by a sitting court without that adjudication being formally integrated into the proceedings. Coordination with the Probate Court is not a courtesy. It is a prerequisite to fair adjudication.

For vulnerable elderly patients, the current system is a revolving door with no clear pathway out. When prescription medication, medical treatment or the care plan is mismanaged, at home or in a care facility entrusted with their care, the patient destabilizes, is swept into hospitalization or criminal-legal contact and is returned to the same uncorrected setting, because no part of the system identified the cause and no pathway exists to resolve the matter. SEIU-M’s contribution is coordination: it brings every participating authority to the same table, anchored by the Probate Court and the guardian acting on behalf of the ward. Its medication-safety review and causation-investigation steps correct the cause; its coordination supplies the resolution pathway the system now lacks.

Empirical Anchoring

- Forensic patients occupy approximately 93 percent of available Ohio state psychiatric hospital beds, displacing civil patients and constraining capacity. Source: Office of the Governor of Ohio, Governor’s Work Group on Competency Restoration and Diversion, 2024.
- Ohio’s active adult guardianship caseload rose from approximately 42,000 in 2011 to approximately 49,000 in 2020, with 6,000 to 7,000 new applications annually. Source: Supreme Court of Ohio, Case Management Section.
- State forensic bed operational cost is approximately $790 per bed per day. A single multi-year forensic placement of an unrestorable defendant exceeds $280,000 per year before associated clinical, judicial and administrative costs. Source: Texas HHSC State Hospital Cost Study, 2024, used as representative reference.
- Approximately one in ten older adults living independently experiences abuse, neglect or exploitation annually. Source: CDC and National Center on Elder Abuse.

- Among adults 65 and older who present to emergency departments for adverse drug events, 43.6 percent are hospitalized, the highest rate of any age group. Source: Shehab et al., JAMA, 2016.
- The FDA Boxed Warning on antipsychotic mortality risk in elderly patients with dementia-related psychosis, issued in 2005 and extended in 2008, remains in effect.
- Court-ordered competency restoration referrals have increased dramatically, with documented waitlists rising from weeks to months or years in multiple states in tracked state systems. Source: SAMHSA, 2023.
- Federal litigation has established that Jackson standards are not being met in other states. Source: Trueblood v. Washington DSHS, 2015.

Proposed Response

SEIU-M / CIU-M establishes a sequenced operational protocol that places medical stabilization, medication-management review, structured observation, elder-abuse causation investigation and Probate Court coordination ahead of criminal-legal escalation. The protocol does not eliminate criminal-legal accountability for capacitated, intentional conduct. It establishes the predicate clinical and investigative steps that must occur before that authority is exercised against a patient whose legal incompetence has already been adjudicated.

Operational principles. Stabilization before escalation. Causation before prosecution. Coordination before adjudication. Stewardship before continuation.

Proposed Pilot Vehicle

A collaborative state contract structured to operate as both a pilot vehicle and a permanent operational structure. Anchored at the Ohio Department of Behavioral Health (Ohio-DBH / Ohio-MHAS), renamed under Am. Sub. H.B. 96 of the Ohio 136th General Assembly, effective October 1, 2025, as operational host, with primary ownership vested in the Office of the Ohio Attorney General in coordination with its Elder Justice Unit and shared ownership across every participating authority, so coordination is efficient and effective rather than concentrated in any single office. Operational partners would include a participating Ohio health system and a participating electronic health record platform, with information exchange conducted through existing Business Associate Agreement structures under HIPAA. The contract operates within existing federal and state authority. No new statutory authority is requested at this stage.

What Is Requested

Timeframe	Recommended Action
Within 30 Days	Designate interagency review contact within each receiving institution. Identify legal, clinical and operational leads. Conduct initial pilot-feasibility review. Acknowledge receipt and indicate institutional review intentions.
Within 90 Days	Develop activation criteria, operational workflow map, training outline, data-governance approach, fiscal feasibility analysis and advisory group composition. Engage candidate funding authorities. Convene initial multidisciplinary advisory consultation.
Within 6 Months	Launch limited pilot planning in two or three candidate regions. Develop hospital, EMS, court, Probate Court, guardianship, APS, Long-Term Care Ombudsman and Medicaid Fraud Control Unit coordination pathways. Design outcome dashboard.
Within 12 Months	Implement pilot. Evaluate early metrics. Refine protocols. Prepare legislative, regulatory and administrative recommendations for regional expansion or statewide scaling.
Ongoing	Maintain coordination with named authorities. Maintain measurement and reporting cadence. Hold to the four operational principles.

What Is Not Requested

- No new statutory authority during the initial pilot implementation period.
- No replacement of clinical judgment, judicial authority, public safety decision-making or lawful prosecutorial discretion.
- No interference with existing institutional functions.
- No new coercive authority during the pilot phase.

Funding Posture

Pilot funding is anticipated to fall within the scope of existing federal and state authorities: American Rescue Plan Act (ARPA) behavioral health infrastructure funds, Medicaid 1115 and 1915(c) waivers, SAMHSA crisis-response grant categories, Elder Justice Act discretionary appropriations, HRSA workforce programs, PACE under the Balanced Budget Act of 1997, state behavioral-health innovation budgets, Department of Justice civil-rights coordination authorities and philanthropic capital. No new funding category is requested during the pilot phase.

Constitutional Anchoring

Dusky v. United States, 362 U.S. 402 (1960)
Jackson v. Indiana, 406 U.S. 715 (1972)
Olmstead v. L.C., 527 U.S. 581 (1999)
Sell v. United States, 539 U.S. 166 (2003)
Americans with Disabilities Act of 1990, Title II
Section 504 of the Rehabilitation Act of 1973
Elder Justice Act of 2010 (Title XX of the Social Security Act)
Omnibus Budget Reconciliation Act of 1987, Nursing Home Reform provisions

The Human Cost

Families of medically vulnerable individuals are currently expected to function as legal advocates, medical interpreters, medication specialists, interagency diplomats and continuity-of-care coordinators under crisis conditions, with no training, no respite and no defined point of arrival. Most families do not have the legal, clinical, technical or institutional fluency this burden requires. Many that do are exhausted by it. The companion Case Study documents six years of one family's effort to navigate this gap on behalf of one patient. The framework respectfully calls for coordinated modernization before the next family begins the same navigation.

Every reviewer of this memo will, at some point, be a caregiver, a guardian or the person needing one. The infrastructure proposed here is the architecture of a country that protects its most vulnerable as a matter of structural design rather than as a matter of accident, of resources or of who happens to have a family member willing to fight on their behalf.

Evidentiary Anchoring

A separately submitted patient Case Study, available on request to specific institutional authorities and controlled at the level of distribution, documents the operational reality of the Resolution Gap in a situation in which every condition for resolution has been met without producing resolution. Perfect compliance with the existing architecture does not produce resolution. The gap is a function of architecture, not of advocacy.

The SEIU-M / CIU-M Document Package

This memo is one of six documents in the SEIU-M / CIU-M six-document institutional submission package: Fact Sheet (one-page operational summary); Executive Action Memo (this document); Executive Briefing (comprehensive rapid-review leadership document); Operational Implementation Framework (Proposal, full operational architecture); White Paper (policy theory and evidence base); Case Study and Systems-Impact Analysis (evidentiary chronology and documentary backbone).

Requested Meeting and Routing

The presenting party humbly requests the opportunity to meet with the appropriate institutional authorities to discuss the SEIU-M / CIU-M framework and its proposed pathway. The convening of any such discussion, including its participants, format, scheduling and scope, is respectfully left to the discretion of the receiving institutions. The presenting party is prepared to engage in whatever institutional format is determined appropriate.

Correspondence may be directed through the Ohio Probate Court or through the institutional Distribution Authorities identified in Appendix B of the companion Executive Briefing.

In Humility

This memo and the companion documents are offered humbly to every authority that receives them. Recipients are humbly thanked for their consideration.

EXECUTIVE BRIEFING

SEIU-M / CIU-M Proposal

Specialized Emergency Intervention Unit: Medical Stabilization ***- SEIU-M (See-U)***
Crisis Intervention Unit: Medical Stabilization ***- CIU-M (CI U)***

A Statewide and Federally Reviewable Framework for Court-Integrated Medical Stabilization, Elder Justice, Constitutional Safeguards and Coordinated Crisis Response for Medically Vulnerable Populations

Why This Document Is Before You

This briefing is the leadership-level distillation of a six-document institutional submission. It exists because a structural condition in the public-systems architecture is producing measurable, recurring harm and the architectural fix is now achievable within existing federal and state authority.

Here is the condition. Across this country every day, a medically vulnerable person enters the public-systems architecture and that architecture does not coordinate. The hospital does not communicate with the long-term care facility. The facility does not communicate with the emergency department. The emergency department does not communicate with the criminal court. The criminal court does not communicate with the Probate Court that has already, in many cases, adjudicated the same person legally incompetent. Each system performs its function. None performs the integration the person actually needs.

Here is what is proposed. No new agency. No new statutory authority. No new bureaucracy. Coordinated use of existing authority by existing institutions, in the correct sequence, with the coordination infrastructure required to make existing constitutional protections operationally functional at the point of a crisis event. Medical stabilization before behavioral interpretation. Causation investigated before charges are filed. The Probate Court in the room before the trial court is asked to decide.

Here is why the timing is now. The demographic transition is no longer a projection. The forensic-bed capacity strain is no longer a future concern. The growth of guardianship caseloads is no longer hypothetical. Each is present tense. The architecture is built before the transition arrives or it is built after. Both options have a cost. Only one has a return.

Every reviewer of this briefing will, at some point, be a caregiver, a guardian or the person needing one. The infrastructure proposed here is not partisan. It is the architecture of a country that decides to protect its most vulnerable as a matter of structural design rather than as a matter of accident, of resources or of who happens to have a family member willing to fight on their behalf.

AT A GLANCE

What this is. A court-integrated multidisciplinary medical-stabilization framework that supplements, not replaces, existing crisis-response, judicial, healthcare, public safety, guardianship and protective-services systems. It operates within existing federal and state authorities. No new coercive authority is sought during the pilot phase.

Who is affected. Elderly, cognitively impaired, medically vulnerable, rehabilitation-dependent and behavioral-health populations during periods of crisis instability. The framework gives particular attention to care-facility patients whose legal incompetence has already been adjudicated by the Probate Court under guardianship authority and who are subsequently subjected to criminal-legal contact arising from conduct that may itself be the downstream consequence of institutional elder abuse, prescription medication mismanagement or related clinical conditions.

Why it matters now. Healthcare strain, workforce shortages, accelerating demographic transition, behavioral-health escalation and post-COVID crisis-response fragmentation are converging on the same systems at the same time. A coordination failure at the intersection of criminal jurisdiction, civil commitment, guardianship, behavioral-health administration and Medicaid administration is producing identifiable harm, most acutely in cases where a defendant has been found incompetent and unrestorable and where no statutory or administrative pathway exists to resolve the case. The framework identifies this **Resolution Gap** as a constitutional, public-safety, elder justice and fiscal-stewardship priority.

What is requested. Interagency review, pilot feasibility evaluation, legal and constitutional analysis, clinical workflow design, interagency coordination and phased implementation planning consistent with the architectures described in this briefing. No new statutory authority is requested at this stage. The request is for institutional review and coordinated planning.

How to engage. Designate an interagency review contact within 30 days. Identify legal, clinical and operational leads within 90 days. Convene a multidisciplinary advisory group for protocol design within 6 months. Pilot launch and outcome evaluation within 12 months. The Action Pathway in Part VI details each phase. Direct correspondence through the Ohio Probate Court or through the institutional authorities identified in Appendix B.

The SEIU-M / CIU-M Document Package

This Executive Briefing is one of six coordinated documents in the institutional submission package.

- **Fact Sheet.** One-page operational summary for initial transmittal and executive scanning.
- **Executive Action Memo.** Single-page action memo for cabinet secretary and White House review.
- **Executive Briefing (this document).** Comprehensive rapid-review leadership document with the full institutional argument.
- **Operational Implementation Framework (Proposal).** Full operational architecture, workflow design, training and fiscal model.
- **White Paper.** Policy theory, evidence base and modernization argument.
- **Case Study and Systems Impact Analysis.** Evidentiary chronology and documentary backbone of the package.

Part I: Foundation

I. Mission Statement

SEIU-M / CIU-M proposes a court-integrated, medically informed and rehabilitation-focused crisis-response coordination model for medically vulnerable populations whose needs are too complex for fragmented emergency, forensic, custodial or psychiatric systems to evaluate in isolation. The framework strengthens, it does not replace, the institutional authorities those systems already hold.

II. Scope Statement

This Executive Briefing is the rapid-review leadership document for decision-makers who require the core problem, the proposed solution, stakeholder benefits, implementation pathway and requested action in a concise institutional format.

This document does not replace clinical judgment, judicial authority, public-safety decision-making, emergency response, lawful prosecutorial discretion or constitutionally appropriate court procedure. It strengthens the information, coordination, stabilization and accountability infrastructure available to those systems when medically vulnerable individuals are involved in complex crisis events.

III. Reading Frame: Accountability, Not Accusation

This document operates under one foundational principle. Accountability, as used here, is structural. It examines the architecture of decision-making, the flow of information, the design of evaluation frameworks, the operational protocols governing transitions and the procedural standards that determine how evidence enters review. Accusation, by contrast, is individual. It identifies specific persons for blame. The two are not the same exercise and this document does not undertake the second.

The analysis that follows identifies structural gaps and proposes structural remedies. It treats the actors within the system as professionals operating within frameworks not of their own design, performing difficult work under significant operational constraint. Where the record reflects outcomes that warrant institutional concern, the document names the framework that produced those outcomes, not the individuals constrained to operate within it.

Structural diagnosis is more useful for systems modernization than individual identification. A framework that can be redesigned can be improved at scale. The SEIU-M / CIU-M proposal is oriented toward that end.

IV. Terminology Note: Ohio-DBH / Ohio-MHAS

Throughout this briefing the Ohio state behavioral-health agency is referenced in paired form as Ohio-DBH / Ohio-MHAS. The full institutional name is the Ohio Department of Behavioral Health (Ohio-DBH), previously known as the Ohio Department of Mental Health and Addiction Services (Ohio-MHAS). The rename was enacted under Am. Sub. H.B. 96 of the Ohio 136th General Assembly, effective October 1, 2025. The paired form is used throughout to support reviewer recognition across both current and legacy institutional references.

V. Executive Summary

The SEIU-M / CIU-M framework proposes the development of a court-integrated, medically informed and rehabilitation-focused crisis-response coordination model for medically vulnerable populations. The model operates at the intersection of healthcare, behavioral-health, rehabilitation, guardianship, judicial and public-safety systems, strengthening, not replacing, the institutional authorities for those systems already hold.

Three operational findings ground the framework. First, current crisis-response systems were not originally designed to manage the growing volume of medically vulnerable, cognitively impaired, rehabilitation-dependent and behaviorally complex individuals now requiring coordinated interdisciplinary reassessment. Second, fragmentation across criminal-legal, civil-commitment, guardianship, behavioral-health and Medicaid frameworks produces measurable harm to vulnerable patients, families, providers and public systems. Third, the resulting coordination gap is most acute for defendants found incompetent to stand trial and clinically determined to be unrestorable, particularly those already adjudicated incompetent by the Probate Court, for whom no functional resolution pathway currently exists in statutory or administrative practice.

The scale of the populations and pressures the framework addresses is documented. Approximately one in ten older adults living independently experiences abuse, neglect or exploitation annually (CDC, National Center on Elder Abuse). Adults age 65 and older accounted for an estimated 34.5 percent of emergency-department visits for adverse drug events and the highest rate of subsequent hospitalization, 43.6 percent, in the 2013 to 2014 surveillance period (Shehab et al., JAMA, 2016), with approximately 99,628 emergency hospitalizations for adverse drug events occurring annually in this population (Budnitz et al., NEJM, 2011). National prevalence of antipsychotic use among long-stay nursing-home residents was reduced from 23.9 percent in 2011 to 14.4 percent by 2021 under the CMS National Partnership to Improve Dementia Care. Court-ordered competency restoration referrals have increased dramatically, with documented waitlists rising from weeks to months or years in multiple states in tracked state systems (SAMHSA, 2023), generating waitlists that have produced federal litigation (Trueblood v. Washington DSHS, 2015).

The framework responds with a sequenced operational model that places medical stabilization, medication-management review, structured observation, elder-abuse causation investigation, Probate Court coordination and multidisciplinary review ahead of restrictive escalation. The model is grounded in constitutional standards established in Jackson v. Indiana, Dusky v. United States, Sell v. United States and Olmstead v. L.C., in federal authority including the Americans with Disabilities Act and the Elder Justice Act of 2010 and in state authority over criminal procedure, civil commitment, guardianship, behavioral-health and Medicaid administration.

This briefing requests interagency review, pilot feasibility evaluation, legal and constitutional analysis, clinical workflow design and phased implementation planning. The Pathway Comparison Matrix at Appendix A, the Distribution Authorities at Appendix B, the References at Appendix C and the Glossary at Appendix D provide the institutional architecture supporting the body of the briefing.

Part II: The Case for Action

VI. Why This Moment Requires Action

The COVID-19 era exposed profound structural vulnerabilities across healthcare systems, emergency-response systems, long-term care systems, guardianship systems, behavioral-health systems, rehabilitation systems and continuity-of-care coordination nationwide. Many families experienced fragmentation, delayed reassessment, institutional overload, isolation, interrupted care continuity and escalating medical and behavioral instability during periods of crisis and system strain. The patient-level circumstances documented in the companion Case Study helped expose broader systemic concerns involving interdisciplinary communication failures, continuity-of-care breakdowns, reassessment delays, fragmented institutional coordination, guardianship-system complexity and the operational strain families encounter while attempting to protect medically vulnerable loved ones during periods of instability.

Large-scale crisis instability affecting medically vulnerable, cognitively impaired, elderly, rehabilitation-dependent and behavioral-health populations has implications extending beyond individual institutions. Widespread systemic instability affects healthcare capacity, emergency-response systems, long-term sustainability, workforce stability, public confidence and statewide operational resilience.

The crisis addressed within this proposal does not discriminate based upon financial status, political affiliation, professional background or social influence. Families across all communities have experienced varying forms of system fragmentation, delayed reassessment, barriers to continuity-of-care, institutional instability and unequal access to coordinated intervention during periods of crisis. Too often, the determining factor influencing outcomes during periods of crisis becomes access to resources, institutional influence, financial capacity, legal support, advocacy strength or the ability to navigate highly complex systems. This framework helps strengthen coordinated reassessment, accountability, continuity-of-care, stabilization review and interdisciplinary support so that medically vulnerable individuals and families are not dependent solely upon wealth, connections or institutional access to receive appropriate intervention.

VII. Prevention, Preparedness and Crisis-Response Readiness

As a country, we have invested enormous energy into prevention, regulation, protective policies, reporting systems, compliance structures and institutional safeguards. Those efforts are necessary. But prevention alone does not answer the harder question this proposal raises: what happens when prevention fails, when a crisis actually occurs and when a medically vulnerable person, an overwhelmed family, a facility, an Emergency Department, a court and multiple public systems all collide at once?

The COVID-19 era exposed that the nation was not adequately prepared for complex crisis response involving medically vulnerable, elderly, cognitively impaired, rehabilitation-dependent, behavioral-health and long-term care populations. It exposed weaknesses in emergency coordination, continuity-of-care, facility accountability, family communication, guardianship coordination, workforce resilience and interdisciplinary reassessment. That lesson should not be ignored.

This is why the issue rises beyond one family, one facility, one agency or one political perspective. A nation that cannot coordinate crisis response for its medically vulnerable people during periods of system strain faces a public-safety, public-health, constitutional and operational-resilience concern. Every family is only one medical emergency, one cognitive decline, one medication failure, one

hospitalization, one guardianship crisis or one facility breakdown away from needing the very systems this proposal seeks to strengthen.

The SEIU-M / CIU-M initiative is therefore not a partisan proposal. It is a public-interest, family protection, constitutional, healthcare, elder justice and national resilience proposal that should encourage collaborative participation from both parties and from every organization committed to protecting vulnerable people during crisis.

VIII. National Demographic Realities and System Pressures

The United States is entering one of the largest demographic transitions in modern history. As the Baby Boomer generation continues aging, the country is simultaneously confronting rapid increases in cognitive decline and dementia-related conditions, growing caregiver strain, accelerating healthcare and long-term care workforce shortages, Emergency Department overcrowding and rising rates of cognitive and behavioral-health instability across communities nationwide.

The scale is documented. An estimated 53 million U.S. adults provide unpaid care to a family member or friend. Approximately 11 million are caring for someone with Alzheimer's disease or another dementia. The population aged 65 and older will reach 80 million by 2040. One in three adults will, at some point, serve as a family caregiver. One in nine adults over 65 lives with Alzheimer's disease or related dementia.

Ohio reflects the national pattern at state scale. More than 2.2 million Ohioans are aged 65 and older. Ohio recorded 4,452 overdose deaths in 2023 (Ohio Department of Health, Ohio State Epidemiological Outcomes Workgroup), with more than 291,000 naloxone kits distributed through the state’s primary distribution program between 2019 and 2023, a 520 percent increase (Ohio Department of Health, Project DAWN). Approximately 60 of Ohio's 88 counties offered some form of adult mobile crisis service as of 2025 and Ohio's Mobile Response and Stabilization Services model was scheduled for statewide implementation by summer 2025 (Ohio-DBH / Ohio-MHAS, 2025 Annual Report). The infrastructure being built statewide is the infrastructure the framework is designed to complement.

Without stronger interdisciplinary coordination, continuity-of-care structures, reassessment systems and crisis-management preparedness, fragmented responses will continue producing preventable deterioration, institutional overload, family instability and long-term systemic consequences.

IX. Equity, Public Safety and the Ethical Duty to Protect the Most Vulnerable

Equity, public safety and the ethical-duty considerations addressed in this section are treated as a distinct pillar of the framework rather than absorbed into constitutional considerations. Constitutional principles establish what protective systems must not do. Equity establishes what protective systems must affirmatively do to function legitimately. The two concepts operate on different planes and require separate institutional articulation.

What Equity Truly Means

Equity does not mean special treatment. It does not mean favoritism. It does not mean lowering standards. Equity means fairness applied in context. Equality treats every situation the same. Equity ensures that individuals are treated proportionately based on their medical condition, cognitive capacity, vulnerabilities, available support, demonstrated behavior and actual risk. When unequal situations are treated as identical, the result is not fairness. It is a distortion. When liberty is involved, distortion becomes injustice.

Public Safety Must Be Evidence-Based, Not Wealth-Based

Public-safety decisions must rest on current clinical presentation, objective medical documentation, demonstrable ongoing risk, proportional assessment and least-restrictive alternatives. They must never be influenced by financial status, access to private experts, ability to fund prolonged litigation or institutional power imbalances. When outcomes correlate with wealth rather than evidence, public safety becomes uneven and inequity, even when unintended, becomes injustice.

This framework saves taxpayer money and is fiscally responsible. The empirical case for fiscally responsible public safety in this population is documented. Vulnerable older adults experience adverse drug events at rates that drive a disproportionate share of emergency department visits and hospitalizations. Elder abuse occurs at one-in-ten prevalence among community-dwelling older adults and with parallel prevalence in institutional settings. The conditions producing the behavioral presentations encountered by public-safety personnel, adverse drug events, medication mismanagement, institutional abuse and neglect, cognitive impairment, are demonstrable, clinically identifiable and, in most cases, reversible upon correction. Decisions framed as public-safety judgments in this population are, in practice, frequently clinical judgments operating without clinical information.

The Duty to Protect the Most Vulnerable

Protective systems exist to serve the elderly, the disabled, the cognitively impaired, the mentally incompetent, stroke survivors, individuals with neurological disorders, those with seizure disorders, those with metabolic instability and those unable to advocate for themselves. They were designed to shield vulnerability, prevent exploitation, ensure due process, guard against overreach, maintain proportionality and preserve dignity. Vulnerable individuals who lack financial resources, advocacy, legal sophistication, educational background or emotional stamina are at heightened risk of imbalance and systems must be especially careful in those cases.

Fairness and Reasonableness in Charges and Confinement

When concerns arise during a documented medical crisis involving a neurologically vulnerable or elderly individual, proportionality is essential. Fairness requires asking whether the conduct was medically precipitated, whether the individual was cognitively intact, whether documented physiological destabilization was present, whether stabilization has since occurred and whether ongoing dangerousness is demonstrable. When confinement continues despite stabilization and the availability of structured oversight, reassessment is required. Civil systems must not allow historical crisis to permanently define present stability, medical vulnerability to be interpreted as criminal intent or temporary physiological impairment to be treated as chronic violent pathology. Protective systems must protect the vulnerable, not inadvertently compound their vulnerability.

Cultural and Linguistic Access

Cultural and linguistic disparities in forensic evaluation are a documented barrier for medically vulnerable populations. Individuals whose primary language is not English and those whose behavioral expression is shaped by cultural frameworks not assumed in standard forensic instruments, face compounded barriers in competency evaluation, including the absence of qualified interpreter services and gaps in culturally competent assessment. Language access and cultural competency are clinical requirements, not administrative accommodations. The framework designates primary-language interpreter access, including Tigrinya and Amharic, as a mandatory intake requirement and requires coordinated review for all qualifying individuals regardless of financial status, language or cultural background.

Representation, Power and Structural Imbalance

A structural reality must be acknowledged. Individuals with significant wealth can secure immediate independent evaluations, retain multiple attorneys, fund extensive forensic review and absorb long legal processes without destabilization. Individuals without those means cannot. The result is that access to justice can become correlated with access to financial resources. That correlation is incompatible with the design of public safety, healthcare and judicial systems. Protection systems must protect equally, otherwise they risk protecting institutional power rather than the people the systems were built to serve.

Economic Stewardship and Public Responsibility

High-level psychiatric beds, custodial placements and acute crisis settings are finite public resources. Maintaining a medically stabilized, non-violent individual within such a setting consumes taxpayer funds, occupies capacity intended for acute crisis patients and extends institutional costs without proportional necessity. Responsible stewardship therefore demands ongoing reassessment whenever clinical conditions change. Equity includes fairness in resource allocation, both public and private.

When protective systems disadvantage the vulnerable, whether intentionally or through structural imbalance, the institutional consequence is loss of public faith in fairness. Loss of confidence in due process. Loss of the moral legitimacy of public safety systems. Due process, least-restrictive principles, guardianship oversight and independent review are not procedural inconveniences. They are the operational safeguards that make protective systems legitimate.

Part III: The Framework

X. Current System Limitations vs Proposed Modernized Response

Current crisis-response systems often rely on fragmented escalation pathways involving isolated reassessment, delayed interdisciplinary coordination, inconsistent continuity-of-care communication, insufficient family integration and limited medical-collaborative review structures during periods of instability affecting medically vulnerable populations.

The SEIU-M / CIU-M framework proposes a more coordinated stabilization approach emphasizing interdisciplinary medical reassessment, rehabilitation-focused intervention, continuity-of-care coordination, structured family integration, collaborative physician consultation, discharge preparedness and least-restrictive safe stabilization planning whenever medically appropriate. Further objectives include reducing preventable Emergency Department cycling, delayed reassessment, fragmented discharge planning, institutional overload, preventable crisis escalation and unnecessary system strain affecting healthcare systems, courts, behavioral-health systems, rehabilitation systems and families during periods of crisis.

Current System Limitation	SEIU-M / CIU-M Modernized Response
Fragmented reassessment across disconnected institutional silos.	Integrated interdisciplinary review pathways with unified clinical information.
Behavioral presentation automatically triggers medication escalation.	Medication-safety reassessment and psychotropic-risk review, including non-psychiatric medications, before escalation.
Discharge instability and continuity-of-care breakdown.	Structured continuity-of-care coordination and discharge preparedness protocols.
Repeated crisis cycling without root-cause review.	Rehabilitation-focused stabilization addressing underlying clinical drivers.
Isolated institutional response without cross-system coordination.	Collaborative systems coordination through a unified interagency framework.
No resolution pathway for defendants found incompetent and unrestorable.	SEIU-M Resolution Gap protocol: stabilization, medication review, observation, elder-abuse investigation, guardian coordination, multidisciplinary review and coordinated disposition.
Guardian and family excluded from crisis decisions.	Structured family integration and guardian participation as formal stabilization partners.

XI. Core Operational Findings

Multidisciplinary review of current crisis-response and forensic-evaluation systems identifies six recurring operational findings affecting medically vulnerable populations during periods of crisis instability.

- Overreliance on isolated or single-discipline forensic evaluation models in medically complex cases.
- Misclassification of neurological, endocrine, medication-related, developmental, cognitive or trauma-related instability as psychiatric-only presentation.
- Fragmented information exchange between courts, hospitals, jails, Emergency Departments, rehabilitation providers, Ohio-DBH / Ohio-MHAS systems, guardianship structures and community-care teams.
- Insufficient integration of neurorehabilitation, outpatient stabilization, functional recovery and longitudinal treatment progress into risk and placement decisions.
- Unequal access to independent medical advocacy, specialist consultation, rehabilitation documentation and multidisciplinary evaluation based on income, insurance status, family capacity or institutional connections.
- Default escalation toward incarceration, psychiatric institutionalization or repeated emergency cycling when more clinically precise stabilization pathways may be available.

XII. The SEIU-M / CIU-M Solution

SEIU-M / CIU-M supplements existing emergency, forensic, behavioral-health, judicial and public-safety systems with a multidisciplinary stabilization review pathway that integrates medical, neurological, psychiatric, rehabilitation, trauma-informed, guardianship and continuity-of-care information. The model does not replace existing institutional authority. It strengthens the clinical, operational and constitutional information environment in which that authority is exercised.

Operational Workflow Summary

- A qualified crisis event, court concern, facility concern, Emergency Department escalation, jail intake concern or guardianship concern is identified.
- Initial safety stabilization and emergency medical screening are initiated without presuming intentionality, criminality or psychiatric causation before underlying causes are reviewed.
- SEIU-M / CIU-M activation pathway is initiated when the matter involves medical complexity, cognitive impairment, disability, guardianship, medication instability, rehabilitation disruption or ambiguous behavioral presentation.
- Multidisciplinary review begins, including medical, neurological, psychiatric, rehabilitation, trauma-informed, social-work, guardianship and continuity-of-care inputs as clinically and legally appropriate.
- Medication history, functional baseline, discharge history, facility-care context, caregiver information and prior treatment records are requested and organized for integrated review.
- Risk stratification is completed to distinguish acute psychiatric danger, medical complexity, neurological decline, trauma response, medication destabilization, developmental-disability communication barriers and public-safety concerns.
- The least-restrictive stabilization environment is recommended from the full continuum of medically appropriate settings.

Recognized Stabilization Alternatives

The full continuum of medically appropriate stabilization settings is recognized and placement decisions are calibrated to clinical presentation, public-safety considerations and least-restrictive principles.

- Hospital inpatient medical units.
- Emergency Department observation and stabilization pathways.
- Psychiatric inpatient units when clinically necessary.
- Neurorehabilitation hospitals and programs.
- Inpatient rehabilitation facilities (IRF).
- Skilled nursing facilities (SNF) when clinically appropriate.
- Jail-based medical stabilization or custodial medical monitoring units.
- Ohio-DBH / Ohio-MHAS-linked stabilization programs.
- Step-down transitional treatment facilities.
- Structured outpatient stabilization and rehabilitation programs.
- Family-supported community stabilization when safe, supervised and clinically appropriate.

Discharge to home with family is one legitimate option within this continuum and is in many cases the least-restrictive setting clinically available. Home discharge protects the patient only when the home environment is operationally capable of sustaining the care the patient requires. For elderly, cognitively impaired and medically vulnerable patients on complex medication regimens, including psychotropic medications, GLP-1 receptor agonists, anticoagulants, insulin and other agents with metabolic, cardiovascular or neurological monitoring requirements, the home environment, on its own, is rarely equipped for safe discharge.

The framework therefore identifies a category of medically complex patients for whom neither restrictive institutional placement nor unsupported home discharge is appropriate. For this population, the requirement is the middle of the care continuum: rehabilitation-focused alternatives including skilled nursing with rehabilitation focus, inpatient rehabilitation facilities, structured outpatient day programs, adult day health services, assisted living with supplemental care coordination, transitional behavioral-health residences and family-supported community stabilization paired with paid in-home supports. The development and availability of this middle continuum is a condition of the framework's operational integrity.

Part IV: The Resolution Gap

XIII. The Resolution Gap for Defendants Found Incompetent and Unrestorable

Among the most consequential and least addressed gaps in modern criminal-legal, healthcare and judicial coordination involves the absence of a functional resolution pathway for defendants found incompetent to stand trial and clinically determined to be unrestorable. While restorability cases possess statutorily defined pathways supported by decades of established procedure, unrestorability cases enter a procedural void that no existing system was designed to resolve. The framework identifies this gap as an urgent statewide, federal and constitutional modernization priority, particularly given its disproportionate impact on elderly individuals, individuals with dementia, stroke-affected populations, individuals with progressive neurological conditions and medically vulnerable populations whose cognitive capacity will not return through restoration treatment.

The Bifurcation: A Clear Pathway for Restorable Defendants, No Pathway for Unrestorable Defendants

Here is the structural injustice at the analytical center of this briefing, stated plainly.

There is a clear pathway for the person found legally incompetent and restorable.

There is no clear pathway for the person found legally incompetent and unrestorable.

The SEIU-M Operational Framework is built to close that asymmetry.

Once a court finds that a defendant lacks the present capacity to understand the proceedings or assist in their defense under the Dusky v. United States standard, the legal process formally branches. Defendants found incompetent and restorable enter a well-developed procedural channel. Restoration treatment is initiated under time-limited standards. Periodic competency reviews are conducted. If restoration succeeds, the case resumes. If restoration fails within the constitutionally permitted period, the proceedings transition toward civil-commitment evaluation or charge resolution. The pathway is imperfect, but it exists. Every actor inside the system understands its sequence.

Defendants found incompetent and unrestorable enter a pathway that has no comparable architecture. The clinical finding that restoration is not possible, typically grounded in dementia, traumatic brain injury, advanced cognitive decline, progressive neurological disease, severe developmental disability or stable post-acute medical conditions, is one of the most clinically definitive determinations a competency evaluator can render. Yet the procedural consequence of that determination is, in many jurisdictions, indeterminate. There is no equivalent statutory timeline. No clearly assigned coordinating authority. No defined transition mechanism. No consistent endpoint. The case enters legal limbo. It does not move forward. It does not close. It does not transition. It continues.

The Already-Adjudicated Incompetent Patient: Who This Population Actually Is

The most overlooked population within the Resolution Gap is not the criminally accused individual whose competency is in question for the first time. It is the patient whose legal incompetence has already been adjudicated, often years earlier, by the Probate Court. Under guardianship statutes including Ohio Revised Code Chapter 2111 governing guardianship of persons and estates and corresponding guardianship frameworks in every state, these patients have already been determined by a court of competent jurisdiction to lack the capacity to manage their own medical care and treatment consent, their own medication regimen, their own residential placement, their own financial affairs, their own legal decisions, their own daily routines and personal welfare, their own communication with institutions and their own participation in administrative or judicial proceedings.

A court-appointed guardian, operating under continuing Probate Court supervision, holds legal authority over these domains. The patient is, by definition and by prior adjudication, not legally responsible for the management of their person, their care or their estate. This is not a clinical observation. It is a judicial finding entered on the record by a sitting court.

When such a patient is subsequently subjected to criminal-legal contact, through arrest, charge, prosecution or competency-to-stand-trial evaluation, the criminal-legal system proceeds, as a matter of operational default, as though the patient were a free legal actor with intact capacity, full mens rea formation and the ability to participate meaningfully in their own defense. The Probate Court's prior adjudication of legal incapacity is, in most jurisdictions, neither formally noticed to the criminal court, nor administratively transmitted, nor automatically given weight. The two judicial systems operate in parallel without an interface.

A justice system judge cannot make a fair decision about a defendant whose legal incompetence has already been adjudicated by a sitting court without that adjudication being formally integrated into the proceedings. Coordination with the Probate Court is not a courtesy. It is a prerequisite to fair adjudication, for all parties: defendant, prosecutor, trial court, Probate Court, guardian, family, professionals.

The framework asks for that coordination to happen by structural design. The sequence is straightforward. Discovery before charges. Causation before indictment. Coordination with the Probate Court before the trial court is asked to decide. None of that requires new authority. All of it requires that existing authority be exercised in the right order.

Why Justice-System Contact Occurs Despite Existing Legal Incompetence

Care-facility patients under guardianship encounter the criminal-legal system for an identifiable set of reasons. The institutional reviewer should understand that the population is not the population for which the criminal code was designed.

Behavioral and Medical Origins

- Behavioral escalation arising from dementia, delirium, post-stroke disinhibition, traumatic brain injury, frontotemporal degeneration or progressive neurological disease.
- Acute medical destabilization including hypoglycemia, urinary tract infection delirium, hypoxia, hyponatremia and hepatic encephalopathy producing transient altered mental status read as criminal conduct.
- Seizure activity, post-ictal confusion or non-convulsive status epilepticus.
- Trauma response, PTSD trigger or dissociative episode in the context of care delivery.
- Sundowning episodes, wandering and resistance to redirection.

Facility-Initiated Reasons

- Facility staff filing charges in response to incidents that could have been clinically managed.
- Facility administration using law-enforcement involvement as a transfer or discharge mechanism for patients perceived as difficult, expensive or beyond facility scope.
- Facility seeking criminal-legal leverage to manage Medicaid reimbursement constraints, staffing constraints or behavioral-management capacity limits.
- Facility-staff allegations made in the context of disputed care episodes, restraint events or medication administration disputes.

The Clinical Chain: Elder Abuse, Medication Mismanagement and Functional Neurological Consequences

In a recognizable subset of cases, the clinical chain runs in this order. Medication mismanagement, neglect or environmental stressor at the facility produces medical destabilization in the patient. Destabilization expresses as behavioral or neurological symptom. Symptom is interpreted by facility staff as primary behavioral pathology. Behavioral interpretation produces escalation, restraint, ED transfer or police involvement. Criminal-legal contact follows. By the time the patient enters the criminal-legal system, the institutional context that produced the destabilization is no longer in the foreground of decision-making.

One driver of this chain warrants specific attention. The commercial emergence of GLP-1 receptor agonists such as semaglutide, marketed as Ozempic and Wegovy, has created a specific financial incentive for medication diversion in facilities serving elderly diabetic patients. At approximately $1,000 per month, semaglutide is not a controlled substance and is not tracked by DEA diversion monitoring, which means a cognitively impaired resident on semaglutide presents as the lowest-risk, highest-value diversion target in the building, with no electronic access trail. The black market for this medication is documented and active. A diabetic patient denied prescribed semaglutide presents with uncontrolled blood glucose producing behavioral manifestations clinically indistinguishable from primary psychiatric pathology. The SEIU-M causation-investigation step exists for exactly this reason.

The federal regulatory architecture reinforces causation review. The Centers for Medicare and Medicaid Services enforces nursing-home Conditions of Participation under 42 C.F.R. Part 483, establishing binding standards for resident rights, quality of care and pharmacy services. Medication-management failures that the causation-investigation protocol identifies are subject to enforcement through F-tag citations, creating an administrative record of regulatory failure independent of any criminal proceeding.

The framework's coordination architecture inverts the sequence. Institutional context is brought into the foreground at the point of intake. Medication safety is reviewed before behavioral interpretation. Causation is investigated before charges. Probate Court is informed before the trial court is asked to decide.

The SEIU-M / CIU-M Operational Response: Safeguards Before Criminal-Legal Escalation

When a care-facility patient under guardianship is the subject of an incident that would otherwise trigger criminal-legal escalation, the SEIU-M / CIU-M protocol initiates the following seven-step sequence.

1. **Step 1: Medical Stabilization.** The patient is medically and neurologically evaluated. Restraint, custodial transfer and criminal-legal proceedings are deferred until stabilization is established.
2. **Step 2: Medication-Management Review.** A full medication reconciliation is completed across psychiatric and non-psychiatric prescriptions.
3. **Step 3: Structured Observation Upon Return to a Corrected Regimen.** When medication mismanagement is identified, the patient is restored to a clinically appropriate regimen and observed for a defined period.
4. **Step 4: Elder Abuse Causation Investigation.** Adult Protective Services (administered in Ohio by the Ohio Department of Job and Family Services, ODJFS), Long-Term Care Ombudsman, MFCU and the state survey agency are notified per existing statutory authority.
5. **Step 5: Coordination with Probate Court Guardian.** The court-appointed guardian is contemporaneously notified, afforded standing and provided with the findings. The Probate Court is informed of the criminal-legal contact.
6. **Step 6: Multidisciplinary Review and Recommendation.** The SEIU-M / CIU-M multidisciplinary team reviews the assembled record and provides recommendations to the prosecutor, defense counsel, trial court, Probate Court and treating systems.
7. **Step 7: Deferred or Declined Escalation When Indicated.** Where findings establish that the conduct was the downstream consequence of institutional failure, that stabilization has resolved the underlying presentation and that guardianship-supported placement is available, criminal-legal escalation is deferred, declined, diverted or dismissed in coordination with the trial court, the prosecutor and the Probate Court.

Where the multidisciplinary record establishes that conduct was the downstream consequence of institutional failure or medication mismanagement, the prosecutor has a documented basis for nolle prosequi or dismissal without prejudice. The framework does not constrain prosecutorial discretion. It informs it.

The seven-step protocol is grounded in four operational principles: stabilization before escalation, causation before prosecution, coordination before adjudication and stewardship before continuation.

Constitutional Foundation and the Jackson v. Indiana Standard

Jackson v. Indiana, 406 U.S. 715 (1972), is settled constitutional law. A defendant committed solely on the basis of incompetency to stand trial cannot be held indefinitely. Continued confinement must bear a reasonable relationship to the purpose of restoration. If restoration is not possible within a reasonable period, the State must either initiate the customary civil-commitment proceedings or release the individual. The doctrine has been on the books for more than fifty years. Its operational implementation in cases of unrestorable defendants, particularly those already adjudicated incompetent under R.C. Ch. 2111, is not yet settled in practice. The framework is designed to make Jackson operationally functional in every case.

The Jackson holding rests on both due process and equal protection grounds under the Fourteenth Amendment. The Court held that commitment cannot exceed the reasonable period necessary to determine whether there is a substantial probability of restoration to competency. For defendants already found incompetent under Probate Court guardianship that substantial probability does not exist. The constitutional standard has been met and exceeded. The framework operationalizes the resolution

Jackson requires. The Sixth Amendment speedy trial right, analyzed under Barker v. Wingo (1972), is separately implicated: a defendant in procedural limbo for years, whose charges are neither tried nor dismissed, has a documented Sixth Amendment claim. The framework resolves that claim by producing resolution rather than extending delay. Defendants committed on incompetency grounds were held to more stringent standards and more prolonged conditions than those committed civilly, without equivalent procedural protections. That disparity is the constitutional basis for federal enforcement authority. ADA Title II and the Olmstead integration mandate further require that qualified individuals with disabilities receive community-based services when appropriate and when such placement can be reasonably accommodated. Defendants found incompetent and unrestorable who remain institutionalized when guardianship-supported community placement is clinically appropriate and available are being denied the integration Title II and Olmstead require.

The Constitutional Impossibility of Restoration in Already-Adjudicated Patients

For patients already adjudicated incompetent under R.C. Ch. 2111, restoration is not a clinical pathway. It is a constitutional impossibility. The Probate Court has already found that the patient lacks the capacity to make medical decisions, manage medication, manage finances, execute legal instruments and participate in administrative proceedings. To assert that the same patient may be restored to a competency to stand trial, a more demanding cognitive task than the daily-living tasks the Probate Court has already determined the patient cannot perform, is to assert that the patient can recover capacities the Probate Court has already determined are not recoverable. The two adjudications cannot coexist coherently. One of them must give way.

Jackson v. Indiana established that incompetency-based confinement cannot be indefinite. In the population of already-adjudicated incompetent patients, the Jackson protection is operationally defeated by the absence of any mechanism through which the Probate Court's prior adjudication produces a different procedural outcome in the criminal court.

Operational Manifestations and Compounding Harms

The operational scale of the Resolution Gap is documented. SAMHSA's 2023 publication identifies the gap as a national policy concern. State-level data illustrate the trajectory: court-ordered competency restorations in Colorado, in a published state-level analysis, increased from approximately 87 cases in 2001 to approximately 900 cases by 2017, more than a tenfold increase over a sixteen-year period.

The SEIU-M / CIU-M framework is the missing implementation piece for the national behavioral health crisis strategy. It is structurally aligned with the federal behavioral health crisis transformation now underway. The Bipartisan Safer Communities Act of 2022 and the American Rescue Plan Act of 2021 established and funded the 988 Suicide and Crisis Lifeline and directed federal investment toward building a continuum of crisis services including mobile crisis response, crisis stabilization units and crisis receiving centers. The Substance Abuse and Mental Health Services Administration’s National Guidelines for Behavioral Health Crisis Care (2020) established the no wrong door principle: any entry point into the crisis system should connect individuals to the appropriate level of care. SEIU-M / CIU-M implements that principle for the specific and underserved population of medically vulnerable individuals whose crisis contact occurs through the criminal-legal system rather than the behavioral health system. It extends the federal crisis continuum to a population the 988 architecture does not currently reach.

The Ohio operational record reflects the same pattern at the state level. The Office of the Governor of Ohio convened the Governor's Work Group on Competency Restoration and Diversion in April 2024 in direct response to capacity strain at Ohio's six regional psychiatric hospitals. As of the Work Group's convening, forensic patients accounted for approximately 93 percent of available state psychiatric hospital beds, squeezing civil capacity to approximately one bed in ten of total available capacity. Ohio's active adult guardianship caseload rose from approximately 42,000 cases in 2011 to

approximately 49,000 cases in 2020, with 6,000 to 7,000 new guardianship applications filed annually (Supreme Court of Ohio, Case Management Section).

For elderly defendants and medically vulnerable populations, the gap translates directly into measurable clinical and human harm. Cognitive decline accelerates within institutional environments. Continuity-of-care erodes. Medication regimens destabilize. Rehabilitation gains regress. Family separation compounds vulnerability. Trauma compounds upon trauma. Mortality risk increases. In a meaningful number of cases, defendants do not survive the resolution process.

The Human Experience: Stuck, Helpless, Hopeless, Abandoned, Confused, Misunderstood

Behind every procedural description of this gap is a human experience. The defendant is stuck inside a system that cannot proceed. Capable neither of advancing nor of withdrawing from the process. Confronted with the recognition that no path forward exists. Abandoned inside a process no actor can independently resolve. Required to navigate procedural complexity that cognitive impairment precludes. Interpreted through legal categories that do not align with clinical reality. Forgotten by systems whose calendars no longer prioritize the case. Procedurally invisible to administrative structures that lack metrics for unresolved unrestorability cases. Deprived of the dignity of resolution.

For families, the experience parallels and compounds the experience of the defendant. Families are unable to plan because no timeline exists. Families are unable to coordinate because no coordinating authority is designated. Families are unable to advocate effectively because the system contains no clearly defined point of advocacy. Families are unable to grieve a loss that has not occurred and unable to celebrate a return that may never be permitted. The family becomes a chronic-stress population within an unresolved process.

Case Study Reference: When Perfect Execution Still Produces No Resolution

The framework is submitted with reference to a separately-submitted patient Case Study, available on request to specific institutional authorities and controlled at the level of distribution to protect the identity and ongoing circumstances of the patient. The Case Study documents a situation in which every condition for resolution has been met.

- Medical and neurological stabilization is documented and ongoing.
- Dangerousness has resolved and is not clinically demonstrable.
- A receiving placement is prepared, resourced and ready.
- A court-appointed guardian is in place and prepared to assume full caregiving responsibility.
- Continuity-of-care providers across multiple specialties are coordinated and engaged.
- Family advocacy is sustained, professional and aligned with clinical, legal and constitutional standards.
- Public-safety risk is, by every available metric, addressed.

Despite every condition for resolution being satisfied, the case remains procedurally unresolved. The system contains no mechanism through which the satisfaction of those conditions produces an exit. The Case Study therefore functions as institutional evidence that the gap is not a function of incomplete advocacy, insufficient documentation, inadequate clinical stabilization or absent family preparedness. The gap is a function of systemic architecture. Perfect compliance does not produce resolution.

Proposed Resolution Pathway Architecture

What the resolution pathway requires is not complex. It requires the things the existing system has for restorable defendants but withholds from unrestorable ones. A designated coordinating authority that owns the resolution and is accountable for its outcome. A defined timeline that bounds the period between an unrestorability finding and a formal disposition, the same way restoration timelines bound the restorable pathway. A structured transition protocol that moves stabilized defendants from criminal-legal custody to guardianship-supported community placement. The other elements, medication continuity, constitutional review safeguards, a dismissal-with-protection protocol, Probate Court coordination, outcome measurement and workforce training, are the operational components of a pathway that treats unrestorable defendants as the law already requires. The architecture exists. The coordination to activate it does not. That is what this framework builds.

ETHICS

There is also no clear pathway here for the lawyers on either side. For the defense attorney, there is no ethical road map for representing a client who has been found incompetent and unrestorable, a client who cannot meaningfully assist in their own defense and whose case the system offers no way to resolve. For the prosecutor, there is no clear pathway to discharge the duty to protect public safety while also doing justice, when a case can neither fairly proceed nor properly conclude. This is not sustainable, and it is not sound as a matter of judicial, legislative or systemic design. A system that leaves both the defense and the prosecution without a framework serves no one: not the defendant, not the public and not the court.

Part V: Implementation

XIV. Family Integration, Stabilization and Caregiver Partnership

Families and long-term caregivers often possess critical insight involving baseline functioning, medication history, trauma responses, rehabilitation patterns, behavioral changes, continuity-of-care history and stabilization needs that may not be immediately visible during isolated crisis evaluation. The framework recognizes families not as external observers during crisis periods but as potential stabilization partners capable of supporting continuity, rehabilitation progress and long-term recovery when collaborative structures are functioning appropriately.

The Burden Families Carry

Behind every gap in the architecture this briefing describes is a family carrying weight no family was designed to carry. Guardians, caregivers and family members of medically vulnerable individuals are routinely expected to function, under crisis conditions, as legal advocates, medical interpreters, medication-management specialists, hospital navigators, insurance and Medicaid experts, legislative and administrative-law interpreters, interagency diplomats, court coordinators, communication specialists between systems that do not speak to one another, financial guardians under fiduciary duty, records custodians, appointment schedulers, transportation coordinators, crisis responders when professional response fails and emotional anchors for a loved one whose condition is the reason they are fighting in the first place. They are asked to perform these roles concurrently, with no training, no respite and no defined point of arrival.

Many of the people asked to carry this burden are not equipped, through no fault of their own, to carry it in the form the systems require. Most families do not have legal training. Most do not have clinical training. Most do not have the technical infrastructure, the institutional vocabulary, the time, the financial reserves or the procedural fluency that effective navigation of these systems demands. Even families that do carry one or more of these competencies find themselves exhausted by the scale of what coordination across these systems requires when the systems themselves do not coordinate.

What families need is not heroism. What families need is institutional infrastructure: coordinated guidance, accessible resources, dedicated navigators, integrated information systems, defined points of contact and the assurance that the systems responsible for protecting medically vulnerable individuals will not require their family members to become lawyers, clinicians, legislative interpreters and diplomats to secure that protection. The framework respectfully submits that asking families to perform this institutional labor, under crisis conditions, in the absence of coordinated support, is itself a form of preventable harm.

The companion Case Study documents six years of one family's effort to navigate this gap on behalf of one medically vulnerable individual. The framework respectfully calls for coordinated modernization to occur before the next family begins the same navigation.

Discharge to Home: Operational Realities and Required Support Infrastructure

Discharge to home with family is, on its face, the least-restrictive setting clinically available and is in many cases the most therapeutic, dignified and humane option for medically vulnerable patients. Home discharge protects the patient only when the home environment can sustain the care the patient requires. For elderly, cognitively impaired and medically vulnerable patients on complex regimens, the home environment, on its own, is rarely equipped for safe discharge without support.

Meaningful home-discharge planning requires the assembly, around the discharging patient, of an operationalized home-support infrastructure that does not currently exist as a coordinated package.

The elements exist piecemeal across multiple authorities, Medicaid Home and Community-Based Services under 1915(c), Medicare home health benefit, PACE under the Balanced Budget Act of 1997, Older Americans Act caregiver-support, State Long-Term Care Ombudsman programs, Adult Protective Services, Federally Qualified Health Centers, geriatric care management services, telehealth monitoring, adult day health services. The coordination mechanism that assembles these elements around an individual patient at the point of discharge does not exist.

The framework proposes that home discharge be recognized as a legitimate least-restrictive option only when paired with documented assembly of the support infrastructure the patient's clinical complexity requires. Where home-support infrastructure cannot be assembled at the level required, the framework identifies the middle of the care continuum as the location for discharge planning: rehabilitation-focused settings including skilled nursing with rehabilitation focus, inpatient rehabilitation facilities, structured outpatient day programs, adult day health services, assisted living with supplemental care coordination, transitional behavioral-health residences and family-supported community stabilization with paid in-home supports.

XV. Workforce Support, Provider Protection and System Stabilization

The SEIU-M / CIU-M framework is also intended to support healthcare professionals, behavioral-health providers, rehabilitation personnel, emergency-response teams and interdisciplinary specialists operating under extraordinary crisis pressure during periods of system strain and instability. When professionals are required to make high-consequence decisions about medically vulnerable individuals without access to complete clinical context, medication history, guardianship information, continuity-of-care records or interdisciplinary consultation, they are exposed to both clinical risk and institutional liability. That exposure is not the result of individual inadequacy. It is the result of structural insufficiency.

Strengthening interdisciplinary collaboration, coordinated reassessment, medical consultation pathways and stabilization-review structures helps reduce isolated provider burden, improve interdisciplinary communication, reduce preventable escalation pressure, support workforce sustainability and improve stabilization coordination for medically vulnerable populations. Long-term crisis-response modernization should strengthen outcomes not only for vulnerable individuals and families, but also for the professionals and institutions responsible for protecting them.

XVI. Pilot Implementation Pathway

- Select one or more pilot counties with court, hospital, Ohio-DBH / Ohio-MHAS and public-safety participation.
- Establish activation criteria for medically complex crisis events.
- Develop multidisciplinary review teams and telehealth specialty consultation options.
- Coordinate Emergency Department, jail medical, rehabilitation and outpatient stabilization pathways.
- Measure outcomes over a twelve-to-twenty-four-month period.
- Report findings to executive, legislative, judicial and interagency leadership.

Candidate Funding Authorities and Implementation Resources

The framework identifies existing federal and state funding authorities that, in combination, could support pilot implementation and phased expansion without requiring new statutory authority during the initial implementation period. Each authority below is named to indicate institutional fluency with existing mechanisms, not to predict specific funding outcomes. Final funding architecture is appropriately the subject of feasibility analysis in coordination with the relevant agencies.

- **Medicaid Section 1115 demonstration waiver authority.** Permits states to test innovative service delivery and payment approaches that improve care for Medicaid beneficiaries.
- **Medicaid Home and Community-Based Services waivers under Section 1915(c).** Authority for community-based stabilization, family-supported placement and continuity-of-care coordination for nursing-home-eligible individuals served in the community.
- **SAMHSA crisis-response grant categories.** Including Certified Community Behavioral Health Clinic grants and Mental Health Block Grant funding with crisis-services set-aside requirements.
- **Federal Elder Justice Act discretionary appropriations.** For elder-abuse prevention, investigation and coordination infrastructure.
- **HRSA workforce-development authorities.** Supporting interdisciplinary workforce capacity in geriatrics, behavioral health and rehabilitation.
- **PACE program authority under the Balanced Budget Act of 1997.** For elderly populations requiring coordinated care.
- **State behavioral-health innovation budgets.** For pilot infrastructure under Ohio-DBH / Ohio-MHAS administration.
- **Philanthropic capital.** For pilot research, evaluation and implementation support from aging-focused, justice-focused and rehabilitation-focused foundations.
- **U.S. Department of Justice civil-rights coordination.** Supporting constitutional review and federal alignment.

XVII. Outcomes Framework: Measurement, Accountability and Early Warning Indicators

The framework's outcome measurement architecture is designed to demonstrate value to funders, support institutional confidence and drive continuous improvement. Metrics are organized into five categories.

Clinical Performance

- Time from crisis identification to medical stabilization.
- Rate of medication-mismanagement identification at intake.
- Resolution rate for unrestorability cases under the seven-step protocol.
- Preservation of continuity-of-care provider relationships through transition.
- Mortality and readmission rates within twelve months.

System Coordination

- Emergency Department cycling reduction for the pilot population.
- Jail medical burden reduction.
- Forensic-bed waitlist reduction.
- Court calendar throughput for incompetency cases.

Financial and Utilization

- Cost per case under the coordinated pathway compared to historical baseline.
- Medicaid expenditure patterns across acute, post-acute, long-term and community settings.
- Total cost per resolved case compared to total cost per unresolved case under the status quo.

Rights, Safety and Accountability

- Jackson v. Indiana time-bounded review compliance rates.
- Rate of formal Probate Court notification and guardian standing in criminal-legal proceedings involving adjudicated-incompetent patients.
- Olmstead v. L.C. community-integration outcomes.
- Due-process protections at the points of arrest, charge, evaluation, hearing and disposition.

CMS and Federal Alignment

- Alignment with CMS National Partnership to Improve Dementia Care performance indicators.
- Alignment with CMS Rules of Participation for Long-Term Care Facilities.
- Alignment with SAMHSA Crisis Care Coordination standards.

XVIII. SEIU-M / CIU-M Operational Workflow Schematic

The operational workflow proceeds through five phases. Phase I, Crisis Identification and Immediate Safety Stabilization. Phase II, Interdisciplinary Activation Review. Phase III, Integrated Medical, Neurological and Rehabilitation Review. Phase IV, Stabilization and Placement Analysis. Phase V, Reintegration and Continuity Restoration. Each phase produces documented findings that inform the next and that are integrated into the multidisciplinary record on which subsequent court, clinical and placement decisions rest.

Part VI: Decision and Action

XIX. Decision-Maker Summary

Question	Briefing Answer
What is SEIU-M / CIU-M?	A multidisciplinary medical-stabilization and court-support framework for medically complex crisis events involving vulnerable populations.
Why now?	Post-COVID systems strain, aging populations, workforce shortages, behavioral-health escalation and crisis-response fragmentation are increasing risk simultaneously.
What does it change?	Adds integrated medical, neurological, rehabilitation, guardianship and continuity-of-care review before restrictive escalation whenever feasible.
Who benefits?	Courts, prosecutors, defense counsel, healthcare systems, EMS, jails, families, Medicaid systems and vulnerable individuals.
What is requested?	Interagency review, pilot feasibility discussion, legal analysis, clinical workflow design and phased implementation planning. No new statutory authority during the pilot phase.

XX. Benefits for Key Stakeholders

Stakeholder	Benefit
Executive Agencies	Clear implementation framework for coordinated statewide response.
Courts	Better information before liberty-impacting decisions.
Prosecutors	Improved clinical context for charging, diversion and resolution decisions.
Defense Counsel	Improved access to medically relevant records and specialist context.
Healthcare Systems	Reduced Emergency Department cycling and stronger discharge coordination.
Public Safety	Reduced recurrence through root-cause stabilization.
Families and Guardians	More meaningful participation in baseline and continuity-of-care information.
Medicaid and Fiscal Systems	Potential reduction in avoidable hospitalization, jail medical costs and repeated stabilization failures.

XXI. 30-Day, 90-Day, 6-Month and 12-Month Action Pathway

Timeframe	Recommended Action
Within 30 Days	Designate interagency review contact within each receiving institution. Identify legal, clinical and operational leads. Conduct initial pilot-feasibility review. Acknowledge receipt and indicate institutional review intentions.
Within 90 Days	Develop activation criteria, operational workflow map, training outline, data-governance approach, fiscal feasibility analysis and advisory group composition. Engage candidate funding authorities. Convene initial multidisciplinary advisory consultation.
Within 6 Months	Launch limited pilot planning in two or three candidate regions. Develop hospital, EMS, court, Probate Court, guardianship, APS, Long-Term Care Ombudsman and Medicaid Fraud Control Unit coordination pathways. Design outcome dashboard.
Within 12 Months	Implement pilot. Evaluate early metrics. Refine protocols. Prepare legislative, regulatory and administrative recommendations for regional expansion or statewide scaling.
Ongoing	Maintain coordination with the authorities identified in Appendix B. Maintain measurement and reporting cadence. Hold to the four operational principles: stabilization before escalation, causation before prosecution, coordination before adjudication, stewardship before continuation.

XXII. Executive Risk of Inaction

The fiscal and operational scale of continued inaction is documented. Adverse drug events drive more than 1.5 million emergency-department visits annually in the United States, with nearly 500,000 resulting in hospitalization (CDC Medication Safety FastStats, 2024). Antipsychotic medications alone accounted for approximately $7.6 billion in Medicare Part D spending in 2011, the second-highest drug class and approximately 8.4 percent of total Part D expenditures (CMS, 2014). State forensic bed operational costs are estimated at approximately $790 per bed per day (Texas HHSC State Hospital Cost Study, 2024), consistent with Ohio's own CY 2023 inpatient daily rate of approximately $610 to $938 for all payors (Ohio LSC).

Continued inaction carries identifiable operational, fiscal and public-trust consequences.

- Continued Emergency Department cycling and crisis recurrence.
- Greater jail medical burden and correctional liability exposure.
- Psychiatric bed pressure from cases that may require medical or rehabilitative care instead.
- Delayed diagnosis of neurological, endocrine, medication-related or trauma-driven instability.
- Reduced public trust when vulnerable individuals and families experience repeated fragmentation.
- Higher long-term costs from late intervention rather than early stabilization.

Illustrative Fiscal Architecture

The cost of the status quo is substantial and recurring. A single multi-year forensic placement of an unrestorable defendant, at $790 per bed per day, exceeds $280,000 per year in bed cost alone, before associated clinical, judicial, transportation, evaluation and administrative costs. Acute inpatient psychiatric placement at private market rates ranges from approximately $500 to $2,000 per day. Medicaid average monthly payment for nursing facility care has been reported at approximately $6,000 per resident, with annualized cost per resident accordingly in the $72,000 range.

Against these recurring costs, the savings are real and measurable. Reducing a single three-year forensic placement to a six-month coordinated resolution produces over $560,000 in direct taxpayer savings before associated judicial and administrative costs. A full directional return-on-investment analysis is developed in the companion White Paper.

For vulnerable elderly patients whose medication or care plan is mismanaged, at home or in the facility entrusted with their care, the system is a revolving door with no clear pathway out: destabilization brings hospitalization or criminal-legal contact, the patient returns to the same uncorrected setting and the cycle repeats. SEIU-M's contribution is coordination: it brings every participating authority to the same table, anchored by the Probate Court and the guardian acting on behalf of the ward. This coordination supplies the correction and the resolution pathway the system now lacks.

Aggregated across the populations the framework addresses, the recurring fiscal exposure of fragmented crisis-response, prolonged unrestorability cases, repeated Emergency Department cycling, jail medical burden, avoidable hospitalization, medication-mismanagement complications, institutional elder-abuse litigation and continuity-of-care collapse is substantial. The fiscal frame the framework advances is straightforward. Continued inaction is not cost-neutral. A coordinated framework that reduces these recurring costs while improving clinical, constitutional and public-safety outcomes is, in fiscal terms, a stewardship investment rather than a new expenditure category.

XXIII. Bottom Line for Leadership

SEIU-M / CIU-M is a practical modernization proposal. It does not ask leaders to choose between compassion and public-safety. It strengthens public-safety by improving clinical accuracy, stabilizing root causes, supporting courts with better information and reducing the repeated crisis cycles that burden families, hospitals, jails and public systems.

The cost of inaction is not abstract. The Case Study submitted separately documents one family's six-year navigation of this gap on behalf of one medically vulnerable individual. The framework respectfully calls for coordinated modernization to occur before the next family begins the same navigation.

XXIV. Consolidated Request: What This Briefing Asks

This briefing is offered humbly to every institution, authority and individual who receives it. The framework is presented with full recognition that the institutions it addresses carry decades of expertise, statutory authority and operational responsibility. The request below is a request, not a demand. It is a request for coordination, not a prescription. The framework is submitted in the spirit of service to vulnerable individuals and families, in deference to the institutional authorities responsible for protecting them and in humble recognition that meaningful change in this domain requires the leadership, judgment and good faith of every authority named in this briefing. Recipients are humbly thanked for their consideration.

Specific Authorities Requested

The framework does not request the creation of new statutory authority during the initial pilot implementation period. It requests coordinated use of existing federal and state authorities (Medicaid 1115 and 1915(c) waivers, SAMHSA grant authorities, federal Elder Justice Act discretionary appropriations, HRSA workforce-development authorities, PACE, state behavioral-health innovation budgets, Department of Justice authorities), supplemented by administrative coordination among the receiving institutions. Demonstrated pilot outcomes during the twelve-month evaluation period would inform any subsequent recommendation regarding longer-term statutory or administrative scaling.

Coordinated National Context

While the statutory citations in this briefing are Ohio-specific, the structural gap addressed exists in every state. Coordination with federal authorities, HHS, CMS, the DOJ Civil Rights Division, SAMHSA, CDC, the Administration for Community Living and White House and federal policy review, is as important as state-level coordination and is requested as part of the implementation pathway.

XXV. Anticipated Concerns and Responses

Concern: The framework adds another layer of coordination to systems already burdened with coordination requirements.

Coordination is added at one specific decision point, the moment a medically vulnerable individual would otherwise enter restrictive escalation and the coordination is designed to reduce, not increase, downstream institutional burden. Reduced Emergency Department cycling, reduced jail medical burden, reduced unrestorability case duration and reduced avoidable hospitalization are the operational outcomes the proposal is designed to produce. The pilot phase is structured to test whether these reductions materialize at scale.

Concern: The framework asks public-safety personnel and prosecutors to defer to clinical judgment in cases where public-safety considerations are paramount.

The framework does not displace public-safety judgment. It establishes that medical stabilization, medication-management review and elder-abuse causation investigation occur as predicate steps before criminal-legal escalation, so that public-safety personnel and prosecutors are operating with complete clinical and investigative information rather than incomplete information. Better-informed public-safety decisions are stronger public-safety decisions.

Concern: The framework's empirical claims rely on data that varies in age and methodology.

Every empirical figure is cited with its source and publication date visible. Where the canonical source is older, the date is shown. Where more recent data exists, the recent data is cited. Where the empirical record contains genuine uncertainty, the uncertainty is named rather than obscured.

Concern: The framework assumes coordination is possible across systems that historically do not coordinate well.

The framework acknowledges that the coordination it proposes does not currently exist and is the gap the framework addresses. The pilot phase is specifically designed to test whether coordination can be established within existing statutory authority. If the pilot demonstrates that coordination is achievable, the framework's structural claim is supported. If it does not, the pilot will identify which specific coordination barriers require legislative or administrative attention. Either outcome advances the institutional understanding of the problem.

Concern: The framework is presented by a non-institutional author.

The framework is presented by The Guardian, under Ohio Probate Court jurisdiction, in coordination with clinical, legal, operational and policy contributors. The institutional analysis, statutory citations, empirical anchoring and operational architecture meet the standards expected of work submitted to executive, legislative, judicial, regulatory and federal review. The framework asks to be evaluated on the merits of its analysis rather than on the institutional standing of its author. The separately-submitted Case Study provides the evidentiary record supporting the framework's claims.

Limitations, Assumptions and Pilot Recalibration

This briefing operates within explicit assumptions and is subject to defined limitations. The fiscal estimates are directional, not actuarial. The briefing does not claim pilot outcomes in advance of a pilot; it claims that the structural conditions documented here support proceeding to pilot planning. If twelve-month pilot outcomes require design adjustment, the framework is structured for recalibration rather than termination. The structural problem the framework addresses does not disappear if the first implementation design requires adjustment and the constitutional and fiscal case does not depend on first-cycle perfection.

XXVI. What This Proposal Is Not

This proposal is not intended to:

- Replace physicians, courts or judicial authority.
- Reduce public-safety.
- Eliminate behavioral-health intervention.
- Interfere with lawful emergency response.
- Prevent clinically necessary psychiatric intervention.
- Excuse intentional abuse, violence or criminal conduct.

Rather, the framework seeks to strengthen interdisciplinary reassessment, medically informed stabilization, continuity-of-care coordination, medication-safety review, rehabilitation-focused alternatives, crisis-response preparedness and fair, reasonable and stabilization-focused decision-making during periods of crisis involving medically vulnerable populations.

Behind every operational principle in this briefing is a person whose protection depends on whether the principle is operationalized. The reform this document proposes is the architecture of a country that protects its most vulnerable as a matter of structural design rather than as a matter of accident, of resources or of who happens to have a family member willing to fight on their behalf.

Appendix A: Pathway Comparison Matrix

This matrix presents a side-by-side comparison of the procedural pathway available to defendants found incompetent and restorable against the absence of an equivalent pathway for defendants found incompetent and unrestorable. The matrix is offered to support institutional review of where statutory and administrative architecture is present and where it is structurally absent. Citations are to Ohio Revised Code where applicable. Comparable provisions exist in every state.

Pathway Element	Restorable Defendants	Unrestorable Defendants
Statutory framework	Ohio R.C. sec. 2945.37 to 2945.402 establish a developed framework for evaluation, restoration treatment, periodic review and disposition.	No equivalent statutory framework defining a resolution sequence for cases where restoration is not clinically possible.
Coordinating authority	Trial court, with statutory referral to Ohio-DBH / Ohio-MHAS restoration facility. Responsibility is assigned by statute.	No single authority is assigned ownership of the resolution. Each actor performs their role. No actor is empowered to advance the case to disposition.
Statutory timeline	Bounded restoration period under Ohio R.C. sec. 2945.38, calibrated to the seriousness of the underlying charge.	No equivalent bounded timeline for case disposition after an unrestorability finding.
Periodic review	Periodic competency review conducted by qualified evaluators with court oversight.	Periodic review occurs but produces no procedural advance because no transition pathway is statutorily defined.
Treatment authority	Restoration treatment is authorized under defined clinical standards.	No treatment-to-resolution pathway is defined. Treatment continues without an articulated endpoint.
Civil commitment interface	If restoration fails, civil commitment evaluation may be initiated under Ohio R.C. sec. 5122 standards.	Civil-commitment standards frequently cannot be met for stabilized, guardianship-supported elderly defendants. The defendant is too stabilized for commitment but procedurally tethered to charges.
Probate Court coordination	Coordination with Probate Court is not routinely contemplated, as the population is presumed to lack prior incompetence adjudication.	No mechanism for formal notice to or coordination with the Probate Court that has already adjudicated the patient legally incompetent under Ohio R.C. Chapter 2111.
Guardian standing	Guardian standing is not routinely contemplated, as the population is presumed not to have an appointed guardian.	No defined mechanism through which the court-appointed guardian, who holds legal authority over the patient's medical, residential and personal welfare, is formally engaged in the criminal proceeding.

Pathway Element	Restorable Defendants	Unrestorable Defendants
Elder-abuse causation review	Not routinely triggered as part of competency-to-stand-trial proceedings.	Not routinely triggered. The conduct underlying the charge is not investigated for the institutional causation that may have produced it.
Medication-management review	Restoration treatment includes medication management. Pre-charge medication review is not routinely contemplated.	No predicate medication-mismanagement review before criminal-legal escalation. Behavioral presentation that may be medication-driven is treated as volitional conduct.
Disposition	Restoration success leads to trial. Restoration failure leads to civil-commitment review or release per Jackson v. Indiana.	No defined disposition. Charges remain open. The case continues. No statutory closure mechanism applies.
Continuity-of-care preservation	Not formally contemplated.	Not formally contemplated. Established treating relationships, medication regimens and rehabilitation plans are routinely disrupted.
Measurement and oversight	Restoration outcomes are measured by treating facilities and reported to courts.	No measurement infrastructure for unrestorability case duration, resolution rates, transition outcomes or continuity-of-care preservation.
Constitutional anchor	Jackson v. Indiana, 406 U.S. 715 (1972); Dusky v. United States, 362 U.S. 402 (1960); Sell v. United States, 539 U.S. 166 (2003).	Same constitutional standards apply, but operational implementation is structurally absent. Jackson is theoretically protective and operationally inert.

Note. The matrix above identifies the structural gap as a function of architecture, not of individual institutional performance. Every actor within the system is performing their statutorily defined role. The architecture itself does not provide a defined sequence for the unrestorability population. The framework therefore proposes architectural development rather than individual-level remediation.

Appendix B: Distribution Authorities

This appendix identifies the institutional authorities the framework respectfully proposes for review and coordination consideration. The list is comprehensive by design and is not intended to predict where coordination will or should originate. That determination rests with the receiving institutions. The list is organized by branch and function. Recipients are not bound to participate. The framework is presented for review.

Ohio Executive Branch

- Office of the Governor of Ohio.
- Office of the Lieutenant Governor of Ohio.
- Office of the Ohio Attorney General.
- Ohio Department of Behavioral Health (Ohio-DBH) / Ohio Department of Mental Health and Addiction Services (Ohio-MHAS).
- Ohio Department of Aging.
- Ohio Department of Job and Family Services.
- Ohio Department of Medicaid.
- Ohio Department of Developmental Disabilities.
- Ohio Department of Health.
- Ohio Department of Rehabilitation and Correction.
- Ohio Department of Public Safety.
- Ohio Department of Insurance.
- Ohio Office of Budget and Management.

Ohio Legislative Branch

- Ohio General Assembly: Ohio Senate and Ohio House of Representatives.
- Ohio Senate Committee on Health and Human Services, Committee on Judiciary and Committee on Finance.
- Ohio House Committee on Aging and Long-Term Care, Committee on Health Provider Services, Committee on Behavioral Health, Committee on Civil Justice, Committee on Criminal Justice and Committee on Finance.
- Ohio Legislative Service Commission.

Ohio Judicial Branch

- Supreme Court of Ohio.
- Ohio Judicial Conference.
- Ohio Probate Court Judges Association.
- Ohio Probate Courts (district by district as appropriate).
- Ohio Common Pleas Courts (district by district as appropriate).
- Ohio Public Defender Commission and Office of the Ohio Public Defender.

Ohio Healthcare and behavioral health coordination

- Ohio Hospital Association.

- Ohio State Medical Association.
- Ohio Psychiatric Physicians Association.
- Ohio Association of Health Plans.
- Ohio Medicaid Managed Care Organizations.
- Ohio Health Care Association.
- LeadingAge Ohio.
- Ohio Long-Term Care Ombudsman Program.
- Ohio Adult Protective Services networks.

Federal Executive and Healthcare Coordination

- The President of the United States and the Office of the President.
- White House Domestic Policy Council and Office of Public Engagement.
- U.S. Department of Health and Human Services, Office of the Secretary.
- Centers for Medicare and Medicaid Services.
- Substance Abuse and Mental Health Services Administration.
- Administration for Community Living.
- Health Resources and Services Administration.
- Agency for Healthcare Research and Quality.
- Centers for Disease Control and Prevention.
- National Institute on Aging, National Institute of Mental Health, National Institute of Neurological Disorders and Stroke.
- U.S. Department of Justice, Office of the Attorney General, Civil Rights Division and Office of Justice Programs.

Federal Legislative

- United States Senate Special Committee on Aging, Committee on the Judiciary, Committee on Finance and Committee on Health, Education, Labor and Pensions.
- United States House Committee on the Judiciary, Committee on Energy and Commerce and Committee on Ways and Means.

Implementation, Coordination and Quality

- National Association of State Mental Health Program Directors.
- National Association of State Medicaid Directors.
- National Association of Medicaid Fraud Control Units.
- National Adult Protective Services Association.
- National Association of State Long-Term Care Ombudsman Programs.
- National Center on Elder Abuse.
- National Council on Aging.
- National Guardianship Association.
- National Center for State Courts, Center on Adult Guardianship.
- American Society on Aging.

Academic, Research and Policy Review

- AARP and AARP Ohio.
- Alzheimer's Association and Alzheimer's Association Ohio chapters.
- Brain Injury Association of America and Brain Injury Association of Ohio.
- Epilepsy Foundation.
- American Diabetes Association.
- National Alliance on Mental Illness and NAMI Ohio.
- Disability Rights Ohio.
- Pro Seniors, Inc. and Ohio Legal Aid network.
- Area Agencies on Aging (regional Ohio offices).
- Faith-based, civic and community organizations engaged in elder care, disability rights and family-caregiver support.

Appendix C: References and Authorities Cited

United States Supreme Court Decisions

- Dusky v. United States, 362 U.S. 402 (1960).
- Jackson v. Indiana, 406 U.S. 715 (1972).
- Olmstead v. L.C., 527 U.S. 581 (1999).
- Sell v. United States, 539 U.S. 166 (2003).
- Pennsylvania Department of Corrections v. Yeskey, 524 U.S. 206 (1998).
- Tennessee v. Lane, 541 U.S. 509 (2004).

Federal Litigation

- Trueblood v. Washington State Department of Social and Health Services, 101 F. Supp. 3d 1010 (W.D. Wash. 2015).
- Oregon Advocacy Center v. Mink, 322 F.3d 1101 (9th Cir. 2003).

Federal Statutes and Regulations

- Americans with Disabilities Act of 1990, 42 U.S.C. sec. 12101 et seq.
- Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. sec. 794.
- Older Americans Act of 1965, 42 U.S.C. sec. 3001 et seq.
- Elder Justice Act of 2010, Title XX of the Social Security Act, 42 U.S.C. sec. 1397j et seq.
- Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. sec. 1320d et seq.; 45 C.F.R. Parts 160 and 164.
- Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2.
- Nursing Home Reform Act (OBRA 1987), 42 U.S.C. sec. 1395i-3 and 1396r.
- Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).
- Balanced Budget Act of 1997, PACE program authority, Pub. L. No. 105-33, sec. 4801.
- 21st Century Cures Act, Pub. L. No. 114-255 (2016).
- Medicaid statutes: 42 U.S.C. sec. 1396 et seq., including sec. 1115 demonstration authority and sec. 1915(c) HCBS waiver authority.
- Federal criminal-procedure competency provisions: 18 U.S.C. sec. 4241 to 4247.

Ohio Revised Code

- Ohio Revised Code Chapter 2111, Guardianship of Persons and Estates.
- Ohio Revised Code Chapter 2945, Criminal Procedure including competency to stand trial.
- Ohio Revised Code Chapter 5119, Department of Behavioral Health (formerly Mental Health and Addiction Services).
- Ohio Revised Code Chapter 5122, Civil Commitment for Mental Illness.
- Ohio Revised Code Chapter 5160, Department of Medicaid.
- Ohio Revised Code Chapter 5101, Adult Protective Services and aging-related authorities.
- Ohio Revised Code Chapter 5165, Nursing Facilities.
- Am. Sub. H.B. 96 of the Ohio 136th General Assembly, effective October 1, 2025.

Federal Agencies and Surveillance Publications

- U.S. Department of Health and Human Services.
- Centers for Medicare and Medicaid Services, including the National Partnership to Improve Dementia Care.
- Substance Abuse and Mental Health Services Administration.
- Administration for Community Living.
- Health Resources and Services Administration.
- Agency for Healthcare Research and Quality.
- Centers for Disease Control and Prevention, Medication Safety FastStats (2024).
- CDC and National Center on Elder Abuse, Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements (2016).
- HHS Office of Inspector General reports on antipsychotic medication use in nursing homes.
- Government Accountability Office.

Peer-Reviewed Clinical Literature

- Shehab N, Lovegrove MC, Geller AI, et al. US Emergency Department Visits for Outpatient Adverse Drug Events, 2013 to 2014. JAMA, 2016;316(20):2115-2125.
- Budnitz DS, Lovegrove MC, Shehab N, Richards CL. Emergency Hospitalizations for Adverse Drug Events in Older Americans. New England Journal of Medicine, 2011;365:2002-2012.
- Inouye SK, et al. Delirium in Elderly People. The Lancet, 2014;383:911-922.
- SAMHSA, Forensic and Competency-to-Stand-Trial Trends Analysis (2023).
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, 2013, including Conversion Disorder (Functional Neurological Symptom Disorder).
- International Classification of Diseases, 11th Revision (ICD-11), World Health Organization.
- Alzheimer's Association, 2024 Alzheimer's Disease Facts and Figures.
- AARP and National Alliance for Caregiving, Caregiving in the United States 2020.

State and National Authorities

- Office of the Governor of Ohio, Governor's Work Group on Competency Restoration and Diversion (2024).
- Supreme Court of Ohio, Case Management Section, Guardianship Caseload Data (2011 baseline through 2020 reporting).
- Texas Health and Human Services Commission, State Hospital Cost Study (2024) (representative reference for state forensic bed cost).
- Ohio Department of Health, Ohio State Epidemiological Outcomes Workgroup, 2023 overdose-mortality data.
- Ohio-DBH / Ohio-MHAS, 2025 Annual Report, including Mobile Response and Stabilization Services implementation.

Appendix D: Glossary of Terms

- **ADA.** Americans with Disabilities Act, 42 U.S.C. sec. 12101 et seq.
- **APS.** Adult Protective Services.
- **Asymmetry of Pathways.** The structural fact that defendants found incompetent and restorable enter a defined procedural channel, while defendants found incompetent and unrestorable enter procedural suspension that no actor can independently advance or close.
- **CIT.** Crisis Intervention Team. Pre-arrest behavioral-health diversion model originated in Memphis, 1988.
- **CIU-M.** Crisis Intervention Unit: Medical Stabilization.
- **CMS.** Centers for Medicare and Medicaid Services.
- **CSU.** Crisis Stabilization Unit.
- **Dusky standard.** Constitutional standard for competency to stand trial, Dusky v. United States, 362 U.S. 402 (1960).
- **FND.** Functional Neurological Disorder.
- **HCBS.** Home and Community-Based Services.
- **Jackson standard.** Constitutional standard prohibiting indefinite confinement of defendants found incompetent to stand trial, Jackson v. Indiana, 406 U.S. 715 (1972).
- **MFCU.** Medicaid Fraud Control Unit.
- **Ohio-DBH.** Ohio Department of Behavioral Health (formerly Ohio-MHAS).
- **Ohio-MHAS.** Ohio Mental Health and Addiction Services (renamed Ohio-DBH effective October 1, 2025).
- **PACE.** Program of All-Inclusive Care for the Elderly, Balanced Budget Act of 1997.
- **Probate Court Coordination.** Contemporaneous integration of Probate Court guardianship adjudications under R.C. Ch. 2111 into subsequent institutional decision-making involving the adjudicated incapacitated person.
- **Resolution Gap.** The structural absence of an operational pathway for defendants found incompetent and unrestorable, particularly those already adjudicated incompetent by Probate Court under R.C. Ch. 2111.
- **SAMHSA.** Substance Abuse and Mental Health Services Administration.
- **SEIU-M.** Specialized Emergency Intervention Unit: Medical Stabilization.
- **Sell standard.** Constitutional standard for involuntary medication to restore competency, Sell v. United States, 539 U.S. 166 (2003).
- **Olmstead standard.** Integration mandate under Title II of the ADA, Olmstead v. L.C., 527 U.S. 581 (1999).

In Humility

Our Country. Our Constitution. Every reviewer of this briefing will, at some point, be a caregiver, a guardian or the person needing one. This country was founded on a promise that grows only when each generation chooses to honor it. Compassion. Integrity. Dignity. Due process. Protection of those who cannot protect themselves. These are not new values. They are the values our Constitution was built to protect and the values we are asked, in our time, to extend to the Americans this country's promise has not yet reached. The work before us is to stand united in building the protection they deserve, to honor what we all deserve as Americans and to keep faith with our values not by intention alone but by what we are willing to build, uphold and honor.

This Executive Briefing and the companion documents submitted with it are offered humbly to every authority that receives them. The framework is presented in deference to the institutional expertise, statutory authority and operational responsibility the receiving institutions hold. It is a humble request for coordination, not a prescription. Every professional named in this distribution list is trusted to exercise the full authority and judgment their role requires. What is asked is only this: that the coordination infrastructure described here be given the serious and good-faith institutional review it is designed to merit, so that the families who cannot wait and the defendants who have already waited too long do not have to wait any longer.

Proposed Pilot Vehicle

A collaborative state contract structured to operate as both a pilot vehicle and a permanent operational structure. Anchored at the Ohio Department of Behavioral Health (Ohio-DBH / Ohio-MHAS) as operational host, with primary ownership vested in the Office of the Ohio Attorney General in coordination with its Elder Justice Unit and shared ownership across every participating authority, so coordination is efficient and effective rather than concentrated in any single office. Operational partners would include a participating Ohio health system and a participating electronic health record platform, with information exchange conducted through existing Business Associate Agreement structures under HIPAA. The contract operates within existing Federal and State authority. No new statutory authority is requested at this stage.

Closing

This Executive Briefing has presented the institutional argument for a coordinated modernization of crisis-response architecture for medically vulnerable populations. The structural diagnosis is documented. The constitutional foundation is settled. The fiscal case is supported. The implementation pathway is achievable within existing federal and state authority. The Case Study companion document provides the evidentiary record. The Operational Implementation Framework provides the full operational architecture.

The framework humbly requests the institutional reviewers identified in Appendix B to consider its substance, distribute as appropriate, identify points of coordination and inquiry and engage in continued institutional discussion. No specific action is required at the stage of initial review. The framework's authors recognize that careful institutional review takes time and that thoughtful coordination across the multiple systems the framework engages is itself a substantial undertaking.

The four operational principles articulated within the framework, stabilization before escalation, causation before prosecution, coordination before adjudication and stewardship before continuation, are the operational standards under which the framework respectfully requests its proposals be evaluated. They are not partisan principles. They are not novel principles. They are the standards by which a constitutional, fiscally responsible, clinically informed and humane crisis-response architecture has historically been recognized.

FACT SHEET

SEIU-M / CIU-M Proposal
Specialized Emergency Intervention Unit: Medical Stabilization ***- SEIU-M (See-U)***
Crisis Intervention Unit: Medical Stabilization ***- CIU-M (CI U)***

Fact 1:	There is a clear pathway for the person found legally incompetent and restorable.
Fact 2:	There is no clear pathway for the person found legally incompetent and unrestorable.

The first pathway is law. The second is silence. We have clear protections for prevention but what happens when a crisis actually strikes? The SEIU-M / CIU-M framework exists to end that silence.

Behind that silence is a person who cannot speak for themselves: elderly, disabled, medically vulnerable, often already declared legally incompetent. They cannot tell you which medication was withheld. They cannot explain why they were rushed to the ER or arrested for behavior the right medication would have prevented. And now they are trapped inside a system with no clear way out or worse, dead from the negligence and abuse that poisoned their care.

These are the people this framework exists to protect.

At a Glance

What this is. A court integrated multidisciplinary medical stabilization framework. It supplements existing crisis response, judicial, healthcare, public safety, guardianship and protective services systems. It operates within existing federal and state authorities. It seeks no new coercive authority. It does not request a new agency to be created. This framework saves taxpayer money. What it adds is the coordination missing where medical vulnerability meets institutional response.

Who is affected. Elderly, cognitively impaired, medically vulnerable and rehabilitation-dependent individuals and their families and guardians. The framework attends in particular to care-facility patients whose legal incompetence has already been adjudicated by a Probate Court under guardianship and who are then subjected to criminal-legal contact arising from conduct that may be the consequence of institutional elder abuse or prescription medication mismanagement.

Why it matters now. The Resolution Gap is a national structural condition. Ohio is the proposed pilot venue. Cases involving defendants found incompetent and unrestorable enter procedural limbo. Charges remain open. Civil commitment is unavailable because the patient has stabilized. No agency owns the resolution. The constitutional standard in Jackson v. Indiana, 406 U.S. 715 (1972) is defeated in operational fact by the absence of an implementation pathway. Other states are addressing comparable gaps under federal court supervision after litigation: Trueblood v. Washington DSHS, 2015.

The Revolving Door. For vulnerable elderly patients whose medication or care plan is mismanaged at home or in a facility, the system is a revolving door with no clear pathway out. SEIU-M's coordination, anchored by the Probate Court and the guardian on behalf of the ward, supplies the correction and the pathway it now lacks.

Probate Court coordination. A defendant cannot receive fair adjudication when two courts are deciding the same question of capacity in parallel without one knowing what the other has already found. The Probate Court has already ruled. The criminal court proceeds as if it has not. The framework integrates that prior adjudication at intake, not after disposition.

What is requested. Interagency review, pilot feasibility evaluation, legal and constitutional analysis, clinical workflow design and phased implementation planning.

Proposed pilot vehicle. A collaborative state contract structured to operate as both a pilot vehicle and a permanent operational structure. Anchored at the Ohio Department of Behavioral Health (Ohio-DBH / Ohio-MHAS), renamed under Am. Sub. H.B. 96 of the Ohio 136th General Assembly, effective October 1, 2025, as operational host, with primary ownership vested in the Office of the Ohio Attorney General in coordination with its Elder Justice Unit and shared ownership across every participating authority, so coordination is efficient and effective rather than concentrated in any single office. Operational partners would include a participating Ohio health system and a participating electronic health record platform, with information exchange conducted through existing Business Associate Agreement structures under HIPAA. The contract operates within existing federal and state authority. No new statutory authority is requested at this stage.

How to engage. The presenting party humbly requests the opportunity to meet with the appropriate institutional authorities to discuss the framework. Participants, format, scheduling and scope are respectfully left to the discretion of the receiving institutions. Correspondence may be directed through the Ohio Probate Court or through the Distribution Authorities identified in the companion Executive Briefing (Appendix B).

Three Data Anchors

The scale of the gap is documented in published federal and state sources.

- Forensic patients occupy approximately 93 percent of available Ohio state psychiatric hospital beds, displacing civil patients and constraining capacity. Source: Office of the Governor of Ohio, Governor's Work Group on Competency Restoration and Diversion, 2024.
- Ohio's active adult guardianship caseload rose from approximately 42,000 in 2011 to approximately 49,000 in 2020, with 6,000 to 7,000 new applications filed annually. Source: Supreme Court of Ohio, Case Management Section.
- State forensic bed cost is approximately $790 per day. A single multi-year forensic placement of an unrestorable defendant exceeds $280,000 per year before associated clinical, judicial and administrative costs. Source: Texas HHSC State Hospital Cost Study, 2024, used as representative reference.

Funding posture. Coordinated use of existing federal and state authorities is anticipated to cover pilot funding: Medicaid 1115 and 1915(c) waivers, SAMHSA crisis-response grants, Elder Justice Act discretionary appropriations, HRSA workforce programs, PACE under the Balanced Budget Act of 1997, state behavioral-health innovation budgets and DOJ civil-rights coordination authorities.

Companion documents. Fact Sheet (this document). Executive Action Memo. Executive Briefing. Operational Implementation Framework (Proposal). White Paper. Case Study and Systems-Impact Analysis. This Fact Sheet is part of the SEIU-M / CIU-M six-document institutional submission package.

Constitutional anchors. Dusky v. United States (1960). Jackson v. Indiana, 406 U.S. 715 (1972). Barker v. Wingo, 407 U.S. 514 (1972). Olmstead v. L.C. (1999). Sell v. United States (2003). ADA Title II. Section 504 of the Rehabilitation Act of 1973. Elder Justice Act of 2010.

Operational Principles

Stabilization before escalation. Causation before prosecution. Coordination before adjudication. Stewardship before continuation.

Bipartisan foundation. This framework has no partisan valence. Protecting elderly and cognitively impaired Americans from unconstitutional institutional confinement is a constitutional obligation that precedes political affiliation. Fiscal responsibility, accountability and the rule of law are values this framework serves.

In Humility

This Fact Sheet and the companion documents submitted with it are offered humbly to every authority that receives them. The framework is presented in deference to the institutional expertise, statutory authority and operational responsibility the receiving institutions hold and as a humble request for coordination rather than as a prescription. Recipients are humbly thanked for their consideration.

Our Country. Our Constitution

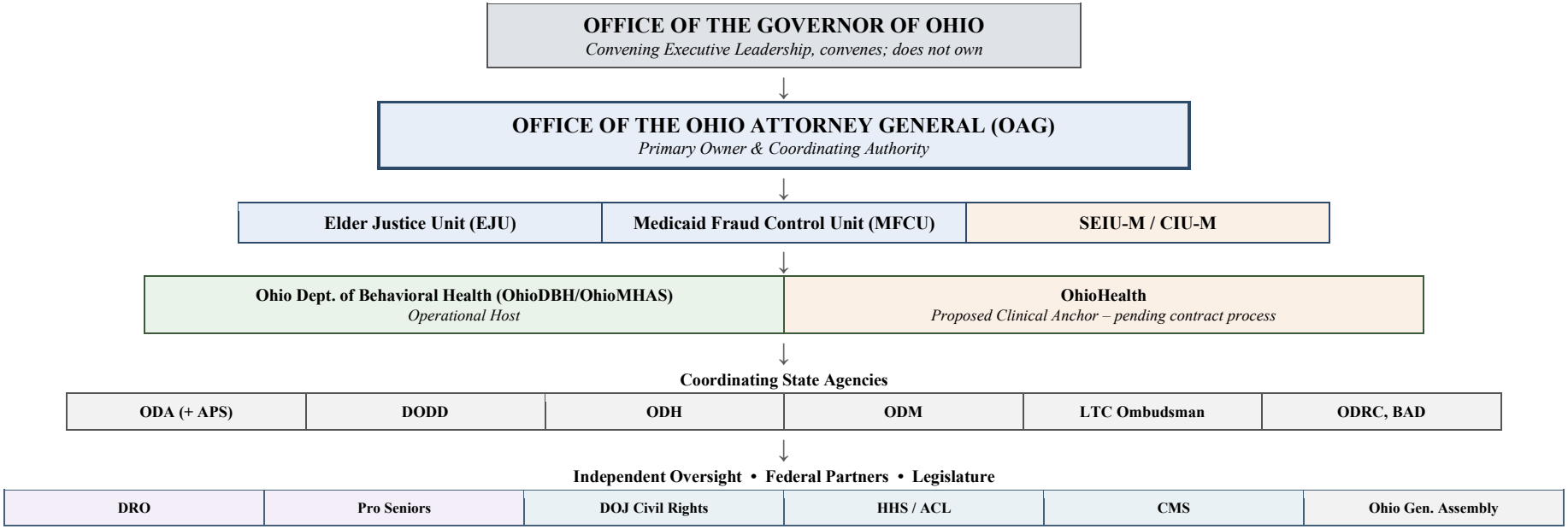
Every reviewer of this document will, at some point, be a caregiver, a guardian or the one who needs them. This country was founded on a promise that grows only when each generation chooses to honor it. Compassion. Integrity. Dignity. Due process. Protection of those who cannot protect themselves. These are not new values. They are the values our Constitution was built to protect and the values we are asked, in our time, to extend to the Americans this country's promise has not yet reached. We all deserve the dignity of growing old in peace, without the worry of being abused, exploited or taken advantage of. The work before us is to stand united in building the protection they deserve, to honor what we all deserve as Americans and to keep faith with our values not by intention alone but by what we are willing to build, uphold and honor.

CONFIDENTIAL INSTITUTIONAL SUBMISSION

Prepared for Institutional Review, Not for Public Distribution Without Authorization

THE SEIU-M / CIU-M OHIO PILOT

Structure at a Glance



Governor convenes • Attorney General owns • OhioDBH hosts • OhioHealth anchors • agencies coordinate • oversight & federal partners hold accountable

KEY

Ownership	Host	Clinical Anchor	Coordinating	Oversight	Federal

Presented by: The Guardian, Nebiat (Nebby) Gebru Gebreziabher, under Ohio Probate Court Jurisdiction
206.753.7910 • nebbyg@outlook.com • Columbus, Ohio

Ownership Breakdown

The pilot operates entirely within existing authority. No new agency is created and no new statutory authority is requested during the pilot phase. Ownership is deliberately tight; coordination is deliberately broad.

Convening Leadership

- **Office of the Governor of Ohio,** Convenes the participating authorities. The Governor does not own or direct the pilot, the Attorney General is a separately elected officer, but only the Governor's office can bring every agency, court and partner to a common table. The Governor signed the legislation (H.B. 96) whose mind-body premise the framework operationalizes.

The Ownership Core (within the Office of the Ohio Attorney General)

- **Office of the Ohio Attorney General (OAG),** Primary owner and coordinating authority. Holds the constitutional-enforcement, elder-justice and fraud-investigation mandates the gap implicates.
- **Elder Justice Unit (EJU),** Within the OAG. Built for the elderly, cognitively impaired and medically vulnerable, the population SEIU-M serves.
- **Medicaid Fraud Control Unit (MFCU),** Within the OAG. Investigates patient abuse, neglect and medication diversion in Medicaid-funded facilities, the conditions this case exposes.
- **SEIU-M / CIU-M,** The coordinated, court-integrated medical-stabilization framework, anchored within the OAG alongside the EJU and MFCU.

Operational Host & Clinical Anchor

- **Ohio Department of Behavioral Health (OhioDBH/OhioMHAS),** Operational host. Provides the forensic-services pathway, the regional behavioral-health hospitals and the clinical workforce. Reconstituted under H.B. 96 around the mind-body connection, the framework's founding premise.
- **OhioHealth,** the proposed clinical partner for the pilot. Provides multidisciplinary medical depth and continuity of care. Clinical participation, including OhioHealth's, is to be selected and approved through a contract process, should all parties be in agreement.
- **Shared ownership,** extends across every participating authority so coordination is efficient and effective rather than concentrated in any single office.

Coordination & Collaboration Breakdown

The framework brings every participating authority to a common table, anchored by the Probate Court and the guardian acting on behalf of the ward. Each body performs the role it already holds, coordinated, in sequence. Coordination, not coercion. Sequence, not new authority.

Coordinating State Agencies

- **Ohio Department of Aging (ODA), incl. Adult Protective Services (APS),** elder-justice review and protective-services investigation.
- **Ohio Department of Developmental Disabilities (DODD),** developmental- and cognitive-disability expertise and the integration mandate.
- **Ohio Department of Health (ODH),** facility survey and certification, brought to bear contemporaneously rather than after the harm.
- **Ohio Department of Medicaid (ODM),** home- and community-based waiver authority and least-restrictive-placement financing.
- **Long-Term Care Ombudsman,** independent advocacy for the resident, summoned in time.
- **Ohio Department of Rehabilitation and Correction (ODRC), Bureau of Adult Detention (BAD),** custodial-phase coordination and jail-standards authority. Because a medically vulnerable adult in crisis may reach a county jail before any pathway intervenes, the custodial system must be at the table so that diversion and stabilization can occur before escalation, rather than after.

Independent Oversight & Advocacy

- **Disability Rights Ohio (DRO),** Ohio's federally designated Protection & Advocacy (P&A) organization; independent investigation and federal reporting. Reports to, not owned by, the pilot.
- **Pro Seniors,** independent elder-law, long-term-care ombudsman and Senior Medicare Patrol advocacy.

Federal Partners

- **U.S. Department of Justice, Civil Rights Division,** ADA Title II and the Olmstead integration mandate.
- **HHS Administration for Community Living (ACL),** Elder Justice Act, the Long-Term Care Ombudsman program and the Protection & Advocacy system.
- **Centers for Medicare & Medicaid Services (CMS),** facility survey and certification; 1115 and 1915(c) waiver authority.

Legislative Pathway

- **Ohio General Assembly,** legislative awareness, funding feasibility and the statutory pathway to regional expansion and statewide scaling.

Proposed Operational Coordination Pathway

At a qualifying crisis event involving a medically vulnerable adult under guardianship, the framework sequences the work each authority already performs, within five operational phases (crisis identification; interdisciplinary activation; integrated medical review; stabilization & placement; reintegration & continuity).

The four principles the sequence embodies: stabilize before you escalate; find the cause before you prosecute; coordinate before you decide; be a faithful steward before you continue.

One Trusted Anchor Per State, National Replication

ONE TRUSTED ANCHOR PER STATE

One anchor medical institution • one behavioral-health host • one elder-justice authority • one pilot

Fifty replicable pilots, national readiness for a population the country has never been able to coordinate.

Our Country. Our Constitution.

Compassion. Dignity. Due process. The protection of those who cannot protect themselves.

One unified stand, to protect the public and the best interest of us all.

Presented by: The Guardian, Nebiat (Nebby) Gebru Gebreziabher, under Ohio Probate Court Jurisdiction
206.753.7910 • nebbyg@outlook.com • Columbus, Ohio

SEIU-M / CIU-M Proposal

Specialized Emergency Intervention Unit: Medical Stabilization ***- SEIU-M (See-U)***
Crisis Intervention Unit: Medical Stabilization ***- CIU-M (CI U)***

SEIU-M Systems Modernization Proposal and Operational Implementation Framework

A Court-Integrated, Medically Informed and Integrated Medical-Behavioral-Legal Crisis Coordination Framework for Medically Vulnerable Populations, Operating Within Existing Federal and State Authority

Pre-Meeting Transmittal and Reference Note

This Proposal is provided as a formal pre-meeting reference document for named recipient agencies, offices and officials. It is designed to be reviewed in advance of any interagency discussion, executive briefing or institutional consultation regarding the SEIU-M / CIU-M Collaborative Crisis Coordination Framework. This Proposal is part of a six-document institutional submission package: Proposal, Executive Briefing, White Paper, Case Study, Executive Action Memo and Fact Sheet.

The framework is presented for institutional review, collaborative evaluation and continued discussion. It is not a directive. It does not require any specific action at the stage of initial review. Recipients are respectfully asked to review the document independently, distribute it internally to relevant staff and identify points of further coordination, inquiry or engagement to bring to any subsequent interagency discussion.

The document opens with an AT A GLANCE summary designed to orient any reviewer within five minutes. The full operational framework, constitutional analysis and Resolution Gap findings follow in sequential sections. Appendices J and K contain the Pathway Comparison Matrix and the full References and Authorities Cited, supporting legal and regulatory review of the framework's institutional foundations.

This document is intended for interagency review purposes. It is not for public distribution without authorization from the presenting party. Questions regarding the framework, requests for supplemental materials or inquiries regarding scheduling of any interagency discussion should be directed through established institutional channels.

Why This Document Is Before You

Across the country every day, a medically vulnerable person enters the public-systems architecture and that architecture does not coordinate. The hospital does not communicate with the long-term care facility. The facility does not communicate with the emergency department. The emergency department does not communicate with the criminal court. The criminal court does not communicate with the Probate Court that has, in many cases, already adjudicated the same person legally incompetent. Each system performs its function. None of them performs the integration the person actually needs.

This Proposal is the operational architecture that closes that gap. It does not ask any of the existing systems to do something they were not built to do. It asks them to do, in coordination and in the correct order, the work each of them is already authorized to do alone.

The populations the framework addresses are the people every reader of this document will become or will care for. The retired teacher with early dementia. The veteran with traumatic brain injury. The grandmother in skilled nursing whose evening medication was missed for the third night in a row. The accountant who had a stroke at 58. The faith leader whose neurological baseline cascaded after a documented medical event. They are not strangers. They are the future of every family represented around the table when this Proposal is read.

The framework proposes coordination, not coercion. Sequence, not new authority. Medical stabilization before behavioral interpretation. Causation investigated before charges are filed. The Probate Court in the room before the trial court is asked to decide. Continuity of care preserved through transitions. Families received as partners rather than treated as obstacles. Least-restrictive options considered. Stabilization, when it succeeds, allowed to lead to resolution rather than to indefinite suspension.

ETHICS

There is also no clear pathway here for the lawyers on either side. For the defense attorney, there is no ethical road map for representing a client who has been found incompetent and unrestorable, a client who cannot meaningfully assist in their own defense and whose case the system offers no way to resolve. For the prosecutor, there is no clear pathway to discharge the duty to protect public safety while also doing justice, when a case can neither fairly proceed nor properly conclude. This is not sustainable, and it is not sound as a matter of judicial, legislative or systemic design. A system that leaves both the defense and the prosecution without a framework serves no one: not the defendant, not the public and not the court.

Behind every operational principle in this Proposal is a person whose protection depends on whether the principle is operationalized. Behind every section is a population that the existing architecture has been leaving in the space between systems. The reform this document proposes is the architecture of a country that protects its most vulnerable as a matter of structural design rather than as a matter of accident, of resources or of who happens to have a family member willing to fight on their behalf.

AT A GLANCE

What this is: A court-integrated multidisciplinary medical-stabilization framework proposing the Specialized Emergency Intervention Unit: Medical Stabilization (SEIU-M) and the Crisis Intervention Unit: Medical Stabilization (CIU-M). The framework supplements, it does not replace existing crisis response, judicial, healthcare, public-safety, guardianship and protective-services systems. It operates within existing federal and state authorities. No new coercive authority is sought during the pilot phase. No new agency is created.

Who is affected: Elderly, cognitively impaired, medically vulnerable, rehabilitation-dependent and behavioral-health populations during periods of crisis instability. Particular attention is given to care facility patients whose legal incompetence has already been adjudicated by Probate Court under guardianship authority and who are subsequently subjected to criminal-legal contact arising from conduct that may itself be the downstream consequence of institutional elder abuse or prescription medication mismanagement.

Why it matters now: Healthcare strain, workforce shortages, accelerating demographic transition, behavioral-health escalation and post-COVID crisis-response fragmentation are converging on the same systems at the same time. A coordination failure at the intersection of criminal jurisdiction, civil commitment, guardianship, behavioral-health administration and Medicaid administration is producing identifiable harm, most acutely in cases where a defendant has been found incompetent and unrestorable and where no statutory or administrative pathway exists to resolve the case. The framework identifies this **Resolution Gap** as a constitutional, public-safety, elder justice and fiscal stewardship priority.

What is requested: Interagency review, pilot feasibility evaluation, legal and constitutional analysis, clinical workflow design, interagency coordination and phased implementation planning consistent with the architectures described in this Proposal. No new statutory authority is requested at this stage. The request is for institutional review and coordinated planning.

How to engage: Designate an interagency review contact within 30 days. Identify legal, clinical and operational leads within 90 days. Convene a multidisciplinary advisory group within 6 months. Pilot launch and outcome evaluation within 12 months. The 30-Day, 90-Day and 12-Month Action Pathway in Section 18 details each phase.

The SEIU-M / CIU-M Document Package

This Operational Implementation Framework is one of six coordinated documents in the institutional submission package.

- **Operational Implementation Framework (this document).** The full operational architecture, workflow design, training and fiscal model.
- **Executive Briefing.** Comprehensive rapid-review leadership document with the full institutional argument.
- **Executive Action Memo.** Single-page action memo for cabinet secretary and White House review.
- **Fact Sheet.** One-page operational summary for initial transmittal and executive scanning.
- **White Paper.** Policy theory, evidence base and modernization argument.
- **Case Study and Systems-Impact Analysis.** Evidentiary chronology and documentary backbone of the package.

Citation anchors of the form [CS sec.N] or [CS App-X] refer to the corresponding section or appendix in the Case Study companion document.

Document Purpose and Institutional Scope

This Proposal is a formally structured operational implementation framework. It is not an advocacy document. It is not a theoretical white paper. It is not a preliminary discussion draft. It is a comprehensive, institutionally grounded blueprint for a coordinated medical, mental and legal crisis-stabilization model designed for executive, interagency, legislative, judicial, clinical and federal review.

The framework addresses a documented structural gap in Ohio's crisis-response architecture: the absence of a unified, real-time coordination infrastructure capable of integrating medical, neurological, behavioral-health, rehabilitation, legal and guardianship information during crisis events involving medically vulnerable populations. That gap produces measurable harm, measurable cost and measurable institutional risk. This Proposal provides the operational structure to close it.

This document is not intended to replace clinical judgment, judicial authority, public-safety decision-making, emergency response, lawful prosecutorial discretion or constitutionally appropriate court procedure. It is designed to strengthen the information, coordination, stabilization and accountability infrastructure available to those systems when medically vulnerable individuals are involved in complex crisis events.

Mission Statement

The purpose of SEIU-M / CIU-M is to strengthen medically informed, interdisciplinary and constitutionally balanced crisis-response systems for vulnerable populations during complex emergency situations, not by replacing existing institutions, but by improving the information, coordination and stabilization infrastructure those institutions depend upon to function at their best.

Scope Statement

This Proposal is the operational implementation framework for a coordinated medical, mental and legal crisis-stabilization model. It is intended to be read as a systems-modernization initiative: a practical, institutionally grounded framework for improving coordination, stabilization accuracy, continuity-of-care infrastructure and crisis-response preparedness across Ohio's existing public systems.

The model does not replace clinical judgment, judicial authority, public-safety decision-making or lawful prosecutorial discretion. It strengthens the information, coordination, stabilization and accountability infrastructure available to those systems. SEIU-M / CIU-M is not anti-law-enforcement, anti-court, anti-hospital or anti-psychiatry. It is a collaborative modernization model: solutions-oriented, operationally mature, multidisciplinary, administratively credible and implementation-focused.

This document is not intended to excuse intentional abuse, violence, exploitation or criminal conduct. It is not intended to prevent clinically necessary psychiatric hospitalization or lawful emergency intervention. It is not intended to reduce public safety. It is intended to improve the clinical accuracy on which genuine public safety depends.

Reading Frame: Accountability, Not Accusation

This document operates under one foundational principle. Accountability, as used here, is structural. It examines the architecture of decision-making, the flow of information, the design of evaluation frameworks, the operational protocols governing transitions and the procedural standards that determine how evidence enters review. Accusation, by contrast, is individual. It identifies specific persons for blame. The two are not the same exercise and this document does not undertake the second.

The analysis that follows identifies structural gaps and proposes structural remedies. It treats the actors within the system as professionals operating within frameworks not of their own design, performing difficult work under significant operational constraint. Where the record reflects outcomes that warrant institutional concern, the document names the framework that produced those outcomes, not the individuals constrained to operate within it.

Terminology Note: Ohio-DBH / Ohio-MHAS

Throughout this Proposal, the Ohio state behavioral-health agency is referenced in paired form as Ohio-DBH / Ohio-MHAS. The full institutional name is the Ohio Department of Behavioral Health (Ohio-DBH), previously known as the Ohio Department of Mental Health and Addiction Services (Ohio-MHAS). The rename was enacted under Am. Sub. H.B. 96 of the Ohio 136th General Assembly, effective October 1, 2025. The paired form is used throughout to support reviewer recognition across both current and legacy institutional references.

Table of Contents

1. Executive Summary
2. System Gap, Problem Analysis and National Context
3. Root Cause Analysis
4. SEIU-M / CIU-M Framework Overview
5. Integrated Crisis Classification and Risk Stratification Model
6. Governance, Interagency Coordination and Oversight Structure
7. Legal Advocacy, Ohio Bar Association Consultation and Pro Bono Infrastructure
8. Elder Abuse Investigation and Protective Review Framework
9. Statewide Operational Workflow and Activation Architecture
10. Training, Certification and Workforce Readiness Architecture
11. Fiscal, Medicaid, CMS and Systems Efficiency Alignment
12. Performance Metrics, KPIs, Quality Review and Audit Systems
13. Implementation Model and Phased Deployment Strategy
    Pilot Recalibration Posture.
14. Ohio-DBH / Ohio-MHAS State Facility Collaboration
15. Liability Risk Management and Collaborative Protection Framework
16. Elder Justice Unit Immediate Coordination Provision
17. Legislative Liability Protection and Public-System Safeguard Framework
18. Requested Next Steps and Action Pathway
19. Final Policy Shift and Final Statement
20. The Resolution Gap: Defendants Found Incompetent and Unrestorable

Appendix A. Multidisciplinary Consultation Checklist
Appendix B. Ohio Bar Association Consultative and Incentive Role Summary
Appendix C. Emergency Stabilization Intake Checklist
Appendix D. Medical and Rehabilitation Review Team Functions
Appendix E. Court-Integrated Review Pathway
Appendix F. Risk Stratification and Placement Logic Reference
Appendix G. Agency Role Alignment
Appendix H. Training and Certification Architecture
Appendix I. Distribution Authority Framework
Appendix J. Pathway Comparison Matrix: Restorable vs Unrestorable
Appendix K. References and Authorities Cited

Closing Statement

1. Executive Summary

The SEIU-M / CIU-M framework proposes a court-integrated, medically informed and rehabilitation-focused crisis-response coordination model for medically vulnerable populations. The model is designed to operate at the intersection of healthcare, behavioral-health, rehabilitation, guardianship, judicial and public-safety systems, strengthening, not replacing, the institutional authorities those systems already hold.

Three Foundational Operational Findings

- **First.** Current crisis-response systems were not originally designed to manage the growing volume of medically vulnerable, cognitively impaired, rehabilitation-dependent and behaviorally complex individuals now requiring coordinated interdisciplinary reassessment.
- **Second.** Fragmentation across criminal-legal, civil-commitment, guardianship, behavioral-health and Medicaid frameworks produces measurable harm to vulnerable patients, families, providers and public systems.
- **Third.** The resulting coordination gap is most acute for defendants found incompetent to stand trial and clinically determined to be unrestorable, particularly those already adjudicated legally incompetent by Probate Court under Ohio Revised Code Chapter 2111, for whom no functional resolution pathway currently exists in statutory or administrative practice.

There is a clear pathway for the legally incompetent person who can be restored.

There is no clear pathway for the legally incompetent person who cannot.

The first pathway is law. The second is silence. We have clear protections for prevention but what happens when a crisis actually strikes? The SEIU-M / CIU-M framework exists to end that silence.

Behind that silence is a person who cannot speak for themselves: elderly, disabled, medically vulnerable, often already declared legally incompetent. They cannot tell you which medication was withheld. They cannot explain why they were rushed to the ER or arrested for behavior the right medication would have prevented. And now they are trapped inside a system with no clear way out or worse, dead from the negligence and abuse that poisoned their care.

These are the people this framework exists to protect.

The framework is built to close that asymmetry.

Proposed Solution

A sequenced operational model that places medical stabilization, medication-management review, structured observation, elder-abuse causation investigation, Probate Court coordination and multidisciplinary review ahead of restrictive escalation. The model is grounded in constitutional standards established in Jackson v. Indiana, Dusky v. United States, Sell v. United States and Olmstead v. L.C., in federal authority including the Americans with Disabilities Act and the Elder Justice Act of 2010 and in state authority over criminal procedure, civil commitment, guardianship, behavioral-health and Medicaid administration.

Core Objectives

- Improve the clinical accuracy and constitutional adequacy of crisis-response decisions affecting medically vulnerable populations.
- Reduce avoidable Emergency Department cycling, jail medical burden, psychiatric inpatient overuse and forensic-bed capacity strain.
- Establish a defined resolution pathway for defendants found incompetent and unrestorable, with particular attention to care-facility patients under guardianship.
- Strengthen elder-justice protections and integrate elder-abuse and medication-mismanagement causation investigation into crisis-response coordination.
- Coordinate with the Probate Court, court-appointed guardians and continuity-of-care providers as formal stabilization partners.
- Support healthcare professionals, behavioral-health providers, emergency-response personnel and interdisciplinary specialists with the coordination infrastructure their work requires.
- Demonstrate measurable patient, system, fiscal and constitutional outcomes through a structured pilot evaluation.

2. System Gap, Problem Analysis and National Context

The National Context

The United States is entering one of the largest demographic transitions in modern history. As the Baby Boomer generation continues aging, the country is simultaneously confronting rapid increases in cognitive decline and dementia-related conditions, growing caregiver strain, accelerating healthcare and long-term care workforce shortages, Emergency Department overcrowding and rising rates of cognitive and behavioral-health instability across communities nationwide. Adults aged 65 and older accounted for an estimated 34.5 percent of emergency-department visits for adverse drug events and the highest rate of subsequent hospitalization, 43.6 percent, in the 2013 to 2014 surveillance period, according to research published in JAMA in 2016 by Shehab and colleagues. Approximately 99,628 emergency hospitalizations for adverse drug events occur annually in this population, per Budnitz and colleagues in the New England Journal of Medicine, 2011.

Court-ordered competency-to-stand-trial referrals have increased dramatically in tracked state systems over recent decades, with documented waitlists rising from weeks to months or years in multiple states, according to SAMHSA's 2023 analysis. That trend has produced federal litigation in some jurisdictions, including Trueblood v. Washington Department of Social and Health Services in 2015, in which a federal court placed a state behavioral-health system under supervision after sustained capacity failures.

The scale matters because it determines whether the architecture this Proposal describes is incidentally useful or structurally necessary. An estimated 53 million U.S. adults provide unpaid care to a family member or friend. Approximately 11 million are caring for someone with Alzheimer's disease or another dementia. The population aged 65 and older will reach 80 million by 2040. One in three adults will, at some point, serve as a family caregiver. One in nine adults over 65 lives with Alzheimer's disease or related dementia. The architecture this Proposal describes is built for these numbers.

Ohio-Specific Data and the Documented Scale of the Gap

Three data anchors document the operational scale of the gap in Ohio.

- Forensic patients now occupy approximately 93 percent of available Ohio state psychiatric hospital beds, displacing civil patients and constraining capacity. Source: Office of the Governor of Ohio, Governor's Work Group on Competency Restoration and Diversion, 2024.
- Ohio's active adult guardianship caseload rose from approximately 42,000 cases (2011) to approximately 49,000 cases (2020), with 6,000 to 7,000 new guardianship applications filed annually. Source: Supreme Court of Ohio, Case Management Section.
- State forensic bed cost is approximately $790 per day. A single multi-year forensic placement of an unrestorable defendant exceeds $280,000 per year before associated costs. Source: Texas HHSC State Hospital Cost Study, 2024, used as representative reference.

Prevention, Preparedness and Crisis-Response Readiness

The COVID-19 era exposed that the nation was not adequately prepared for complex crisis response involving medically vulnerable, elderly, cognitively impaired, rehabilitation-dependent, behavioral-health and long-term-care populations. It exposed weaknesses in emergency coordination, continuity-of-care, facility accountability, family communication, guardianship coordination, workforce resilience and interdisciplinary reassessment. Prevention is necessary but insufficient. What happens when prevention fails, when a crisis actually occurs and when a medically vulnerable person, an overwhelmed family, a facility, an Emergency Department, a court and multiple public systems all collide at once, is the question this Proposal answers.

The Operational Reality of Fragmented Response

Current crisis-response systems often rely on fragmented escalation pathways involving isolated reassessment, delayed interdisciplinary coordination, inconsistent continuity-of-care communication, insufficient family integration and limited medical-collaborative review structures during periods of instability affecting medically vulnerable populations.

Current System Limitations vs Proposed Modernized Response

Current System Limitation	SEIU-M / CIU-M Modernized Response
Fragmented reassessment across disconnected institutional silos.	Integrated interdisciplinary review pathways with unified clinical information.
Behavioral presentation automatically triggers medication escalation.	Medication-safety reassessment and psychotropic-risk review, including non-psychiatric medications, before escalation.
Discharge instability and continuity-of-care breakdown.	Structured continuity-of-care coordination and discharge preparedness protocols.
Repeated crisis cycling without root-cause review.	Rehabilitation-focused stabilization addressing underlying clinical drivers.
Isolated institutional response without cross-system coordination.	Collaborative systems coordination through a unified interagency framework.
No resolution pathway for defendants found incompetent and unrestorable.	SEIU-M Resolution Gap protocol: stabilization, medication review, observation, elder-abuse investigation, guardian coordination, multidisciplinary review and coordinated disposition.
Guardian and family excluded from crisis decisions.	Structured family integration and guardian participation as formal stabilization partners.

Resulting System Failures

1. Crisis Misclassification

Neurological events processed as behavioral incidents. Medication-driven destabilization treated as psychiatric-only presentation. Adverse drug events misclassified as primary behavioral pathology. Every subsequent intervention is then built on a defective clinical premise.

2. Fragmented Decision-Making

Crisis decisions made in isolation by individual responders, agencies and clinicians without an integrated multidisciplinary record. The professional decision is sound on the available information. The information is incomplete.

3. Delayed Clinical Validation

Reassessment of cognitive, neurological and medication status delayed beyond the period when intervention would have been most effective.

4. Facility Accountability Gaps

Institutional medication mismanagement, neglect, supervision failures and elder-abuse conditions not investigated when the patient's resulting conduct enters the criminal-legal system.

5. Emergency System Overreliance

Emergency Departments and emergency responders functioning as the de facto coordinating authority for crises that require coordinated multidisciplinary review beyond the ED's scope.

6. Guardianship and Representation Breakdown

Prior adjudications of legal incompetence by the Probate Court under Ohio Revised Code Chapter 2111 are not formally noticed to criminal courts. Court-appointed guardians are not contemporaneously notified of patient justice-system involvement. The Probate Court's prior work is not integrated into subsequent decision-making by other constitutional decision-makers.

7. Insufficient Neurorehabilitation and Continuity-of-Care Integration

Rehabilitation gains, ongoing treating relationships and established medication regimens are disrupted by crisis-response transitions, with no preservation mechanism in place.

Core Operational Findings

Multidisciplinary review of current crisis-response and forensic-evaluation systems identifies six recurring operational findings affecting medically vulnerable populations.

- Overreliance on isolated or single-discipline forensic evaluation models in medically complex cases.
- Misclassification of neurological, endocrine, medication-related, developmental, cognitive or trauma-related instability as psychiatric-only presentation.
- Fragmented information exchange between courts, hospitals, jails, Emergency Departments, rehabilitation providers, Ohio-DBH / Ohio-MHAS systems, guardianship structures and community-care teams.
- Insufficient integration of neurorehabilitation, outpatient stabilization, functional recovery and longitudinal treatment progress into risk and placement decisions.
- Unequal access to independent medical advocacy, specialist consultation, rehabilitation documentation and multidisciplinary evaluation based on income, insurance status, family capacity or institutional connections.

Disparities in access to fair forensic evaluation are documented and directly relevant to the populations this framework serves. Individuals whose primary language is not English and those whose behavioral expression is shaped by cultural frameworks not assumed in standard forensic instruments, face compounded barriers, including language-access limitations, cultural-competency gaps in clinical evaluation and systemic inequities in access to independent medical advocacy. These disparities arise from structural conditions: the absence of coordinated review, reliance on crisis-contact systems that do not integrate prior longitudinal clinical history and the differential access to private resources that allows some families to navigate the gap while others cannot. The SEIU-M / CIU-M framework addresses these structural conditions directly. By requiring coordinated interdisciplinary review and primary-language interpreter access at intake for all qualifying individuals regardless of financial status, language or cultural background, it applies constitutional protections equitably.

- Default escalation toward incarceration, psychiatric institutionalization or repeated emergency cycling when more clinically precise stabilization pathways may be available.

Interdisciplinary Medical and Behavioral Reassessment Considerations

Crisis evaluation in medically vulnerable populations must consider, in addition to standard psychiatric review: medication reconciliation across psychiatric and non-psychiatric prescriptions; polypharmacy assessment; adverse drug event surveillance; drug-drug interaction screening; anticholinergic burden assessment; GLP-1 receptor agonist effects; insulin and hypoglycemic management; anticoagulant levels; corticosteroid exposure; opioid burden; neuropsychiatrically-active antibiotic exposure; withdrawal phenomena; delirium screening (CAM, CAM-ICU); neurological examination; FND screening; infection workup; electrolyte and metabolic panel; thyroid function; hepatic encephalopathy screening; urinary tract infection screening; hypoxia assessment; and trauma history review. None of these are exotic in the geriatric and rehabilitation literature. They are routine in well-functioning interdisciplinary review.

Medication Safety, Psychotropic Risk and Polypharmacy as a Structural Gap

The framework treats medication safety as a structural rather than incidental concern. Polypharmacy in the elderly population, commonly defined in geriatric literature as concurrent use of five or more medications, is associated with increased risk of adverse drug events, drug-drug interactions, falls, delirium and cognitive impairment. National prevalence of antipsychotic use among long-stay nursing-home residents was reduced from 23.9 percent in 2011 to 14.4 percent by 2021 under the CMS National Partnership to Improve Dementia Care. The reduction demonstrates that structural intervention can meaningfully change institutional medication practice. It also demonstrates that the prior baseline was substantially higher than clinical appropriateness justified. Mismanagement of non-psychiatric medications, GLP-1 receptor agonists, insulin, anticoagulants, diuretics, corticosteroids, anticholinergic agents, opioids, neuropsychiatrically-active antibiotics, produces clinical consequences that are functionally indistinguishable from psychiatric presentation when read without medical context.

3. Root Cause Analysis

The operational failures documented in Section 2 are downstream of a smaller number of root causes. Identifying these correctly is essential to designing interventions that remediate the causes rather than the symptoms.

System Fragmentation

Healthcare, behavioral-health, judicial, custodial, guardianship and protective-services systems operate under separate statutory frameworks, separate information systems and separate workforce pipelines. Coordination across them depends on individual relationships, ad hoc communications and case-specific advocacy. There is no structural mechanism for unified information flow across the systems that engage a single medically vulnerable individual during a crisis event.

Limited Specialized Triage Capacity

Existing triage frameworks are designed for primary psychiatric presentations, primary medical presentations or primary public safety presentations. Cases that combine medical complexity, neurological vulnerability, behavioral presentation and guardianship status fall outside the standard triage pathways. Default escalation is the structural response to triage uncertainty.

Absence of Standardized Multidisciplinary Review

Multidisciplinary review of medically complex crisis cases occurs, when it occurs, on an ad hoc basis. There is no standardized convening mechanism, no defined participant set, no documented review template and no integration of multidisciplinary findings into the decision-making record on which courts, prosecutors and placement authorities rely.

Default Escalation Architecture

In the absence of coordinated multidisciplinary review, the safer institutional choice is escalation. ED admission rather than community stabilization. Psychiatric hospitalization rather than rehabilitation placement. Custodial transfer rather than least-restrictive placement. Restoration treatment rather than unrestorability finding. Each individual escalation is defensible on the available information. The cumulative architecture defaults to restriction.

Information Siloing

HIPAA, 42 C.F.R. Part 2 and state confidentiality frameworks permit information sharing for treatment, payment and healthcare operations under defined conditions. The legal authority exists. The operational infrastructure for routine, structured, real-time information exchange across the systems that engage medically vulnerable populations during crisis events does not.

Forensic Evaluation Limitations in Medically Complex Populations

Forensic evaluation training is, in most jurisdictions, oriented toward primary psychiatric pathology. Coverage of medical complexity, neurological differentiation, FND, polypharmacy and rehabilitation context is variable. Evaluation windows are typically short. Longitudinal treating-provider observation is not consistently integrated. Each of these is a structural limit, not an individual failing.

Absence of Rehabilitation-Centered Stabilization Doctrine

Stabilization, in the existing crisis-response architecture, is generally defined as the resolution of acute behavioral or medical crisis. It is not generally defined to include rehabilitation participation, mobility recovery, functional restoration, neurorehabilitation outcomes or continuity-of-care preservation. The narrower definition produces a stabilization standard that does not capture the full clinical picture.

The Resolution Gap as a Root Cause

The absence of an operational pathway for defendants found incompetent and unrestorable is itself a root cause. It produces downstream forensic-bed occupancy, court calendar load, Medicaid expenditure, family burden and constitutional exposure that early resolution would not produce. The framework identifies the Resolution Gap as a structural priority. Section 20 develops the full analysis.

4. SEIU-M / CIU-M Framework Overview

System Role

SEIU-M / CIU-M is a coordination layer that bridges medical, behavioral-health, rehabilitation, judicial, guardianship and protective-services systems during qualifying crisis events involving medically vulnerable populations. It does not duplicate or replace any of these systems. It performs the integration work that the systems, operating independently, are not structurally positioned to perform.

Core Functions

1. **Crisis identification and intake screening.** Qualifying events are identified at point of intake using defined criteria including age, guardianship status, care-facility origin, medical complexity and presenting circumstances.
2. **Activation of multidisciplinary review.** Activation triggers convening of the multidisciplinary review team within defined time windows.
3. **Medical stabilization coordination.** Medical, neurological, endocrine, rehabilitation and pharmacological stabilization is coordinated before any other downstream decision is made.
4. **Medication-management review.** Full medication reconciliation, psychiatric and non-psychiatric, is conducted as the predicate step in behavioral interpretation.
5. **Elder-abuse and institutional-failure causation investigation.** APS, the Long-Term Care Ombudsman, MFCU and the state survey agency are notified contemporaneously at qualifying intake events involving care-facility patients.
6. **Probate Court guardianship coordination.** The Probate Court and the appointed guardian are contemporaneously notified of subsequent criminal-legal contact involving the adjudicated incapacitated patient.
7. **Continuity-of-care preservation.** Established treating-provider relationships, medication regimens and rehabilitation plans are maintained through periods of crisis transition.
8. **Least-restrictive placement analysis.** Placement decisions consider the full continuum of medically appropriate settings consistent with the Olmstead integration mandate.
9. **Family and guardian integration.** Families and court-appointed guardians are received as formal stabilization partners.
10. **Documentation, audit and outcome measurement.** Coordinated documentation supports outcome measurement, audit and continuous improvement.
11. **Workforce support.** The framework reduces the isolated decision-making burden on professionals operating within fragmented systems.
12. **Federal alignment.** Coordination with federal authorities, HHS, CMS, SAMHSA, DOJ Civil Rights, ACL, CDC, supports state-level implementation and cross-state learning.

What SEIU-M / CIU-M Is

- A coordination architecture across existing institutional authorities.
- A multidisciplinary review pathway for medically complex crisis cases.
- A medical-stabilization, rehabilitation-focused, continuity-preserving operational layer.
- A Probate Court coordination interface for cases involving adjudicated incapacitated patients.
- An elder-justice coordination pathway.
- A constitutional-protections operationalization mechanism.
- A workforce-support and provider-protection framework.
- A fiscal-stewardship and public-systems-efficiency initiative.

What SEIU-M / CIU-M Is Not:

Not a new agency. Not a new statutory authority. Not a directive to any existing institution. Not a replacement for clinical judgment, judicial authority or institutional expertise. A coordination architecture that makes the authority and expertise already present in the system operationally functional at the point of a crisis event.

- Not a new state agency.
- Not a replacement for clinical judgment, judicial authority or public-safety decision-making.
- Not a coercive treatment authority.
- Not a substitute for forensic evaluation.
- Not an immunity mechanism for private facilities.
- Not anti-law-enforcement, anti-court, anti-hospital or anti-psychiatry.
- Not a vehicle for case-specific litigation or individual grievance.
- Not a partisan initiative.

Coordinated Crisis Response Vision:

The framework's coordinated crisis-response vision is a system in which a qualifying crisis event triggers an integrated medical, neurological, behavioral-health, rehabilitation and continuity-of-care review within hours, not weeks. Medication-safety review is the predicate step for behavioral interpretation. Probate Court guardianship status is contemporaneously identified and integrated into every crisis response. Elder-abuse and institutional-failure causation is investigated before criminal-legal escalation, not after disposition. Continuity-of-care provider relationships are preserved through transition. Least-restrictive stabilization is selected from the full care continuum. Families and guardians are formal stabilization partners. Outcome measurement enables continuous improvement, demonstrates value to funders and supports institutional confidence.

Framework Boundaries:

The framework operates within existing federal and state authority. No new statutory authority is requested during the pilot. Existing constitutional protections, statutory frameworks and institutional authorities are preserved without modification. The framework's contribution is the coordination infrastructure that makes existing authorities operationally functional at the point of a crisis event.

A Framework Built to Support the Professionals Inside the Systems:

The framework is designed to support, not to scrutinize, the professionals who currently perform crisis-response work without the coordination infrastructure they need. Emergency physicians making boarding decisions. Prosecutors weighing charges. Public defenders carrying complex caseloads. Corrections officers managing medically complex defendants. Social workers absorbing case complexity beyond their statutory authority. Judges making permanent decisions on incomplete records. Clinicians attempting cross-system coordination without information-exchange infrastructure. Facility staff working inside survey frameworks not always equipped for the medical complexity they encounter. The framework reduces, rather than adds to, the operational burden each of these professionals carries.

5. Integrated Crisis Classification and Risk Stratification Model

Accurate crisis classification is the foundational requirement for appropriate stabilization. When a crisis is misclassified, every subsequent intervention is built on a defective premise. The SEIU-M / CIU-M integrated crisis classification model ensures that crisis events are evaluated within a multidisciplinary framework before escalation pathways become operationally fixed. The model is grounded in constitutional standards established in Jackson v. Indiana, 406 U.S. 715 (1972), Dusky v. United States, 362 U.S. 402 (1960), Sell v. United States, 539 U.S. 166 (2003) and Olmstead v. L.C., 527 U.S. 581 (1999).

Americans with Disabilities Act, Title II (ADA Title II), 42 U.S.C. sec. 12132, prohibits public entities from excluding qualified individuals with disabilities from participation in or the benefits of public services and programs. The Olmstead integration mandate, derived from Title II and affirmed in Olmstead v. L.C., requires states to provide community-based services to persons with mental disabilities when such services are appropriate, when the affected persons do not oppose community placement and when community placement can be reasonably accommodated. Defendants found incompetent and unrestorable who remain in forensic institutional settings when community-supported, guardianship-coordinated placement is available and clinically appropriate are being denied the integration to which Title II and Olmstead entitle them. The SEIU-M / CIU-M framework's transition protocol and least-restrictive placement analysis are designed to operationalize the Olmstead mandate at the point of crisis contact rather than after prolonged institutional placement.

The Jackson holding rests on both due process and equal protection grounds under the Fourteenth Amendment to the United States Constitution. The Court held that a defendant committed solely on incompetency grounds cannot be held beyond the reasonable period of time necessary to determine whether there is a substantial probability that he will attain competency in the foreseeable future. Where no substantial probability of restoration exists the state must civilly commit or release. For defendants already adjudicated incompetent under Probate Court guardianship that substantial probability is a legal and clinical impossibility. The constitutional clock is not running. It has expired. The Court held that Indiana's commitment procedures violated equal protection because defendants committed on incompetency grounds were subjected to more stringent standards and more prolonged confinement than defendants committed through civil commitment pathways, without the procedural protections civil commitment provides. That asymmetry persists. The population this framework addresses, defendants already adjudicated incompetent under Probate Court guardianship and then re-engaged by the criminal-legal system, faces exactly the disparity Jackson identified: more burdensome institutional status, fewer procedural protections and no defined path to resolution. The equal protection argument is not theoretical. It is the constitutional ground on which federal enforcement authority rests.

The Sixth Amendment to the United States Constitution guarantees the right to a speedy trial. In Barker v. Wingo, 407 U.S. 514 (1972), the Supreme Court established a four-factor balancing test for speedy trial violations: length of delay, reason for delay, the defendant's assertion of the right and prejudice to the defendant. A defendant found incompetent and unrestorable who remains in procedural limbo for years, whose charges are neither tried nor dismissed and who has been denied the resolution Jackson v. Indiana requires, satisfies each of these factors. The Resolution Gap is not only a due process and equal protection violation. It is a Sixth Amendment violation. The framework addresses the Sixth Amendment concern directly: by producing a documented clinical and causation record that supports timely resolution, the framework ends the delay rather than extending it.

Primary Classification Pathways

Pathway 1. Medical Crisis

Medical crises include acute illness, medication mismanagement, medication interaction, infection, dehydration, metabolic instability, neurological deterioration, endocrine and diabetic destabilization and Functional Neurological Disorder presentation. Primary systems: hospitals, EMS, medical specialists and Ohio Department of Health-aligned providers.

Pathway 2. Psychiatric and Behavioral Crisis

Psychiatric and behavioral crises include psychosis, severe anxiety, mania, psychiatric destabilization, behavioral escalation, suicidality and acute trauma response. The critical clinical distinction is between primary psychiatric presentation and behavioral manifestation of underlying medical, neurological or medication-related drivers. Primary systems: Ohio-DBH / Ohio-MHAS, regional behavioral-health providers, psychiatric stabilization systems and crisis intervention teams.

Pathway 3. Cognitive and Neurological Crisis

Cognitive and neurological crises include dementia-related behavioral presentations, delirium, cognitive impairment, traumatic neurological decline, traumatic brain injury, FND and communication barriers associated with developmental disability. Primary systems: geriatrics, neurology, memory-care systems, guardianship coordination and rehabilitation medicine.

Pathway 4. Facility-Driven Crisis

Facility-driven crises are those in which the proximate cause is institutional rather than individual: medication errors, neglect, staffing breakdowns, supervision failures, environmental instability, restraint events and communication failures between providers. Primary systems: State Long-Term Care Ombudsman programs, Ohio Department of Aging, Elder Justice coordination, Medicaid Fraud Control Unit and state survey regulatory review.

Pathway 5. Justice-System Pathway

The justice-system pathway applies to crisis events involving competency concerns, emergency custody, public-safety allegations involving cognitively or medically vulnerable individuals, probate escalation, bond review or court-ordered evaluation issues. SEIU-M response includes integrated medical-legal review, court-support findings, least-restrictive stabilization options analysis and public-safety balancing consistent with Dusky, Jackson and Olmstead standards.

Pathway 6. Resolution Gap Pathway

This pathway applies specifically to defendants found incompetent to stand trial and clinically determined to be unrestorable, including individuals already adjudicated legally incompetent by Probate Court under Ohio Revised Code Chapter 2111, for whom no functional statutory or administrative resolution pathway currently exists under Ohio Revised Code Chapter 2945. SEIU-M / CIU-M provides a defined seven-step operational response described in full in Section 20.

Risk Stratification and Placement Logic

Risk Level	Clinical / Operational Profile	Recommended Stabilization Direction
Level I. Monitoring and Coordination	Stable or stabilizing presentation with care-continuity concerns, medication questions or family / guardian coordination needs.	Structured outpatient stabilization, family-support coordination, provider follow-up and medication review.
Level II. Moderate Clinical Complexity	Behavioral or cognitive instability with suspected medical, neurological, trauma-related, medication-related or rehabilitation factors.	SEIU-M multidisciplinary review, ED or crisis observation, specialist consultation and structured step-down planning.
Level III. High Medical Complexity	Significant medical fragility, neurological decline, diabetes / endocrine instability, delirium risk, FND complexity, injury, infection risk or rehabilitation deterioration.	Inpatient medical stabilization, neurorehabilitation, hospital-based review, custodial medical monitoring or specialized medical-stabilization placement.
Level IV. Acute Psychiatric / Public-Safety Risk	Immediate risk requiring secure intervention after medical contributors are reviewed to the extent clinically feasible.	Psychiatric inpatient stabilization or secure placement with continued medical, neurological and rehabilitation review.

Crisis Classification Pathway Response Matrix

Pathway	Primary Clinical Concern	SEIU-M / CIU-M Coordination Response
Medical Destabilization	Medication interruption, endocrine instability, infection, delirium, injury, dehydration or acute medical decline.	Emergency medical review, medication reconciliation, specialist consultation and stabilization planning.
Neurological / Cognitive	FND, dementia, delirium, TBI, cognitive impairment, seizure-like symptoms or neurobehavioral changes.	Neurology consultation, functional baseline review, rehabilitation-potential assessment and communication accommodations.
Psychiatric / Behavioral-Health	Psychosis, mood destabilization, severe trauma response, suicidality or acute psychiatric symptoms.	Psychiatric stabilization, medical rule-out, trauma-informed assessment and least-restrictive treatment planning.
Facility / Guardianship	Care-continuity breakdown, medication-administration concern, discharge failure, guardianship conflict or protective-service concern.	Facility accountability review, guardian notification, care-continuity restoration and protective oversight referral.
Justice-System	Competency concern, custody, public-safety allegation, probate escalation or court-ordered evaluation issue.	Integrated medical-legal review, court-support findings, least-restrictive stabilization options and public-safety balancing.
Resolution Gap	Defendant found incompetent and unrestorable; Probate Court ward under R.C. Ch. 2111; conduct possibly downstream of elder abuse or medication mismanagement.	Seven-step SEIU-M protocol: stabilization, medication review, observation, elder-abuse investigation, guardian coordination, multidisciplinary review and coordinated disposition.

6. Governance, Interagency Coordination and Oversight Structure

The governance architecture of SEIU-M / CIU-M is designed to function as a coordinated support layer rather than a competing authority structure. Its operational purpose is to organize, synthesize and refer complex crisis information so that existing clinical, legal, judicial and administrative authorities can act with a more complete interdisciplinary record.

Ownership and Coordination

Primary ownership rests with the Ohio Attorney General's Office in coordination with its Elder Justice Unit. The Ohio Department of Behavioral Health serves as the operational host. The initiative is a harmonized, collaborative effort of shared ownership across every participating authority: the Ohio Attorney General's Office and its Elder Justice Unit, the Ohio Department of Health, the Ohio Department of Aging, the Ohio Department of Developmental Disabilities, the justice system, the Ohio Department of Behavioral Health, Ohio's healthcare systems and Adult Protective Services, anchored throughout by the Probate Court and by the guardian acting under Probate Court jurisdiction on behalf of the ward. The structure is designed to coordinate efficiently and effectively rather than to concentrate control in any single office. Specific administrative arrangements remain within the discretion of executive review.

Core Governance Architecture

- Centralized interagency coordination authority for pilot oversight, referral standards and quality-assurance review.
- Clinical advisory structure involving emergency medicine, neurology, psychiatry, rehabilitation medicine, geriatric care, trauma-informed care and behavioral-health stakeholders.
- Legal advisory structure involving due process, disability rights, guardianship coordination, Elder Justice, public-safety balancing, court procedure and Resolution Gap protocol oversight.
- Quality assurance and accountability structure for documentation standards, performance metrics, audit review and continuous operational improvement.
- Community and caregiver advisory participation to ensure implementation frameworks reflect real-world barriers experienced by families and care networks.
- Data governance architecture ensuring HIPAA-aware information exchange, limited-purpose interdisciplinary review and constitutional and privacy safeguard compliance.
- **Probate Court coordination interface** ensuring that prior adjudications of legal incompetence under R.C. Ch. 2111 are formally integrated into crisis classification and escalation review processes. This interface is the framework's structural answer to the recurring pattern in which the Probate Court's prior work is not contemporaneously brought into criminal, behavioral-health or custodial decision-making.

A justice system judge cannot make a fair decision about a defendant whose legal incompetence has already been adjudicated by a sitting court without that adjudication being formally integrated into the proceedings. Coordination with the Probate Court is not a courtesy. It is a prerequisite to fair adjudication, for all parties: defendant, prosecutor, trial court, Probate Court, guardian, family, professionals.

Healthcare System Partners

- Ohio Department of Health (ODH).
- Hospitals and affiliated health systems.
- Emergency departments.
- Medical specialists and specialty consulting networks.

Behavioral-Health System Partners

- Ohio Department of Behavioral Health (Ohio-DBH), previously known as Ohio Mental Health and Addiction Services (Ohio-MHAS), under R.C. Ch. 5119.
- Regional behavioral health providers.
- Psychiatric crisis stabilization units.
- State-operated and state-aligned behavioral health facilities.

Legal and Rights Oversight Partners

- Ohio Attorney General's Office, Elder Justice Unit.
- Probate Courts under R.C. Ch. 2111 guardianship jurisdiction.
- Ohio Public Defenders Office.
- Ohio Bar Association (consultative role only).

Aging, Advocacy and Community Systems

- Area Agencies on Aging network.
- Ohio Long-Term Care Ombudsman Program, federal authority under the Older Americans Act.
- Adult Protective Services.
- Ohio Legal Aid Network and Pro Seniors.
- Medicaid Fraud Control Unit, federal authority for patient abuse and neglect investigation in Medicaid-certified facilities.

Medicaid, Funding Oversight and Corrections

- Ohio Department of Medicaid under R.C. Ch. 5160.
- CMS alignment systems.
- Medicaid Managed Care Organizations.
- Ohio Department of Rehabilitation and Correction.
- Ohio Department of Developmental Disabilities.

Agency Role Alignment

Entity	Primary SEIU-M / CIU-M Coordination Role
Ohio-DBH / Ohio-MHAS (R.C. Ch. 5119)	Behavioral-health coordination, psychiatric stabilization interface, community treatment infrastructure, forensic system alignment and state-facility collaboration.
Ohio Department of Aging / Elder Justice	Elder vulnerability review, protective oversight, aging-population preparedness, caregiver support planning and Resolution Gap elder-abuse investigation coordination.
ODM / Medicaid (R.C. Ch. 5160)	Funding pathways, managed-care coordination, discharge continuity, rehabilitation authorization, cost-impact evaluation and Resolution Gap placement funding review.
ODH	Public-health readiness, facility-quality interface, hospital-system coordination and regulatory learning loops.
ODRC / Jail Medical	Custodial medical stabilization, jail diversion interface, intake screening, medication continuity and reintegration coordination.
ODPS / EMS	Emergency-response sequencing, crisis communication, transport coordination and public-safety stabilization triggers.
Probate Courts (R.C. Ch. 2111)	Prior incompetency adjudication coordination, guardianship communication, integrated medical-legal findings, Resolution Gap jurisdiction interface and stabilization status hearings.
DODD	Developmental disability coordination, communication accommodations and continuity-of-care support for affected populations.

7. Legal Advocacy, Ohio Bar Association Consultation and Pro Bono Infrastructure

Ohio Bar Association: Consultative and Incentive Role Only

The Ohio Bar Association is humbly asked to consider participating in a strictly consultative and incentive-oriented role. The OBA does not have and is not asked to assume, any operational, decision-making or oversight authority over the framework. Its participation is limited to legal-education coordination, pro bono coordination, attorney-incentive structure consultation and continuing-education partnership. Boundaries are explicit and preserved in Appendix B.

Legal Aid and Advocacy Integration

The Ohio Legal Aid Network, Pro Seniors and Disability Rights Ohio are partner organizations for legal-services coordination involving the populations the framework addresses. Their involvement is operational and case-supportive, not regulatory. They contribute to continuity-of-representation, court accompaniment, guardianship coordination, fair-housing intersections, disability-rights advocacy and protective-services interface.

Pro Bono Engagement and Incentive Framework

Pro bono engagement is supported through coordinated structures including continuing legal education credit incentives, attorney recognition for elder-justice pro bono work, simplified case-acceptance pathways for SEIU-M / CIU-M coordinated cases and Bar Association continuing education programs that prepare practitioners for the constitutional, statutory and clinical context the framework engages.

8. Elder Abuse Investigation and Protective Review Framework

Elder-abuse investigation, in the institutional context this framework addresses, is not a parallel process to crisis response. It is an integral component of crisis response. The behavioral or cognitive presentation that produced the crisis event may itself be the downstream consequence of the institutional abuse, neglect or medication mismanagement the framework is designed to detect. Investigation cannot be deferred until after disposition without compromising both the patient's interests and the institutional record.

Causation before prosecution. No criminal-legal proceeding against a care-facility patient under guardianship should advance until elder-abuse and medication-mismanagement causation have been investigated by the appropriate civil and administrative authorities, with findings made available to the criminal court.

Review Triggers

Activation of integrated elder-abuse investigation is recommended when any of the following indicators are present at crisis intake.

- Patient is a resident of a long-term care facility, assisted-living facility, skilled nursing facility, rehabilitation facility or other congregate-care setting.
- Patient is under guardianship adjudicated by Probate Court under R.C. Ch. 2111.
- Behavioral or cognitive presentation is acute or substantially changed from prior baseline.
- Medication regimen has been recently changed, escalated, discontinued or otherwise altered.
- Polypharmacy is present, particularly with psychotropic medications, GLP-1 receptor agonists, anticoagulants, anticholinergic agents, opioids or neuropsychiatrically-active antibiotics.
- Facility-initiated criminal complaint, particularly against a patient with documented cognitive impairment.
- Prior survey deficiencies, complaints, ombudsman reports or APS referrals involving the facility.
- Indicators of physical injury, psychological trauma, financial exploitation, sexual abuse, neglect or self-neglect.

Required Multidisciplinary Review Scope

Integrated elder-abuse review includes:

- Medical and physical examination for indicators of abuse or neglect.
- Medication reconciliation across psychiatric and non-psychiatric agents, with attention to recent changes.
- Facility-level review including staffing, supervision, restraint use, medication administration practices and prior survey findings.
- Psychological assessment for trauma indicators and stress-mediated neuropsychiatric phenomena.
- Financial review for indicators of exploitation.

- Communication with the court-appointed guardian, treating providers and family where appropriate.
- Coordination with APS, the State Long-Term Care Ombudsman, the Medicaid Fraud Control Unit and the state survey agency per existing statutory authority.

Prior Care Continuity Review

Review of the patient's prior continuity-of-care record is essential. Established treating relationships, prior medication regimens, prior baseline functioning, prior rehabilitation gains and prior advance care planning are the clinical foundation against which the current crisis presentation must be evaluated. Where this record is incomplete or inaccessible, the operational task is to assemble it from the relevant providers, facilities and family sources, not to proceed on the available institutional narrative alone.

Facility Accountability and System Failure Review

The framework distinguishes between three categories of facility-related contribution to a crisis event. First, good-faith care delivered under structural constraint (workforce shortage, regulatory burden, reimbursement structure) that produced an unintended outcome. Second, systemic neglect rising to regulatory violation but not intentional misconduct. Third, intentional abuse, exploitation or misconduct. Each category requires a different institutional response. Conflating them produces both unjust outcomes for good-faith providers and inadequate accountability for genuine misconduct.

Elder Justice and Rights Protection Coordination

The federal Elder Justice Act of 2010, Title XX of the Social Security Act, establishes federal authority for elder-abuse prevention, investigation and coordination. State Adult Protective Services frameworks, Long-Term Care Ombudsman programs and Medicaid Fraud Control Units operate within this federal architecture. The framework proposes coordinated activation of these existing authorities at qualifying intake events, rather than the creation of new investigative authority.

Resolution Gap and Elder-Abuse Causation

Within the Resolution Gap population, elder-abuse causation investigation is not optional. A defendant who is already adjudicated incompetent under R.C. Ch. 2111, who is a resident of a long-term care facility and whose behavioral conduct at the facility produced the criminal-legal contact, is a defendant for whom the question of whether the conduct was downstream of institutional abuse must be investigated before criminal-legal escalation proceeds. This is the operational predicate captured in the second of the framework's four operational principles.

9. Statewide Operational Workflow and Activation Architecture

Activation Triggers

SEIU-M / CIU-M activation is recommended at any of the following qualifying events.

- Emergency Department arrival of a patient with cognitive impairment, dementia, guardianship status, complex polypharmacy or documented care-facility origin.
- EMS or law-enforcement contact with a patient meeting the same criteria.
- Jail intake of an individual with documented cognitive impairment, dementia, guardianship status or care-facility origin.
- Facility-initiated transfer of a patient to an Emergency Department, behavioral-health unit or law-enforcement custody.
- Court-ordered competency evaluation of an individual with documented guardianship or care-facility residence.
- Guardian-initiated request for SEIU-M / CIU-M coordination.
- Family-initiated request supported by clinical or guardianship documentation.
- Adult Protective Services (administered in Ohio by the Ohio Department of Job and Family Services, ODJFS), Long-Term Care Ombudsman, Medicaid Fraud Control Unit or Elder Justice Unit referral.

Five-Phase Operational Workflow

Phase I. Crisis Identification and Immediate Safety Stabilization

The qualifying event is identified and recorded. Immediate safety stabilization is initiated by the responding institution (ED, EMS, law enforcement, facility) without presuming intentionality, criminality or psychiatric causation before underlying causes are reviewed. SEIU-M / CIU-M activation is initiated in parallel. Initial guardianship and continuity-of-care records are requested. The patient's clinical baseline is documented to the extent available.

Phase II. Interdisciplinary Activation Review

Multidisciplinary review is convened, including medical, neurological, psychiatric, rehabilitation, trauma-informed, social-work, guardianship and continuity-of-care inputs as clinically and legally appropriate. Medication history, functional baseline, discharge history, facility-care context, caregiver information and prior treatment records are requested and organized for integrated review.

Phase III. Integrated Medical, Neurological and Rehabilitation Review

Comprehensive medical workup: medication reconciliation; polypharmacy assessment; drug-drug interaction screening; anticholinergic burden assessment; GLP-1 effects; insulin and hypoglycemic review; anticoagulant levels; corticosteroid review; opioid burden; neuropsychiatrically-active antibiotic review; electrolyte and metabolic panel; infection workup; delirium screening (CAM, CAM-ICU); neurological examination; FND screening; trauma history review. Rehabilitation status, functional capacity, prior baseline and rehabilitation potential are documented.

Phase IV. Stabilization and Placement Analysis

Based on integrated review, risk stratification is completed (Levels I through IV per Section 5). The least-restrictive stabilization environment is selected from the full continuum of medically appropriate settings: hospital inpatient medical unit; ED observation; psychiatric inpatient when clinically necessary;

neurorehabilitation hospital; inpatient rehabilitation facility; skilled nursing facility where appropriate; jail-based medical stabilization or custodial medical monitoring; Ohio-DBH / Ohio-MHAS-linked stabilization; step-down transitional treatment; structured outpatient stabilization; or family-supported community stabilization when safe, supervised and clinically appropriate.

Phase V. Reintegration and Continuity Restoration

Discharge planning is conducted with operational assembly of home-support infrastructure where home discharge is the selected setting (Medicaid HCBS waiver coordination, Medicare home health, PACE eligibility review, OAA caregiver support, FQHC integration, geriatric care management, telehealth monitoring, adult day health services). Continuity-of-care provider relationships are preserved through transition. Guardianship and family integration is formalized. Outcome data is submitted to the measurement framework.

Family Integration, Stabilization and Caregiver Partnership

Families and long-term caregivers possess critical insight involving baseline functioning, medication history, trauma responses, rehabilitation patterns, behavioral changes, continuity-of-care history and stabilization needs that may not be immediately visible during isolated crisis evaluation. The framework recognizes families as potential stabilization partners capable of supporting continuity, rehabilitation progress and long-term recovery when collaborative structures are functioning appropriately.

Family Stabilization, Education and Home-Support Considerations

Discharge to home with family is, on its face, the least-restrictive setting clinically available and is, in many cases, the most therapeutic, dignified and humane option. Home discharge protects the patient only when the home environment can sustain the care the patient requires. For elderly, cognitively impaired and medically vulnerable patients on complex regimens (psychotropic medications, GLP-1 receptor agonists, insulin and oral hypoglycemics, anticoagulants, anticholinergic agents, opioids, corticosteroids), the home environment, on its own, is rarely equipped for safe discharge without support. The framework requires that home discharge be paired with documented assembly of the support infrastructure the patient's clinical complexity requires.

The Cost Families Carry

Behind every gap in the architecture this Proposal describes is a family carrying weight no family was designed to carry. Guardians, caregivers and family members of medically vulnerable individuals are routinely expected to function, under crisis conditions, as legal advocates, medical interpreters, medication-management specialists, hospital navigators, insurance and Medicaid experts, legislative and administrative-law interpreters, interagency diplomats, court coordinators, communication specialists between systems that do not speak to one another, financial guardians under fiduciary duty, records custodians, appointment schedulers, transportation coordinators, crisis responders when professional response fails and emotional anchors for a loved one whose condition is the reason they are fighting in the first place.

Many of the people asked to carry this burden are not equipped, through no fault of their own, to carry it in the form the systems require. Most families do not have legal training. Most do not have clinical training. Most do not have the technical infrastructure, the institutional vocabulary, the time, the financial reserves or the procedural fluency that effective navigation of these systems demands. Even families that do carry one or more of these competencies find themselves exhausted by the scale of what coordination across these systems requires when the systems themselves do not coordinate.

Families Should Not Have to Make These Sacrifices

What families need is not heroism. What families need is institutional infrastructure: coordinated guidance, accessible resources, dedicated navigators, integrated information systems, defined points of contact and the assurance that the systems responsible for protecting medically vulnerable individuals will not require their family members to become lawyers, clinicians, legislative interpreters and diplomats to secure that protection. The framework respectfully submits that asking families to perform this institutional labor, under crisis conditions, in the absence of coordinated support, is itself a form of preventable harm.

What This Framework Asks of Families and What It Owes Them in Return

In six years of navigating the systems this proposal addresses on behalf of her father, the author of this framework was required to become, simultaneously and without preparation, a medical expert capable of interpreting neurological evaluations and medication interaction records, a legal expert fluent in guardianship statutes and probate procedure, an administrative law expert able to identify regulatory violations within long-term care facilities, a legislative expert capable of tracing the statutory gaps that allow defendants to remain indefinitely unresolved within the criminal-legal system, a healthcare compliance expert capable of recognizing medication mismanagement and documenting it in terms that institutions could not dismiss, a diplomatic coordinator capable of engaging simultaneously with courts, healthcare systems, Elder Justice authorities, state agencies, behavioral health administrators and facility administrators, often without the cooperation of any of them and a crisis-response professional capable of making high-stakes decisions in real time without institutional support, without training and without rest.

The Guardian is educated. Has a technical background. Is capable, persistent and informed. And it nearly broke her.
Most families are not her. Most families do not have her professional background, her research capacity, her ability to read a CMS regulation or parse a Probate Court filing or identify the precise statutory gap that is trapping their loved one in a procedural void. Most families do not speak the language of the systems their loved ones are caught inside. They are not lawyers. They are not physicians. They are not legislative analysts. They are daughters and sons and spouses and grandchildren who love someone and cannot get that someone out of a system that was supposed to protect both of them.

We ask these families to navigate institutional complexity that trained professionals struggle to coordinate. We ask them to advocate within legal frameworks they were never taught. We ask them to document, file, escalate, follow up and persist within systems that frequently do not respond, do not coordinate with one another and do not acknowledge the family as a legitimate participant in the process. We ask them to do this without compensation, without recognition, without institutional infrastructure and without an end date.

This is not a sustainable model for a nation entering the largest demographic transition in its modern history.

The COVID-19 era made visible what those inside these systems had known for years: the country was not prepared. Not prepared for coordinated crisis response at scale. Not prepared for the volume of medically vulnerable, cognitively impaired and rehabilitation-dependent individuals who would require simultaneous interdisciplinary stabilization. Not prepared for the families who would be left holding everything when the systems could not hold it themselves.

We are not prepared for the next crisis. The question before every reviewing authority named in this proposal is not whether that wave is coming. It is coming. The question is whether the systems entrusted with public welfare will be ready to receive it.
Families should not need a law degree, a medical license, a regulatory background and six years of sustained advocacy to secure humane and constitutionally sound treatment for a vulnerable loved one. That is not a standard any public system should require of the people it was built to serve. This proposal exists because that standard must change and it must change now, before another generation of families is asked to pay a price that the systems around them were designed to prevent.

Emergency Response and Hospital Coordination

Emergency-response and hospital coordination protocols are recommended to include: dispatch screening for SEIU-M / CIU-M qualifying criteria; ED intake flagging for cognitive impairment, guardianship and care-facility origin; rapid medication-history retrieval through pharmacy networks and prescription monitoring programs; rapid prior-provider notification; rapid guardianship-status verification through Probate Court interfaces; standardized handoff documentation; rapid SEIU-M / CIU-M consultation activation; and discharge coordination that preserves continuity-of-care relationships.

Documentation and Accountability

Every stage of the workflow generates documentation supporting both clinical care and institutional accountability: intake documentation, medication-reconciliation findings, multidisciplinary review notes, elder-abuse investigation triggers, guardianship coordination records, placement decisions, discharge planning, outcome data and audit-ready records. Documentation standards are designed to support, not duplicate, the existing record-keeping requirements of each participating institution.

10. Training, Certification and Workforce Readiness Architecture

Core Training Domains

- Geriatrics and dementia-informed crisis response.
- Psychiatric crisis stabilization and behavioral differentiation from medical and neurological causation.
- Trauma-informed intervention across vulnerable populations.
- Disability rights and developmental disability-informed communication.
- Guardianship systems, probate procedures and R.C. Ch. 2111 coordination.
- Medication safety, reconciliation, polypharmacy assessment and psychotropic-risk review, including non-psychiatric medications.
- Civil rights and constitutional protections, including Jackson v. Indiana, Dusky, Sell and Olmstead standards.
- Documentation standards and accountability review procedures.
- Elder abuse and neglect indicators, investigation triggers and mandatory reporting requirements.
- Facility accountability review and system failure analysis.
- Neurological and endocrine destabilization recognition, including FND, TBI and diabetes-related presentations.
- Resolution Gap recognition, protocol activation and coordinated disposition procedures.
- Public-safety balancing within a constitutionally informed stabilization framework.
- Rehabilitation and step-down planning principles and least-restrictive placement analysis.

Workforce Support, Provider Protection and Operational Sustainability

This Proposal is designed not only to protect vulnerable individuals and families. It is equally designed to support healthcare professionals, behavioral-health providers, rehabilitation personnel, emergency-response teams, legal professionals and interdisciplinary specialists currently operating under extraordinary pressure in crisis environments that lack adequate coordination infrastructure.

When professionals are required to make high-consequence decisions about medically vulnerable individuals without access to complete clinical context, medication history, guardianship information, continuity-of-care records or interdisciplinary consultation, they are exposed to both clinical risk and institutional liability. That exposure is not the result of individual inadequacy. It is the result of structural insufficiency. SEIU-M / CIU-M addresses that insufficiency directly, by building the coordination infrastructure that reduces isolated provider burden, improves interdisciplinary communication, reduces preventable escalation pressure and supports workforce sustainability.

The behavioral health workforce is experiencing a documented crisis of burnout. Vacancy rates in forensic evaluation, inpatient psychiatric care and long-term care clinical staffing are at historic highs. The isolation of decision-making that fragmented crisis-response systems impose compounds this crisis: clinicians making high-stakes decisions without adequate information support interdisciplinary consultation or shared accountability frameworks experience accelerated burnout at rates that further deplete the workforce the system depends on. The SEIU-M / CIU-M coordination architecture directly reduces the conditions that produce burnout. Shared accountability distributed decision-making interdisciplinary consultation pathways and a coordination infrastructure that provides clinicians with the information they need to make sound decisions reduces the isolated burden that drives workforce attrition. A framework that addresses burnout is not only a clinical reform. It is a workforce sustainability strategy.

Training and Certification Architecture

Training Module	Operational Purpose and Scope
Module I. Crisis Recognition and Medical Complexity	Recognition and differentiation of delirium, dementia, diabetes / endocrine destabilization, medication interruption, FND, TBI, cognitive impairment, trauma response and developmental-disability communication needs in crisis settings.
Module II. Legal and Constitutional Interface	Due process requirements, least-restrictive placement doctrine, ADA-informed accommodations, guardianship participation under R.C. Ch. 2111, public-safety balancing, Jackson v. Indiana, Dusky, Sell and Olmstead standards and Resolution Gap protocol coordination.
Module III. ED and EMS Coordination	Dispatch intake sequencing, handoff documentation standards, medication reconciliation including non-psychiatric medications, family / guardian notification protocols and stabilization escalation triggers.
Module IV. Court and Forensic Integration	Parallel forensic and medical-stabilization review standards, integrated report preparation, hearing preparation, evidentiary relevance, record completeness and Resolution Gap seven-step protocol coordination.
Module V. Rehabilitation and Reintegration	Neurorehabilitation pathways, OT / PT / SLP integration, cognitive rehabilitation, discharge readiness assessment, community support coordination and post-crisis follow-up standards.
Module VI. Facility Accountability and Good-Faith Review	Distinguishing neglect, system overload, medication oversight gaps and intentional misconduct; elder-abuse causation investigation triggers; good-faith caregiver and provider protection standards.

11. Fiscal, Medicaid, CMS and Systems Efficiency Alignment

Fiscal Note for Legislative and Budget Review. This is a fiscally responsible proposal. No new statutory authority is requested during the pilot phase. No new state agency is created. Pilot funding is anticipated through existing federal and state authorities identified in this section. The directional fiscal case is as follows. The current fragmented architecture produces documented recurring costs: approximately $790 per forensic bed per day, with unresolved unrestorability cases persisting across multiple years at a documented annual cost exceeding $280,000 per year per case before associated judicial, clinical and administrative costs. Forensic patients currently occupy approximately 93 percent of Ohio's available state psychiatric hospital beds. A pilot that produces even one resolved case at six months rather than three years produces a documented net return measured in hundreds of thousands of dollars for that single case. The aggregate fiscal return from systematic coordinated resolution, applied to the documented scale of the Resolution Gap across Ohio's six regional hospitals, substantially exceeds the infrastructure investment the pilot requires. The cost savings are real and measurable. The fiscal case for this framework does not require optimistic projections. It requires only that the current cost of inaction be measured against the cost of coordination. That comparison is not close. This framework saves taxpayer money. Reducing a single three-year forensic placement to a six-month coordinated resolution produces a documented taxpayer saving of over $560,000 in direct bed costs alone, before associated judicial, clinical and administrative savings. At the scale the Ohio forensic psychiatric system operates, the aggregate taxpayer return from systematic coordinated resolution is substantial. A full directional return-on-investment analysis is developed in Section 38 of the companion White Paper. The medication cost dimension alone reflects the scale of the problem: antipsychotic medications accounted for approximately $7.6 billion in Medicare Part D spending in 2011, the second-highest drug class by expenditure. A framework that reduces inappropriate antipsychotic use through earlier and more accurate causation review produces fiscal returns that extend well beyond the direct cost of forensic bed placement.

For the vulnerable elderly, the current system is a revolving door with no clear pathway out. When prescription medication, medical treatment or the care plan is mismanaged, whether in the patient's own home or in a care facility entrusted with their care, the patient destabilizes, is swept into hospitalization or criminal-legal contact and is then returned to the same uncorrected setting, because no part of the system identified the cause and no pathway exists to resolve the matter. SEIU-M's contribution is coordination: it brings every participating authority to the same table, anchored by the Probate Court and the guardian acting on behalf of the ward. Its medication-safety review and causation-investigation steps correct the cause; its coordination supplies the resolution pathway the system now lacks.

SEIU-M / CIU-M is designed as a cost-avoidance and coordination-efficiency framework rather than a standalone permanent cost center. The fiscal case rests on a straightforward systems-efficiency analysis. Fragmented crisis cycling consumes public resources through repeated Emergency Department visits, psychiatric boarding, jail medical strain, delayed competency restoration, preventable hospitalizations, litigation exposure, discharge failure and long-term institutional dependence. The framework redirects those costs toward earlier stabilization and better information at the front end of crisis response.

National Preparedness and Demographic Fiscal Context

The SEIU-M / CIU-M framework is the missing implementation piece for the national behavioral health crisis strategy. It aligns with the federal behavioral health crisis transformation now underway. The Bipartisan Safer Communities Act of 2022 and the American Rescue Plan Act of 2021 established and funded the 988 Suicide and Crisis Lifeline and directed federal investment toward mobile crisis response, crisis stabilization units and crisis receiving centers. SAMHSA's National Guidelines for Behavioral Health Crisis Care (2020) established the no wrong door principle: any entry point into the crisis system should connect individuals to the appropriate level of care. SEIU-M / CIU-M implements that principle for the specific and underserved population of medically vulnerable individuals whose crisis contact occurs through the criminal-legal system. It extends the federal crisis continuum to a population the 988 architecture does not currently reach.

The fiscal pressure driving this Proposal is not static. The United States is entering a period of extraordinary interdisciplinary complexity involving aging-population growth, increasing dementia prevalence, workforce shortages, escalating continuity-of-care demands and rising crisis-response burden across healthcare, rehabilitation, behavioral-health and justice-system environments. Demand for coordinated interdisciplinary stabilization, rehabilitation-focused intervention, continuity-of-care support and family-centered crisis-response systems will continue increasing significantly over the coming decades. The infrastructure required to support that demand is already operating under strain. Early investment through SEIU-M / CIU-M represents a fiscally responsible commitment to the infrastructure Ohio will unavoidably require.

Empirical Anchoring: The Data Behind the Gap

The populations this framework addresses are not marginal. They are central to the demographic and clinical reality every state now confronts.

Approximately one in ten older adults living independently experiences abuse, neglect or exploitation annually, according to the CDC and the National Center on Elder Abuse. Within institutional settings, detection rates are lower and prevalence is higher.

Adults 65 and older account for 43.6 percent of all emergency hospitalizations from adverse drug events, per research published in JAMA in 2016 by Shehab and colleagues. Approximately 99,628 emergency hospitalizations for adverse drug events occur annually in this population, per Budnitz and colleagues in the New England Journal of Medicine, 2011. Court-ordered competency-to-stand-trial restorations have increased by an dramatic scale in tracked state systems per SAMHSA's 2023 analysis. Adverse drug events drive more than 1.5 million emergency-department visits annually in the United States, with nearly 500,000 resulting in hospitalization, per CDC Medication Safety FastStats, 2024.

Targeted Cost Reduction Areas

- Reduced Emergency Department over-utilization and repeat emergency cycling.
- Reduced avoidable hospitalization and unnecessary institutionalization.
- Reduced duplication of response costs across agencies responding to the same crisis event independently.
- Reduced litigation exposure from improper escalation, rights violations and documentation failures.
- Earlier identification of facility-level failures before they escalate into costly regulatory and legal events.
- Reduced jail medical costs and avoidable custodial deterioration.

- Reduced psychiatric bed overuse when medical or rehabilitation stabilization is more appropriate.
- Reduced competency restoration cycles caused by incomplete medical review during prior crisis escalation.
- Reduced Resolution Gap holding costs, eliminating prolonged placements in high-acuity settings for stabilized unrestorable defendants.
- Improved Medicaid managed-care coordination under R.C. Ch. 5160 and reduced care-fragmentation costs.
- Reduced long-term institutionalization costs when rehabilitation continuity is restored earlier in the crisis cycle.

Medicaid and CMS Strategic Alignment

Care continuity, discharge planning, rehabilitation integration, avoidable hospitalization reduction and crisis-cycling prevention align directly with current CMS quality-improvement priorities and Medicaid managed-care performance frameworks. The CMS National Partnership to Improve Dementia Care, CMS Rules of Participation for Long-Term Care Facilities and CMS staffing-adequacy standards each reflect priorities that this framework puts into operational practice at the crisis-response level. Pilot implementation data demonstrating measurable reduction in emergency utilization, rehospitalization rates and institutionalization costs would support development of sustainable Medicaid reimbursement or waiver structures under R.C. Ch. 5160.

Identified Funding Pathways for Pilot Implementation

Pilot funding is anticipated to fall within the scope of existing federal and state authorities. No new funding category is requested during the pilot phase. The following vehicles are identified for fiscal feasibility review.

- **Medicaid Section 1115 demonstration waivers,** which permit states to test new approaches to financing and delivering Medicaid services, including crisis stabilization and coordinated behavioral-health responses.
- **Medicaid Section 1915(c) Home and Community-Based Services waivers,** which fund services for individuals who would otherwise require institutional care, directly relevant to the unrestorable defendant population this framework addresses.
- **SAMHSA crisis-response grant categories,** including Certified Community Behavioral Health Clinic grants and Mental Health Block Grant funding with crisis-services set-aside requirements.
- **Federal Elder Justice Act discretionary appropriations** for elder-abuse prevention, investigation and coordination infrastructure.
- **HRSA workforce-development authorities** supporting interdisciplinary workforce capacity in geriatrics, behavioral health and rehabilitation.
- **PACE program authority under the Balanced Budget Act of 1997** for elderly populations requiring coordinated care.
- **State behavioral-health innovation budgets** for pilot infrastructure under Ohio-DBH / Ohio-MHAS administration.
- **Philanthropic capital** for pilot research, evaluation and implementation support from aging-focused, justice-focused and rehabilitation-focused foundations.
- **U.S. Department of Justice civil-rights coordination** supporting constitutional review and federal alignment.

Fiscal Risk of Inaction

Continued operation of the current fragmented architecture is not cost-neutral. Each unresolved unrestorability case continues to consume forensic-bed capacity, court calendar capacity, Medicaid expenditure and healthcare workforce capacity year after year. Each preventable institutional escalation produces downstream costs across healthcare, behavioral-health, custodial and judicial systems. Each litigation exposure produces remedial expense that early coordinated reform would have prevented. The fiscal risk of inaction compounds annually. Early coordinated intervention reduces that compounding.

12. Performance Metrics, KPIs, Quality Review and Audit Systems

The framework's outcome measurement architecture is designed to demonstrate value to funders, support institutional confidence, drive continuous operational improvement and produce the evidence base on which longer-term policy decisions can rest. Metrics are organized into five categories: clinical performance, system coordination, financial and utilization, rights and safety and federal alignment.

Clinical Performance Metrics

- Time from crisis identification to medical stabilization.
- Time from crisis identification to completion of medication reconciliation.
- Rate of medication-mismanagement identification at intake.
- Rate of FND identification or differentiation.
- Rate of delirium identification at intake.
- Rate of multidisciplinary review convening within defined time windows.
- Rate of elder-abuse causation investigation initiation at qualifying intake events.
- Resolution rate for unrestorability cases under the seven-step protocol.
- Time from unrestorability finding to coordinated disposition.
- Rate of guardianship-supported community placement following resolution.
- Preservation of continuity-of-care provider relationships through transition.
- Mortality rate within twelve months of intake.
- Readmission and re-cycling rate within twelve months of disposition.
- Patient and family satisfaction with the coordination process.

System Coordination Metrics

- Emergency Department cycling reduction for the pilot population.
- Jail medical burden reduction.
- Psychiatric inpatient bed utilization shift toward acute crisis needs.
- Forensic bed waitlist reduction.
- Restoration treatment efficiency.
- Court calendar throughput for incompetency cases.
- Rate of facility-driven escalation events.
- Deficiency citation patterns for participating care facilities.
- APS, Ombudsman and Medicaid Fraud Control Unit case-load and resolution patterns.
- Provider workforce sustainability indicators.

Financial and Utilization Metrics

- Cost per case under the coordinated pathway compared to historical baseline cost.
- Medicaid expenditure patterns across acute, post-acute, long-term and community settings for the pilot population.
- State behavioral-health expenditure shifts.
- Correctional medical cost shifts.
- Psychiatric inpatient bed-day costs preserved for acute crisis use.
- Total cost per resolved case compared to total cost per unresolved case under the status quo.

Rights, Safety and Accountability Metrics

- Jackson v. Indiana time-bounded review compliance rates.
- Rate of formal Probate Court notification and guardian standing in criminal-legal proceedings involving adjudicated-incompetent patients.
- Sell v. United States compliance rates in forced-medication considerations.
- Olmstead v. L.C. community-integration outcomes.
- Due process protections at the points of arrest, charge, evaluation, hearing and disposition.
- Outcomes disaggregated by funding source, primary language, urban / suburban / rural distribution, care-facility ownership category, age stratum and underlying clinical condition.

CMS and Federal Alignment Metrics

- Alignment with CMS National Partnership to Improve Dementia Care performance indicators.
- Alignment with CMS Rules of Participation for Long-Term Care Facilities.
- Alignment with SAMHSA Crisis Care Coordination standards.
- Alignment with HRSA workforce development priorities.
- Alignment with HHS Office of Inspector General oversight findings on nursing-home psychotropic utilization.

13. Implementation Model and Phased Deployment Strategy

Phase 1. Pilot Development and Interagency Foundation

Designate an interagency review contact within each receiving institution. Identify legal, clinical and operational leads. Conduct initial pilot-feasibility review. Develop activation criteria, operational workflow map, training outline, data-governance approach, fiscal feasibility analysis and advisory group composition. Engage candidate funding authorities. Convene initial multidisciplinary advisory consultation. Anticipated timeframe: 0 to 6 months.

Phase 2. Regional Coordination Expansion

Launch limited pilot in two or three candidate regions. Develop hospital, EMS, court, Probate Court, guardianship, APS, Long-Term Care Ombudsman and Medicaid Fraud Control Unit coordination pathways. Design outcome dashboard. Implement workforce training Modules I through VI. Initial pilot operations begin with data collection. Anticipated timeframe: 6 to 18 months.

Phase 3. Statewide Framework Alignment

Evaluate pilot outcomes against the performance framework. Refine protocols based on operational findings. Prepare legislative, regulatory and administrative recommendations for regional expansion or statewide scaling. Coordinate with state budget processes for sustained funding architecture. Anticipated timeframe: 18 to 30 months.

Phase 4. Federal Alignment and Scalability

Coordinate with HHS, CMS, SAMHSA, the DOJ Civil Rights Division, the Administration for Community Living and CDC on federal alignment, learning, replicability and federal funding architecture. Submit pilot findings to federal review for consideration in national policy guidance. Anticipated timeframe: 24 to 36 months.

Phase 5. National Scalability

Where pilot and statewide outcomes support broader replication, coordinate with the National Association of State Mental Health Program Directors, the National Association of State Medicaid Directors, the National Center for State Courts, the National Center on Elder Abuse and analogous national bodies to support multi-state replication. Anticipated timeframe: 30 to 48 months.

Data Governance and HIPAA-Aware Coordination

All information exchange under SEIU-M / CIU-M is conducted consistent with HIPAA (45 C.F.R. Parts 160 and 164), 42 C.F.R. Part 2 where applicable for substance-use disorder records, FERPA where applicable, state confidentiality laws and the federal Privacy Act. Limited-purpose information exchange between treating institutions, courts, guardians, APS, Ombudsman, MFCU and SEIU-M coordination staff is operationally feasible under existing authority through Business Associate Agreements, Qualified Service Organization Agreements and standard exceptions for treatment, payment, healthcare operations and judicial process.

14. Ohio-DBH / Ohio-MHAS State Facility Collaboration

Ohio-DBH / Ohio-MHAS state behavioral-health facilities, operating under R.C. Ch. 5119, are essential institutional partners in the framework. The framework proposes a collaborative interface that supports, rather than displaces, the statutory authority of state behavioral-health facilities and the clinical authority of their professional staff.

Core Functions

- Coordinated intake screening for patients meeting SEIU-M / CIU-M criteria.
- Integration of medical, neurological and rehabilitation review into state-facility evaluation pathways.
- Medication-safety review across psychiatric and non-psychiatric agents.
- Probate Court guardianship coordination for adjudicated-incompetent patients.
- Elder-abuse causation investigation for patients arriving from long-term care facilities.
- Discharge coordination supporting continuity-of-care preservation.
- Resolution Gap protocol coordination for defendants found incompetent and unrestorable.

Collaborative Function and Core Principle

The collaborative function is built on the core principle that state behavioral-health facilities are partners, not subordinates, in this coordination architecture. Its role is to support the clinical, operational and constitutional information environment in which state-facility professionals exercise their statutory authority. It does not direct, override or replace any element of state-facility clinical or administrative judgment.

15. Liability Risk Management and Collaborative Protection Framework

Liability exposure is a structural concern across every system the framework engages. Healthcare providers, behavioral-health providers, emergency responders, law-enforcement personnel, judicial officers, public defenders, guardians, family caregivers and state agencies all operate within liability environments that influence how decisions are made under crisis conditions. The framework recognizes this reality and addresses it directly.

Collaborative Risk Reduction Architecture

The framework's coordination infrastructure reduces liability exposure by improving the quality of information available at the point of high-stakes decisions. Better information produces better decisions. Better decisions reduce the rate of outcomes that generate liability exposure. Structured documentation supports defensibility of good-faith decisions made within the framework's protocols.

Systems Protected Through Coordinated Review

- Healthcare systems benefit from coordinated medication reconciliation, multidisciplinary consultation and discharge planning, supporting reduced liability exposure for adverse drug events and discharge failures.
- Emergency-response systems benefit from intake screening and consultation infrastructure, supporting reduced liability for misclassified crisis events.
- Behavioral-health systems benefit from medical and neurological review supporting accurate clinical attribution.
- Judicial systems benefit from coordinated medical, neurological and guardianship information supporting constitutionally adequate review under Jackson v. Indiana, Dusky, Sell and Olmstead.
- Public-safety systems benefit from improved clinical context supporting proportional response decisions.
- Guardianship systems benefit from coordinated Probate Court interface supporting timely notification and integration of prior incompetency adjudications.
- Good-faith caregivers and providers benefit from a framework that distinguishes structural constraint from intentional misconduct.

Explicit Exclusion of Private Facility Protection

The framework explicitly does not provide liability protection to private long-term care facilities, assisted-living facilities or rehabilitation facilities for documented institutional elder abuse, neglect, medication mismanagement or facility-driven harm. Liability protection within the framework is oriented toward good-faith professional decision-making under structural constraint. It does not extend to facility-level institutional misconduct, which remains subject to existing civil, regulatory and federal-administrative accountability mechanisms.

Documentation and Accountability Alignment

Documentation standards developed under the framework are designed to support both clinical care and institutional defensibility. Standardized documentation enables consistent record review, supports accountability for both good-faith and bad-faith institutional conduct and provides the evidentiary foundation that distinguishes structural constraint from intentional misconduct.

16. Elder Justice Unit Immediate Coordination Provision

The Ohio Attorney General's Elder Justice Unit holds statutory authority for elder-abuse investigation and prosecution in coordination with state and federal authorities. The framework proposes an immediate-coordination interface activated at qualifying intake events involving justice-system contact and medically vulnerable adults.

Justice-System Triggering Events

- Arrest, charge or prosecution of a patient under guardianship adjudicated by Probate Court under R.C. Ch. 2111.
- Arrest, charge or prosecution of a long-term care facility resident for conduct that occurred at the facility.
- Competency evaluation of an individual with documented cognitive impairment, dementia or progressive neurological disease.
- Custodial deterioration of an elderly defendant during pretrial detention.
- Facility-initiated criminal complaint against a resident with documented cognitive impairment.
- Indicators of elder abuse, neglect or medication mismanagement underlying the conduct at issue.

Collaborative Coordination Structure

Elder Justice Unit coordination is structured as a collaborative interface, not a delegation of authority. The Unit retains its full statutory authority. The framework supports the Unit's work by providing integrated medical, neurological, medication-safety, facility-context and guardianship information at the point at which the Unit's authority is most operationally relevant.

Core Protective Principle

The core protective principle is that an elderly defendant whose conduct may itself be the downstream consequence of institutional elder abuse or medication mismanagement should not proceed through criminal-legal escalation without the Elder Justice Unit, APS, the Long-Term Care Ombudsman and the Medicaid Fraud Control Unit being formally informed of the case. This is the operational predicate captured in the second of the framework's four operational principles.

17. Legislative Liability Protection and Public-System Safeguard Framework

Core Legislative Principle

The following identifies a category of legislative and administrative activity that in subsequent phases may support this coordinated operational architecture. No legislative action is requested during the pilot phase. The proposal operates entirely within existing federal and state authority. The legislative and administrative provisions identified below are forward-looking, identifying the architecture that could be developed if pilot outcomes support broader scaling.

Proposed Legislative and Administrative Authority Areas

- **Good-faith caregiver and provider protection.** Statutory or administrative protection for healthcare professionals, behavioral-health providers and emergency responders acting in good faith within SEIU-M / CIU-M protocols, distinguishing structural constraint from intentional misconduct.
- **Resolution Gap pathway development.** Statutory development of a defined resolution pathway for defendants found incompetent and unrestorable, including coordination with Probate Court guardianship jurisdiction under R.C. Ch. 2111.
- **Probate Court and criminal court coordination authority.** Statutory or administrative authority enabling formal notice to and coordination with the Probate Court that has already adjudicated a patient legally incompetent, when that patient is subsequently subjected to criminal-legal contact.
- **Medication-safety review authority.** Statutory or administrative authority establishing medication-safety review as a predicate step for behavioral interpretation in cases involving medically vulnerable populations.
- **Elder-abuse causation investigation authority.** Statutory or administrative authority requiring activation of APS, Long-Term Care Ombudsman, Medicaid Fraud Control Unit and state survey agency review in qualifying intake events involving care-facility residents.
- **Continuity-of-care preservation authority.** Statutory or administrative authority supporting the preservation of established treating relationships, medication regimens and rehabilitation plans through crisis-response transitions.
- **Data and outcomes infrastructure.** Statutory or administrative authority supporting structured measurement, reporting and audit of crisis-response outcomes for medically vulnerable populations.
- **Funding sustainability.** Statutory or administrative authority supporting long-term funding architecture for sustained operation following pilot evaluation.

Explicit Exclusion of Private Facility Immunity

The framework explicitly does not propose civil, administrative or criminal immunity for private long-term care facilities, assisted-living facilities or rehabilitation facilities for documented institutional elder abuse, neglect, medication mismanagement or facility-driven harm. The framework's legislative architecture is oriented toward good-faith professional decision-making under structural constraint. It does not provide cover for facility-level institutional misconduct.

Resolution Gap Legislative Priority

Among the legislative architecture identified above, the development of a defined Resolution Gap pathway is the most consequential. Other legislative elements may proceed at the pace appropriate to their respective subject matters. The Resolution Gap pathway, however, addresses a structural absence that produces measurable constitutional, clinical, fiscal and human harm in real time. Its development warrants legislative priority.

Elder Justice Protection Clause

Any legislative architecture developed in support of the framework should include explicit elder-justice protection language ensuring that the framework's protections for good-faith professionals do not, by inadvertence or operation, extend to those who perpetrate, conceal or fail to report institutional elder abuse, medication mismanagement or facility-driven harm.

Legislative Intent Statement

The legislative architecture identified in this Proposal is presented as a forward-looking framework consistent with the operational findings of pilot implementation. Its substance, sequencing and statutory form are appropriately the subject of legislative deliberation in coordination with the Ohio General Assembly, the Office of the Governor of Ohio, the Office of the Ohio Attorney General, the Ohio Supreme Court and the federal authorities identified in Appendix I.

18. Requested Next Steps and Action Pathway

The framework respectfully requests the following coordinated next steps. No new statutory authority is requested during the initial pilot implementation period. The request is for institutional review, pilot feasibility evaluation, legal and constitutional analysis, clinical workflow design, interagency coordination and phased implementation planning consistent with the architectures described in this Proposal.

30-Day, 90-Day, 6-Month, 12-Month and Ongoing Action Pathway

Timeframe	Recommended Action
Within 30 Days	Designate interagency review contact within each receiving institution. Identify legal, clinical and operational leads. Conduct initial pilot-feasibility review. Acknowledge receipt and indicate institutional review intentions.
Within 90 Days	Develop activation criteria, operational workflow map, training outline, data-governance approach, fiscal feasibility analysis and advisory group composition. Engage candidate funding authorities. Convene initial multidisciplinary advisory consultation.
Within 6 Months	Launch limited pilot planning in two or three candidate regions. Develop hospital, EMS, court, Probate Court, guardianship, APS, Long-Term Care Ombudsman and Medicaid Fraud Control Unit coordination pathways. Design outcome dashboard.
Within 12 Months	Implement pilot. Evaluate early metrics. Refine protocols. Prepare legislative, regulatory and administrative recommendations for regional expansion or statewide scaling.
Ongoing	Maintain coordination with the authorities identified in Appendix I. Maintain measurement and reporting cadence consistent with the performance framework. Hold to the four operational principles: stabilization before escalation, causation before prosecution, coordination before adjudication, stewardship before continuation.

19. Final Policy Shift and Final Statement

A Systems Modernization Imperative

The framework is, at its core, a systems modernization initiative. It does not propose to reinvent any institution. It proposes to give every institution the integrated information environment its statutory work requires. The frameworks under which Ohio's existing public systems operate are sound. The coordination infrastructure connecting those systems is not yet adequate to the clinical, constitutional and demographic complexity the systems now confront.

The Structural Argument

The structural argument advanced in this Proposal is straightforward. The populations the framework addresses are growing. The clinical complexity is increasing. The fiscal pressure is intensifying. The constitutional concerns are real and documented. The coordination infrastructure required to address all four is achievable within existing federal and state authority. The longer coordinated modernization is deferred, the more expensive, more complex and more politically difficult it becomes.

The Constitutional and Fiscal Imperative

Jackson v. Indiana, 406 U.S. 715 (1972), is settled constitutional law. Its operational implementation in cases of unrestorable defendants is not yet settled in practice. The framework respectfully submits that the constitutional standard the Supreme Court articulated more than five decades ago retains its full force and that the operational infrastructure required to make it functional in every case is now a structural priority. The fiscal architecture supporting that infrastructure is identifiable within existing federal and state authority. The framework respectfully requests coordinated review of both.

United Response, National Resilience and Shared Responsibility

This is not a partisan proposal. It is a public-interest, family-protection, constitutional, healthcare, elder-justice and national-resilience proposal that should humbly request support and leadership from both parties and from every organization committed to protecting vulnerable people during crisis. Every family is only one medical emergency, one cognitive decline, one medication failure, one hospitalization, one guardianship crisis or one facility breakdown away from needing the very systems this Proposal seeks to strengthen.

Long-Term Humanitarian and Institutional Impact

The framework's long-term impact, if implemented at the scale proposed, would be measurable across multiple dimensions. Patient outcomes would improve through earlier and more accurate stabilization. System outcomes would improve through reduced cycling, better resource allocation and stronger interdisciplinary coordination. Fiscal outcomes would improve through reduced avoidable hospitalization, jail medical burden and unrestorability case duration. Constitutional outcomes would improve through more rigorous application of Jackson, Dusky, Sell and Olmstead standards. Workforce outcomes would improve through stronger coordination infrastructure and reduced isolated decision-making burden. Family outcomes would improve through institutional integration as stabilization partners rather than external observers. Each of these outcomes is independently measurable. Together, they constitute the framework's institutional case.

Historical and National Responsibility

The framework is presented at a moment of accumulated institutional learning. Decades of federal investment in elder justice, behavioral-health crisis response, Medicaid system development, judicial procedure reform, civil-rights enforcement and disability rights have produced an institutional architecture that, in theory, contains every element required to protect medically vulnerable populations during periods of crisis. The institutional architecture exists. The integration of that architecture, in real time, at the point of a crisis event affecting a specific medically vulnerable person, does not yet exist at the scale required. The framework's contribution is the proposed integration mechanism.

What This Framework Means for Families

For families navigating the crisis-response architecture this framework addresses, implementation would mean: a defined coordinating authority instead of fragmented agencies; integrated multidisciplinary review instead of isolated assessments; formal participation as stabilization partners instead of exclusion as external observers; preservation of continuity-of-care relationships through transitions instead of disruption; structured navigators instead of self-directed institutional learning; and the operational assurance that the protection of vulnerable individuals will not require family members to function as lawyers, clinicians, legislative interpreters and diplomats to secure it.

Vision of Success

Success, as the framework defines it, is a coordinated crisis-response environment in which medically vulnerable individuals receive integrated multidisciplinary review within hours of a qualifying event. Medication-safety review precedes behavioral interpretation. Probate Court guardianship status is contemporaneously integrated into every crisis response. Elder-abuse and institutional-failure causation is investigated before criminal-legal escalation. Continuity-of-care provider relationships are preserved through transition. Least-restrictive stabilization is selected from the full care continuum. Families and guardians participate as formal stabilization partners. Outcome measurement supports continuous improvement. The constitutional standards articulated in Jackson v. Indiana are operationally functional in every case.

20. The Resolution Gap: Defendants Found Incompetent and Unrestorable

The analytical center of the Proposal. The operational architecture this Proposal proposes is built around the structural condition this section names. Every operational element in Sections 1 through 19 supports the response described here.

A Clear Pathway for Restorable Defendants, No Pathway for Unrestorable Defendants

Here is the structural injustice at the center of this Proposal, stated plainly.

There is a clear pathway for the person found legally incompetent and restorable.

There is no clear pathway for the person found legally incompetent and unrestorable.

Once a court finds that a defendant lacks the present capacity to understand the proceedings or assist in their own defense under the Dusky v. United States standard, the legal process formally branches. The defendant found incompetent and restorable enters a well-developed procedural channel. Restoration treatment is initiated under time-limited standards. Periodic competency reviews are conducted. If restoration succeeds, the case resumes. If restoration fails within the constitutionally permitted period, proceedings transition toward civil-commitment evaluation or charge resolution. The pathway is imperfect, but it exists. Every actor inside the system understands its sequence.

The defendant found incompetent and unrestorable enters a pathway that has no comparable architecture. The clinical finding that restoration is not possible, typically grounded in dementia, traumatic brain injury, advanced cognitive decline, progressive neurological disease, severe developmental disability or stable post-acute medical conditions, is one of the most clinically definitive determinations a competency evaluator can render. Yet the procedural consequence of that determination is, in many jurisdictions, indeterminate. There is no equivalent statutory timeline. No clearly assigned coordinating authority. No defined transition mechanism. No consistent endpoint.

This is the asymmetry. It is the structural fact the entire Proposal is built around. The architectural choice to develop a careful pathway for the restorable while leaving the unrestorable in indefinite procedural suspension is not a neutral choice. It is the choice to make a population disappear inside a process that no one can advance and no one is responsible for closing.

The Already-Adjudicated Incompetent Patient

The most overlooked population inside the Resolution Gap is not the criminally accused individual whose competency is being evaluated for the first time. It is the person whose legal incompetence has already been adjudicated, often years earlier, by Probate Court under R.C. Ch. 2111.

These wards have already been determined by a court of competent jurisdiction to lack the capacity to manage their own medical care, their medications, their residential placement, their financial affairs, their legal decisions, their daily routines, their communication with institutions and their participation in administrative or judicial proceedings. A sitting court has done this work. The Probate Court's adjudication is on the record.

The criminal-legal system that engages with such a patient is not engaging with a free legal actor of intact capacity. It is engaging with an adjudicated incapacitated person whose authority over his own medical care, residence and participation in proceedings has been vested in a court-appointed guardian.

A justice-system judge cannot make a fair decision about a defendant whose legal incompetence has already been adjudicated by a sitting court without that adjudication being formally integrated into the proceedings. Coordination with the Probate Court is not a courtesy. It is a prerequisite to fair adjudication, for all parties: defendant, prosecutor, trial court, Probate Court, guardian, family, professionals.

The framework asks for that coordination to happen by structural design, not by family advocacy. The sequence the framework proposes is straightforward. Discovery before charges. Causation before indictment. Coordination with the Probate Court before the trial court is asked to decide. None of that requires new authority. All of it requires that existing authority be exercised in the right order.

Behavioral and Medical Origins

Conduct that produces criminal-legal contact for medically vulnerable elderly defendants under guardianship is, in a meaningful number of cases, the downstream consequence of medical, neurological, medication-related or trauma-related factors rather than the expression of volitional misconduct. The framework does not assume causation in any individual case. It requires that causation be investigated before charges advance.

Recognizable clinical drivers include:

- Medication mismanagement, including missed psychiatric doses, missed non-psychiatric doses (GLP-1 agonists, insulin, anticoagulants, anticholinergic agents, opioids), inappropriate substitutions and unaddressed adverse drug events.

A distinct and underinvestigated category of medication mismanagement in the institutional context is diversion: the theft or substitution of a resident's prescribed medication by facility staff or others with access to the medication supply. Long-term care facilities face structural vulnerabilities to diversion that hospitals do not. Many use paper-based medication records rather than electronic systems with access audit trails. Medications are often pre-dispensed to residents' medication carts, with no real-time electronic record of who handled them. Residents with cognitive impairment and adjudicated legal incompetence are the population least able to detect, describe or report what occurred. They cannot say that their medication was not given. They cannot identify the person who withheld it. They cannot describe what was substituted. For a diverter, a cognitively impaired resident on a high-value medication is the lowest-risk target in the facility.

The commercial emergence of GLP-1 receptor agonists, including semaglutide marketed as Ozempic and Wegovy, has created a specific and previously nonexistent financial incentive for medication diversion in facilities serving elderly diabetic patients. At list prices of approximately $1,000 per month before insurance, semaglutide is among the highest-value prescription medications a long-term care facility resident is likely to carry. Unlike opioids and other controlled substances, semaglutide is not a scheduled drug under the Controlled Substances Act. It is not tracked by the DEA's drug diversion monitoring infrastructure. It does not appear in DEA diversion statistics. A facility employee who diverts a resident's semaglutide is stealing a medication worth $1,000 per month per patient from a patient who cannot report it, in a setting with no electronic access trail, for a medication that no federal diversion-monitoring system is designed to find. That is not a theoretical risk. It is a structural gap.

- Delirium produced by infection, metabolic instability, dehydration or polypharmacy.
- Neurological events including stroke, TIA, seizure activity and post-stroke cognitive change.
- Functional Neurological Disorder presentations responding to environmental and trauma-related stressors.
- Hyperglycemic or hypoglycemic encephalopathy.

- Hypertensive crisis with associated cognitive change.
- Trauma reactivation produced by institutional environment, displacement or perceived loss of safety.
- Dementia-related behavioral expression including agitation, paranoia, sundowning and confusion.

Conduct presenting in any of these contexts is not, on its face, indistinguishable from volitional misconduct. It is distinguishable. The framework's coordination architecture is designed to make the distinction operationally available to the prosecutor, defense counsel and trial court at the point of the charging decision.

Facility-Initiated Reasons

The framework also identifies a recognizable category of cases in which the proximate cause of criminal-legal contact is facility-level rather than patient-level: medication administration failures, staffing breakdowns, supervision failures, environmental displacement, retaliatory documentation, premature restraint, premature police involvement, premature criminal complaint and institutional pattern-and-practice failures documented in prior survey or complaint records.

Where a care-facility patient under guardianship is the subject of a facility-initiated criminal complaint, the framework requires that the facility's contribution to the precipitating event be reviewed contemporaneously, not deferred until after disposition. This review does not presume facility misconduct. It ensures that any facility contribution is on the record before the criminal-legal proceeding advances.

The Clinical Chain: Elder Abuse, Medication Mismanagement and FND

In a recognizable subset of cases, the clinical chain runs in this order. Medication mismanagement, neglect or environmental stressor at the facility produces medical destabilization in the patient. Destabilization expresses as behavioral or neurological symptom. Symptom is interpreted by facility staff as primary behavioral pathology. Behavioral interpretation produces escalation, restraint, ED transfer or police involvement. Criminal-legal contact follows. By the time the patient enters the criminal-legal system, the institutional context that produced the destabilization is no longer in the foreground of decision-making.

In the specific case of a diabetic patient on a GLP-1 agonist such as semaglutide, the chain may run differently but with the same consequence. A resident whose prescribed semaglutide was diverted, withheld or substituted will present with uncontrolled blood glucose. In an elderly patient with dementia or cognitive impairment, uncontrolled blood glucose produces behavioral manifestations clinically indistinguishable from agitation, confusion, aggression or paranoia. The behavioral presentation becomes the incident report. The incident report becomes the police call. The police call becomes the arrest. The arrest becomes the criminal charge. At every stage, every actor in the system is responding rationally to the information they have. No actor in the existing system is designed to look upstream at the medication record, at the dispensing log, at the access trail that does not exist, at the market value of what the patient was prescribed. The SEIU-M causation investigation step exists for exactly this reason.

The framework's coordination architecture inverts the sequence. Institutional context is brought into the foreground at the point of intake. Medication safety is reviewed before behavioral interpretation. Causation is investigated before charges. Probate Court is informed before the trial court is asked to decide. The clinical chain is named and examined rather than absorbed into a criminal narrative built on the institutional account alone.

Functional Neurological Disorder

Functional Neurological Disorder is a recognized neurological condition with established diagnostic criteria, evidence-based treatment pathways and substantial rehabilitation potential. It can present with motor, sensory, cognitive or seizure-like symptoms. What defines it clinically is that symptoms fluctuate based on identifiable variables, including stress, fear, trauma exposure, environmental instability and medical destabilization. Inside correctional, forensic and emergency behavioral-health systems, the diagnostic frameworks in use are often older. Symptoms that fluctuate under stress can be misread as inconsistent, malingered or performative. This is not a criticism of individual evaluators. It is a structural observation about what the operational framework currently does and does not consistently include. The framework's coordination architecture brings modern FND diagnostic context into the multidisciplinary review on which placement and charging decisions are made.

Jackson v. Indiana and the Implementation Gap

Jackson v. Indiana, 406 U.S. 715 (1972), is settled constitutional law. A defendant committed solely on the basis of incompetency to stand trial cannot be held indefinitely. Continued confinement must bear a reasonable relationship to the purpose of restoration. If restoration is not possible within a reasonable period, the State must either initiate the customary civil-commitment proceedings or release the individual. The doctrine has been on the books for more than fifty years. Its operational implementation in cases of unrestorable defendants, particularly those already adjudicated incompetent under R.C. Ch. 2111, is not yet settled in practice. The framework's coordination architecture is designed to make Jackson operationally functional in every case.

The Civil Commitment Mismatch

The default exit from a Jackson timeline is civil commitment. For many unrestorable defendants, civil commitment criteria are not met. The patient may not be acutely dangerous to self or others. The patient may not have a primary psychiatric diagnosis warranting psychiatric commitment. The patient may, on a corrected medication regimen and in a coordinated care environment, be stable. Stable patients do not generally meet civil-commitment criteria. The mismatch produces an operational impasse. The criminal court cannot proceed because the defendant is not restorable. The civil-commitment system cannot absorb the case because the defendant is not committable. The patient remains in institutional placement without a defined transition pathway. The framework's coordination architecture is the response to that operational impasse.

The Administrative Blackhole: No Agency Owns the Resolution

The structural reason this gap persists is that no single agency owns the resolution. Courts await competency evaluations. Evaluators await placement availability. Placement authorities await court orders. Prosecutors await guidance. Defense counsel await the orders prosecutors are awaiting. Hospitals and behavioral-health systems await discharge authorization that cannot be issued because charges are open. Probate Courts and guardianship systems await coordination with criminal courts that lack defined coordination protocols. Each actor performs their role correctly. Each actor lacks authority to advance the case beyond their role. No actor possesses the authority to close the gap unilaterally.

The Human Experience: Stuck, Helpless, Hopeless, Abandoned, Confused, Misunderstood

Behind every procedural description of this gap is a human experience. The defendant is stuck inside a system that cannot proceed. Capable neither of advancing nor of withdrawing from the process. Confronted with the recognition that no path forward exists. Abandoned inside a process no actor can independently resolve. Required to navigate procedural complexity that cognitive impairment precludes. Interpreted through legal categories that do not align with clinical reality. Forgotten by systems whose calendars no longer prioritize the case. Deprived of the dignity of resolution.

For families, the experience parallels and compounds the experience of the defendant. The labor required to keep a loved one's case from disappearing into the gap is unsustainable for most families. Most families do not have the time, the education, the technical infrastructure or the financial reserves it requires. The framework is, in significant part, designed for the families who cannot do what some families have managed to do.

Compounding Harms to Elderly and Medically Vulnerable Defendants

For medically vulnerable elderly patients, the Resolution Gap produces compounding harms that exceed those produced for younger, less medically complex populations: accelerating cognitive decline associated with prolonged institutional placement, sustained disruption of treating-provider relationships, sustained disruption of established medication regimens, sustained risk of medication mismanagement within institutional contexts, sustained loss of rehabilitation gains, sustained loss of cultural, linguistic, faith and community continuity, sustained family separation, sustained trauma exposure and increased mortality risk associated with elder institutional placement under conditions of disrupted continuity. In a meaningful number of cases, elderly defendants do not survive the resolution process. People are dying inside this gap before resolution reaches them. That fact deserves to be stated.

Seven-Step Protocol: Safeguards Before Criminal-Legal Escalation

When a care-facility patient under guardianship is the subject of an incident that would otherwise trigger criminal-legal escalation, the SEIU-M / CIU-M protocol initiates the following seven-step sequence.

Step 1. Medical Stabilization

Language access and interpreter services are an operational requirement of the SEIU-M / CIU-M intake protocol and are not discretionary. A medically vulnerable individual whose primary language is not English cannot receive a constitutionally adequate forensic evaluation, a clinically accurate medication history review or meaningful participation in any competency proceeding without interpreter services conducted in their primary language. This requirement extends to the full range of languages represented in Ohio’s medically vulnerable and elderly populations including Tigrinya and Amharic spoken by Ethiopian and Eritrean community members who constitute a documented and growing portion of Ohio’s elderly immigrant population. Cultural competency in clinical evaluation requires more than translation. It requires evaluators who understand the cultural frameworks within which behavior is expressed and symptoms are described. The framework designates interpreter services coordination and cultural competency assessment as mandatory Step 1 components of the medical stabilization and evaluation protocol for all individuals whose primary language is not English.

The patient is medically and neurologically evaluated. Vital signs, glycemic status, blood pressure, infection screening, hydration status, electrolyte panel, medication levels, neurological examination and trauma screening are completed. Restraint, custodial transfer and criminal-legal proceedings are deferred until medical stabilization is established.

Step 2. Medication-Management Review

A full medication reconciliation is completed, covering both psychiatric and non-psychiatric prescriptions, with attention to recent changes, dose adjustments, discontinuations, additions, drug-drug interactions, cumulative anticholinergic burden, GLP-1 receptor agonist effects, insulin and hypoglycemic management, anticoagulant levels, steroid exposure, opioid burden and antibiotic neuropsychiatric exposure.

Step 3. Structured Observation Upon Return to a Corrected Regimen

When medication mismanagement is identified, the patient is restored to a clinically appropriate regimen and observed for a defined period to determine whether the behavioral or cognitive presentation resolves with regimen correction. This observation period is essential. It permits the establishment of a clinical baseline that distinguishes between conduct that was medication-driven and conduct that reflects an underlying condition independent of the medication failure.

Step 4. Elder Abuse Causation Investigation

Adult Protective Services, the State Long-Term Care Ombudsman, the Medicaid Fraud Control Unit and the relevant state survey agency are notified per existing statutory authority. The institutional context, staffing, supervision, medication administration practices, restraint use, prior complaints, prior survey findings, is reviewed.

Step 5. Coordination with Probate Court Guardian

The court-appointed guardian is contemporaneously notified at the earliest stage, is afforded standing to participate and is provided with the medical, medication-management and abuse-investigation findings. The Probate Court's prior adjudication of legal incompetence is formally noticed.

Step 6. Multidisciplinary Review and Recommendation

The SEIU-M / CIU-M multidisciplinary team, medical, neurological, psychiatric, rehabilitation, trauma-informed, guardianship and continuity-of-care expertise, reviews the assembled record and provides recommendations to the prosecutor, defense counsel, trial court, Probate Court and treating systems.

Step 7. Deferred or Declined Escalation When Indicated

When the findings establish that the conduct was the downstream consequence of institutional failure, when stabilization has resolved the underlying presentation and when guardianship-supported placement is available, criminal-legal escalation is deferred, declined, diverted or dismissed in coordination with the trial court, the prosecutor and the Probate Court. The prosecutor receives a documented multidisciplinary record supporting nolle prosequi or dismissal without prejudice, preserving prosecutorial discretion to re-engage if circumstances change while ending inappropriate confinement. The framework does not direct prosecutorial outcomes. It produces the documented record on which sound prosecutorial judgment depends.

Four Operational Principles

The seven-step protocol is grounded in four operational principles that distinguish it from the current criminal-legal default.

- **Stabilization before escalation.** No criminal-legal proceeding against a care-facility patient under guardianship should advance until the patient is medically stabilized, on a corrected medication regimen and observed for a clinically defined period sufficient to establish whether the presenting conduct resolves with regimen correction.
- **Causation before prosecution.** No criminal-legal proceeding against a care-facility patient under guardianship should advance until elder-abuse and medication-mismanagement causation have been investigated by the appropriate civil and administrative authorities, with findings made available to the criminal court.
- **Coordination before adjudication.** No criminal-legal proceeding against a patient already adjudicated incompetent by the Probate Court should advance without formal notice to and coordination with the Probate Court, the appointed guardian and the treating continuity-of-care providers.
- **Stewardship before continuation.** No criminal-legal proceeding consuming finite public-safety, judicial, healthcare and Medicaid resources should continue against a patient whose conduct has resolved with stabilization, whose underlying causation reflects institutional failure rather than volitional misconduct and whose appropriate long-term framework is guardianship-supported care under Probate Court oversight.

The Statutory Intersection Where No Title Owns the Resolution

The framework respectfully identifies the statutory intersection at which the Resolution Gap persists. Ohio Revised Code Chapter 2945 governs criminal procedure, including competency to stand trial. Ohio Revised Code Chapter 5122 governs civil commitment for mental illness. Ohio Revised Code Chapter 2111 governs guardianship of persons and estates. Ohio Revised Code Chapter 5119 governs the Department of Behavioral Health. Ohio Revised Code Chapter 5160 governs the Department of Medicaid. Each chapter establishes statutory authority within its domain. No chapter establishes coordinated authority across the others for cases that simultaneously implicate all of them. The Resolution Gap is the consequence of statutory architectures that operate adjacent to but not integrated with one another.

Proposed Resolution Pathway Architecture

The framework proposes the development of a defined resolution pathway for defendants found incompetent and unrestorable. Core elements include:

- **A designated coordinating authority.** An interdisciplinary review structure with assigned responsibility for advancing unrestorability cases from finding to resolution.
- **A defined timeline.** A statutorily or administratively bounded period within which unrestorability findings must trigger a formal disposition pathway.
- **A structured transition protocol.** A defined sequence for moving stabilized defendants from criminal-legal custody to guardianship-supported, continuity-of-care-aligned placement.
- **A medication-safety and continuity-of-care preservation mechanism.** Protocols ensuring that long-term treating providers, established medication regimens and rehabilitation plans are preserved through transition.
- **A constitutional review safeguard.** An independent reassessment mechanism ensuring continued procedural status remains justified by current necessity.

- **A standardized dismissal-with-protection protocol.** A procedural framework permitting case closure where unrestorability is established and conditions for safe community-supported placement are met.
- **A coordination interface with Probate Court and guardianship systems.** A defined mechanism by which criminal courts can transfer or coordinate matters with probate jurisdiction where guardianship is the appropriate long-term framework.
- **A data, metrics and reporting infrastructure.** Administrative measurement of unrestorability case duration, resolution rates, transition outcomes and continuity-of-care preservation.
- **A workforce-support and training pathway.** Coordinated education across judicial, prosecutorial, defense, evaluator, clinical and guardianship roles.

Fiscal and Public-Resource Consequences

The fiscal consequences of unresolved Resolution Gap cases are substantial and recurring. State forensic bed cost is approximately $790 per day per the Texas HHSC State Hospital Cost Study, 2024, used as a representative reference. A single multi-year forensic placement of an unrestorable defendant exceeds $280,000 per year in bed cost alone, before associated clinical, judicial, transportation, evaluation and administrative costs. Acute inpatient psychiatric placement at private market rates ranges from approximately $500 to $2,000 per day. Aggregated across the populations the framework addresses, the recurring fiscal exposure of fragmented crisis-response, prolonged unrestorability cases, repeated Emergency Department cycling, jail medical burden, avoidable hospitalization, medication-mismanagement complications, institutional elder-abuse litigation and continuity-of-care collapse is substantial. The fiscal frame is straightforward: continued inaction is not cost-neutral.

Behind every operational principle in this framework is a person whose protection depends on whether the principle is operationalized. Behind every section of this Proposal is a population whose vulnerability is structural, whose protection is constitutional and whose dignity is not negotiable. The reform this document proposes is the architecture of a country that protects its most vulnerable as a matter of structural design rather than as a matter of accident, of resources or of who happens to have a family member willing to fight on their behalf.

Appendix A. Multidisciplinary Consultation Checklist

Activation of SEIU-M / CIU-M coordination triggers structured consultation across the following parties as clinically, legally and operationally appropriate. The checklist is operational guidance, not a procedural mandate. Consultation occurs where it adds value to the case at hand.

- Treating physicians, including primary care, geriatrics, neurology, psychiatry, endocrinology, cardiology and rehabilitation medicine.
- Treating behavioral-health providers, including outpatient psychiatrists, psychologists, counselors and behavioral-health case managers.
- Treating rehabilitation providers, including occupational therapy, physical therapy, speech-language pathology and cognitive rehabilitation specialists.
- Pharmacists with access to comprehensive medication history across prescribers and dispensing pharmacies.
- Witnesses to prior incidents or changes in condition.
- EMS and prior emergency responders.
- Hospitals and discharge planners.
- Home health, hospice or palliative-care teams, where applicable.
- Legal representatives, Legal Aid and Pro Seniors, where applicable.
- Court-appointed guardian under Ohio Revised Code Chapter 2111.
- Adult Protective Services where elder-abuse indicators are present.
- Medicaid Fraud Control Unit where facility-based medication mismanagement or abuse is suspected.
- Long-Term Care Ombudsman where facility complaints or systemic concerns are present.
- Ohio Attorney General's Elder Justice Unit when justice-system involvement or abuse and neglect indicators are present.
- State survey agency where regulatory deficiencies, complaint history or facility-quality concerns are present.
- Ohio Public Defenders Office where the patient is or may become subject to criminal-legal proceedings.
- Probate Court coordinator where the patient is under Probate Court guardianship.
- Family members and long-term caregivers where appropriate and authorized.

Appendix B. Ohio Bar Association Consultative and Incentive Role Summary

The Ohio Bar Association (OBA) is recommended as a consultative professional standards and incentive partner only. OBA is not proposed as an SEIU-M / CIU-M owner, enforcement body, state authority, operational lead or decision-maker. Its role is deliberately bounded to preserve the distinction between legal professional governance and interagency operational authority.

Identified Areas of Possible OBA Consultation

- Continuing Legal Education (CLE) development in elder law, disability rights, guardianship systems, behavioral-health crisis response and the Jackson v. Indiana Resolution Gap framework.
- Pro bono incentive concept development supporting expanded access to legal representation for medically vulnerable populations.
- Attorney recognition structures for service in elder-justice, guardianship and Resolution Gap representation.
- Interdisciplinary legal education, including coordination with medical, behavioral-health, rehabilitation and guardianship training partners.
- Legal ethics consultation regarding representation of incapacitated and medically vulnerable clients.
- Access-to-justice support for populations historically underrepresented in crisis-response legal advocacy.
- Professional standards guidance for attorneys representing patients under guardianship in criminal-legal proceedings.
- Attorney referral and volunteer panel development for pilot regions.

Explicit Boundaries

OBA does not exercise any operational, custodial, clinical, judicial, prosecutorial, regulatory or administrative authority within the framework. OBA does not direct, supervise or evaluate the work of any participating clinical, judicial or administrative institution. OBA does not adjudicate any case under the framework. OBA's role is professional consultation and incentive development.

Appendix C. Emergency Stabilization Intake Checklist

Upon activation of SEIU-M / CIU-M coordination, the following intake steps are initiated and documented:

- Emergency trigger identified and documented.
- Immediate safety stabilization completed and confirmed.
- Emergency medical screening initiated, including delirium screening (CAM, CAM-ICU as appropriate), vital signs, focused neurological examination and basic metabolic and infectious workup.
- Medication administration history and psychotropic-risk profile requested from relevant providers and facilities, covering both psychiatric and non-psychiatric medications.
- Continuity-of-care disruption analysis initiated.
- Guardian or family notification attempted and documented where legally appropriate.
- Probate Court guardianship status reviewed and guardian of record identified where applicable under Ohio Revised Code Chapter 2111.
- Public safety balancing review documented.
- Integrated findings documentation initiated.
- Rehabilitation history reviewed where available.
- Prior hospitalization and facility records requested.
- Witness and collateral information reviewed where available.
- Resolution Gap protocol activation reviewed where the patient is or may be subject to criminal-legal contact and where prior incompetency adjudication is present.

Appendix D. Medical and Rehabilitation Review Team Functions

The medical and rehabilitation review team functions within SEIU-M / CIU-M coordination encompass the following clinical responsibilities:

- Medical stabilization oversight and clinical coordination.
- Medication reconciliation, polypharmacy review and psychotropic-risk assessment.
- Non-psychiatric medication review including GLP-1 receptor agonists, insulin and oral hypoglycemics, diuretics, anticoagulants, corticosteroids, anticholinergic agents, opioids, neuropsychiatrically-active antibiotics, cardiac medications, antiepileptics and dopaminergic agents.
- Drug-drug interaction screening, cumulative anticholinergic burden assessment and identification of recent regimen changes.
- Neurological differentiation and neurological consultation coordination, including assessment for stroke, TBI, dementia, frontotemporal degeneration, Parkinsonian syndromes, seizure disorders and post-ictal states.
- Delirium and dementia screening and cognitive baseline review using validated instruments where available.
- FND recognition and differentiation from malingering and from primary psychiatric pathology, consistent with DSM-5 and ICD-11 standards.
- Trauma-informed clinical assessment.
- Endocrine and metabolic review including diabetes-related destabilization, thyroid dysfunction, electrolyte abnormality and hepatic and renal contributors to altered mentation.
- Infection workup including urinary tract infection, pneumonia, soft-tissue infection and central nervous system infection where clinically indicated.
- Rehabilitation potential review and functional assessment.
- Discharge planning and reintegration pathway coordination.
- Physical Medicine and Rehabilitation (PM&R) consultation where clinically appropriate.
- Coordination with treating providers to preserve established medication regimens and rehabilitation plans through transition.

Appendix E. Court-Integrated Review Pathway

The court-integrated review pathway provides a structured mechanism by which criminal courts, Probate Courts, prosecutors, defense counsel, evaluators and the SEIU-M / CIU-M multidisciplinary review team may exchange information under existing authority to support constitutionally adequate review under Jackson v. Indiana, Dusky, Sell and Olmstead standards.

Pathway Elements

- **Intake notification.** Upon criminal-legal contact involving a patient meeting SEIU-M / CIU-M criteria, the trial court is notified of the framework's availability and the patient's prior incompetency adjudication, where applicable.
- **Probate Court coordination.** Where the patient is under Probate Court guardianship, the Probate Court is contemporaneously notified, the appointed guardian is afforded standing and the prior adjudication of legal incompetence is formally noticed.
- **Multidisciplinary review submission.** The SEIU-M / CIU-M multidisciplinary team submits integrated medical, neurological, medication-safety, rehabilitation, facility-context and guardianship findings to the court, prosecution and defense for consideration.
- **Competency evaluation coordination.** Where competency evaluation is ordered, the evaluator is provided with the integrated multidisciplinary record to support a more complete clinical foundation.
- **Hearing support.** Where evidentiary hearings are required, SEIU-M / CIU-M coordinators support timely production of records, scheduling of witnesses and presentation of integrated findings.
- **Disposition coordination.** Where the case proceeds to disposition, SEIU-M / CIU-M coordinators support transition planning, continuity-of-care preservation, guardianship coordination and continued review under the four operational principles.
- **Jackson v. Indiana review.** Where the patient is found incompetent and unrestorable, SEIU-M / CIU-M coordinators support time-bounded review consistent with the Jackson standard, including coordination with Probate Court, civil-commitment review and Resolution Gap protocol activation.
- **Sell v. United States review.** Where forced medication is at issue, SEIU-M / CIU-M coordinators support the production of medical, neurological and rehabilitation findings relevant to the Sell factors.
- **Olmstead v. L.C. review.** In every transition decision, SEIU-M / CIU-M coordinators support least-restrictive placement analysis consistent with the Olmstead standard.

Appendix F. Risk Stratification and Placement Logic Reference

Appendix F provides extended operational reference for the risk-stratification framework introduced in Section 5. Risk levels are clinical-operational categories supporting consistent placement decisions across institutions. They are not statutory or judicial classifications.

Level I. Monitoring and Coordination

Stable or stabilizing presentation. Care-continuity concerns, medication questions or family / guardian coordination needs. Acute clinical risk is low. operational priorities: structured outpatient stabilization, family-support coordination, provider follow-up, medication review and continuity-of-care preservation. Placement direction: community setting with structured outpatient and home-support services.

Level II. Moderate Clinical Complexity

Behavioral or cognitive instability with suspected medical, neurological, trauma-related, medication-related or rehabilitation factors. Acute clinical risk is moderate. operational priorities: SEIU-M / CIU-M multidisciplinary review, Emergency Department or crisis observation, specialist consultation and structured step-down planning. Placement direction: short-term observation followed by clinically appropriate step-down placement (home with home health, inpatient rehabilitation facility, skilled nursing facility, structured outpatient stabilization).

Level III. High Medical Complexity

Significant medical fragility, neurological decline, diabetes / endocrine instability, delirium risk, FND complexity, injury, infection risk or rehabilitation deterioration. Acute clinical risk is high. operational priorities: inpatient medical stabilization, neurorehabilitation, hospital-based review, custodial medical monitoring or specialized medical-stabilization placement. Placement direction: hospital inpatient medical or neurorehabilitation setting until stabilization is established, followed by structured transition.

Level IV. Acute Psychiatric / Public-Safety Risk

Immediate risk requiring secure intervention after medical contributors are reviewed to the extent clinically feasible. Acute clinical risk is severe. operational priorities: psychiatric inpatient stabilization or secure placement with continued medical, neurological and rehabilitation review. Placement direction: psychiatric inpatient or appropriate secure setting with continued multidisciplinary review and transition planning.

Cross-Cutting Operational Principles

Across all levels: least-restrictive placement consistent with safety; preservation of continuity-of-care relationships; medication-safety review as predicate to behavioral interpretation; Probate Court and guardian coordination where applicable; elder-abuse causation investigation where indicators are present; outcome measurement supporting continuous improvement.

Appendix G. Agency Role Alignment

Appendix G extends the agency-role alignment table in Section 6 with operational detail supporting cross-agency coordination. Roles described here are coordination roles. Each agency retains its full statutory authority.

State Executive Authorities

- **Office of the Governor of Ohio.** Executive coordination authority, interagency convening, executive-budget alignment and pilot designation authority.
- **Office of the Ohio Attorney General.** Constitutional review, criminal-procedure consultation, civil-rights review and Elder Justice Unit coordination.
- **Ohio Department of Aging.** Elder-vulnerability review, protective oversight, aging-population preparedness and caregiver-support planning.
- **Ohio Department of Behavioral Health (Ohio-DBH / Ohio-MHAS).** Behavioral-health coordination, psychiatric stabilization interface, community treatment infrastructure, forensic-system alignment and state-facility collaboration.
- **Ohio Department of Medicaid.** Funding pathways, managed-care coordination, discharge continuity, rehabilitation authorization, cost-impact evaluation and waiver review.
- **Ohio Department of Health.** Public-health readiness, facility-quality interface, hospital-system coordination, regulatory learning loops and state survey agency coordination.
- **Ohio Department of Developmental Disabilities.** Developmental-disability coordination, communication accommodations and continuity-of-care support.
- **Ohio Department of Rehabilitation and Correction.** Custodial medical stabilization, jail-diversion interface, intake screening, medication continuity and reintegration coordination.
- **Ohio Department of Public Safety.** Emergency-response sequencing, crisis communication, transport coordination and public-safety stabilization triggers.

Judicial Authorities

- **Supreme Court of Ohio.** Judicial administration, court coordination, education and case-management support.
- **Ohio Probate Courts.** Prior incompetency adjudication coordination, guardianship communication, integrated medical-legal findings, Resolution Gap jurisdictional interface and stabilization status hearings.
- **Common Pleas Courts.** Criminal-procedure coordination, competency evaluation oversight and Resolution Gap protocol coordination.

Federal Authorities

- **U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services.** Medicaid alignment, waiver review, dementia-care partnership coordination and federal quality-improvement priorities.
- **Substance Abuse and Mental Health Services Administration.** Crisis-response coordination, competency-restoration analysis and behavioral-health workforce development.
- **Administration for Community Living.** Elder-justice coordination, aging-population preparedness and caregiver-support infrastructure.

- **U.S. Department of Justice, Civil Rights Division.** Constitutional review, ADA enforcement, Olmstead implementation and civil-rights remedies.
- **Health Resources and Services Administration.** Workforce development, behavioral-health and geriatrics workforce programs and rural and underserved access.
- **Federal Bureau of Investigation.** Elder-justice coordination on federal financial-exploitation and trafficking-of-elders matters where applicable.

Appendix H. Training and Certification Architecture

Appendix H provides extended operational detail on the six-module training architecture introduced in Section 10. Each module is designed to support consistent workforce readiness across institutions participating in the framework.

Module I. Crisis Recognition and Medical Complexity

Recognition and differentiation of delirium, dementia, diabetes / endocrine destabilization, medication interruption, FND, TBI, cognitive impairment, trauma response and developmental-disability communication needs in crisis settings. Use of validated screening instruments (CAM, CAM-ICU, AD8, GDS, MoCA where appropriate). Differential diagnosis principles for behavioral presentations in medically vulnerable populations. Recognition of acute metabolic, endocrine, infectious and neurological contributors to altered mentation.

Module II. Legal and Constitutional Interface

Due-process requirements, least-restrictive placement doctrine, ADA-informed accommodations, guardianship participation under Ohio Revised Code Chapter 2111, public-safety balancing, Jackson v. Indiana, Dusky v. United States, Sell v. United States and Olmstead v. L.C. standards, Resolution Gap protocol coordination, coordination with Probate Court, public defender and prosecutor offices and family and guardian standing in proceedings affecting incapacitated persons.

Module III. Emergency Department and EMS Coordination

Dispatch intake sequencing, handoff documentation standards, medication reconciliation including non-psychiatric medications, family and guardian notification protocols, stabilization escalation triggers, coordination with hospital case management and discharge planning and coordination with continuity-of-care providers.

Module IV. Court and Forensic Integration

Parallel forensic and medical-stabilization review standards, integrated report preparation, hearing preparation, evidentiary relevance, record completeness, coordination with competency evaluators, Resolution Gap seven-step protocol coordination and coordination with Probate Court guardianship jurisdiction.

Module V. Rehabilitation and Reintegration

Neurorehabilitation pathways, OT, PT and SLP integration, cognitive rehabilitation, discharge readiness assessment, community-support coordination, PACE program coordination where eligible, HCBS waiver coordination, FQHC integration, geriatric care management, telehealth monitoring, post-crisis follow-up standards and family education and respite-resource coordination.

Module VI. Facility Accountability and Good-Faith Review

Distinguishing neglect, system overload, medication-oversight gaps and intentional misconduct. Elder-abuse causation investigation triggers. Coordination with APS, Long-Term Care Ombudsman, MFCU and state survey agency. Documentation standards supporting distinction between structural constraint and intentional misconduct. Good-faith caregiver and provider protection standards. Recognition of facility-driven crisis indicators.

Certification and Continuing Education

Certification structures, CEU and CLE accreditation, recertification cycles, interdisciplinary educational partnerships and integration with existing professional-education requirements are appropriate subjects of pilot-phase development. Education is designed to integrate with, not duplicate, existing professional-education obligations.

Appendix I. Distribution Authority Framework

Appendix I identifies the executive, legislative, judicial, healthcare, federal-healthcare, implementation and public-awareness authorities to which this institutional submission package is appropriately directed. The list is comprehensive in intent and adaptable to specific institutional review priorities.

Executive Branch, Regulatory and Interagency Authorities

- The President of the United States and the Office of the President.
- The Vice President of the United States and the Office of the Vice President.
- The White House Domestic Policy Council.
- The White House Office of Public Engagement.
- The White House Office of Faith-Based and Neighborhood Partnerships.
- The U.S. Department of Health and Human Services, Office of the Secretary.
- The U.S. Department of Justice, Office of the Attorney General.
- The Office of the Governor of Ohio.
- The Office of the Lieutenant Governor of Ohio.
- The Office of the Ohio Attorney General, Elder Justice Unit.
- The Office of the Ohio Auditor of State.
- The Office of the Ohio Treasurer of State.
- Ohio Department of Aging.
- Ohio Department of Behavioral Health (Ohio-DBH / Ohio-MHAS).
- Ohio Department of Medicaid.
- Ohio Department of Health.
- Ohio Department of Developmental Disabilities.
- Ohio Department of Rehabilitation and Correction.
- Ohio Department of Public Safety.
- Ohio Department of Job and Family Services.
- Ohio Department of Insurance.
- Ohio Office of Budget and Management.

Legislative, Policy and Government Affairs Authorities

- The United States Senate Special Committee on Aging.
- The United States Senate Committee on the Judiciary.
- The United States Senate Committee on Finance.
- The United States Senate Committee on Health, Education, Labor and Pensions.
- The United States House Committee on the Judiciary.
- The United States House Committee on Energy and Commerce.
- The United States House Committee on Ways and Means.
- The Ohio General Assembly: Ohio Senate and Ohio House of Representatives.
- The Ohio Senate Committee on Health and Human Services.

- The Ohio Senate Committee on Judiciary.
- The Ohio Senate Committee on Finance.
- The Ohio House Committee on Aging and Long-Term Care.
- The Ohio House Committee on Health Provider Services.
- The Ohio House Committee on Behavioral Health.
- The Ohio House Committee on Civil Justice.
- The Ohio House Committee on Criminal Justice.
- The Ohio House Committee on Finance.
- The Ohio Legislative Service Commission.

Judicial, Constitutional and Civil Rights Authorities

- The Supreme Court of Ohio.
- The Ohio Judicial Conference.
- The Ohio Probate Court Judges Association.
- Ohio Probate Courts (district by district as appropriate).
- Ohio Common Pleas Courts (district by district as appropriate).
- The Ohio Public Defender Commission and the Office of the Ohio Public Defender.
- The U.S. Department of Justice, Civil Rights Division.
- The U.S. Department of Justice, Office of Legal Counsel.
- The U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance.
- The National Center for State Courts.
- The American Bar Association Commission on Law and Aging.

Healthcare, Medicaid, Clinical and Long-Term Care Leadership

- The American Medical Association.
- The American Geriatrics Society.
- The American Psychiatric Association.
- The American Academy of Neurology.
- The American Academy of Physical Medicine and Rehabilitation.
- The American Medical Directors Association (AMDA, The Society for Post-Acute and Long-Term Care Medicine).
- The American Health Care Association.
- The LeadingAge association.
- The Ohio Health Care Association.
- LeadingAge Ohio.
- The Ohio Hospital Association.
- The Ohio State Medical Association.
- The Ohio Psychiatric Physicians Association.
- The Ohio Association of Health Plans.
- Ohio Medicaid Managed Care Organizations.

Federal Healthcare, National Oversight and Public Health Authorities

- The Centers for Medicare and Medicaid Services.
- The Substance Abuse and Mental Health Services Administration.
- The Administration for Community Living.
- The Health Resources and Services Administration.
- The Agency for Healthcare Research and Quality.
- The Centers for Disease Control and Prevention.
- The National Institute on Aging.
- The National Institute of Mental Health.
- The National Institute of Neurological Disorders and Stroke.
- The HHS Office of Inspector General.
- The Government Accountability Office.
- The Medicaid and CHIP Payment and Access Commission.
- The Medicare Payment Advisory Commission.

Implementation, Oversight and Systems Modernization Authorities

- The National Association of State Mental Health Program Directors.
- The National Association of State Medicaid Directors.
- The National Association of Medicaid Fraud Control Units.
- The National Adult Protective Services Association.
- The National Association of State Long-Term Care Ombudsman Programs.
- The National Center on Elder Abuse.
- The National Council on Aging.
- The National Guardianship Association.
- The National Center for State Courts Center on Adult Guardianship.
- The American Society on Aging.

Public Awareness, Community Engagement and National Coordination

- AARP and AARP Ohio.
- The Alzheimer's Association and the Alzheimer's Association Ohio chapters.
- The Brain Injury Association of America and Brain Injury Association of Ohio.
- The Epilepsy Foundation.
- The American Diabetes Association.
- The National Alliance on Mental Illness and NAMI Ohio.
- Disability Rights Ohio.
- The Ohio Disability Rights Network.
- Long-Term Care Ombudsman programs (Ohio and national).
- Adult Protective Services networks (Ohio and national).
- Pro Seniors, Inc. and Ohio Legal Aid network.
- Area Agencies on Aging (regional Ohio offices).

- Faith-based, civic and community organizations engaged in elder care, disability rights and family-caregiver support.

Appendix J. Pathway Comparison Matrix: Restorable vs Unrestorable

Appendix J presents a side-by-side operational comparison of the procedural pathway for defendants found incompetent and restorable against the procedural pathway for defendants found incompetent and unrestorable. The comparison illustrates the architectural asymmetry that produces the Resolution Gap.

There is a clear pathway for the person found legally incompetent and restorable.

There is no clear pathway for the person found legally incompetent and unrestorable.

Element	Incompetent and Restorable	Incompetent and Unrestorable
Statutory Framework	Ohio R.C. Ch. 2945 competency and restoration provisions. Federal counterparts include 18 U.S.C. sec. 4241.	No dedicated statutory resolution pathway. The case falls in the intersection of R.C. Ch. 2945, R.C. Ch. 5122, R.C. Ch. 2111 and R.C. Ch. 5119 without an integrating provision.
Coordinating Authority	Designated restoration facility or program. Trial court retains supervision.	No agency holds resolution authority. Courts, evaluators, prosecutors, defense and treating systems each perform their roles within their respective boundaries.
Timeline	Time-bounded restoration treatment with statutory caps. Periodic competency review under Jackson v. Indiana standards.	Indefinite. Jackson v. Indiana time-bounded review is the governing standard, but operational implementation varies significantly by jurisdiction.
Periodic Review	Required at defined intervals. Restoration progress is the central question.	Often nominal. Review may continue indefinitely with no defined exit criterion.
Treatment Authority	Forced medication may be considered under Sell v. United States factors where restoration is the purpose.	Sell does not authorize forced medication where restoration is impossible. The legal basis for continued forced medication becomes attenuated.
Civil Commitment Interface	Not typically engaged unless restoration fails.	Anticipated by Jackson. Frequently inapplicable when the defendant has stabilized and does not currently meet civil-commitment criteria.
Probate Court Coordination	Not typically required.	Essential where the defendant has been adjudicated incompetent under R.C. Ch. 2111. Currently not formally integrated in most jurisdictions.

Element	Incompetent and Restorable	Incompetent and Unrestorable
Guardian Standing	Not typically engaged.	Essential. The court-appointed guardian holds legal authority over the defendant's medical, residential and administrative affairs.
Elder-Abuse Review	Not typically engaged.	Essential where the defendant is a care-facility resident or under guardianship. Activation of APS, Long-Term Care Ombudsman, MFCU and state survey agency is the operational predicate.
Medication-Management Review	Standard practice within forensic clinical review.	Essential and frequently absent. Mismanagement of psychiatric and non-psychiatric medications is a recognized contributor to the underlying presentation.
Disposition	Restoration to competency followed by resumption of proceedings or transition to civil commitment if restoration fails.	No defined disposition pathway. Cases remain open indefinitely. SEIU-M / CIU-M proposes coordinated transition to guardianship-supported placement under Probate Court oversight.
Continuity of Care	Disrupted by restoration treatment. Reintegration anticipated upon resumption.	Disrupted indefinitely. Established treating relationships, medication regimens and rehabilitation plans erode over time.
Measurement	Standard forensic-system metrics including restoration rates and time-to-restoration.	Largely unmeasured. Few state systems track unrestorability case duration, resolution rate or transition outcomes.
Constitutional Anchor	Dusky v. United States, 362 U.S. 402 (1960). Jackson v. Indiana, 406 U.S. 715 (1972). Sell v. United States, 539 U.S. 166 (2003).	Jackson v. Indiana governs but is operationally underdeveloped. Olmstead v. L.C., 527 U.S. 581 (1999) supports least-restrictive placement analysis.

Appendix K. References and Authorities Cited

United States Supreme Court Decisions

- Dusky v. United States, 362 U.S. 402 (1960).
- Jackson v. Indiana, 406 U.S. 715 (1972).
- Olmstead v. L.C., 527 U.S. 581 (1999).
- Sell v. United States, 539 U.S. 166 (2003).
- Pennsylvania Department of Corrections v. Yeskey, 524 U.S. 206 (1998).
- Tennessee v. Lane, 541 U.S. 509 (2004).

Federal Court Decisions

- Trueblood v. Washington State Department of Social and Health Services, 101 F. Supp. 3d 1010 (W.D. Wash. 2015).
- Oregon Advocacy Center v. Mink, 322 F.3d 1101 (9th Cir. 2003).

Federal Statutes

- Americans with Disabilities Act of 1990, 42 U.S.C. sec. 12101 et seq.
- Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. sec. 794.
- Older Americans Act of 1965, 42 U.S.C. sec. 3001 et seq.
- Elder Justice Act of 2010, Title XX of the Social Security Act, 42 U.S.C. sec. 1397j et seq.
- Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. sec. 1320d et seq.; 45 C.F.R. Parts 160 and 164.
- Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2.
- Nursing Home Reform Act (OBRA 1987), 42 U.S.C. sec. 1395i-3 and 1396r.

The Centers for Medicare and Medicaid Services enforces the nursing home Conditions of Participation under 42 C.F.R. Part 483. These regulations establish binding standards for resident rights (483.10), quality of care (483.25), pharmacy services (483.45) and comprehensive care planning (483.21). Medication management failures of the kind the SEIU-M framework's causation investigation protocol is designed to identify, including missed doses, inappropriate substitutions, inadequate monitoring and undocumented medication changes, are subject to citation and enforcement under the Conditions of Participation. CMS survey deficiencies in these categories are documented through F-tag citations, which create an administrative record of regulatory failure independent of any criminal or civil proceeding. The SEIU-M / CIU-M causation investigation step is designed to integrate with, rather than duplicate, CMS survey authority. Where a qualifying intake event involves a care-facility resident, the framework's elder-abuse causation investigation protocol coordinates with the state survey agency to ensure that any regulatory violations at the facility level are identified, documented and referred through the appropriate enforcement channel.

- Emergency Medical Treatment and Active Labor Act, 42 U.S.C. sec. 1395dd.
- Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).
- Balanced Budget Act of 1997, PACE program authority, Pub. L. No. 105-33, sec. 4801.
- 21st Century Cures Act, Pub. L. No. 114-255 (2016).
- Medicaid statutes: 42 U.S.C. sec. 1396 et seq., including sec. 1115 demonstration authority and sec. 1915(c) HCBS waiver authority.

- Federal criminal-procedure competency provisions: 18 U.S.C. sec. 4241 to 4247.

Ohio Revised Code

- Ohio Revised Code Chapter 2111, Guardianship of Persons and Estates.
- Ohio Revised Code Chapter 2945, Criminal Procedure including competency to stand trial provisions.
- Ohio Revised Code Chapter 5119, Department of Behavioral Health (formerly Mental Health and Addiction Services).
- Ohio Revised Code Chapter 5122, Civil Commitment for Mental Illness.
- Ohio Revised Code Chapter 5160, Department of Medicaid.
- Ohio Revised Code Chapter 5101, Adult Protective Services and aging-related authorities.
- Ohio Revised Code Chapter 5165, Nursing Facilities.
- Am. Sub. H.B. 96 of the Ohio 136th General Assembly, effective October 1, 2025 (renaming Ohio-MHAS to Ohio-DBH).

Federal Agencies and Regulatory Authorities

- U.S. Department of Health and Human Services.
- Centers for Medicare and Medicaid Services.
- Substance Abuse and Mental Health Services Administration.
- Administration for Community Living.
- Health Resources and Services Administration.
- Agency for Healthcare Research and Quality.
- Centers for Disease Control and Prevention.
- National Institute on Aging, National Institute of Mental Health, National Institute of Neurological Disorders and Stroke.
- U.S. Department of Justice, including the Civil Rights Division, the Office of Justice Programs and the Office for Victims of Crime.
- HHS Office of Inspector General.
- Government Accountability Office.

Peer-Reviewed and Clinical References

- Shehab N, Lovegrove MC, Geller AI, et al. US Emergency Department Visits for Outpatient Adverse Drug Events, 2013 to 2014. JAMA, 2016;316(20):2115-2125.
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- HHS OIG, Reports on Antipsychotic Medication Use in Nursing Homes.
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, 2013, including Conversion Disorder (Functional Neurological Symptom Disorder).
- International Classification of Diseases, 11th Revision (ICD-11), World Health Organization.
- Alzheimer's Association, 2024 Alzheimer's Disease Facts and Figures.
- AARP and National Alliance for Caregiving, Caregiving in the United States 2020.

State and National Authorities

- Office of the Governor of Ohio, Governor's Work Group on Competency Restoration and Diversion (2024).
- Supreme Court of Ohio, Case Management Section, Guardianship Caseload Data (2011 baseline through 2020 reporting).
- Texas Health and Human Services Commission, State Hospital Cost Study (2024) (representative reference for state forensic bed cost).
- National Association of State Mental Health Program Directors, Forensic Hospital Capacity Reports.
- National Center for State Courts, Center on Adult Guardianship.
- National Adult Protective Services Association, State Data Reports.

Limitations and Assumptions

This proposal operates within a set of explicit assumptions and is subject to defined limitations that reviewers should consider. The fiscal estimates are directional, not actuarial. The $790 per-bed-per-day figure is drawn from Texas HHSC data as a representative reference and falls within Ohio's own range; the Ohio Legislative Service Commission reports that the inpatient daily rate at the six OhioMHAS / DBH regional psychiatric hospitals ranged from approximately $610 to $938 for all payors in CY 2023 (Ohio LSC fiscal note, citing OhioMHAS Hospital Rates). The cross-state benchmarking draws on publicly available program data and published evaluations. The proposal does not claim pilot outcomes in advance of a pilot. It claims that the structural conditions documented here create the predicate for a coordinated response and that the available evidence supports proceeding to pilot planning. If twelve-month pilot outcomes require design adjustment, the framework is structured for recalibration rather than termination. The structural problem this framework addresses persists regardless of first-cycle implementation results.

In Humility

This proposal and the companion documents submitted with it are offered humbly to every authority that receives them. The framework is presented in deference to the institutional expertise, statutory authority and operational responsibility the receiving institutions hold. It is a humble request for coordination, not a prescription. Every professional named in this distribution list is trusted to exercise the full authority and judgment their role requires. What is asked is only this: that the coordination infrastructure described here be given the serious and good-faith institutional review it is designed to merit, so that the families who cannot wait and the defendants who have already waited too long do not have to wait any longer.

Our Country. Our Constitution

Every reviewer of this proposal will, at some point, be a caregiver, a guardian or the person needing one. This country was founded on a promise that grows only when each generation chooses to honor it. Compassion. Integrity. Dignity. Due process. Protection of those who cannot protect themselves. These are not new values. They are the values our Constitution was built to protect and the values we are asked, in our time, to extend to the Americans this country's promise has not yet reached. We all deserve the dignity of growing old in peace, without the worry of being abused, exploited or taken advantage of. The work before us is to stand united in building the protection they deserve, to honor what we all deserve as Americans and to keep faith with our values not by intention alone but by what we are willing to build, uphold and honor.

Closing Statement

This Operational Implementation Framework is presented for institutional review and coordinated planning. It is not a directive. It is not a finished statutory product. It is a comprehensive operational blueprint developed on the basis of documented clinical, constitutional, fiscal and demographic evidence, designed to support the existing institutional authorities responsible for protecting medically vulnerable populations during periods of crisis.

The recipients identified in Appendix I are humbly asked to consider this proposal's substance, distribute it internally as appropriate, identify points of coordination and inquiry and engage in continued institutional discussion. No specific action is required at the stage of initial review. Careful institutional review takes time and thoughtful coordination across multiple systems is itself a substantial undertaking. That time and effort are respected and anticipated.

The four operational principles articulated within the framework, stabilization before escalation, causation before prosecution, coordination before adjudication and stewardship before continuation, are the operational standards under which the framework respectfully requests its proposals be evaluated. They are not partisan principles. They are not novel principles. They are the standards by which a constitutional, fiscally responsible, clinically informed and humane crisis-response architecture has historically been recognized.

This proposal is offered in the spirit of constructive institutional collaboration. The challenges it identifies are real. The architecture it proposes is achievable within existing federal and state authority. The populations it addresses are protected by the same constitutional and statutory authorities that protect every citizen. What is missing is the coordination infrastructure that makes those existing protections operationally functional at the point of a crisis event. That infrastructure is what this proposal builds.

Every reviewer of this document will, at some point, be a caregiver, a guardian or the person needing one. The architecture proposed in this Operational Implementation Framework is the architecture of a country that decides to protect its most vulnerable as a matter of structural design rather than as a matter of accident, of resources or of who happens to have a family member willing to fight on their behalf. That country is the one this framework is for.

WHITE PAPER

SEIU-M / CIU-M Proposal

Specialized Emergency Intervention Unit: Medical Stabilization ***- SEIU-M (See-U)***
Crisis Intervention Unit: Medical Stabilization ***- CIU-M (CI U)***

Constitutional, Statutory, Clinical, Demographic and Comparative-Systems Foundations for a Court-Integrated Crisis Stabilization Model Protecting Medically Vulnerable Populations

Prepared for Policy Research Audiences, Legislative Counsel,
Federal Policy Staff, Academic Reviewers and Interagency Review

Why This Document Is Before You

Across this country every day, a person whose medical condition no one investigated, whose medication no one reconciled, whose guardian no one consulted, enters a public system that was not designed to coordinate with the other public systems that have already engaged with their life. The healthcare system that treated them does not communicate with the long-term care facility that houses them. The facility does not communicate with the emergency department that admits them. The emergency department does not communicate with the criminal court that charges them. The criminal court does not communicate with the Probate Court that, in many cases, has already adjudicated them legally incompetent.

Each system performs its function. None integrates with the others. The result is a population caught in the space between, growing as the country ages, costing more each year that the architecture remains uncoordinated. Costing in dollars. Costing in court time. Costing in forensic-bed capacity. Costing in healthcare workforce burden. Costing, most consequentially, in lives.

This White Paper documents the policy theory, the empirical foundations and the constitutional architecture supporting a coordinated response. The framework it presents, SEIU-M / CIU-M, does not propose new authority. It proposes that existing authority be exercised, by existing institutions, in the correct sequence, with the coordination infrastructure required to make the constitutional protections already in law operationally functional at the point of a crisis event.

The question this paper poses to policy reviewers is direct. The aging of the United States is not hypothetical. The growth of guardianship caseloads is not projected. The strain on forensic-bed capacity is not future. Each is happening now. The architectural question is whether the public-systems response is built before the demographic transition arrives or after.

Every reviewer of this paper will, at some point in their life, be a caregiver, a guardian or the person needing one. The infrastructure proposed here is not partisan. It is not abstract. It is the infrastructure of a country that decides to protect its most vulnerable as a matter of structural design rather than as a matter of accident, of resources or of who happens to have a family member willing to spend years fighting on their behalf.

Executive Transmittal Letter

For Institutional Review and Collaborative Consideration

This White Paper is the policy theory and evidence base supporting the SEIU-M / CIU-M institutional submission package. It is designed to be read by policy research audiences, academic and think-tank reviewers, legislative counsel and federal policy staff alongside the package's other five documents: the Fact Sheet, the Executive Action Memo, the Executive Briefing, the Operational Implementation Framework (Proposal) and the Case Study and Systems-Impact Analysis.

The framework is presented for institutional review, collaborative evaluation and continued discussion. It is not a directive. It does not require any specific action at the stage of initial review. Recipients are respectfully invited to review the document, distribute it internally as appropriate to relevant policy and legal staff and identify points of further coordination, inquiry or engagement to bring to any subsequent interagency discussion.

This document is intended for interagency and policy review purposes. It is not for public distribution without authorization from the presenting party. Questions regarding the framework, requests for supplemental materials or inquiries regarding scheduling of any interagency discussion should be directed through established institutional channels.

Author's Note

This White Paper is presented by The Guardian, under Ohio Probate Court jurisdiction, on behalf of medically vulnerable populations whose protection depends upon coordinated public systems and on behalf of the families and institutional professionals who serve them. The analytical, statutory and comparative-systems work in this document was developed because the operational gap it describes is not abstract. It is the gap into which medically vulnerable people, their families and the institutions trying to serve them continue to fall. The voice of this document is institutional by design.

The framework presented here is not a theoretical exercise. It emerges from sustained direct guardianship experience, documented patient-specific clinical destabilization and navigation of the intersection of healthcare, long-term care, behavioral-health, guardianship, judicial, prosecutorial and protective-services systems on behalf of elderly individuals whose conduct during periods of documented medical destabilization led to consequences the existing system was not designed to resolve. The chronology that informs the framework is preserved in the Case Study companion document.

Terminology note. Throughout this White Paper the Ohio state behavioral-health agency is referenced in paired form as Ohio-DBH / Ohio-MHAS. The full institutional name is Ohio Department of Behavioral Health (Ohio-DBH), previously known as Ohio Mental Health and Addiction Services (Ohio-MHAS). The rename was enacted under Am. Sub. H.B. 96 of the Ohio 136th General Assembly, effective October 1, 2025. The paired form is used throughout to support reviewer recognition across both current and legacy institutional references.

Reading Frame: Accountability, Not Accusation

This document operates under one foundational principle. Accountability, as used here, is structural. It examines the architecture of decision-making, the flow of information, the design of evaluation frameworks, the operational protocols governing transitions and the procedural standards by which evidence enters review. Accusation, by contrast, is individual. It identifies specific persons for blame. The two are not the same exercise and this document does not undertake the second.

The analysis that follows identifies structural gaps and proposes structural remedies. The professionals working inside the systems engaged by this framework do difficult work in frameworks they did not design. Where the record reflects outcomes that deserve institutional concern, the document names the framework that produced them, not the individuals constrained to operate within it.

That is not a softening of the analysis. It is what makes the analysis useful. A framework can be redesigned. A person identified for criticism becomes defensive and defensiveness produces no reform. The SEIU-M / CIU-M proposal embedded in this paper is oriented toward redesign.

Why This Document Exists

No document of comparable scope addressed the operational gap this paper describes. The framework is the product of sustained direct caregiving and advocacy on behalf of medically vulnerable family members beginning in March 2020, at the onset of the COVID-19 pandemic. The patient at the center of the chronology that informs the framework experienced a documented cascade of severe medical destabilization beginning in March 2021.

What was encountered along the way was not what was expected. Not from healthcare. Not from long-term care. Not from behavioral-health systems. Not from the courts. Not from the agencies tasked with protecting vulnerable adults. The encounter was with fragmentation. With systems that did not coordinate. With institutions that treated families as obstacles rather than partners. With processes that mistook medical destabilization for criminal intent. With prolonged jurisdiction that had no defined endpoint. With silence where coordinated response should have existed.

This paper was developed because the families coming behind this one deserve a coordinated pathway where none existed. Because the professionals working inside these systems, many of whom genuinely care, many of whom are themselves overwhelmed, deserve infrastructure equal to the complexity they face. Because the people who cannot advocate for themselves deserve a system designed around their dignity rather than around institutional convenience.

The document is offered in recognition that real change requires more than acknowledgment. It requires structural design, coordinated authority and the willingness of institutional leaders to act before another family is left without recourse. Because the difference between a coordinated response and a fragmented one is, in some cases, the difference between a person living and a person not. No family, anywhere in Ohio, anywhere in this country, should have to learn the lessons of this chronology in order for their loved ones to be safe.

Specific Request and Action Pathway: 30, 90, 180 and 365 Days

The requests below identify the executive, legislative, interagency and operational actions sought through the broader SEIU-M / CIU-M submission package. Each request is supported by the analysis, findings and institutional recommendations developed throughout this White Paper and its companion documents.

Phase	Recommended Action
Within 30 Days	Designate an interagency review contact within each receiving institution. Name legal, clinical and operational leads. Conduct initial pilot-feasibility review. Acknowledge receipt and indicate institutional review intentions. The Office of the Governor and Ohio-DBH / Ohio-MHAS are respectfully asked to convene a candidate-counties meeting during this phase so pilot region selection can begin transparently.
Within 90 Days	Develop activation criteria. Map the operational workflow. Draft training outline, data-governance approach, fiscal feasibility analysis and advisory group composition. Engage candidate funding authorities including Medicaid 1115 and 1915(c) waivers, SAMHSA crisis-response categories, Elder Justice Act discretionary appropriations, HRSA workforce programs, PACE under the Balanced Budget Act of 1997, state behavioral-health innovation budgets and philanthropic capital. Convene the initial multidisciplinary advisory consultation.
Within 6 Months	Launch limited pilot planning in two or three regions selected from the urban, suburban-exurban and rural-multi-county profile types identified in the Pilot Region Specifications section. Develop hospital, EMS, trial-court, Probate Court, guardianship, APS, Long-Term Care Ombudsman and Medicaid Fraud Control Unit coordination pathways. Design the outcome dashboard consistent with the Pilot Region success criteria. Finalize the inter-agency MOU.
Within 12 Months	Implement the pilot. Evaluate early metrics across clinical, operational, judicial, family-and-guardian and fiscal domains. Refine protocols against pilot findings. Prepare legislative, regulatory and administrative recommendations for regional expansion or statewide scaling, grounded in the pilot's outcome data.
Ongoing	Maintain coordination with the executive, legislative, judicial, regulatory and federal authorities identified in the broader package. Maintain a measurement and reporting cadence consistent with the Pilot Region success criteria. Hold to the four operational principles: stabilization before escalation, causation before prosecution, coordination before adjudication, stewardship before continuation.

Specific Authorities Requested

No new statutory authority is requested during the pilot. What is requested is coordinated use of existing federal and state authorities: Medicaid 1115 and 1915(c) waivers, SAMHSA crisis-response grant authorities, federal Elder Justice Act discretionary appropriations, HRSA workforce-development authorities, PACE, state behavioral-health innovation budgets, philanthropic capital and U.S. Department of Justice civil-rights coordination, supplemented by administrative coordination among the receiving institutions. Pilot outcomes during the twelve-month evaluation period would inform any subsequent recommendation regarding longer-term statutory or administrative scaling.

Federal Coordination

The statutory citations in this paper are Ohio-specific. The structural Resolution Gap the framework addresses is not. Coordination with federal authorities, including HHS, CMS, the Department of Justice Civil Rights Division, SAMHSA, CDC, the Administration for Community Living and White House and federal policy review, is therefore as important as state-level coordination. It is respectfully requested as part of the implementation pathway.

The SEIU-M / CIU-M Document Package

This White Paper is part of a coordinated six-document institutional submission package developed for executive, legislative, judicial, healthcare and interagency review. Each document serves a different reader at a different level of review. They are intended to be read together, but a reviewer can enter the package through whichever document best matches their role.

Document	Primary Function	Entry Point For
Fact Sheet	One-page operational summary for initial transmittal and executive scanning.	Initial transmittal, scanning, public-affairs contexts.
Executive Action Memo	Single-page memo presenting core finding, anchoring, response and authorities requested.	Cabinet-secretary level, agency-head level, White House review.
Executive Briefing	Rapid-review leadership document presenting problem, solution, benefits, pathway, ask.	Executive, legislative and federal decision-makers.
Operational Implementation Framework (Proposal)	Full operational architecture, workflow, training, fiscal model, phased rollout.	Implementing agencies, regulatory authorities, operational leadership.
White Paper (this document)	Policy theory, evidence base, comparative context, modernization argument.	Policy researchers, legislative counsel, federal policy staff.
Case Study and Systems-Impact Analysis	Evidentiary chronology, longitudinal medical record, working demonstration of the Resolution Gap.	Deep-context reviewers, judicial and constitutional analysts, federal civil-rights authorities.

How This White Paper Relates to the Companion Documents

Each document in the package carries a different load. The Executive Briefing makes the institutional argument for rapid review. The Operational Implementation Framework sets out the architecture for making it implementable. The Case Study holds the chronology, the medical and rehabilitation record, the regulatory findings and the documentary evidence on which the analysis rests. The Executive Action Memo distills the request for cabinet-level and White House review. The Fact Sheet is the one-page operational summary. This White Paper develops the policy theory, the empirical anchoring, the constitutional architecture and the comparative-systems context that situate the framework within the broader institutional context.

Citation anchors of the form [CS sec.N] or [CS App-X] refer to the corresponding section or appendix in the Case Study companion document. References from this White Paper into the Case Study use those anchors.

Glossary of Key Terms and Acronyms

Terms and acronyms used throughout this White Paper are defined here for reviewer reference. Statutory and clinical terms are summarized; full statutory text and clinical reference works are listed in Appendix A.

Acronyms

- **ACL.** Administration for Community Living.
- **ADA.** Americans with Disabilities Act, 42 U.S.C. sec. 12101 et seq.
- **AHRQ.** Agency for Healthcare Research and Quality.
- **AOT.** Assisted Outpatient Treatment.
- **APS.** Adult Protective Services.
- **CDC.** Centers for Disease Control and Prevention.
- **CIT.** Crisis Intervention Team.
- **CIU-M.** Crisis Intervention Unit: Medical Stabilization.
- **CMS.** Centers for Medicare and Medicaid Services.
- **COBH.** Central Ohio Behavioral Healthcare.
- **CSU.** Crisis Stabilization Unit.
- **DOJ.** United States Department of Justice.
- **ED.** Emergency Department.
- **EMS.** Emergency Medical Services.
- **EMTALA.** Emergency Medical Treatment and Active Labor Act.
- **FND.** Functional Neurological Disorder.
- **HCBS.** Home and Community-Based Services.
- **HHS.** United States Department of Health and Human Services.
- **HIPAA.** Health Insurance Portability and Accountability Act.
- **HRSA.** Health Resources and Services Administration.
- **MFCU.** Medicaid Fraud Control Unit.
- **ODH.** Ohio Department of Health.
- **Ohio-DBH.** Ohio Department of Behavioral Health (formerly Ohio-MHAS).
- **Ohio-MHAS.** Ohio Mental Health and Addiction Services (renamed Ohio-DBH effective October 1, 2025).
- **PACE.** Program of All-Inclusive Care for the Elderly, Balanced Budget Act of 1997.
- **SAMHSA.** Substance Abuse and Mental Health Services Administration.
- **SEIU-M.** Specialized Emergency Intervention Unit: Medical Stabilization.
- **TBI.** Traumatic Brain Injury.
- **TIA.** Transient Ischemic Attack.
- **TVBH.** Twin Valley Behavioral Healthcare.

Framework-Specific Concepts

- **Resolution Gap.** The structural absence of an operational pathway for defendants found incompetent and unrestorable, particularly those already adjudicated incompetent by Probate Court under R.C. Ch. 2111. The asymmetry between the well-developed pathway available to restorable defendants and the absent pathway available to unrestorable defendants. Developed in detail in Part V of this paper.
- **Asymmetry of Pathways.** The structural fact that defendants found incompetent and restorable enter a defined procedural channel, while defendants found incompetent and unrestorable enter procedural suspension that no actor can independently advance or close.
- **Probate Court Coordination.** The contemporaneous integration of Probate Court guardianship adjudications under R.C. Ch. 2111 into subsequent institutional decision-making involving the adjudicated incapacitated person.
- **Causation Investigation.** Contemporaneous review of medication mismanagement, institutional context and elder-abuse factors by APS, Long-Term Care Ombudsman, MFCU and the state survey agency before criminal-legal escalation against a care-facility patient.
- **Least-Restrictive Stabilization.** Placement analysis considering the full continuum of medically appropriate settings, consistent with the Olmstead integration mandate, rather than defaulting to the most restrictive available.
- **Multidisciplinary Review.** Coordinated medical, neurological, psychiatric, rehabilitation, endocrine, trauma-informed, guardianship and continuity-of-care review of a crisis case before high-consequence decisions are made.
- **continuity-of-care preservation. operational mechanism for maintaining established treating-provider relationships, medication regimens and rehabilitation plans through periods of crisis transition.**
- **Four Operational Principles.** Stabilization before escalation. Causation before prosecution. Coordination before adjudication. Stewardship before continuation.

Table of Contents

Eight parts and an appendix. Each section is independently citable.

Front Matter
- Executive Transmittal Letter
- Author's Note
- Reading Frame: Accountability, Not Accusation
- Why This Document Exists
- Specific Request and Action Pathway: 30, 90, 180 and 365 Days
- The SEIU-M / CIU-M Document Package
- Glossary of Key Terms and Acronyms

Part I. The Cost Families Carry and Why This Framework Matters
1. What Families Are Asked to Be
2. What Most Families Cannot Do
3. Six Years of Sustained Caregiving
4. The Cost Families Carry
5. Families Should Not Have to Make These Sacrifices
6. Why SEIU-M / CIU-M Matters
7. Setting Families Up for Success

Part II. The Systems-Level Argument
8. What Many Current Systems Continue Lacking
9. Framework Definition and Systems-Analysis Scope
10. Equity, Public Safety and the Ethical Duty to Protect the Most Vulnerable
11. Why This Moment Requires Action
12. National Crisis Preparedness Doctrine
13. Prevention, Preparedness and Crisis-Response Readiness
14. Structural Gaps Driving Medically Complex Crisis Escalation

Part III. Empirical Anchoring and Ohio Operational Context
15. National Empirical Foundations
16. Ohio Data Baseline and Operational Context
17. Comparative Systems Analysis
18. Alignment With Existing Federal and State Priorities

Part IV. Cross-State Benchmarking
19. Florida: Miami-Dade Eleventh Judicial Circuit Criminal Mental Health Project
20. California: Community Assistance, Recovery and Empowerment Act
21. Washington: Trueblood v. DSHS and the Litigation Pathway
22. Texas: Jail-Based Competency Restoration and Forensic Bed Economics
23. Memphis Model: Crisis Intervention Team Origin
24. Cross-State Summary

Part V. The Statutory Intersection and the Resolution Gap
25. The Statutory Intersection Where No Title Owns the Resolution

26. The Resolution Gap: Two Pathways, One Missing
27. Why Action Cannot Wait

Part VI. The Operational Architecture

28. Current System Limitations vs Proposed Modernized Response
29. Family Integration, Stabilization and Caregiver Partnership
30. Least Restrictive Stabilization and Rehabilitation
31. Workforce Support, Provider Protection and System Stabilization
32. Coordinated Crisis-Response Vision
33. Activation Sequence and Risk Stratification
34. Illustrative Case Vignette
35. Seven-Step Operational Protocol

Part VII. Implementation Framework

36. Phased Rollout Schedule
37. Pilot Region Specifications and Success Criteria
38. Directional Cost-Benefit Analysis
39. Anticipated Concerns and Considered Responses

Part VIII. Closing

40. Vision of Success
41. Historical and National Responsibility

Appendix A. References and Authorities Cited

Part I. The Cost Families Carry and Why This Framework Matters

Why begin a policy theory paper with families? Because the operational gap this paper describes is, in the current architecture, filled by families. The framework's premise is that it should not be.

1. What Families Are Asked to Be

Behind every gap in the architecture this paper describes is a family carrying weight no family was designed to carry. Guardians, caregivers and family members of medically vulnerable individuals are routinely expected to function, under crisis conditions, as legal advocates, medical interpreters, medication-management specialists, hospital navigators, insurance and Medicaid experts, legislative and administrative-law interpreters, interagency diplomats, court coordinators, communication specialists between systems that do not speak to one another, financial guardians under fiduciary duty, records custodians, appointment schedulers, transportation coordinators, crisis responders when professional response fails and emotional anchors for a loved one whose condition is the reason they are fighting in the first place.

This is what families are silently asked to be. The expectation is not articulated. It is built into the structure of crisis-response systems that have not coordinated with one another and into the absence of a coordinating institution responsible for filling the space between them. Where systems are fragmented, families perform the integration. Where institutions do not communicate, families carry the messages. Where information does not transmit, families assemble the record. Where decisions are made in isolation, families coordinate among the decision-makers. This labor is essential to the function of the systems involved. It is invisible inside the formal operations of any of them.

2. What Most Families Cannot Do

Many of the people asked to carry this burden are not equipped, through no fault of their own, to carry it in the form the systems require. Most families do not have legal training. Most do not have clinical training. Most do not have the technical infrastructure, the institutional vocabulary, the time, the financial reserves or the procedural fluency that effective navigation of these systems demands. Even families that do carry one or more of these competencies, including families with education, with professional backgrounds, with the resources to retain counsel and consult specialists, find themselves exhausted by the scale of what coordination across these systems requires when the systems themselves do not coordinate.

The families that cannot do what is asked are not failing. The framework is failing them. A crisis-response architecture that requires family members to function as lawyers, clinicians, legislative interpreters and diplomats to secure protection for a vulnerable loved one is an architecture that has shifted institutional labor onto private individuals. The framework presented in this paper proposes the institutional infrastructure that would relieve families of work that was never properly theirs.

3. Six Years of Sustained Caregiving

The chronology that informs this framework spans approximately six years of sustained direct caregiving and advocacy, beginning at the onset of the COVID-19 pandemic in March 2020 and intensifying with the documented cascade of severe medical destabilization that began in March 2021. Within that period the guardian navigated, on behalf of medically vulnerable family members, the intersection of healthcare systems, long-term care facilities, behavioral-health systems, Probate Court guardianship, common-pleas criminal proceedings, prosecutorial offices, public-defender systems, hospital case management, discharge planning, Adult Protective Services, the Long-Term Care Ombudsman, the Medicaid Fraud Control Unit and federal regulatory authorities. The chronology is documented in the Case Study companion document and informs every operational recommendation in this paper.

The framework's authors recognize that the chronology behind this document is one chronology among many. Across Ohio, across every state, families with comparable experiences exist in numbers that the public record substantially understates. The systems-level proposals in this paper are designed for those families.

4. The Cost Families Carry

The cost families carry is not only emotional. It is financial. It is occupational. It is medical. It is relational. In many cases, it is permanent. Family caregivers experience documented increases in their own mortality risk. They experience documented decreases in their own labor-force participation. They experience documented increases in their own clinical depression, anxiety, sleep disruption and stress-related medical conditions. They experience documented loss of retirement savings, professional advancement, social capital and personal time. None of these costs are tracked in the operating budgets of the systems that produce them. They are externalities, in the formal economic sense.

The proposals in this paper are designed, in part, to internalize these externalities. Where the systems carry their own coordination burden, families are not required to carry it on the systems' behalf. Where the systems carry the costs of their own fragmentation, the costs do not silently transfer to families who cannot afford them.

5. Families Should Not Have to Make These Sacrifices

What families need is not heroism. What families need is institutional infrastructure: coordinated guidance, accessible resources, dedicated navigators, integrated information systems, defined points of contact and the assurance that the systems responsible for protecting medically vulnerable individuals will not require their family members to become lawyers, clinicians, legislative interpreters and diplomats to secure that protection.

The framework respectfully submits that asking families to perform institutional labor under crisis conditions, in the absence of coordinated support, is itself a form of preventable harm. The harm is preventable because the institutional architecture required to relieve it is identifiable, fiscally feasible and consistent with existing federal and state authority. The framework presented in this paper describes that architecture.

The current architecture works for some families. It works for families with resources, with time, with professional connections, with the education to navigate institutional vocabulary and the financial reserves to absorb the cost of years-long advocacy. Most families are not those families. The framework is for the rest.

6. Why SEIU-M / CIU-M Matters

SEIU-M / CIU-M matters because the populations the framework addresses are growing, not shrinking. The clinical complexity is increasing, not decreasing. The fiscal pressure is intensifying, not abating. The constitutional concerns are real and documented, not theoretical. The coordination infrastructure required to address all four is achievable within existing federal and state authority. And the longer coordinated modernization is deferred, the more expensive, more complex and more politically difficult it becomes.

It matters, finally, because of the people the framework is designed to protect. Elderly patients in care facilities. Cognitively impaired adults under guardianship. Adults with traumatic brain injury, dementia, FND, progressive neurological disease, severe developmental disability. People who cannot advocate for themselves. People whose protection depends on the coordinated function of the public systems that exist to provide it. The framework matters because the protection of these populations is, at its core, the test of whether a public-system architecture is functional in the way its constitutional foundations require.

7. Setting Families Up for Success

Workforce Stabilization Considerations

The framework is designed to support not only families but also the healthcare professionals, behavioral-health providers, rehabilitation personnel, emergency responders, judicial officers, public defenders, prosecutors, guardians and interdisciplinary specialists who serve the populations the framework addresses. Workforce stabilization is itself an outcome the framework is designed to produce. When professionals are required to make high-consequence decisions about medically vulnerable individuals without access to complete clinical context, medication history, guardianship information or interdisciplinary consultation, they are exposed to both clinical risk and institutional liability. SEIU-M / CIU-M addresses that exposure directly.

Long-Term Systems Sustainability Considerations

Sustainability requires that the public systems addressed by this framework continue to function as the demographic transition intensifies. The framework's coordination architecture is designed to reduce the operational load that fragmentation currently produces, so that the existing institutions can continue performing their statutory functions without being overwhelmed by the cost of coordinating across each other in real time.

Integrated Clinical, Constitutional and Operational Review Stakeholders

The framework is designed for review across the full institutional context: clinical leadership in hospital systems, long-term care facilities and behavioral-health institutions; constitutional review in judicial and federal civil-rights authorities; and operational review in Medicaid, APS, Long-Term Care Ombudsman, MFCU and survey-and-certification agencies. Each reviewer brings a different lens. The framework is designed to be coherent under each lens.

Executive Overview for Interagency Review

The framework is intentionally designed for interagency review rather than for any single agency's exclusive consideration. The Office of the Governor, the Office of the Attorney General, Ohio-DBH / Ohio-MHAS, the Ohio Department of Medicaid, the Ohio Department of Aging, the Ohio Department of Health, the Supreme Court of Ohio's administrative leadership, the General Assembly's relevant committees, county Probate Courts and county Boards of Developmental Disabilities each have institutional interests the framework is designed to support.

Collaborative Interdisciplinary Modernization Discussion

The framework's authors invite collaborative discussion across the institutional context. The framework is not presented as a finished product. It is presented as the architectural foundation on which a coordinated pilot can be built, with input and refinement from every institutional partner who would carry implementation responsibility.

ETHICS

There is also no clear pathway here for the lawyers on either side. For the defense attorney, there is no ethical road map for representing a client who has been found incompetent and unrestorable, a client who cannot meaningfully assist in their own defense and whose case the system offers no way to resolve. For the prosecutor, there is no clear pathway to discharge the duty to protect public safety while also doing justice, when a case can neither fairly proceed nor properly conclude. This is not sustainable, and it is not sound as a matter of judicial, legislative or systemic design. A system that leaves both the defense and the prosecution without a framework serves no one: not the defendant, not the public and not the court.

Part II. The Systems-Level Argument

The structural diagnosis. What the public-systems architecture is missing and why.

8. What Many Current Systems Continue Lacking

Across the systems engaged by this framework, certain structural gaps persist despite the documented competence of the professionals operating within them. The gaps are operational, not individual. They are produced by the institutional architecture rather than by the people working within it.

Stated as plainly as possible, these are the absences:

- **Unified real-time coordination infrastructure** capable of integrating medical, neurological, behavioral-health, rehabilitation, legal and guardianship information during crisis events involving medically vulnerable populations.
- **A defined resolution pathway** for defendants found incompetent to stand trial and clinically determined to be unrestorable. There is a clear pathway for the restorable defendant. There is no clear pathway for the unrestorable defendant. This asymmetry is the framework's central structural diagnosis and is developed in full in Part V.
- **Coordinated medication-safety review** for psychiatric and non-psychiatric medications at the point of crisis intake.
- **A formal Probate Court interface** for the contemporaneous integration of prior incompetency adjudications under R.C. Ch. 2111 into criminal-legal proceedings.
- **A coordinated elder-abuse and institutional-failure causation investigation process** triggered by qualifying intake characteristics.
- **A continuity-of-care preservation mechanism** that maintains established treating relationships through periods of crisis transition.
- **A least-restrictive placement analysis** that considers the full continuum of medically appropriate settings rather than defaulting to the most restrictive available.
- **A formalized family and guardian integration mechanism** that treats families as stabilization partners rather than external observers.
- **Standardized documentation infrastructure** supporting outcome measurement, audit and continuous improvement.
- **Workforce-support infrastructure** that reduces isolated decision-making burden and supports interdisciplinary consultation.

Each of these absences produces a corresponding harm. The framework's coordination architecture is designed to address them as a coordinated set rather than as discrete reforms. Coordinated implementation, rather than piecemeal reform of any single component, is what produces the systems-level result the framework is designed to achieve.

9. Framework Definition and Systems-Analysis Scope

The SEIU-M / CIU-M framework is defined as a coordinated medical, mental and legal crisis-stabilization layer operating across existing institutional authorities. It is a coordination architecture, not an authority structure. It supplements clinical, judicial, administrative and public-safety institutions. It does not replace them. The framework's scope is bounded by the populations and crisis events it addresses: medically vulnerable individuals, particularly elderly, cognitively impaired, rehabilitation-dependent and guardianship-supported individuals, during qualifying crisis events that intersect with multiple public systems simultaneously.

The systems-analysis scope of this paper is comparable. The paper examines the systems that engage these populations during crisis events, identifies the structural gaps in their coordination, situates the gaps within the broader constitutional, statutory, clinical, demographic and comparative-systems context and proposes a coordination architecture that closes the gaps. The paper does not undertake a comprehensive analysis of any single institution, profession or statutory framework. Its analytical focus is the interstitial space between them.

10. Equity, Public Safety and the Ethical Duty to Protect the Most Vulnerable

Equity, public safety and the ethical duty to protect the most vulnerable are treated as a distinct pillar of the framework. Constitutional principles establish what protective systems must not do. Equity establishes what protective systems must affirmatively do to function legitimately. The two concepts operate on different planes and require separate institutional articulation.

Equity does not mean special treatment. It does not mean favoritism. It does not mean lowering standards. Equity means fairness applied in context and context matters enormously when the individuals at the center of a crisis event are medically fragile, cognitively impaired, developmentally disabled or dependent upon systems they cannot navigate independently. Equality treats every situation the same. Equity ensures that individuals are treated proportionately based on their medical condition, cognitive capacity, vulnerabilities, available supports, demonstrated behavior and actual risk. When unequal situations are treated as identical, the result is not fairness. It is distortion. When liberty is involved, distortion becomes injustice.

Public safety decisions must rest on current clinical presentation, objective medical documentation, demonstrable ongoing risk, proportional assessment and least-restrictive alternatives. They must never be influenced by financial status, access to private experts, ability to fund prolonged litigation or institutional power imbalances. When outcomes correlate with wealth rather than evidence, public safety becomes uneven and inequity, even when unintended, becomes injustice.

Disparities in access to fair forensic evaluation are documented and directly relevant to the populations this framework serves. Individuals whose primary language is not English and those whose behavioral expression is shaped by cultural frameworks not assumed in standard forensic instruments, face compounded barriers, including language-access limitations, cultural-competency gaps in clinical evaluation and systemic inequities in access to independent medical advocacy and specialist review. These disparities do not arise primarily from individual bias. They arise from structural conditions: the absence of coordinated review, reliance on crisis-contact systems that do not integrate prior longitudinal clinical history and the differential access to private resources that allows some families to navigate the gap while others cannot. The SEIU-M / CIU-M framework addresses these structural conditions. By requiring coordinated interdisciplinary review and primary-language interpreter access at intake for all qualifying individuals regardless of financial status, family connections, language or

cultural background, it applies constitutional protections equitably rather than leaving their application to the resources each family can assemble.
Protective systems exist to serve the elderly, the disabled, the cognitively impaired, stroke survivors, individuals with neurological disorders, those with metabolic instability and those unable to advocate for themselves. Safeguards such as due process, least-restrictive principles, guardianship oversight and independent review are not procedural inconveniences. They are the operational safeguards that make protective systems legitimate.

When protective systems disadvantage the vulnerable, whether intentionally or through structural imbalance, the institutional consequence is loss of public faith in fairness. Loss of confidence in due process. Loss of the moral legitimacy of public safety systems. Systems designed to protect must not inadvertently burden the vulnerable more heavily than the powerful. This framework exists to help ensure they do not.

11. Why This Moment Requires Action

The current moment is defined by the convergence of demographic transition, healthcare workforce shortage, behavioral-health escalation, post-pandemic crisis fragmentation, accelerating guardianship caseloads and constrained forensic-system capacity. Each pressure intensifies the others. The infrastructure required to address them is achievable within existing federal and state authority. The longer coordinated modernization is deferred, the larger the cost of deferral becomes. The framework is presented not on the premise that current conditions are catastrophic, but on the premise that current trajectories are unsustainable in the absence of coordinated response.

The behavioral health workforce is experiencing a documented crisis of burnout. Vacancy rates in forensic evaluation, inpatient psychiatric care and long-term care clinical staffing are at historic highs. The isolation of decision-making that fragmented crisis-response systems impose compounds this crisis: clinicians making high-stakes decisions without adequate information support interdisciplinary consultation or shared accountability frameworks experience accelerated burnout at rates that further deplete the workforce the system depends on. The SEIU-M / CIU-M coordination architecture directly reduces the conditions that produce burnout. Shared accountability distributed decision-making interdisciplinary consultation pathways and a coordination infrastructure that provides clinicians with the information they need to make sound decisions reduces the isolated burden that drives workforce attrition. A framework that addresses burnout is not only a clinical reform. It is a workforce sustainability strategy.

12. National Crisis Preparedness Doctrine

The COVID-19 era demonstrated that the United States was not adequately prepared for large-scale crisis-response coordination involving medically vulnerable populations. Healthcare systems, long-term care facilities, behavioral-health systems, courts, guardianship structures and protective-services agencies operated under unprecedented strain. Some performed well. Many did not. The lessons of that period are not academic. They inform the design of crisis-response architecture from this point.

National crisis preparedness doctrine, as developed in federal authorities including FEMA, CDC, the HHS Office of the Assistant Secretary for Preparedness and Response and the HHS Office of the Assistant Secretary for Aging, has historically been oriented toward acute event response: disasters, public-health emergencies, mass-casualty incidents. The doctrine has been less developed in the area of sustained crisis preparedness for the populations this framework addresses, populations whose

vulnerability is structural rather than event-driven and whose coordinated protection requires sustained infrastructure rather than emergency mobilization.

13. Prevention, Preparedness and Crisis-Response Readiness

Prevention is necessary but insufficient. Prevention reduces the rate at which crisis events occur. It does not eliminate them. Preparedness reduces the harm produced by crisis events when they occur. It does not eliminate that harm. Crisis-response readiness, in the context this framework addresses, is the operational capacity to coordinate effectively across multiple public systems when a qualifying crisis event has begun and the response systems are simultaneously engaged. The framework's contribution is in the third category.

14. Structural Gaps Driving Medically Complex Crisis Escalation

Crisis events involving medically vulnerable individuals escalate, in many cases, not because the underlying clinical situation requires escalation but because the response architecture lacks the coordination infrastructure to identify the less-restrictive alternative. The structural gaps driving this escalation include:

- Fragmented intake architecture in which different responding systems (EMS, ED, law enforcement, behavioral-health crisis teams) receive different subsets of the patient's history.
- Time-pressured decision environments in which the comprehensive review the case requires is not operationally available.
- Limited information exchange between treating institutions and crisis-response institutions, even where HIPAA authority for the exchange exists.
- Defaulted escalation in cases of clinical uncertainty, where escalation is the safer institutional choice in the absence of integrated information.
- Absence of structured medication-safety review as a predicate step in behavioral interpretation.
- Absence of routine elder-abuse causation review in care-facility-originating cases.
- Absence of routine Probate Court guardianship coordination in cases involving previously adjudicated incompetent patients.
- Absence of standardized continuity-of-care preservation mechanisms through transition periods.

A distinct and underinvestigated structural gap is medication diversion. The commercial emergence of GLP-1 receptor agonists such as semaglutide, marketed as Ozempic and Wegovy, has created a specific and previously nonexistent financial incentive for diversion in facilities serving elderly diabetic patients. At approximately $1,000 per month, semaglutide is not a controlled substance and is not tracked by DEA diversion monitoring, which means a cognitively impaired resident on semaglutide presents as the lowest-risk, highest-value diversion target in the building, with no electronic access trail. The black market for this medication is documented and active. A diabetic patient denied prescribed semaglutide presents with uncontrolled blood glucose producing behavioral manifestations clinically indistinguishable from primary psychiatric pathology. That presentation becomes the incident report; the incident report becomes the arrest. The framework’s causation-investigation step exists for exactly this reason.

Equity of Access and the Public Coordination Imperative

The framework's analysis includes attention to equity of access to coordinated crisis response. Access to high-quality interdisciplinary review during crisis events is, in the current system, substantially correlated with private resources. Language access compounds this disparity. Medically vulnerable individuals whose primary language is Tigrinya, Amharic or another language other than English face additional barriers in forensic evaluation proceedings, competency hearings and clinical review processes that assume English-language communication. The framework designates interpreter services in the patient’s primary language as a mandatory intake protocol requirement not a discretionary accommodation. Families with means can retain consultants, second opinions, specialist evaluations, private counsel and independent medical advocacy. Families without means cannot. The framework's public-coordination architecture is designed to support comparable access regardless of private resources. Constitutional protections and equity considerations align in this design.

Core Constitutional and Civil-Rights Principles

Six core constitutional and civil-rights principles anchor the framework: due process, equal protection and equal protection of the laws under the Fourteenth Amendment to the United States Constitution, the right to be free from indefinite confinement under Jackson v. Indiana, the right to community integration under Olmstead v. L.C. and Title II of the ADA, the right to procedural and substantive fairness in competency proceedings under Dusky v. United States and Sell v. United States and the right to reasonable accommodations under Section 504 of the Rehabilitation Act. These principles are not modified by the framework. They are operationalized by it.

Part III. Empirical Anchoring and Ohio Operational Context

The numbers behind the argument. National foundations and Ohio-specific data baseline.

15. National Empirical Foundations

The framework's empirical case rests on a small number of well-documented national findings, supplemented by Ohio-specific data and by the comparative-systems literature reviewed in Part IV. The headline findings are these.

Adverse drug events in older adults. Adults 65 and older account for 43.6 percent of all emergency hospitalizations from adverse drug events, per research published in JAMA in 2016 by Shehab and colleagues. Approximately 99,628 emergency hospitalizations for adverse drug events occur annually in this population, per Budnitz and colleagues in the New England Journal of Medicine, 2011. Adverse drug events drive more than 1.5 million emergency-department visits annually in the United States, with nearly 500,000 resulting in hospitalization, per CDC Medication Safety FastStats, 2024.

Elder abuse prevalence. Approximately one in ten older adults living independently experiences abuse, neglect or exploitation annually, according to the CDC and the National Center on Elder Abuse. Within institutional settings, detection rates are lower and prevalence is higher.

Competency restoration trend. Court-ordered competency-to-stand-trial referrals have increased dramatically in tracked state systems over recent decades, with documented waitlists rising from weeks to months or years in multiple states, according to SAMHSA's 2023 analysis.

Forensic-bed cost. State forensic bed cost is approximately $790 per day, per the Texas Health and Human Services Commission State Hospital Cost Study, 2024, used as a representative reference figure. A single multi-year forensic placement of an unrestorable defendant exceeds $280,000 per year in bed cost alone, before associated clinical, judicial, transportation, evaluation and administrative costs.

Antipsychotic utilization shift. National prevalence of antipsychotic use among long-stay nursing-home residents was reduced from 23.9 percent in 2011 to 14.4 percent by 2021 under the CMS National Partnership to Improve Dementia Care. The reduction demonstrates that structural intervention can meaningfully change institutional medication practice. It also demonstrates that the prior baseline was substantially higher than clinical appropriateness justified.

National caregiving scale. An estimated 53 million U.S. adults provide unpaid care to a family member or friend. Approximately 11 million are caring for someone with Alzheimer's disease or another dementia. The population aged 65 and older will reach 80 million by 2040. One in three adults will, at some point, serve as a family caregiver. One in nine adults over 65 lives with Alzheimer's disease or related dementia. Sources include the Alzheimer's Association 2024 Facts and Figures and AARP / National Alliance for Caregiving, Caregiving in the United States 2020.

16. Ohio Data Baseline and Operational Context

Behavioral Health and Criminal Justice Intersection

The intersection of behavioral health and criminal justice is, in operational terms, the location where most of the framework's qualifying cases originate. Crisis-response infrastructure in Ohio includes the 988 Suicide and Crisis Lifeline (established under the Bipartisan Safer Communities Act of 2022), regional mobile crisis teams, Crisis Stabilization Units, hospital Emergency Departments and law-enforcement Crisis Intervention Team programs. Each component performs its function within its scope. The framework adds a multidisciplinary medical-stabilization, forensic-support and guardianship-coordination layer that bridges these components when medical, neurological, rehabilitation and continuity-of-care factors intersect with public-safety or judicial decision-making.

Forensic Competency System

Forensic patients now occupy approximately 93 percent of available Ohio state psychiatric hospital beds, per the Office of the Governor of Ohio, Governor's Work Group on Competency Restoration and Diversion, 2024. The displacement of civil patients and the constraint of state-facility capacity by forensic occupancy is a documented operational reality, not a projection. The framework's coordination architecture is designed to reduce forensic-bed demand for cases in which forensic placement is not the appropriate clinical response.

Adult Guardianship Caseload

Ohio's active adult guardianship caseload rose from approximately 42,000 cases in 2011 to approximately 49,000 cases in 2020, with 6,000 to 7,000 new guardianship applications filed annually, per the Supreme Court of Ohio, Case Management Section. The growth trajectory is consistent with the broader demographic transition and is projected to continue. Coordinated interface between criminal courts and Probate Courts is, accordingly, an increasingly structural rather than occasional need.

Ohio Aging Population and Demographic Pressure

Ohio's population aged 65 and older is projected to continue growing through 2040, consistent with national trends. Demographic pressure on healthcare, long-term care, behavioral-health, judicial and protective-services systems will continue intensifying. The framework's coordination architecture is designed to support these systems through the demographic transition rather than to add new institutional load to systems already operating under strain.

Adult Protective Services and Elder Justice

Ohio's Adult Protective Services framework, administered by the Ohio Department of Job and Family Services (ODJFS) and operating under R.C. Ch. 5101 and coordinated with the Ohio Attorney General's Elder Justice Unit, holds state authority for elder-abuse investigation. The framework's elder-abuse causation investigation protocol is designed to support, not replace, this existing statutory authority by triggering its activation at qualifying intake events.

The federal regulatory architecture reinforces this authority. The Centers for Medicare and Medicaid Services enforces nursing-home Conditions of Participation under 42 C.F.R. Part 483, establishing binding standards for resident rights, quality of care and pharmacy services. Medication-management failures that the framework’s causation investigation identifies are subject to enforcement through F-tag citations, creating an administrative record of regulatory failure that is independent of and parallel to any criminal proceeding.

Crisis Response Infrastructure

Ohio's crisis-response infrastructure includes 988, regional mobile crisis teams, Crisis Stabilization Units, hospital Emergency Departments and law-enforcement CIT programs. Each component performs its function. The framework adds the multidisciplinary medical-stabilization, forensic-support and guardianship-coordination layer that connects them at the point of a qualifying event.

Operational Implications for Framework Design

The Ohio data baseline supports four operational implications for framework design. First, the populations the framework addresses are large enough to make coordinated infrastructure structurally necessary rather than incidentally useful. Second, the forensic-system capacity strain is sufficient to make coordinated upstream triage fiscally and operationally rational. Third, the demographic transition will continue intensifying pressure on every public system the framework engages. Fourth, the existing institutional architecture contains the statutory authorities required for coordinated implementation; what is missing is the coordination infrastructure itself.

17. Comparative Systems Analysis

Existing crisis-response, behavioral-health and forensic-evaluation programs each address a portion of the complexity surrounding medically vulnerable individuals in crisis. None integrates the full range of disciplines required for cases involving overlapping medical, neurological, psychiatric, cognitive, developmental, trauma-related, rehabilitation and continuity-of-care factors. The table below summarizes the scope of each existing program and the gap SEIU-M / CIU-M is designed to address.

Existing Program	Primary Function	Population Served	Limitation Relative to SEIU-M / CIU-M Scope
Crisis Intervention Team (CIT)	Law enforcement training in mental health de-escalation.	Individuals in behavioral crisis encountered by police.	Officer-level training only; no multidisciplinary medical evaluation, neurological differentiation or court-integrated review.
Mental Health Court	Court-based diversion for defendants with serious mental illness.	Criminal defendants with diagnosed mental illness.	Post-charge intervention; narrow for medical complexity beyond psychiatric; treatment menu typically limited.
Drug Court	Court-based diversion for substance-use-related offenses.	Defendants with primary substance-use issues.	Substance-specific; does not address concurrent neurological, cognitive or medication-stabilization needs.
Crisis Stabilization Unit	Short-stay psychiatric stabilization as alternative to ED or jail.	Acute psychiatric crisis presentations.	Behavioral-health focused; limited neurological, geriatric or rehabilitation integration; not court-integrated.
Mobile Crisis Team	Community-based field response to behavioral-health emergencies.	Individuals in behavioral crisis in the community.	Field-response oriented; limited capacity for sustained multidisciplinary review or forensic support coordination.
Forensic Competency Evaluation	Court-ordered assessment of competency to stand trial.	Defendants whose competency is in question.	Competency-focused; does not address medical stabilization, neurological differentiation or continuity of care.
988 / Crisis Now	Behavioral-health crisis hotline and dispatch coordination.	General population in mental-health crisis.	Triage and dispatch oriented; no sustained multidisciplinary review or forensic interface.
Assisted Outpatient Treatment	Court-ordered outpatient mental-health treatment.	Individuals meeting statutory AOT criteria.	Treatment-compliance focused; does not address acute medical destabilization or rehabilitation continuity.

Existing Program	Primary Function	Population Served	Limitation Relative to SEIU-M / CIU-M Scope
Geriatric Comprehensive Assessment	Outpatient evaluation of older adults' health and function.	Older adults referred for cognitive or functional concerns.	Elective and outpatient; not designed for crisis activation or forensic interface.

SEIU-M / CIU-M does not replicate or replace these programs. It supplements them by providing the multidisciplinary, court-integrated, medical-stabilization layer that bridges them when medical, neurological, rehabilitation and continuity-of-care factors intersect with public-safety or judicial decision-making.

Cross-Program Coordination Pathway

A medically vulnerable individual may interact with several of the above programs sequentially or simultaneously during a single crisis arc. The current default treats each interaction as discrete. SEIU-M / CIU-M coordination treats them as parts of a single stabilization pathway, ensuring that information generated at each stage informs the next decision rather than dissipating between handoffs.

18. Alignment With Existing Federal and State Priorities

The SEIU-M / CIU-M framework is designed to operate within the established federal and state policy environment rather than alongside it. Its medical-stabilization, multidisciplinary-review and least-restrictive-placement architecture align with priorities already articulated in federal civil-rights law, federal behavioral-health policy, federal elder-protection authority and Ohio agency leadership.

In this respect SEIU-M / CIU-M is the missing implementation piece for the national behavioral-health crisis strategy. The Bipartisan Safer Communities Act of 2022 and the American Rescue Plan Act (ARPA) behavioral-health infrastructure funding established and resourced the 988 Suicide and Crisis Lifeline and the broader crisis-response continuum. The framework extends that continuum to the specific population whose crisis contact occurs through the criminal-legal system rather than the behavioral-health system, applying the no-wrong-door principle to a population the 988 architecture does not currently reach.

Existing Federal or State Priority	How the Framework Aligns
ADA Title II Integration Mandate and Olmstead Enforcement	Operationalizes the integration mandate by routing medically complex crises through a least-restrictive-placement review pathway, supporting community integration over institutional default.
Section 504 of the Rehabilitation Act	Provides communication, cognition and functional accommodations within the multidisciplinary review process, consistent with Section 504 program-access obligations.
SAMHSA National Guidelines for Behavioral Health Crisis Care	Adds a court-integrated multidisciplinary medical-stabilization layer to the crisis-care continuum, complementing 988 triage and mobile crisis dispatch.

Existing Federal or State Priority	How the Framework Aligns
988 Suicide and Crisis Lifeline and Crisis Now Best Practices	Provides downstream sustained multidisciplinary review for cases triaged through 988 and dispatched to mobile crisis teams.
Stepping Up Initiative (jail diversion for mental illness)	Adds a medical-stabilization layer to existing county Stepping Up efforts, addressing medically complex cases where psychiatric-only diversion is insufficient.
Elder Justice Act and Elder Justice Coordinating Council priorities	Provides an operational pathway for elder-justice cases requiring coordinated medical, cognitive and protective review.
Older Americans Act service infrastructure	Coordinates with Area Agencies on Aging and existing elder-services networks during crisis events involving older adults.
HIPAA Privacy Rule and minimum-necessary information sharing	Builds documentation infrastructure consistent with HIPAA permitted disclosures for treatment, payment and healthcare operations.
EMTALA emergency screening obligations	Supports compliance by ensuring medical screening is not displaced by premature psychiatric or custodial classification.
Medicaid 1115 demonstrations and 1915(c) HCBS authority	Identifies sustainable funding pathways for multidisciplinary stabilization services through existing Medicaid authority.
Medicare Hospital Conditions of Participation	Supports compliance with discharge planning, care coordination and patient-rights requirements for hospital partners.
Ohio Adult Protective Services authority	Provides operational coordination for APS cases involving medical complexity requiring multidisciplinary review.
Ohio Guardianship Code (R.C. Ch. 2111)	Supports informed guardian participation in stabilization decisions consistent with statutory guardianship duties.
Ohio Competency-to-Stand-Trial procedures (R.C. Ch. 2945)	Supplements forensic competency evaluation with medical, neurological and rehabilitation context where clinically relevant.
Ohio Civil Commitment Statutes (R.C. Ch. 5122)	Ensures medical and neurological differentiation before psychiatric commitment proceedings where clinically appropriate.
AHRQ medication safety and reconciliation guidance	Implements polypharmacy review, medication reconciliation and adverse-effect screening as part of multidisciplinary review.

Each partner agency can recognize the framework as a complement to priorities already in motion, not a new mandate from outside. This means structured extension of work already in its mandate rather than a competing initiative requiring new authority.

Part IV. Cross-State Benchmarking

Ohio is not entering unfamiliar territory. Five states have already confronted this collision point in different ways. Each offers a lesson.

Across the country, states have already confronted the same collision point between psychiatric-hospital capacity limits, forensic-competency backlogs, medically fragile patients and fragmented crisis-response systems. Some expanded diversion authority. Others built regional forensic-coordination structures or relied more heavily on community stabilization networks to reduce institutional strain. The results have been uneven. In several cases the operational gaps simply shifted from one agency to another rather than being resolved. The purpose of this section is not to present a national best-practices catalogue. It is to identify the specific structural lessons, both successful and unsuccessful, that informed development of the SEIU-M / CIU-M framework for Ohio.

19. Florida: Miami-Dade Eleventh Judicial Circuit Criminal Mental Health Project

Judge Steve Leifman established the Eleventh Judicial Circuit Criminal Mental Health Project in 2000. More than two decades later it is the most fully developed jail-diversion and forensic-coordination model in the country. The program runs on two tracks: pre-arrest Crisis Intervention Team training, covering thousands of officers across the Miami-Dade municipal police agencies and post-booking jail diversion for defendants with serious mental illness. Recidivism in the year after release fell from approximately 75 percent to 20 percent for participating defendants.

Capital investment followed sustained results. Miami-Dade County issued substantial general-obligation bond funding to convert a decommissioned 208-bed forensic state hospital into a comprehensive treatment facility. The renovation grew into the Miami Center for Mental Health and Recovery, approximately 181,000 square feet, seven stories, consolidating crisis care, trauma services, supportive housing, primary medical and dental care and a Living Room model for high-utilizers. Miami-Dade County contributed approximately $34.1 million in construction funding. Jackson Memorial Hospital contributed approximately $8 million.

The operational data is directly relevant to Ohio. CIT response logs from the two largest Miami-Dade agencies recorded approximately 83,427 mental-health calls through 2017 with only 149 resulting arrests, an arrest rate of less than two-tenths of one percent. Internal cost analysis put diversion at roughly one-third less per defendant than standard state-hospital competency restoration. The program has hosted study delegations from more than twenty states.

What Ohio takes from Miami-Dade. A sustained judicial-administrative champion. County-level fiscal commitment. Hospital-system partnership. Statutory authority for outpatient and community-based pathways. None of these are transferable as a package, but the component architecture (pre-booking CIT, post-booking diversion, forensic-alternative facility, integrated wraparound) maps cleanly onto what SEIU-M / CIU-M proposes.

20. California: Community Assistance, Recovery and Empowerment Act

Governor Newsom signed the CARE Act in 2022. By December 2024, every one of California's 58 counties was implementing it. The law created a non-criminal civil-court pathway: family members, first responders and healthcare or social-service providers can petition a civil court for court-ordered treatment, services, support and housing for individuals with schizophrenia or other psychotic disorders. CARE plans run up to twelve months, extendable an additional twelve. SB 27, signed in October 2025, expanded eligibility to bipolar I disorder with psychotic features effective January 1, 2026.

California built several protections into the design. Every respondent receives legal counsel. Each can name a voluntary supporter to help navigate the process. Psychiatric advance directives are encouraged. Counties that fail to deliver services ordered by the court can be fined or placed under an external manager. From October 2023 through October 2024, courts received approximately 869 petitions, ordered more than 175 CARE agreements and plans and had approximately 516 petitions actively engaged.

The civil-liberties challenges were predictable and material. Disability Rights California and the Public Interest Law Project argued the program violates due process, equal protection, autonomy and privacy. The California Supreme Court upheld it. The caseload is moving. The cost is real. The friction is permanent. Any state contemplating court-ordered treatment authority should expect a similar trajectory.

Why this matters for SEIU-M / CIU-M. California demonstrates that statewide implementation of a court-integrated mental-health framework is politically feasible at scale and that civil-liberties friction is inevitable wherever the courts order treatment. The SEIU-M / CIU-M proposal sidesteps that friction by design. No new coercive authority is requested during the pilot. Coordination and information-sharing are the levers, not compelled treatment. California's mandatory-counsel and supporter elements are worth borrowing; its coercion architecture is not.

21. Washington: Trueblood v. DSHS and the Litigation Pathway

Washington State did not choose its reform. The federal court chose it for Washington. In Trueblood v. Washington State Department of Social and Health Services (2014), the U.S. District Court for the Western District of Washington found that the state's prolonged detention of competency-restoration defendants, often exceeding constitutional limits established under Jackson v. Indiana (1972), violated due process. The court ordered remedial measures, then issued enforcement orders, then contempt findings, then per-day monetary sanctions when the state continued to fall short. More than a decade later the case is still active. Cumulative remedial expenditure has been substantial.

The lesson for every state with competency-restoration backlogs is direct: inaction is not cost-neutral. Litigation exposure is not theoretical. Ohio has been actively preparing. The 2021 statutory diversion of nonviolent misdemeanors to outpatient competency restoration, the establishment of the Ohio Forensic Centers Consortium in 2022 and the convening of the Governor's Work Group on Competency Restoration and Diversion in 2024 are all parts of that preparation. SEIU-M / CIU-M reinforces it by adding the medical-stabilization layer for cases where competency restoration is not the right clinical answer in the first place.

The federal enforcement dimension of this national pattern is documented and active. The Department of Justice Civil Rights Division has investigated and entered into settlement agreements with multiple states regarding the constitutional adequacy of mental health and competency restoration services for institutionalized persons. These enforcement actions reflect the federal government’s recognition that the Resolution Gap and the constitutional asymmetry Jackson identified, are not aberrations. They are structural conditions present across state systems. Ohio’s decision to address this condition through a

collaborative pilot, before federal court involvement, is the posture that produces the best outcome for every institution the framework engages. Trueblood v. Washington DSHS was not a policy choice. It was a federal court order issued after years of inaction. The SEIU-M / CIU-M proposal is designed to produce the Trueblood outcome through institutional collaboration rather than litigation.

Bottom line. Federal-court remediation is more expensive than early coordinated reform. Washington is the cautionary example.

22. Texas: Jail-Based Competency Restoration and Forensic Bed Economics

Texas chose a different response to state forensic-hospital capacity constraints: jail-based competency restoration units deployed in selected counties. The fiscal pressure that drove the choice is well-documented. The Texas Health and Human Services Commission State Hospital Cost Study put operational cost at approximately $790 per bed per day in state forensic settings. A single multi-year forensic placement of an unrestorable defendant exceeds $280,000 per year in bed cost alone, before any associated clinical, judicial, transportation, evaluation or administrative spending.

Jail-based competency restoration units reduce inpatient demand and per-defendant restoration cost. They also raise hard questions about therapeutic environment, due process and the appropriateness of restoring competency to people who remain in custody throughout. Ohio's outpatient pathway is built specifically to avoid those questions.

For Ohio's planning. Forensic-bed economics make the fiscal case for diversion straightforward. Texas demonstrates one response. Ohio's outpatient and stabilization-first approach is another. SEIU-M / CIU-M sits upstream of the inpatient-versus-jail-based choice, identifying cases where neither restoration setting is appropriate before the system commits to either.

23. Memphis Model: Crisis Intervention Team Origin

The Memphis Police Department and the University of Tennessee developed the Crisis Intervention Team (CIT) model in 1988. It is the foundational pre-arrest behavioral-health diversion framework and jurisdictions across the country, including most large Ohio agencies, have adopted some version of it. CIT provides approximately forty hours of mental-health-response training to law enforcement, paired with partnership with designated psychiatric receiving facilities. The model is mature, well-studied and effective at what it does. It addresses pre-booking field encounters. It does not provide the multidisciplinary medical-stabilization, forensic-support or guardianship-coordination layer SEIU-M / CIU-M proposes.

24. Cross-State Summary

State / Program	Year	Primary Function	Limitation Relative to SEIU-M / CIU-M Scope
Florida: Miami-Dade 11th Circuit CMHP	2000	Pre-arrest CIT + post-booking jail diversion + forensic alternative facility.	Behavioral-health focused; does not specifically address medically complex unrestorable cases or guardianship-court parallel-adjudication conflicts.
California: CARE Act	2022 (statewide 2024)	Civil-court pathway for court-ordered treatment for schizophrenia and psychotic disorders.	Diagnosis-specific; coercive court order with civil-liberties friction; not designed for medically complex multidisciplinary stabilization.
Washington: Trueblood Enforcement	2014 (ongoing)	Federal-court enforcement of competency-restoration timing under Jackson v. Indiana.	Litigation-driven rather than earlyly designed; remedial expense exceeds early system development.
Texas: Jail-Based Competency Restoration	Selected counties, ongoing	In-custody competency restoration as alternative to state hospital placement.	Restoration setting raises therapeutic and due-process concerns; does not address cases unsuitable for restoration.
Memphis (origin) and Ohio: CIT	1988 / progressive adoption	Law-enforcement training for behavioral-health response.	Pre-booking field response only; no multidisciplinary medical evaluation or court-integrated review.
Ohio: SEIU-M / CIU-M (proposed)	Pilot 2026 to 2027	Multidisciplinary medical-stabilization, forensic-support and guardianship-court coordination for medically vulnerable populations, including the unrestorable.	Adds the medical-stabilization, neurological-differentiation and guardianship-coordination layer existing programs do not provide.

The cross-state record makes clear that states eventually move when forensic delays; psychiatric-capacity strain and crisis-system fragmentation begin producing institutional instability, litigation exposure or unsustainable emergency-response burdens. The question is rarely whether reform will occur but whether it will occur early through structured modernization or reactively under external pressure after systemic failure. Existing state models demonstrate pieces of the solution, yet none directly resolves the operational gap involving medically vulnerable, already-adjudicated incompetent individuals whose behaviors may themselves emerge from institutional neglect, medication destabilization, elder abuse or continuity-of-care breakdowns. That unresolved gap is where Ohio has an opportunity to lead nationally instead of being forced later into fragmented corrective action through prolonged litigation, federal intervention or crisis-driven remediation.

Part V. The Statutory Intersection and the Resolution Gap

The analytical center of the paper. The Resolution Gap is the structural diagnosis this White Paper is built around. Every other section in the paper supports the analysis developed here.

25. The Statutory Intersection Where No Title Owns the Resolution

The Resolution Gap exists, in part, because no single statutory title was written to govern it. The table below illustrates the gap across the five Ohio Revised Code chapters that collectively govern this population. Each chapter addresses part of the situation. None owns the resolution.

Ohio Revised Code Chapter	Subject Matter	What It Fails to Provide in the Unrestorable Pathway
Chapter 2945	Criminal Procedure, Competency to Stand Trial and Restoration.	No operational disposition pathway for the patient who cannot be restored and does not meet civil-commitment criteria. The chapter assumes civil commitment or release will absorb the case. Neither mechanism is consistently available.
Chapter 5122	Hospitalization of Mentally Ill Persons, Civil Commitment.	Does not address what happens when a stabilized patient simultaneously has open criminal charges that Chapter 2945 has not resolved. The stabilized unrestorable defendant frequently does not meet civil-commitment criteria.
Chapter 2111	Guardianship of Persons and Estates, Probate Court Jurisdiction.	Contains no mechanism for transferring jurisdiction over a criminal matter from the trial court to the Probate Court. Guardianship governs the patient's person and estate but cannot resolve open criminal charges.
Chapter 5119	Ohio-DBH / Ohio-MHAS, Behavioral Health and Forensic Services.	Delegates restoration treatment to Ohio-DBH / Ohio-MHAS-designated forensic centers but does not delegate to any administrative entity the authority to resolve unrestorability cases the criminal court has not disposed of.
Chapter 5160	Department of Medicaid, Funding and Reimbursement.	Contains no defined category for the continued placement of a stabilized, unrestorable patient with open criminal charges. Funding for prolonged placement without therapeutic justification is operationally ambiguous.

Each chapter presumes the others will provide the missing resolution mechanism and none does. The framework does not propose abolishing the existing chapters. It proposes the creation of a coordination architecture that operates at the intersection: a defined statutory and administrative pathway through which the gap is closed and the patient is afforded a resolution that the current titles, operating independently, cannot produce.

26. The Resolution Gap: Two Pathways, One Missing

Here is the structural injustice at the analytical center of this White Paper, stated as plainly as it can be stated.

There is a clear pathway for the person found legally incompetent and restorable.

There is no clear pathway for the person found legally incompetent and unrestorable.

Once a court finds that a defendant lacks the present capacity to understand the proceedings or assist in their own defense under the Dusky v. United States standard, the legal process formally branches. The defendant found incompetent and restorable enters a well-developed procedural channel. Restoration treatment is initiated under time-limited standards. Periodic competency reviews are conducted. If restoration succeeds, the case resumes. If restoration fails within the constitutionally permitted period, proceedings transition toward civil-commitment evaluation or charge resolution. The pathway is imperfect. It exists. It functions. Every actor inside the system understands its sequence. The defendant moves through it. The case moves toward conclusion.

The defendant found incompetent and unrestorable enters a pathway that has no comparable architecture.

The clinical finding that restoration is not possible, typically grounded in dementia, traumatic brain injury, advanced cognitive decline, progressive neurological disease, severe developmental disability or stable post-acute medical conditions, is one of the most clinically definitive determinations a competency evaluator can render. Yet the procedural consequence of that determination is, in many jurisdictions, indeterminate. There is no equivalent statutory timeline. No clearly assigned coordinating authority. No defined transition mechanism. No consistent endpoint. The case enters legal limbo. It does not move forward. It does not close. It does not transition. It continues.

This is the asymmetry. It is the structural fact this paper is built around. It is the structural fact every other document in the package returns to. It is also, in plain terms, a kind of architectural failure that deserves to be named for what it is. To build a careful pathway for the people the system can restore and to leave the people the system cannot restore in indefinite procedural suspension, is not a neutral architectural decision. It is the choice to make a population disappear inside a process that no one can advance and no one is responsible for closing.

The Already-Adjudicated Incompetent Person and Probate Court Coordination

A particular constitutional concern arises in the case of patients who have already been adjudicated incompetent by Probate Court before their entry into the criminal-legal system. For these patients, the competency analysis is conducted twice: once by the Probate Court under R.C. Ch. 2111 and again by the criminal court under R.C. Ch. 2945.

Under R.C. Ch. 2111, these wards have already been determined by a court of competent jurisdiction to lack the capacity to manage their own medical care, their medications, their residential placement, their financial affairs, their legal decisions, their daily routines, their communication with institutions and their participation in administrative or judicial proceedings. A sitting court has done that work. The Probate Court's adjudication is on the record.

The criminal-legal system that engages with such a patient is not engaging with a free legal actor of intact capacity. It is engaging with an adjudicated incapacitated person whose authority over his own medical care, residence and participation in proceedings has been vested in a court-appointed guardian. The structural question is whether the criminal-legal architecture has the operational

mechanisms to recognize, in real time, that the defendant brought into the system is already adjudicated incompetent under R.C. Ch. 2111 and to integrate the Probate Court's prior adjudication into the criminal proceedings from the moment of intake.

A justice-system judge cannot make a fair decision about a defendant whose legal incompetence has already been adjudicated by a sitting court without that adjudication being formally integrated into the proceedings. Coordination with the Probate Court is not a courtesy. It is a prerequisite to fair adjudication, for all parties: defendant, prosecutor, trial court, Probate Court, guardian, family, professionals.

The framework asks for that coordination to happen by structural design, not by guardian heroics. The sequence the framework proposes is straightforward. Discovery before charges. Causation before indictment. Coordination with the Probate Court before the trial court is asked to decide. None of that requires new authority. All of it requires that existing authority be exercised in the right order.

Constitutional Anchors

The constitutional architecture governing the Resolution Gap is well-developed in doctrine. It is operationally underdeveloped in practice. The governing framework is this:

- **Dusky v. United States, 362 U.S. 402 (1960).** The competency-to-stand-trial standard. A defendant must have sufficient present ability to consult with counsel with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings.
- **Jackson v. Indiana, 406 U.S. 715 (1972).** A defendant committed solely on the basis of incompetency to stand trial cannot be held indefinitely. Continued confinement must bear a reasonable relationship to the purpose of restoration. If restoration is not possible within a reasonable period, the State must either initiate the customary civil-commitment proceedings or release the individual.
- **Sell v. United States, 539 U.S. 166 (2003).** The standard for involuntary medication for the purpose of restoring competency.
- **Olmstead v. L.C., 527 U.S. 581 (1999).** The integration mandate under Title II of the ADA. Public entities must provide services in the most integrated setting appropriate to the needs of the individual.
- **Title II of the Americans with Disabilities Act, 42 U.S.C. sec. 12131 to 12134.** The prohibition on disability-based discrimination by public entities.
- **Section 504 of the Rehabilitation Act, 29 U.S.C. sec. 794.** The prohibition on disability-based discrimination in federally funded programs.
- **The Elder Justice Act of 2010, 42 U.S.C. sec. 1397j et seq.** Federal authority for elder-abuse prevention, investigation and coordination.
- **Barker v. Wingo, 407 U.S. 514 (1972).** The Sixth Amendment speedy trial right is separately implicated by the Resolution Gap. The Court’s four-factor balancing test, weighing length of delay, reason for delay, the defendant’s assertion of the right and prejudice to the defendant, is satisfied for a defendant found incompetent and unrestorable who remains in procedural limbo for years. The Jackson holding further requires that commitment not exceed the reasonable period necessary to determine whether there is a substantial probability that the defendant will attain competency in the foreseeable future. Where no substantial probability of restoration exists, the State must civilly commit or release.

Each of these authorities supports a coordinated, time-bounded, least-restrictive approach to the unrestorable defendant. None of them is altered by the framework. The framework's contribution is the institutional infrastructure required to make the existing constitutional architecture operationally functional at the point of a crisis event.

Humanitarian Considerations

Behind every procedural description of this gap is a human experience. The defendant is stuck inside a system that cannot proceed. Capable neither of advancing nor of withdrawing from the process. Confronted with the recognition that no path forward exists. Abandoned inside a process no actor can independently resolve. Required to navigate procedural complexity that cognitive impairment precludes. Interpreted through legal categories that do not align with clinical reality. Forgotten by systems whose calendars no longer prioritize the case. Deprived of the dignity of resolution.

For medically vulnerable elderly patients, the Resolution Gap produces compounding harms that exceed those produced for younger, less medically complex populations: accelerating cognitive decline associated with prolonged institutional placement; sustained disruption of treating-provider relationships; sustained disruption of established medication regimens; sustained risk of medication mismanagement within institutional contexts; sustained loss of rehabilitation gains; sustained loss of cultural, linguistic, faith and community continuity; sustained family separation during years that cannot be returned; sustained trauma exposure within institutional environments; and increased mortality risk associated with elder institutional placement under conditions of disrupted continuity.

In a meaningful number of cases, elderly defendants do not survive the resolution process. The fiscal, constitutional and humanitarian case for closing the gap is time-sensitive in a way that the gap's current administrative architecture does not acknowledge. People are dying inside this gap before resolution reaches them. That fact deserves to be stated.

27. Why Action Cannot Wait

Action cannot wait because the costs of inaction are accumulating. Each unresolved unrestorability case consumes finite forensic-bed capacity, court calendar capacity, Medicaid expenditure, healthcare workforce capacity and family resilience. Each unaddressed structural gap produces predictable downstream harm. Each year of deferral compounds the demographic transition, the workforce strain and the constitutional exposure that early modernization would mitigate. The framework respectfully submits that the case for coordinated action is supported by both the humanitarian record of harm in the current system and the fiscal record of cost in continued fragmentation.

Part VI. The Operational Architecture

How the framework actually works. From current limitations to modernized response. Including the seven-step protocol that closes the gap.

28. Current System Limitations vs Proposed Modernized Response

The structural argument for SEIU-M / CIU-M can be summarized as the difference between the current fragmented response and the proposed modernized response. The table below presents that contrast at a high level. The Operational Implementation Framework (Proposal) develops each row in operational detail.

Current System Limitation	SEIU-M / CIU-M Modernized Response
Fragmented reassessment across disconnected institutional silos.	Integrated interdisciplinary review pathways with unified clinical information.
Behavioral presentation automatically triggers medication escalation.	Medication-safety reassessment and psychotropic-risk review, including non-psychiatric medications, before escalation.
Discharge instability and continuity-of-care breakdown.	Structured continuity-of-care coordination and discharge-preparedness protocols.
Repeated crisis cycling without root-cause review.	Rehabilitation-focused stabilization addressing underlying clinical drivers.
Isolated institutional response without cross-system coordination.	Collaborative systems coordination through a unified interagency framework.
No resolution pathway for defendants found incompetent and unrestorable.	Resolution Gap protocol: stabilization, medication review, observation, elder-abuse investigation, guardian coordination, multidisciplinary review and coordinated disposition.
Guardian and family excluded from crisis decisions.	Structured family integration and guardian participation as formal stabilization partners.

29. Family Integration, Stabilization and Caregiver Partnership

Families and long-term caregivers possess critical insight involving baseline functioning, medication history, trauma responses, rehabilitation patterns, behavioral changes, continuity-of-care history and stabilization needs that may not be immediately visible during isolated crisis evaluation. The framework recognizes families as potential stabilization partners capable of supporting continuity, rehabilitation progress and long-term recovery when collaborative structures are functioning appropriately. Family integration is treated as an operational element of stabilization, not as an external courtesy.

30. Least Restrictive Stabilization and Rehabilitation

Least-restrictive stabilization is the operational expression of the Olmstead integration mandate. In every transition decision, the framework supports analysis of the full continuum of medically appropriate settings, from home with home-support infrastructure through ED observation, inpatient rehabilitation, skilled-nursing placement and, where clinically necessary, psychiatric inpatient or secure placement. The framework does not predetermine the appropriate setting. It ensures that the analysis is conducted across the full continuum rather than defaulting to the most restrictive available option.

31. Workforce Support, Provider Protection and System Stabilization

The framework is designed to protect not only vulnerable individuals and families but equally the healthcare professionals, behavioral-health providers, rehabilitation personnel, emergency-response teams, legal professionals and interdisciplinary specialists currently operating under extraordinary pressure in crisis environments that lack adequate coordination infrastructure. When professionals are required to make high-consequence decisions about medically vulnerable individuals without access to complete clinical context, medication history, guardianship information, continuity-of-care records or interdisciplinary consultation, they are exposed to both clinical risk and institutional liability. That exposure is not the result of individual inadequacy. It is the result of structural insufficiency. SEIU-M / CIU-M addresses that insufficiency directly.

32. Coordinated Crisis-Response Vision

The vision is a coordinated crisis-response environment in which:

- A qualifying crisis event triggers an integrated medical, neurological, behavioral-health, rehabilitation and continuity-of-care review within hours, not weeks.
- Medication-safety review is the predicate step for behavioral interpretation, not an afterthought.
- Probate Court guardianship status is contemporaneously identified and integrated into every crisis response.
- Elder-abuse and institutional-failure causation is investigated before criminal-legal escalation, not after disposition.
- Continuity-of-care provider relationships are preserved through transition, not disrupted by it.
- Least-restrictive stabilization is selected from the full care continuum rather than defaulting to the most restrictive available setting.
- Families and guardians are formal stabilization partners, not external observers.
- Outcome measurement enables continuous improvement, demonstrates value to funders and supports continued institutional confidence.

33. Activation Sequence and Risk Stratification

The activation sequence proceeds through five phases described in operational detail in the Proposal: Phase I, Crisis Identification and Immediate Safety Stabilization; Phase II, Interdisciplinary Activation Review; Phase III, Integrated Medical, Neurological and Rehabilitation Review; Phase IV, Stabilization and Placement Analysis; Phase V, Reintegration and Continuity Restoration. Risk stratification proceeds across four levels: Level I (Monitoring and Coordination), Level II (Moderate Clinical Complexity), Level III (High Medical Complexity) and Level IV (Acute Psychiatric / public safety risk). The framework's stratification logic supports consistent placement decisions across institutions while preserving clinical discretion in each individual case.

34. Illustrative Case Vignette

A composite scenario. Illustrative, not evidentiary. Designed to show, in concrete terms, what the framework changes about a representative case.

Scenario

A biologically, 71-year-old resident of a Medicaid-certified long-term care facility, under Probate Court guardianship for moderate dementia and complex polypharmacy including insulin and an anticoagulant, has a behavioral incident at the facility. Staff call 911. Emergency Medical Services and law enforcement respond. The patient is brought to the Emergency Department. The patient's guardian is two states away and is reached by phone late that evening. The facility has not contemporaneously shared the patient's recent medication-administration record. The arresting officer does not know the patient is under guardianship.

Pathway A: Current Fragmented Response

The Emergency Department clears the patient medically based on limited workup. The patient is transported to county jail. The patient's home medications are not immediately available to jail medical staff. Insulin and anticoagulant are interrupted. Within 48 hours the patient experiences worsening confusion, fall risk and hyperglycemia. The court orders competency evaluation. Restoration treatment is initiated. The patient is determined to be unrestorable. The case enters indefinite procedural limbo. The Probate Court is not contemporaneously notified. The guardian is not afforded standing. APS is not notified of the facility incident. The Long-Term Care Ombudsman is not notified. The Medicaid Fraud Control Unit is not notified. The state survey agency is not notified. The facility's prior medication-administration record is not reviewed for the pre-incident period. The patient remains in custody for months while procedural questions resolve. Continuity-of-care relationships are lost. Cognitive function declines. Rehabilitation gains regress. The case does not resolve.

Pathway B: Coordinated SEIU-M / CIU-M Response

The Emergency Department intake screening identifies the patient as meeting SEIU-M / CIU-M criteria (age, guardianship status, care-facility origin, complex polypharmacy). SEIU-M / CIU-M activation is initiated in parallel with medical clearance. Pharmacy retrieves complete medication history. Recent administration record is requested from the facility. Guardian is contemporaneously notified. Probate Court is notified of criminal legal contact. The patient is stabilized medically. Medication review identifies a recent change in evening sedating medication and a documented withholding of the patient's evening anti-anxiety regimen on the afternoon of the incident. The patient is restored to the appropriate regimen and observed. Within 24 hours, agitation resolves to baseline. APS, Long-Term Care Ombudsman and the state survey agency are notified. The multidisciplinary review team produces a report documenting that the conduct at issue was the downstream consequence of a

medication-management failure. The report is provided to the prosecutor, defense counsel and the trial court. In coordination with the Probate Court and the appointed guardian, the charge is declined. The patient is returned to a coordinated care setting under guardianship supervision with documented continuity-of-care preservation. The facility-administration practice that produced the medication-withholding is reviewed under existing regulatory authority.

What the Vignette Illustrates

The vignette is illustrative rather than evidentiary. It is designed to show, in a concrete clinical setting, how the framework's coordination architecture would alter the trajectory of a representative case. The patient's underlying condition is unchanged across both pathways. The institutional response is different. The patient's outcome is different. The public-resource expenditure is different. The constitutional exposure is different. The framework's contribution is measured at exactly this level: not by changing the patient's condition but by changing the coordination quality of the response.

35. Seven-Step Operational Protocol

When a care-facility patient under guardianship is the subject of an incident that would otherwise trigger criminal-legal escalation, the SEIU-M / CIU-M protocol initiates the following seven-step sequence. The full operational detail is contained in Section 20 of the Operational Implementation Framework (Proposal). The summary form is provided here for ease of reference.

1. **Step 1: Medical Stabilization.** The patient is medically and neurologically evaluated. Restraint, custodial transfer and criminal-legal proceedings are deferred until stabilization is established.
2. **Step 2: Medication-Management Review.** A full medication reconciliation is completed across psychiatric and non-psychiatric prescriptions.
3. **Step 3: Structured Observation Upon Return to a Corrected Regimen.** When medication mismanagement is identified, the patient is restored to a clinically appropriate regimen and observed for a defined period.
4. **Step 4: Elder Abuse Causation Investigation.** APS, Long-Term Care Ombudsman, MFCU and the state survey agency are notified per existing statutory authority.
5. **Step 5: Coordination with Probate Court Guardian.** The court-appointed guardian is contemporaneously notified, is afforded standing and is provided with the findings. The Probate Court is informed of the criminal-legal contact.
6. **Step 6: Multidisciplinary Review and Recommendation.** The SEIU-M / CIU-M multidisciplinary team reviews the assembled record and provides recommendations to the prosecutor, defense counsel, trial court, Probate Court and treating systems.
7. **Step 7: Deferred or Declined Escalation When Indicated.** Where findings establish that the conduct was the downstream consequence of institutional failure, that stabilization has resolved the underlying presentation and that guardianship-supported placement is available, criminal-legal escalation is deferred, declined, diverted or dismissed in coordination with the trial court, the prosecutor and the Probate Court.

Where the multidisciplinary record establishes that the conduct was the downstream consequence of institutional failure or medication mismanagement, the prosecutor has a documented basis for nolle prosequi or dismissal without prejudice. The framework does not constrain prosecutorial discretion. It informs it.

The Four Operational Principles

- **Stabilization before escalation.** No criminal-legal proceeding against a care-facility patient under guardianship should advance until the patient is medically stabilized, on a corrected medication regimen and observed for a clinically defined period sufficient to establish whether the presenting conduct resolves with regimen correction.
- **Causation before prosecution.** No criminal-legal proceeding against a care-facility patient under guardianship should advance until elder-abuse and medication-mismanagement causation have been investigated by the appropriate civil and administrative authorities, with findings made available to the criminal court.
- **Coordination before adjudication.** No criminal-legal proceeding against a patient already adjudicated incompetent by the Probate Court should advance without formal notice to and coordination with the Probate Court, the appointed guardian and the treating continuity-of-care providers.
- **Stewardship before continuation.** No criminal-legal proceeding consuming finite public-safety, judicial, healthcare and Medicaid resources should continue against a patient whose conduct has resolved with stabilization, whose underlying causation reflects institutional failure rather than volitional misconduct and whose appropriate long-term framework is guardianship-supported care under Probate Court oversight.

Part VII. Implementation Framework

Phased rollout, pilot specifications, cost-benefit, anticipated concerns.

36. Phased Rollout Schedule

Phase	Timeframe	Operational Activities
Phase 1. Pilot Development and Interagency Foundation	0 to 6 months	Designate interagency review contact. Identify legal, clinical and operational leads. Develop activation criteria, workflow map, training outline, data-governance approach, fiscal feasibility analysis and advisory group. Engage candidate funding authorities. Convene initial advisory consultation.
Phase 2. Regional Coordination Expansion	6 to 18 months	Launch limited pilot in two or three candidate regions. Develop hospital, EMS, court, Probate Court, guardianship, APS, Long-Term Care Ombudsman and MFCU coordination pathways. Design outcome dashboard. Implement workforce training Modules I through VI. Begin pilot operations.
Phase 3. Statewide Framework Alignment	18 to 30 months	Evaluate pilot outcomes. Refine protocols. Prepare legislative, regulatory and administrative recommendations for regional expansion or statewide scaling. Coordinate with state budget processes.
Phase 4. Federal Alignment and Scalability	24 to 36 months	Coordinate with HHS, CMS, SAMHSA, DOJ Civil Rights, Administration for Community Living and CDC on federal alignment, learning and replicability. Submit pilot findings to federal review.
Phase 5. National Scalability	30 to 48 months	Where outcomes support replication, coordinate with NASMHPD, NAMD, NCSC, NCEA and analogous national bodies for multi-state replication.

Accountability Owners by Phase

Each phase has identifiable institutional owners. Phase 1 ownership rests primarily with the Ohio Attorney General's Office in coordination with its Elder Justice Unit, working with the Office of the Governor, the Ohio Department of Behavioral Health (Ohio-DBH / Ohio-MHAS) as operational host, the Ohio Department of Aging, the Ohio Department of Medicaid and the Supreme Court of Ohio judicial administrative leadership. Phase 2 ownership extends to participating pilot-region judicial, healthcare, Probate Court, APS, Long-Term Care Ombudsman and MFCU partners. Phase 3 ownership extends to the Ohio General Assembly for any legislative architecture supported by pilot outcomes. Phase 4 ownership extends to federal alignment partners. Phase 5 ownership extends to national replication partners.

37. Pilot Region Specifications and Success Criteria

Pilot Region Selection Criteria

Candidate pilot regions are selected against the following criteria: documented forensic-system strain; documented Emergency Department crisis volume; documented long-term care facility density; documented guardianship caseload; demonstrated institutional willingness to participate; demonstrated judicial leadership engagement; demonstrated Medicaid coordination capacity; demonstrated healthcare-system partnership capacity; demonstrated community and interagency engagement.

Recommended Pilot Region Profile Types

- **Urban high-volume region.** Major metropolitan area with high forensic-system volume, dense healthcare and behavioral-health infrastructure and concentrated long-term care facility presence.
- **Suburban-exurban mixed region.** Mid-sized metropolitan area with mixed urban and suburban demographics and moderate institutional infrastructure.
- **Rural multi-county region.** Multi-county rural area with limited specialized infrastructure where coordinated regional pathways are particularly valuable.

Success Metrics and Key Performance Indicators

Pilot success is measured against the performance framework described in Section 12 of the Operational Implementation Framework (Proposal). Key indicators include clinical performance (time from crisis identification to medical stabilization, rate of medication-mismanagement identification, resolution rate for unrestorability cases, preservation of continuity-of-care relationships, mortality and readmission rates); system coordination (ED cycling reduction, jail medical burden reduction, forensic-bed waitlist reduction, court calendar throughput for incompetency cases); financial and utilization (cost per coordinated case versus historical baseline, Medicaid expenditure patterns); and rights, safety and accountability (Jackson v. Indiana time-bounded review compliance, formal Probate Court notification, due-process protections at each procedural stage).

Ohio Pilot Region Candidate Analysis

Specific candidate-region identification is appropriately the subject of executive consultation during Phase 1. The framework is designed to accommodate pilot launch in any region meeting the selection criteria. The specific region or regions selected will appropriately reflect the priorities of the Office of the Governor, Ohio-DBH / Ohio-MHAS and the participating regional judicial, healthcare, Probate Court and county-administration partners.

38. Directional Cost-Benefit Analysis

This framework saves taxpayer money. The cost savings are real and measurable. A single resolved case at six months rather than three years produces over $560,000 in direct taxpayer savings before associated judicial and administrative costs. The analysis below is directional rather than actuarial; it is offered to locate the order of magnitude, not to predict a specific budget outcome.

Fiscal Note for Legislative and Budget Review

This is a fiscally responsible proposal. It requests no new funding category during the pilot phase and is designed to reduce recurring costs the status quo already incurs.

Cost Categories Where Coordinated Response Is Expected to Produce Savings

- Reduced Emergency Department over-utilization and repeat emergency cycling.
- Reduced avoidable hospitalization and unnecessary institutionalization.
- Reduced duplication of response costs across agencies responding to the same crisis event.
- Reduced litigation exposure from improper escalation, rights violations and documentation failures.
- Earlier identification of facility-level failures before they escalate into costly regulatory and legal events.
- Reduced jail medical costs and avoidable custodial deterioration.
- Reduced psychiatric bed overuse when medical or rehabilitation stabilization is more appropriate.
- Reduced competency restoration cycles caused by incomplete medical review during prior crisis escalation.
- Reduced Resolution Gap holding costs.
- Improved Medicaid managed-care coordination and reduced care-fragmentation costs. Reduced inappropriate antipsychotic prescribing. Antipsychotic medications for Medicaid-enrolled patients with dementia and cognitive impairment accounted for approximately $7.6 billion in Medicare Part D spending in a single year. A framework that produces earlier and more accurate causation review reduces prescribing driven by misclassified behavior rather than clinical need.

Implementation Cost Categories

- Coordination infrastructure development.
- Workforce training across Modules I through VI.
- Documentation and information-exchange infrastructure consistent with HIPAA and applicable disclosure rules.
- Multidisciplinary review team capacity (existing institutional staff serving in coordination roles).
- Data, measurement and outcome-reporting infrastructure.
- Advisory group support.

Directional Return-on-Investment Logic

The directional ROI argument is straightforward. At $790 per state forensic bed-day (Texas representative reference) and at the documented duration of unresolved unrestorability cases, even modest reductions in case duration produce substantial fiscal returns. At documented ED cycling rates for the populations the framework addresses, even modest reductions in cycling produce substantial fiscal returns. At documented jail medical-cost rates for the populations the framework addresses, even modest reductions in custodial duration produce substantial fiscal returns. The implementation cost categories above are bounded by existing institutional staff capacity reorganized into coordination roles. They do not require the creation of new institutional structures.

Why Conservative Assumptions Still Favor Coordinated Response

Conservative assumption sets, applied to each of the cost-reduction categories above, continue to support coordinated response on fiscal grounds. The argument does not depend on optimistic projections. It depends on the observation that current fragmented response is producing recurring costs across multiple state systems simultaneously and that even modest reductions in those costs, applied at the scale of the populations the framework addresses, produce fiscal returns sufficient to support implementation infrastructure.

The Revolving Door: Repetition Without a Pathway

For the vulnerable elderly population this framework serves, the current system operates as a revolving door with no clear pathway out. When prescription medication, medical treatment or the care plan is mismanaged, whether in the patient's own home or in a care facility entrusted with their care and their medication, the patient destabilizes. Destabilization presents as a behavioral or medical crisis, which brings hospitalization, emergency-department transfer or criminal-legal contact. The patient is then returned to the same uncorrected setting, because no part of the system identified the mismanagement as the cause and no defined pathway exists to resolve the matter.

The cycle repeats. Repeated hospitalization, repeated rehabilitation and repeated interruption of hard-won progress are not separate events but one failure recurring: care that treats the episode without correcting the cause. Each repetition is absorbed somewhere, by the patient in lost stability, by the family in sustained labor, by the hospital and the court in duplicated effort and by every public budget in recurring cost. None of it resolves the underlying problem. Rapid readmission is common, with roughly one in six discharged patients readmitted within thirty days (systematic review and meta-analysis, 2023), but the readmission rate only measures the symptom. The cause is uncorrected medication and care mismanagement meeting a system with no resolution pathway.

The repetition is structural, not individual. No single actor is positioned to look upstream at the dispensing record, the care plan or the home-support arrangement that produced the destabilization. No authority owns the patient's continuity across the gap between settings. The framework's medication-safety review and causation-investigation steps identify and correct the cause at the qualifying event rather than absorbing its consequence again and again. Its continuity-of-care preservation gives the stabilization an owner.

Correction at the source requires coordination. That coordination is SEIU-M's central contribution. SEIU-M is the architecture that bridges the parties whose work currently runs in parallel without connecting. At the qualifying event it coordinates the Ohio Attorney General's Office and its Elder Justice Unit, the Ohio Department of Health, the Ohio Department of Aging, the Ohio Department of Developmental Disabilities, the justice system, the Ohio Department of Behavioral Health, Ohio's healthcare systems and Adult Protective Services, anchored throughout by the Probate Court and by the guardian acting under Probate Court jurisdiction on behalf of the ward. Each of these authorities already exists and already holds part of the picture. What has been missing is the mechanism that

brings them to the same table around the same patient at the same time. SEIU-M is that mechanism. It replaces no party. It coordinates them, supplying the resolution pathway the current system lacks. The measure of the framework is whether the next patient cycles through the system fewer times than the last.

39. Anticipated Concerns and Considered Responses

Concern: This is yet another initiative competing with existing programs.

Response. SEIU-M / CIU-M does not replace, replicate or compete with existing crisis-response, behavioral-health, forensic-evaluation, court, hospital or guardianship programs. It is a coordination architecture that operates across them. Section 17 documents the limited scope of existing programs relative to the populations this framework addresses.

Concern: New coordination structures add bureaucracy.

Response. The framework is designed as a coordination layer staffed substantially by existing institutional personnel serving in coordination roles. No new state agency is proposed. Primary ownership rests with the Ohio Attorney General's Office in coordination with its Elder Justice Unit. The Ohio Department of Behavioral Health serves as the operational host. Ownership is shared collaboratively across every participating authority. Specific administrative arrangements remain within the discretion of executive leadership.

Concern: Court-integrated approaches raise civil-liberties concerns.

Response. No new agency is created. The framework proposes no new coercive authority during the pilot phase. The California CARE Act experience demonstrates the civil-liberties friction inherent in court-ordered treatment. The SEIU-M / CIU-M proposal sidesteps that friction by design. Coordination and information-sharing are the levers, not compelled treatment.

Concern: Pilot funding is uncertain.

Response. No new federal or state funding category is requested during the pilot. The framework identifies existing federal and state authorities, Medicaid 1115 and 1915(c) waivers, SAMHSA crisis-response categories, Elder Justice Act discretionary appropriations, HRSA workforce programs, PACE under the Balanced Budget Act of 1997, state behavioral-health innovation budgets and philanthropic capital, that are appropriately available for pilot funding.

Concern: Outcomes are difficult to measure.

Response. The performance framework in Section 12 of the Operational Implementation Framework specifies clinical, system-coordination, financial-utilization and rights-and-safety metrics with operational definitions. The pilot is structured to produce twelve-month outcome data sufficient to inform any subsequent recommendation regarding regional or statewide scaling.

Concern: The Resolution Gap is an Ohio problem.

Response. The statutory citations in this framework are Ohio-specific, but the Resolution Gap is structural and present across multiple state systems. Federal coordination with HHS, CMS, DOJ Civil Rights, SAMHSA, the Administration for Community Living and CDC is therefore part of the implementation pathway and cross-state replication is contemplated in Phase 5.

Concern: Healthcare workforce capacity is constrained.

Response. The framework reduces, rather than adds to, the operational burden on healthcare professionals by providing the coordination infrastructure that their work currently requires but does not have. Improved coordination reduces isolated decision-making burden, reduces clinical risk, reduces institutional liability exposure and supports workforce sustainability.

Concern: Probate Court interface raises jurisdictional questions.

Response. The framework does not propose transferring criminal jurisdiction to the Probate Court or vice versa. It proposes coordination among the existing jurisdictions through formal notification, guardian standing in proceedings affecting the patient and informed decision-making by the trial court with the benefit of the Probate Court's prior adjudication of legal incompetence.

Part VIII. Closing

40. Vision of Success

Success, as the framework defines it, is a coordinated crisis-response environment in which medically vulnerable individuals receive integrated multidisciplinary review within hours of a qualifying event. Medication-safety review precedes behavioral interpretation. Probate Court guardianship status is contemporaneously integrated into every crisis response. Elder-abuse and institutional-failure causation is investigated before criminal-legal escalation. Continuity-of-care provider relationships are preserved through transition. Least-restrictive stabilization is selected from the full care continuum. Families and guardians participate as formal stabilization partners. Outcome measurement supports continuous improvement. The constitutional standards articulated in Jackson v. Indiana are operationally functional in every case.

Success is, fundamentally, the operational realization of constitutional protections that already exist in law but are not yet reliably realized in practice. The framework's contribution is not the creation of new rights. It is the construction of the institutional infrastructure required to make existing rights operationally functional at the point of a crisis event.

41. Historical and National Responsibility

The framework is presented at a moment of accumulated institutional learning. Decades of federal investment in elder justice, behavioral-health crisis response, Medicaid system development, judicial procedure reform, civil-rights enforcement and disability rights have produced an institutional architecture that, in theory, contains every element required to protect medically vulnerable populations during periods of crisis. The institutional architecture exists. The integration of that architecture, in real time, at the point of a crisis event affecting a specific medically vulnerable person, does not yet exist at the scale required. The framework's contribution is the proposed integration mechanism.

This is not a partisan proposal. It is a public-interest, family-protection, constitutional, healthcare, elder-justice and national-resilience proposal that should invite participation from across the political spectrum and from every organization committed to protecting vulnerable people during crisis. Every family is only one medical emergency, one cognitive decline, one medication failure, one hospitalization, one guardianship crisis or one facility breakdown away from needing the very systems this framework seeks to strengthen.

The framework respectfully invites the institutional reviewers identified in the broader package's distribution authority to consider its substance, distribute it internally as appropriate, identify points of coordination and inquiry and engage in continued institutional discussion. No specific action is required at the stage of initial review. The framework's authors recognize that careful institutional review takes time and that thoughtful coordination across the multiple systems the framework engages is itself a substantial undertaking.

The four operational principles articulated within the framework, stabilization before escalation, causation before prosecution, coordination before adjudication and stewardship before continuation, are the operational standards under which the framework respectfully requests its proposals be evaluated. They are not partisan principles. They are not novel principles. They are the standards by which a constitutional, fiscally responsible, clinically informed and humane crisis-response architecture has historically been recognized.

The framework is offered in the spirit of constructive institutional collaboration. The challenges it identifies are real. The architecture it proposes is achievable within existing federal and state authority.

The populations it addresses are protected by the same constitutional and statutory authorities that protect every citizen. The framework's contribution is the coordination infrastructure that makes those existing protections operationally functional at the point of a crisis event.

Behind every operational principle in this framework is a person whose protection depends on whether the principle is operationalized. Behind every section of this White Paper is a population whose vulnerability is structural, whose protection is constitutional and whose dignity is not negotiable. The reform this paper proposes is the architecture of a country that protects its most vulnerable as a matter of structural design rather than as a matter of accident, of resources or of who happens to have a family member willing to fight on their behalf.

Appendix A. References and Authorities Cited

United States Supreme Court Decisions

- Dusky v. United States, 362 U.S. 402 (1960).
- Jackson v. Indiana, 406 U.S. 715 (1972).
- Olmstead v. L.C., 527 U.S. 581 (1999).
- Sell v. United States, 539 U.S. 166 (2003).

Federal Court Decisions

- Trueblood v. Washington State Department of Social and Health Services, 101 F. Supp. 3d 1010 (W.D. Wash. 2015).

Federal Statutes

- Americans with Disabilities Act of 1990, 42 U.S.C. sec. 12101 et seq.
- Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. sec. 794.
- Older Americans Act of 1965, 42 U.S.C. sec. 3001 et seq.
- Elder Justice Act of 2010, Title XX of the Social Security Act, 42 U.S.C. sec. 1397j et seq.
- Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. sec. 1320d et seq.; 45 C.F.R. Parts 160 and 164.
- Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2.
- Nursing Home Reform Act (OBRA 1987), 42 U.S.C. sec. 1395i-3 and 1396r.
- Emergency Medical Treatment and Active Labor Act, 42 U.S.C. sec. 1395dd.
- Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).
- Balanced Budget Act of 1997, PACE program authority, Pub. L. No. 105-33, sec. 4801.
- 21st Century Cures Act, Pub. L. No. 114-255 (2016).
- Medicaid statutes: 42 U.S.C. sec. 1396 et seq., including sec. 1115 demonstration authority and sec. 1915(c) HCBS waiver authority.
- Federal criminal-procedure competency provisions: 18 U.S.C. sec. 4241 to 4247.

Ohio Revised Code

- Ohio Revised Code Chapter 2111, Guardianship of Persons and Estates.
- Ohio Revised Code Chapter 2945, Criminal Procedure including competency to stand trial.
- Ohio Revised Code Chapter 5119, Department of Behavioral Health, formerly Mental Health and Addiction Services.
- Ohio Revised Code Chapter 5122, Civil Commitment for Mental Illness.
- Ohio Revised Code Chapter 5160, Department of Medicaid.
- Ohio Revised Code Chapter 5101, Adult Protective Services and aging-related authorities.
- Ohio Revised Code Chapter 5165, Nursing Facilities.
- Am. Sub. H.B. 96 of the Ohio 136th General Assembly, effective October 1, 2025.

Federal Agencies and Regulatory Authorities

- U.S. Department of Health and Human Services.
- Centers for Medicare and Medicaid Services.
- Substance Abuse and Mental Health Services Administration.
- Administration for Community Living.
- Health Resources and Services Administration.
- Agency for Healthcare Research and Quality.
- Centers for Disease Control and Prevention.
- National Institute on Aging, National Institute of Mental Health, National Institute of Neurological Disorders and Stroke.
- U.S. Department of Justice, including the Civil Rights Division and Office of Justice Programs.
- HHS Office of Inspector General.
- Government Accountability Office.

Peer-Reviewed and Clinical References

- Shehab N, Lovegrove MC, Geller AI, et al. US Emergency Department Visits for Outpatient Adverse Drug Events, 2013 to 2014. JAMA, 2016;316(20):2115-2125.
- Budnitz DS, Lovegrove MC, Shehab N, Richards CL. Emergency Hospitalizations for Adverse Drug Events in Older Americans. New England Journal of Medicine, 2011;365:2002-2012.
- Inouye SK, et al. Delirium in Elderly People. The Lancet, 2014;383:911-922.
- CDC, National Center on Elder Abuse. Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements (2016).
- National Center on Elder Abuse, Research Brief on Prevalence and Reporting.
- SAMHSA, Forensic and Competency-to-Stand-Trial Trends Analysis (2023).
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- HHS OIG, Reports on Antipsychotic Medication Use in Nursing Homes.
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, 2013, including Conversion Disorder (Functional Neurological Symptom Disorder).
- International Classification of Diseases, 11th Revision (ICD-11), World Health Organization.
- Alzheimer's Association, 2024 Alzheimer's Disease Facts and Figures.
- AARP and National Alliance for Caregiving, Caregiving in the United States 2020.

State and National Authorities

- Office of the Governor of Ohio, Governor's Work Group on Competency Restoration and Diversion (2024).
- Supreme Court of Ohio, Case Management Section, Guardianship Caseload Data (2011 baseline through 2020 reporting).
- Texas Health and Human Services Commission, State Hospital Cost Study (2024) (representative reference for state forensic bed cost).
- National Association of State Mental Health Program Directors, Forensic Hospital Capacity Reports.
- National Center for State Courts, Center on Adult Guardianship.

- National Adult Protective Services Association, State Data Reports.
- Eleventh Judicial Circuit Criminal Mental Health Project, Miami-Dade County, Florida.
- California Department of Health Care Services, CARE Act Implementation Data.

Limitations and Assumptions

This White Paper operates within a set of explicit assumptions and is subject to defined limitations that reviewers should consider. The fiscal estimates are directional, not actuarial. The $790 per-bed-per-day figure is drawn from Texas HHSC data as a representative reference and falls within Ohio's own range; the Ohio Legislative Service Commission reports that the inpatient daily rate at the six OhioMHAS / DBH regional psychiatric hospitals ranged from approximately $610 to $938 for all payors in CY 2023 (Ohio LSC fiscal note, citing OhioMHAS Hospital Rates). The guardianship caseload trajectory figures are drawn from the most recently available Supreme Court of Ohio data; current caseload may differ. The cross-state benchmarking in Part IV draws on publicly available program data and published evaluations; outcome comparability across state systems is approximate. The proposal does not claim pilot outcomes in advance of a pilot. It claims that the structural conditions documented here create the predicate for a coordinated response and that the available evidence supports proceeding to pilot planning. These limitations are stated not to weaken the argument but to locate it honestly within the boundary of what the current evidence supports. The case for coordinated response does not require certainty about implementation outcomes. It requires only that the status quo be recognized as producing documented harm at documented scale with no defined resolution pathway. That recognition is what the evidence here supports. If twelve-month pilot outcomes do not support the directional projections in this paper, the appropriate response is recalibration, not abandonment. The underlying structural problem, the absence of a coordination architecture for medically vulnerable defendants found incompetent and unrestorable, does not disappear if the first pilot design requires adjustment. The constitutional asymmetry Jackson identified does not resolve because an early pilot produced mixed results. The pilot is a test of implementation design. The case for addressing the Resolution Gap does not depend on the first implementation being perfect.

In Humility

This White Paper and the companion documents submitted with it are offered humbly to every authority that receives them. The framework is presented in deference to the institutional expertise, statutory authority and operational responsibility the receiving institutions hold. It is a respectful invitation to coordination, not a prescription. What is asked is only this: that the coordination infrastructure described here be given the serious and good-faith institutional review it is designed to merit, so that the families who cannot wait and the defendants who have already waited too long do not have to wait any longer.

Our Country. Our Constitution. Every reviewer of this paper will, at some point, be a caregiver, a guardian or the person needing one. This country was founded on a promise that grows only when each generation chooses to honor it. Compassion. Integrity. Dignity. Due process. Protection of those who cannot protect themselves. The work before us is to stand united in building the protection they deserve, to honor what we all deserve as Americans and to keep faith with our values not by intention alone but by what we are willing to build, uphold and honor.

May 25, 2026

CONFIDENTIAL INSTITUTIONAL SUBMISSION

Prepared for Institutional Review, Not for Public Distribution

To: The Office of the Ohio Attorney General (OAG)

The Honorable Attorney General of Ohio; the Elder Justice Unit; the Medicaid Fraud Control Unit; and, through your leadership, every attorney, investigator and advocate of the Office whose work protects the people of Ohio.

RE: Request for institutional review and primary-ownership consideration of the SEIU-M / CIU-M framework, a coordinated, court-integrated medical-stabilization pathway addressing the constitutional Resolution Gap affecting incompetent, unrestorable wards adjudicated under Ohio Revised Code Chapter 2111.

SUBMITTED BY: The Guardian, under Ohio Probate Court jurisdiction, by and on behalf of the ward and of every comparable family that cannot speak for itself.

None of us is more than one phone call away from needing someone to fight for us and from discovering whether anyone will.

I write to the Office of the Ohio Attorney General to bring before you a structural failure your Office is uniquely equipped to correct and a framework, drawn from my father's case and documented across nearly six years, that the Attorney General and the Elder Justice Unit are, in my respectful judgment, the right authority in Ohio to anchor.

My name is Nebiat (Nebby) Gebreziabher. I am the court-appointed Guardian of the Person for my father, an Ethiopian Orthodox elder, a naturalized American citizen and a father of five known to his church as "Megabi Gebru", "he who brings life to others." Before a medical destabilization crisis that came through no fault of his own, he is a gentle, faith-centered Christian man with no history of violence, no psychiatric history and no criminal record. Today, by the grace of God and through coordinated medical care, he is alive, walking and stabilized. Yet he remains, as of this writing, suspended inside a system that has no defined way to release him.

This letter carries a single request for your consideration: that the Attorney General's Office, in collaboration with OhioHealth as the proposed clinical partner for the pilot, with clinical participation, including OhioHealth's, to be selected and approved through a contract process, should all parties be in agreement and the Ohio Department of Behavioral Health (OhioDBH/OhioMHAS) as operational host, anchor the SEIU-M / CIU-M pilot in Ohio, with primary ownership vested in your Office and its Elder Justice Unit. The case study at its heart is my father's. The reform it carries belongs to every family that comes after him.

I. The Gap and Why It Belongs to Elder Justice

There is a clear pathway for the person found incompetent and restorable. There is none for the person found incompetent and unrestorable. The first pathway is law. The second is silence. SEIU-M exists to end that silence.

There is also no clear pathway here for the lawyers on either side. For the defense attorney, there is no ethical road map for representing a client who has been found incompetent and unrestorable, a client who cannot meaningfully assist in their own defense and whose case the system offers no way to resolve. For the prosecutor, there is no clear pathway to discharge the duty to protect public safety while also doing justice, when a case can neither fairly proceed nor properly conclude. This is not sustainable and it is not sound as a matter of judicial, legislative or systemic design. A system that leaves both the defense and the prosecution without a framework serves no one: not the defendant, not the public and not the court.

There is no guidance because there is no pathway. We need policy reform that builds the pathway; the pathway becomes the guidance we, the public, are all desperately seeking. The SEIU-M framework not only creates an effective and efficient pathway but it produces a solution to a nationwide problem.

Behind that silence is an elderly person who cannot tell you what medication was withheld from them, who was arrested for behavior that medication should have prevented and who is now held inside a system with no way out. For the unrestorable, those whose incapacity arises from dementia, brain injury, advanced decline or Functional Neurological Disorder, charges remain open, civil commitment is unavailable because the patient has stabilized and no agency owns the resolution. The population least able to advocate for itself is the population the architecture forgets.

The constitutional stakes fall squarely within your Office's enforcement authority and they reduce to a principle the Fourteenth Amendment makes plain: the State may not extend to one class of incapacitated citizens a careful, time-bounded pathway to resolution while leaving another class, distinguishable only by the misfortune that their incapacity cannot be cured, in indefinite suspension. *Jackson v. Indiana* (1972), grounded in both due process and equal protection, held exactly this: a person committed solely for incompetency cannot be held indefinitely and where restoration is not possible the State must civilly commit or release. That equal-protection asymmetry, a better pathway for the restorable than for the unrestorable, is defeated in operational fact today by the simple absence of an implementation pathway. The Sixth Amendment speedy-trial right under *Barker v. Wingo* (1972) is independently violated when charges sit for years, neither tried nor dismissed. *Olmstead* (1999), the Americans with Disabilities Act, Section 504 of the Rehabilitation Act and the Elder Justice Act of 2010 each command a coordinated, least-restrictive response. The framework creates no new authority. It makes the constitutional authority that already exists functional at the point of crisis, rather than enforceable only through federal litigation, after years of harm, as in *Trueblood v. Washington DSHS* (2015). The protections at stake here are not novel claims. They are the guarantees the Constitution already extends, awaiting only the architecture to honor them.

II. What the Record Shows

I do not write to assign blame. Most of those who touched my father's care work inside systems that are overwhelmed, underfunded and pulled in a hundred directions. The problem is not their hearts. The problem is that nothing connects them. So let me be precise about what follows: it examines what the architecture did, not what any individual did. Accountability, not accusation.

The record is documented. At a facility entrusted with his care, my father was denied his prescribed medication. When paramedics reached him, his blood sugar had climbed past 400, with crisis-level blood pressure, in a man already living with diabetes, hypertension and a recent stroke. These are not my characterizations. The Ohio Department of Health documented the violations as formal survey findings, findings of the State of Ohio, not allegations of a daughter.

The physicians did not speak to the court. The criminal court could not see what the Probate Court had already ruled. Four separate systems each held one piece of my father and not one of them held the whole man. So the simplest and most decisive question was never asked: what medication was withheld and was the conduct in that report a symptom rather than a crime? Coordination with the Probate Court is not a courtesy. It is a prerequisite to fair adjudication and in this case it did not occur.

Even the oversight that did occur proved the point. When the Ohio Department of Rehabilitation and Correction's Bureau of Adult Detention reviewed the custodial period, it noted in writing that numerous of the concerns raised fell "outside of the Bureau's jurisdiction" and referred them elsewhere, a state oversight body documenting, in its own words, that the questions this case raised belonged to no single authority. That is the gap, stated by the State itself.

Your Office will recognize the elder-justice and fraud dimensions immediately. The withheld medication costs roughly $1,000 a month, is not a controlled substance, is not tracked by the DEA and leaves no electronic trail in a facility still keeping records on paper. For a cognitively impaired resident whose own account carries no independent legal weight, that is the lowest-risk, highest-value diversion target in the building. No part of the current architecture is designed to ask whether withheld or diverted medication caused the conduct that triggered criminal-legal contact. The framework's causation-investigation step, coordinated with your Medicaid Fraud Control Unit, is built to require that inquiry before escalation proceeds.

III. The Proof Already Exists and So Did the Prior Ruling

This is not a theory awaiting a test. The test already happened. On April 21, 2023, the Delaware County Court of Common Pleas released my father to community care under guardian supervision and GPS monitoring. What followed is the empirical center of the entire record: across six months of judicially supervised community stabilization, April through October 2023, there were no violent incidents, no police interactions, no emergency behavioral episodes, no threats to self or others and no safety concerns reported by any provider, neighbor, family member or faith-community member. In that same period he progressed from a wheelchair to unassisted walking and his blood sugar stabilized. Given coordination, continuity and

family, he was a man returning to his life. The framework does not ask the State to imagine that stabilization is possible. It asks the State to recognize that it has already been documented.

There is a further fact that should weigh heavily on the State's chief legal officer. My father was adjudicated legally incompetent by the Franklin County Probate Court on April 13, 2022, six months before the October 2022 incident. The criminal-legal system that engaged him was not engaging a free actor of intact capacity. It was engaging a man a sitting Ohio court had already declared incapacitated, whose authority over his own care had already been vested in a guardian. That prior adjudication was not integrated into the proceedings that followed. A defendant cannot receive fair adjudication when one court decides a question of capacity that another court has already decided, without either knowing what the other has found. That is not a sympathy point. It is a due-process failure carrying the State's own name.

IV. The Four Principles and the One That Is Yours

Stabilize before you escalate. Find the cause before you prosecute. Coordinate before you decide. Be a faithful steward before you continue.

The framework asks no system to do anything new. It asks each to do, together and in the correct sequence, the work it is already authorized to do alone. Coordination, not coercion. Sequence, not new authority. The second principle, causation before prosecution, is the one the Attorney General's Office and its Elder Justice Unit are uniquely positioned to anchor. It holds that before a medically vulnerable adult under guardianship is escalated into the criminal-legal system, the institutional context that produced the conduct must be investigated, contemporaneously, by the authorities equipped to investigate it. The framework does not constrain prosecutorial discretion. It informs it and, where the record establishes that conduct was the downstream consequence of institutional failure or medication mismanagement, it gives the prosecutor a documented basis for the discretion the law already affords.

V. Why the Attorney General's Office

I have weighed, carefully, which authority should hold primary ownership of this work on the state side. The conclusion is the same each time: the Office of the Ohio Attorney General. No other office holds, together, the constitutional enforcement mandate the gap demands, the elder-justice mission the population requires and the fraud-investigation authority the medication evidence implicates. Your Elder Justice Unit exists for precisely the people SEIU-M serves. Your Medicaid Fraud Control Unit holds the authority to investigate the abuse, neglect and diversion this case exposes. And your Office stands as the natural point of coordination across the Probate Courts, the prosecuting authorities, the protective-services agencies and the federal partners, not to direct them, but to convene them.

The proposed structure vests primary ownership in your Office and its Elder Justice Unit, with OhioDBH/OhioMHAS as operational host and OhioHealth as the proposed clinical partner, subject to selection and approval through a contract process and shared ownership across every participating authority so that coordination is efficient rather than concentrated in any single office. The framework requests no new statutory authority, no new coercive power and no new agency, none is created. It is also fiscally

disciplined: a single case resolved in six months rather than three years produces more than $560,000 in direct taxpayer savings before associated judicial and administrative costs. Fiscal responsibility, accountability and the rule of law are the values this framework serves.

VI. One Trusted Anchor Per State

The larger principle this pilot is built to demonstrate is straightforward: the justice system and policy reform should recognize, in each state, one trusted anchor medical organization as the clinical backbone, paired with the state's behavioral health authority and anchored by the constitutional and elder-justice authority of the state's Attorney General, coordinating with its Probate Courts and elder-services systems.

One state. One anchor medical institution. One behavioral health partner. One elder-justice authority. One pilot. Fifty replicable pilots. National readiness for a population the country has never been able to coordinate.

Should OhioHealth, the Attorney General's Office and OhioDBH/OhioMHAS pilot this framework and demonstrate that it works, Ohio becomes the proof case for the nation. That is the opportunity I respectfully place before you.

VII. Interagency Protection Layers and Access to the Judicial Process

A protection that exists in one agency's files but never reaches the decision-maker is no protection at all. The Resolution Gap is, at bottom, a failure of access: the medical record, the guardianship adjudication, the protective-services findings and the documented cause all exist, but they do not reach the judge, the prosecutor or the defender at the moment of decision. SEIU-M builds the interagency protection layers that carry that record to the people empowered to act on it, in time to matter, so that no vulnerable person falls through the space between systems that were each holding a piece of the truth.

Critically, the framework operates on a need-to-know basis. Information reaches the judicial process only to the extent and only in the form necessary for the decision at hand, under the existing privacy protections of HIPAA, including the use of business associate agreements and the minimum-necessary standard and the governing rules of each system and, for the person under guardianship, with the involvement of the guardian and the court that appointed them, so that the individual whose information is at stake always has a protector at the table. Coordination is not exposure. The framework is built to protect both the vulnerable person and the integrity of the process, sharing what must be shared, shielding what must be shielded and never more than the decision requires. As primary owner, the Attorney General is positioned to be the steward of that disciplined exchange, ensuring the record reaches the process without ever becoming an open door. Access without exposure. Protection without surrender. That is the discipline the framework demands.

IX. In Gratitude

I write with deep respect for the work the Office of the Ohio Attorney General performs each day on behalf of the people of this state and with particular gratitude for the Elder Justice Unit, whose very existence affirms that the protection of the vulnerable is a matter of public mission rather than private fortune. I offer the SEIU-M package in the spirit in which it was written: humbly, in deference to the authority and responsibility your Office holds, as a request for consideration rather than a prescription.

This is not a partisan request. Protecting elderly and cognitively impaired Americans from unconstitutional confinement is a constitutional obligation that precedes political affiliation. It matters. It is already making a difference. And the country, I respectfully believe, needs Ohio's Attorney General in this work.

I write this on behalf of every person and every family who has lived this same reality or one like it or felt the weight of this gap and was not heard.

I write this for every vulnerable and voiceless person who went unheard or abandoned. For every family member who felt helpless and alone. For every guardian who fought a system they were never trained to fight. For every elder whose dignity was reduced to a case number. For every patient returned, again and again, to the place that harmed them. For every caregiver who learned a vocabulary no one should ever have to learn. For every family that could not afford to keep fighting and lost someone to the gap. For the ones still inside it tonight, waiting for a pathway that does not yet exist.

I write it for every person still to come, who will live this same reality unless we choose, now, to build the pathway that would spare them.

I write this so that the next person and the next family will be heard. I write it so that the protection we could not always find will be built into the system itself, never again left to chance, to resources, to power or to whoever happens to have someone willing to fight for them. Let it protect every life, especially those with no one to fight for them, not by chance, but by design.

We build it not for one of us, but for all of us, in service of the greater good and of our shared humanity.

God bless you all. God bless America and God bless all those entrusted to protect us all.

With deepest gratitude, respect, appreciation and unwavering faith,

Nebby

Nebiat Gebreziabher

Our Country. Our Constitution.

Compassion. Dignity. Due process. The protection of those who cannot protect themselves.
One unified stand, to protect the public and the best interest of us all.

Presented by: The Guardian, Nebiat (Nebby) Gebru Gebreziabher, under Ohio Probate Court Jurisdiction
206.753.7910 • nebbyg@outlook.com • Columbus, Ohio

Enclosure: The Full-Context and Outlined SEIU-M Proposal

Accompanying package:

1. SEIU-M - Fact Sheet
2. SEIU-M - Executive Action Memo
3. SEIU-M - Executive Briefing
4. SEIU-M Proposal
- The SEIU-M Systems Modernization Proposal and Operational Implementation Framework
5. SEIU-M - White Paper
6. SEIU-M - Case Study and Systems Impact Analysis, offered as the inaugural demonstration case study.
7. SEIU-M - Ownership Diagram (Pyramid).
8. SEIU-M - Distribution List
9. Guardian Testimony

Companion Letter: The proposed Ohio pilot vests primary ownership in the Office of the Ohio Attorney General and its Elder Justice Unit, with the Ohio Department of Behavioral Health (OhioDBH/OhioMHAS) as operational host and OhioHealth as the proposed clinical partner for the pilot, with clinical participation, including OhioHealth's, to be selected and approved through a contract process, should all parties be in agreement; companion letters have been directed to the Ohio Departments of Aging, Developmental Disabilities, Health and Medicaid, the Long-Term Care Ombudsman, the Office of the Governor, the Ohio Department of Rehabilitation and Correction (Bureau of Adult Detention) and the Ohio Association of Health Plans. The case and framework have also been submitted for federal review to the U.S. Department of Justice Civil Rights Division, the HHS Administration for Community Living, the Centers for Medicare and Medicaid Services and SAMHSA and reported to Disability Rights Ohio and Pro Seniors in their independent advocacy capacities. The framework has also been shared, as policy awareness, with Ohio's indigent-defense community (the Office of the Ohio Public Defender and the Ohio Public Defender's Association) and the Ohio Prosecuting Attorneys Association. The framework has also been shared, for professional-education awareness, with the Ohio State Bar Association.

May 25, 2026

CONFIDENTIAL INSTITUTIONAL SUBMISSION

Prepared for Judicial Policy Review, Not for Public Distribution

To: The Honorable Probate Courts of the State of Ohio

Respectfully directed to the Probate Judges of Ohio's eighty-eight counties, through the Ohio Probate Judges Association; and, through their Honors, to the magistrates, court administrators and staff whose work safeguards the wards of this State.

RE: Respectful submission, for judicial-policy awareness only, of the SEIU-M / CIU-M framework, a coordinated, court-integrated medical-stabilization pathway addressing the Resolution Gap affecting incompetent, unrestorable wards adjudicated under Ohio Revised Code Chapter 2111, in which the Probate Courts hold a uniquely central role.

SUBMITTED BY: The Guardian, under Ohio Probate Court jurisdiction, by and on behalf of every comparable ward and family that cannot speak for itself.

Respectful note on scope:

This submission is offered solely as systems-reform policy for the awareness of the Probate Courts as an institution. It does not concern and respectfully requests no action upon, any pending or particular matter before any court. It is not directed to any individual case, party or proceeding. The author's own guardianship matter is referenced only as the documented circumstance that gave rise to the framework and is addressed in the accompanying Case Study; nothing herein is intended as a communication respecting that or any other pending matter.

There is a clear pathway for the person found incompetent and restorable. There is none for the person found incompetent and unrestorable. The first pathway is law. The second is silence. SEIU-M exists to end that silence.

There is also no clear pathway here for the lawyers on either side. For the defense attorney, there is no ethical road map for representing a client who has been found incompetent and unrestorable, a client who cannot meaningfully assist in their own defense and whose case the system offers no way to resolve. For the prosecutor, there is no clear pathway to discharge the duty to protect public safety while also doing justice, when a case can neither fairly proceed nor properly conclude. This is not sustainable and it is not sound as a matter of judicial, legislative or systemic design. A system that leaves both the defense and the prosecution without a framework serves no one: not the defendant, not the public and not the court.

There is no guidance because there is no pathway. We need policy reform that builds the pathway; the pathway becomes the guidance we, the public, are all desperately seeking. The SEIU-M framework not only creates an effective and efficient pathway but it produces a solution to a nationwide problem.

I write to the Probate Courts of Ohio with the deepest respect for the work the Probate bench performs, the quiet, daily guardianship of those the law has found unable to protect themselves. I bring before your Honors, for awareness only, a systems-reform framework in which the Probate Courts hold a role no other institution can fill.

My name is Nebiat (Nebby) Gebreziabher. I am a court-appointed Guardian of the Person, serving under the jurisdiction of an Ohio Probate Court pursuant to Revised Code Chapter 2111. Out of nearly six years of advocacy on behalf of an elderly, cognitively and neurologically disabled ward, a framework emerged, documented in the accompanying Case Study, addressing a structural gap that, in my respectful submission, the Probate Courts are uniquely positioned to help close.

The Gap and the Probate Court's Central Place in Closing It

For the person found incompetent and restorable, the law provides a developed pathway. For the person found incompetent and unrestorable, those whose incapacity arises from dementia, brain injury, advanced decline or Functional Neurological Disorder, there is no comparable architecture. Charges may remain open; civil commitment is unavailable once the patient has stabilized; and no authority owns the resolution. The matter does not move forward and it does not close. The constitutional standard of Jackson v. Indiana (1972) is defeated not in principle but in practice, by the absence of an implementation pathway.

The Probate Courts stand at the very center of this problem and of its solution. When a Probate Court has adjudicated a person incompetent and appointed a guardian under Chapter 2111, that adjudication is among the most consequential facts about that person's subsequent encounters with other systems. Yet across the country, when such a ward is swept into a criminal-legal proceeding, the prior Probate adjudication is too often not integrated into what follows. The framework rests on a principle your Honors will recognize at once:

Coordination with the Probate Court is not a courtesy. It is a prerequisite to fair adjudication.

SEIU-M is built on four principles, stabilize before you escalate; find the cause before you prosecute; coordinate before you decide; be a faithful steward before you continue. It creates no new agency, requests no new statutory authority and disturbs no court's discretion or jurisdiction. It asks only that the systems that already exist coordinate, in the correct order, the authority each already holds, with the Probate Court's prior adjudication and the guardian acting on the ward's behalf, brought into coordination before high-consequence decisions are made elsewhere. Coordination, not coercion. Sequence, not new authority.

Why the Probate Bench

No court understands the vulnerable ward as the Probate Court does. The Probate bench already carries the State's solemn responsibility for guardianship, a responsibility that, by the Supreme Court of Ohio's own Case Management data, has grown markedly as Ohio's population ages. The framework does not ask the Probate Courts to assume new duties. It honors the duty they already hold, by proposing that the rest of the system coordinate with the Probate Court's determinations rather than around them. In doing so, it serves the ward's due-process and equal-protection interests that the Probate Court exists to protect.

Interagency Protection Layers and Access to the Court

A protection that exists in one agency's files but never reaches the decision-maker is no protection at all. The Resolution Gap is, at bottom, a failure of access: the medical record, the guardianship adjudication, the protective-services findings and the documented cause all exist, but they do not reach the judge, the prosecutor or the defender at the moment of decision. The court can only protect the ward it can see; when the prior adjudication and the interagency record do not reach the bench, the protection the law intends is defeated by the architecture, not by any judge. SEIU-M builds the interagency protection layers that carry that record to the court in time to matter.

The framework operates on a need-to-know basis. Information reaches the judicial process only to the extent and only in the form necessary for the decision at hand, under the existing privacy protections of HIPAA, including the use of business associate agreements and the minimum-necessary standard and the governing rules of each system and, for the person under guardianship, with the involvement of the guardian and the appointing court, so that the individual whose information is at stake always has a protector at the table. Coordination is not exposure. The framework is built to protect both the vulnerable person and the integrity of the proceeding, sharing what must be shared, shielding what must be shielded and never more than the decision requires.

What I Humbly Request

I humbly request your Honors' consideration of the following, for awareness only and at whatever pace the courts find appropriate: that the Probate Courts, through the Ohio Probate Judges Association, receive the accompanying package as a matter of judicial-policy awareness; and that the courts consider, in their collective and administrative capacity, whether the framework's court-coordination principle merits attention as Ohio examines how its systems serve incompetent, unrestorable wards. I request no action in any case and nothing in this submission is offered respecting any pending matter. I humbly ask only that the Probate bench be aware of a framework built around the central role your Honors already hold.

I write this on behalf of every person and every family who has lived this same reality or one like it or felt the weight of this gap and was not heard, for every vulnerable and voiceless person who went unheard or abandoned, every guardian who fought a system they were never trained to fight, every elder whose dignity was reduced to a case number, every patient returned again and again to the place that harmed them and for the ones still inside it tonight, waiting for a pathway that does not yet exist. I write it for every person still to come, who will live this same reality unless we choose, now, to build the pathway that would spare them. I write it so that the protection we could not always find will be built into the system itself, never again left to chance, to resources, to power or to whoever happens to have someone willing to fight for them. Let it protect every life, especially those with no one to fight for them, not by chance, but by design.

We build it not for one of us, but for all of us, in service of the greater good and of our shared humanity.

Presented by: The Guardian, Nebiat (Nebby) Gebru Gebreziabher, under Ohio Probate Court Jurisdiction
206.753.7910 • nebbyg@outlook.com • Columbus, Ohio

God bless you all. God bless America and God bless all those entrusted to protect us all.

With deepest gratitude, respect, appreciation and unwavering faith,

Nebby

Nebiat Gebreziabher

Our Country. Our Constitution.

Compassion. Dignity. Due process. The protection of those who cannot protect themselves.
One unified stand, to protect the public and the best interest of us all.

Enclosure: The Full-Context and Outlined SEIU-M Proposal
Accompanying package:

1. SEIU-M - Fact Sheet
2. SEIU-M - Executive Action Memo
3. SEIU-M - Executive Briefing
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Companion Letter: The proposed Ohio pilot vests primary ownership in the Office of the Ohio Attorney General and its Elder Justice Unit, with the Ohio Department of Behavioral Health (OhioDBH/OhioMHAS) as operational host and OhioHealth as the proposed clinical partner for the pilot, with clinical participation, including OhioHealth's, to be selected and approved through a contract process, should all parties be in agreement; companion letters have been directed to the Ohio Departments of Aging, Developmental Disabilities, Health and Medicaid, the Long-Term Care Ombudsman, the Office of the Governor, the Ohio Department of Rehabilitation and Correction (Bureau of Adult Detention) and the Ohio Association of Health Plans. The case and framework have also been submitted for federal review to the U.S. Department of Justice Civil Rights Division, the HHS Administration for Community Living, the Centers for Medicare and Medicaid Services and SAMHSA and reported to Disability Rights Ohio and Pro Seniors in their independent advocacy capacities. The framework has also been shared, as policy awareness, with Ohio's indigent-defense community (the Office of the Ohio Public Defender and the Ohio Public Defender's Association) and the Ohio Prosecuting Attorneys Association. The framework has also been shared, for professional-education awareness, with the Ohio State Bar Association.

May 25, 2026

CONFIDENTIAL INSTITUTIONAL SUBMISSION

Prepared for Institutional Review, Not for Public Distribution

To: The Office of the Governor of Ohio

The Honorable Governor of Ohio; the Office of the Governor; and the senior policy leadership whose coordination across Ohio's agencies, courts and federal partners shapes the protection of the state's most vulnerable citizens.

RE: Submission for the Governor's awareness and leadership consideration, the SEIU-M / CIU-M framework, a coordinated, court-integrated medical-stabilization pathway addressing the constitutional Resolution Gap affecting incompetent, unrestorable wards adjudicated under Ohio Revised Code Chapter 2111, proposed as an Ohio pilot.

SUBMITTED BY: The Guardian, under Ohio Probate Court jurisdiction, by and on behalf of the ward and of every comparable family that cannot speak for itself.

Some failures belong to no single agency, because they live in the space between them. Closing that space is the work of leadership.

I write to the Office of the Governor not to request a single agency action, but to bring to your awareness a framework that spans many of them and that, with your leadership, could position Ohio as the national proof case for a reform the country urgently needs. The agency whose mandate already names this framework's founding premise, the Ohio Department of Behavioral Health, was reconstituted around the mind-body connection under a bill you signed into law. SEIU-M is the operational expression of that very premise.

My name is Nebiat (Nebby) Gebreziabher. I am the court-appointed Guardian of the Person for my father, an Ethiopian Orthodox elder, a naturalized American citizen and a father of five known to his church as "Megabi Gebru", "he who brings life to others." Before a medical destabilization crisis that came through no fault of his own, he is a gentle, faith-centered Christian man with no history of violence, no psychiatric history and no criminal record. Today, by the grace of God and through coordinated medical care, he is alive, walking and stabilized, yet he remains, as of this writing, inside a system with no defined way out. His case is the documented foundation of the framework this submission presents.

There is a clear pathway for the person found incompetent and restorable. There is none for the person found incompetent and unrestorable. The first pathway is law. The second is silence. SEIU-M exists to end that silence.

There is also no clear pathway here for the lawyers on either side. For the defense attorney, there is no ethical road map for representing a client who has been found incompetent and unrestorable, a client who cannot meaningfully assist in their own defense and whose case the system offers no way to resolve. For

the prosecutor, there is no clear pathway to discharge the duty to protect public safety while also doing justice, when a case can neither fairly proceed nor properly conclude. This is not sustainable and it is not sound as a matter of judicial, legislative or systemic design. A system that leaves both the defense and the prosecution without a framework serves no one: not the defendant, not the public and not the court.

There is no guidance because there is no pathway. We need policy reform that builds the pathway; the pathway becomes the guidance we, the public, are all desperately seeking. The SEIU-M framework not only creates an effective and efficient pathway but it produces a solution to a nationwide problem.

Behind that silence is an elderly person who cannot tell you what medication was withheld from them, who was arrested for behavior that medication should have prevented and who is now held inside a system with no way out. SEIU-M is a coordinated, court-integrated medical-stabilization framework built on four principles, stabilize before you escalate; find the cause before you prosecute; coordinate before you decide; be a faithful steward before you continue. It asks no system to do anything new. It asks each to do, together and in the correct sequence, the work it is already authorized to do alone. Coordination, not coercion. Sequence, not new authority.

Why This Belongs Before the Governor

The Resolution Gap is not the failure of any one agency. It is the space between them. My father, adjudicated incompetent by the Probate Court six months before the incident that led to his arrest, passed through a long-term care facility, an emergency room, a county jail, the courts, the behavioral health system and the guardianship system and not one of them held the whole man. Four separate systems each held a piece. Because the gap lives between agencies, no single agency can close it. That is precisely why it rises to the level of the Governor’s coordinating leadership.

The framework asks for no new agency, no new statutory authority during the pilot and no new coercive power. It asks the State’s existing authorities to coordinate, OhioHealth as the proposed clinical partner for the pilot, with clinical participation, including OhioHealth's, to be selected and approved through a contract process, should all parties be in agreement, the Attorney General and its Elder Justice Unit as primary owner, the Department of Behavioral Health as operational host and the Departments of Aging, Developmental Disabilities, Health and Medicaid, together with the Long-Term Care Ombudsman, as coordinating partners. It is fiscally disciplined: a single resolved case at six months rather than three years produces more than $560,000 in direct taxpayer savings and it returns scarce forensic capacity to the civil patients who need it.

And it is replicable. The principle the Ohio pilot is built to demonstrate, one trusted medical anchor, one behavioral health host, one elder-justice authority per state, gives every other state a tested template. Should Ohio pilot this and prove it works, Ohio becomes the proof case for the nation. That is a legacy outcome and it is within the Governor’s reach to convene.

What I Humbly Request

I humbly request the Governor's consideration of the following, at whatever pace the Office finds appropriate: that the Office receive the accompanying package and that it consider the coordinating leadership only the Governor's Office can provide, encouraging the participating agencies to undertake the framework's thirty-day feasibility review and bring their respective authorities to a common table. The constitutional and humanitarian stakes and the fiscal discipline, all point the same direction.

I write this on behalf of every person and every family who has lived this same reality or one like it or felt the weight of this gap and was not heard, for every vulnerable and voiceless person who went unheard or abandoned, every guardian who fought a system they were never trained to fight, every elder whose dignity was reduced to a case number, every patient returned again and again to the place that harmed them and for the ones still inside it tonight, waiting for a pathway that does not yet exist. I write it for every person still to come, who will live this same reality unless we choose, now, to build the pathway that would spare them. I write it so that the protection we could not always find will be built into the system itself, never again left to chance, to resources, to power or to whoever happens to have someone willing to fight for them. Let it protect every life, especially those with no one to fight for them, not by chance, but by design.

We build it not for one of us, but for all of us, in service of the greater good and of our shared humanity.

God bless you all. God bless America and God bless all those entrusted to protect us all.

With deepest gratitude, respect, appreciation and unwavering faith,

Nebby

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May 25, 2026

CONFIDENTIAL INSTITUTIONAL SUBMISSION

Prepared for Institutional Review, Not for Public Distribution

To: The Ohio Department of Behavioral Health (OhioDBH)
Formerly the Ohio Department of Mental Health and Addiction Services (OhioMHAS)

To: The Director of the Ohio Department of Behavioral Health; the Office of Forensic Services; the leadership of the state's regional behavioral healthcare hospitals; and, through your leadership, every clinician, administrator and staff member of the Department whose work serves the behavioral health of Ohioans.

RE: Request for institutional review and operational-host consideration of the SEIU-M / CIU-M framework, a coordinated, court-integrated medical-stabilization pathway addressing the constitutional Resolution Gap affecting incompetent, unrestorable wards adjudicated under Ohio Revised Code Chapter 2111.

SUBMITTED BY: The Guardian, under Ohio Probate Court jurisdiction, by and on behalf of the ward and of every comparable family that cannot speak for itself.

For every patient returned, again and again, to the place that harmed them, with no pathway out, this framework exists to build the pathway.

I write to the Ohio Department of Behavioral Health to bring before you a structural failure your Department is uniquely positioned to help resolve and a framework, drawn from my father's case and documented across nearly six years, that OhioDBH is, in my respectful judgment, the right institution in Ohio to host.

My name is Nebiat (Nebby) Gebreziabher. I am the court-appointed Guardian of the Person for my father, an Ethiopian Orthodox elder, a naturalized American citizen and a father of five known to his church as "Megabi Gebru", "he who brings life to others." Before a medical destabilization crisis that came through no fault of his own, he is a gentle, faith-centered Christian man with no history of violence, no psychiatric history and no criminal record. Today, by the grace of God and through coordinated medical care, he is alive, walking and stabilized. Yet as of this writing he remains in institutional placement, within the Department's own system of care, with no defined pathway out.

This submission carries a single request for your consideration: that OhioDBH serve as operational host of the SEIU-M / CIU-M pilot in Ohio, in collaboration with OhioHealth as the proposed clinical partner for the pilot, with clinical participation, including OhioHealth's, to be selected and approved through a contract process, should all parties be in agreement and with primary ownership vested in the Office of the Ohio Attorney General and its Elder Justice Unit. The case study at its heart is my father's. The reform it carries belongs to every family that comes after him.

Presented by: The Guardian, Nebiat (Nebby) Gebru Gebreziabher, under Ohio Probate Court Jurisdiction
206.753.7910 • nebbyg@outlook.com • Columbus, Ohio

I. Why This Reaches OhioDBH First Among Care Systems

There is a clear pathway for the person found incompetent and restorable. There is none for the person found incompetent and unrestorable. The first pathway is law. The second is silence. SEIU-M exists to end that silence.

There is also no clear pathway here for the lawyers on either side. For the defense attorney, there is no ethical road map for representing a client who has been found incompetent and unrestorable, a client who cannot meaningfully assist in their own defense and whose case the system offers no way to resolve. For the prosecutor, there is no clear pathway to discharge the duty to protect public safety while also doing justice, when a case can neither fairly proceed nor properly conclude. This is not sustainable and it is not sound as a matter of judicial, legislative or systemic design. A system that leaves both the defense and the prosecution without a framework serves no one: not the defendant, not the public and not the court.

There is no guidance because there is no pathway. We need policy reform that builds the pathway; the pathway becomes the guidance we, the public, are all desperately seeking. The SEIU-M framework not only creates an effective and efficient pathway but it produces a solution to a nationwide problem.

Behind that silence is an elderly person who cannot tell you what medication was withheld from them, who was arrested for behavior that medication should have prevented and who is now held inside a system with no way out. For the unrestorable, those whose incapacity arises from dementia, brain injury, advanced decline or Functional Neurological Disorder, charges remain open, civil commitment is unavailable because the patient has stabilized and no agency owns the resolution. These are the patients who fill the Department's forensic capacity. They occupy the beds. They are, disproportionately, the population your hospitals hold while no other system advances their cases. The Resolution Gap is not abstract to OhioDBH. It is, in operational fact, a daily condition of the Department's own system of care.

II. The Department's New Mandate Is the Framework's Founding Premise

On October 1, 2025, under Amended Substitute House Bill 96 of the 136th General Assembly, the Department was reconstituted as the Ohio Department of Behavioral Health, a change of name that reflected a change of mandate, organized around the connection between mental and physical health. That connection is the founding premise of SEIU-M. My father's case is the demonstration of what happens when it is severed: a metabolic and neurological emergency, withheld diabetes medication, a transient ischemic attack, crisis-level blood pressure, was read as behavior and a medical event became a criminal charge. The framework operationalizes precisely the mind-body integration the Department's new mandate now names. In that sense, OhioDBH is not being asked to take on a foreign mission. It is being asked to host the operational expression of the mission it has already declared.

III. The Proof Already Exists and So Did the Prior Ruling

This is not a theory awaiting a test. The test already happened. On April 21, 2023, the Delaware County Court of Common Pleas released my father to community care under guardian supervision and GPS monitoring. Across the six months that followed, April through October 2023, the record documents no violent incidents, no police interactions, no emergency behavioral episodes, no threats to self or others and no safety concerns reported by any provider, neighbor, family member or faith-community member. In that same period he progressed from a wheelchair to unassisted walking and his blood sugar stabilized. Given coordination, continuity and family, he was a man returning to his life. The framework does not ask the Department to imagine that stabilization is possible. It asks the Department to recognize that it has already been documented.

And he had already been adjudicated legally incompetent by the Franklin County Probate Court on April 13, 2022, six months before the October 2022 incident. A sitting Ohio court had already vested authority over his care in a guardian. That prior adjudication was never integrated into what followed. The result is a patient who has now spent years inside the Department's system of care for want of a coordinating pathway that no single authority was positioned to supply.

IV. The Four Principles and the Two That Are Yours

Stabilize before you escalate. Find the cause before you prosecute. Coordinate before you decide. Be a faithful steward before you continue.

The framework asks no system to do anything new. It asks each to do, together and in the correct sequence, the work it is already authorized to do alone. Coordination, not coercion. Sequence, not new authority. Two of the four principles are, by the nature of the Department's work, especially yours. The first, stabilization before escalation, is the clinical conviction at the center of behavioral healthcare: that a person in crisis is stabilized and understood before any irreversible step is taken. The fourth, stewardship before continuation, speaks directly to the Department's forensic capacity: that continued institutional placement is justified only by present clinical necessity, measured against the least-restrictive setting the patient's condition allows. Both principles are already embedded in the Department's clinical ethics. The framework simply gives them an operational pathway across the boundary where behavioral health meets the courts.

V. Why OhioDBH as Operational Host

I have weighed, carefully, which institution should host this work on the operational side. The conclusion is the same each time: the Ohio Department of Behavioral Health. No other body holds, together, the forensic-services mandate the gap implicates, the regional hospital system where these patients already reside, the clinical workforce the framework's stabilization steps require and, since HB 96, the explicit statutory mission organized around the mind-body connection the framework is built upon. OhioDBH is where the unrestorable population already lives within the system. It is therefore the natural place to host the pathway that would move them, safely and lawfully, toward resolution.

The proposed structure places OhioDBH as operational host, with primary ownership vested in the Attorney General's Office and its Elder Justice Unit, OhioHealth as the proposed clinical partner, subject to selection and approval through a contract process and shared ownership across every participating authority so that coordination is efficient rather than concentrated in any single office. The framework requests no new statutory authority, no new coercive power and no new agency, none is created. It is also fiscally disciplined and the discipline falls within the Department's own ledger: a single case resolved in six months rather than three years produces more than $560,000 in direct taxpayer savings in bed costs alone, before associated judicial and administrative costs, capacity returned to the civil patients your hospitals exist to serve.

VI. One Trusted Anchor Per State

The larger principle this pilot is built to demonstrate is straightforward: the justice system and policy reform should recognize, in each state, one trusted anchor medical organization as the clinical backbone, paired with the state's behavioral health authority as operational host and anchored by the constitutional and elder-justice authority of the state's Attorney General, coordinating with its Probate Courts and elder-services systems.

One state. One anchor medical institution. One behavioral health host. One elder-justice authority. One pilot. Fifty replicable pilots. National readiness for a population the country has never been able to coordinate.

Should OhioHealth, the Attorney General's Office and OhioDBH pilot this framework and demonstrate that it works, Ohio becomes the proof case for the nation. That is the opportunity I respectfully place before you.

VIII. In Gratitude

I write with deep respect for the work the Ohio Department of Behavioral Health performs each day on behalf of some of the most vulnerable people in this state and with genuine gratitude for the clinical care my father has received within your system. This submission is not a grievance against the Department. It is a humble request to the Ohio Department of Health to help build the pathway that the DBH, more than any other care system, sees the absence of every day. I offer the SEIU-M package in the spirit in which it was written: humbly, in deference to the clinical expertise and operational responsibility your Department holds, as a request for consideration rather than a prescription.

This is not a partisan request. Protecting elderly and cognitively impaired Americans from indefinite institutional confinement is a constitutional obligation that precedes political affiliation. It matters. It is already making a difference. And the country, I respectfully believe, needs Ohio's behavioral health system in this work.

I write this on behalf of every person and every family who has lived this same reality or one like it or felt the weight of this gap and was not heard.

I write this for every vulnerable and voiceless person who went unheard or abandoned. For every family member who felt helpless and alone. For every guardian who fought a system they were never trained to fight. For every elder whose dignity was reduced to a case number. For every patient returned, again and again, to the place that harmed them. For every caregiver who learned a vocabulary no one should ever have to learn. For every family that could not afford to keep fighting and lost someone to the gap. For the ones still inside it tonight, waiting for a pathway that does not yet exist.

I write it for every person still to come, who will live this same reality unless we choose, now, to build the pathway that would spare them.

I write this so that the next person and the next family will be heard. I write it so that the protection we could not always find will be built into the system itself, never again left to chance, to resources, to power or to whoever happens to have someone willing to fight for them. Let it protect every life, especially those with no one to fight for them, not by chance, but by design.

We build it not for one of us, but for all of us, in service of the greater good and of our shared humanity.

God bless you all. God bless America and God bless all those entrusted to protect us all.

With deepest gratitude, respect, appreciation and unwavering faith,

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May 25, 2026

AN OPEN INSTITUTIONAL LETTER

To: OhioHealth Corporation

The President, CEO, The Executive Leadership Team and through your leadership, to every one of the approximately 35,000 Physicians, Nurses, Advanced Practice Providers, Therapists, Chaplains, Dietitians, Social workers, Associates and Volunteers who together, are OhioHealth.

I write to OhioHealth as a whole because what OhioHealth did for my father and our family was the work of an institution, not of any one person.

My name is Nebiat (Nebby) Gebreziabher. I am the court-appointed Guardian of the Person for my father, an Ethiopian Orthodox elder, a naturalized American citizen and a father of five known to his church as "Megabi Gebru" - "he who brings life to others." Before any of this, he is a gentle, faith-centered Christian man with no history of violence, no psychiatric history and no criminal record before a medical destabilization crisis that came through no fault of his own.

Despite the odds, today he is alive. He is walking. He is stabilized. He went from a wheelchair to unassisted ambulation in six months. That recovery has a name and the name is OhioHealth.

This letter is first a thank you. Thank so much.

It is also a humble request for OhioHealth to strongly consider, in partnership with the Ohio Attorney General's Office, The Elder Justice Unit and the Ohio Department of Behavioral Health (formerly OhioMHAS), might help build for other families what your physicians built for mine. The case study at its heart is my father's. The proposal it carries belongs to every family that comes next.

I. What OhioHealth Did

For nearly five years my father, like others, moved through a chronology no family should navigate alone: a pandemic, COVID-19, a 2021 stroke, a 2022 transient ischemic attack, prolonged custodial confinement, two long-term care facilities later cited by the Ohio Department of Health and a behavioral-health placement that continues today. Through all of it, OhioHealth was the institution that kept its mission, to improve the health of those it serves, when other systems could not.

206.753.7910 • nebbyg@outlook.com • Columbus, Ohio

Your cardinal value is “we honor the dignity and worth of each person.” It was honored at my father’s bedside, in every rehabilitation session, in every clinical decision made with his dignity intact. OhioHealth did not give up on him or supporting our family. By the Grace of God, OhioHealth helped tremendously to restore him. To give our families the answers we we’re desperately searching for and providing the rehabilitation pathway that gave peace of mind to my father and our family.

II. The Team Who Made It Possible

With gratitude, I humbly ask that OhioHealth leadership personally thank the clinicians whose collaboration is the heart of the case study accompanying this letter.

- **Dr. Aniket Natekar**, Neurology, whose 2023 diagnosis of Functional Neurological Disorder (FND) reframed years of misunderstanding into a path forward. FND is a real neurological condition with real treatment, too often misread inside systems built for something else. His clarity changed the trajectory of a life.

- **Dr. Kristen Kilbarger**, Psychiatry, whose courage in discontinuing unnecessary psychiatric medication and referring my father to trauma-informed therapy was one of the most consequential decisions of his recovery. In a system where deprescribing takes more courage than prescribing, she practiced exactly what SEIU-M asks for: stabilization before escalation.

- **Dr. Ruth Egwakhe**, Primary Care, the steady, longitudinal thread across every transition and every return to baseline. Continuity of care is one of the most powerful stabilizers a team can offer and she has been its living example.

- **Dr. Derek Lapp and Dr. Jay Patel**, Endocrinology, who brought my father’s A1C from a dangerous 8.5, accumulated through medication mismanagement outside your system, to a stable 6.9 and to 6.3 today. That is a documented endocrine restoration in a medically complex elderly stroke survivor.

- **OhioHealth Neuroscience Rehabilitation Services**, the neuro PT, OT and speech team who walked my father from a wheelchair, to a rollator, to a cane, to walking unassisted, in six months. This program already does, in clinical practice, what SEIU-M asks the rest of the system to formalize.

- **OhioHealth Cardiology, Urology and Clinical Dietetics** and every consulting physician whose name lives in the record and in our family’s memory. Each carried a piece of his care. Each, by carrying it well, made the whole possible.

To every clinician, nurse, therapist, chaplain and staff member who surrounded them, thank you. You did not just treat a patient. You restored a father, a community elder and the heart of a family. My family.

GOD BLESS YOU ALL!

III. The Six Months That Prove the Model

Between April 21, 2023 and October 11, 2023, six months of judicially supervised community stabilization under guardian oversight and OhioHealth's coordinated outpatient care, the record shows no violent incidents, no police contact, no emergency behavioral episodes, no safety concerns. Active rehabilitation across neurology, psychiatry, endocrinology, primary care, cardiology, urology, dietetics and neuro PT/OT/speech. Mobility from wheelchair to cane to unassisted walking. A1C holding near 6.9. Faith, family and community fully engaged.

That was the only sustained period of stability my father has known since 2021. It was not luck. It was coordination. It is the empirical answer to every objection against least-restrictive, rehabilitation-focused care for medically vulnerable elders and it exists because OhioHealth assembled the team that produced it.

IV. The Gap That Nearly Killed Him

I do not write to blame anyone. Most of the people who touched my father's care work inside systems that are overwhelmed, underfunded and pulled in a hundred directions. The problem is not their hearts or their intentions. The problem is that nothing connects them. So I want to be clear about what follows: it examines what the architecture did, not what any individual did. Accountability, not accusation.

Here is what the record shows. At a facility entrusted with his care, my father's prescribed medication was withheld. When paramedics reached him, his blood sugar had climbed past 400, with crisis-level blood pressure, in a man already living with diabetes, hypertension and a recent stroke. These are not my accusations. The Ohio Department of Health documented the violations as survey findings on the record , findings, by the State of Ohio, not allegations.

I come from a technical background; I solve flawed systems for a living. What happened to my father was a flawed system in need of policy and administrative reform. The doctors did not talk to the court. The criminal court could not see what the Probate Court had already ruled. Four different systems each held one piece of my father and not one of them held the whole man. So no one asked the simplest question: what medication was withheld and was the behavior in that report a symptom, not a crime? Coordination with the Probate Court is not a courtesy. It is a prerequisite to fair adjudication and it did not happen. This is how the revolving door turns: the patient destabilizes, is swept into hospitalization or criminal-legal contact and is returned to the same uncorrected setting, because no part of the system identified the cause and no pathway existed to resolve it.

Consider how it happened. The withheld medication costs about $1,000 a month, is not a controlled substance, is not tracked by the DEA and leaves no electronic trail in a facility still keeping records on paper. No system in place was built to catch it. That is not one nurse's error or one doctor's failing. It is a gap built into the architecture itself and my father is not the only one who has fallen through it.

V. What I Built and Why It Is OhioHealth's Mission

Out of those five years, a framework emerged: SEIU-M, the Specialized Emergency Intervention Unit: Medical Stabilization (also CIU-M, the Crisis Intervention Unit: Medical Stabilization). It is a court-integrated, multidisciplinary medical-stabilization framework that supplements existing systems, seeks no new coercive authority and rests on four principles drawn directly from what should have happened for my father and did not:

Stabilize before you escalate. Find the cause before you prosecute. Coordinate before you decide. Be a faithful steward before you continue.

Those principles are not foreign to OhioHealth. They are your mission in operational form. "To improve the health of those we serve" is stabilization before escalation. "Exceptional care for all… that earns a lifetime of trust" is causation before prosecution. Your values, Compassion, Excellence, Inclusion, Integrity, Stewardship, are coordination before adjudication and stewardship before continuation. And your cardinal value, the dignity and worth of each person, is the constitutional principle SEIU-M exists to operationalize: Dusky, Jackson v. Indiana, Olmstead, Sell, Barker v. Wingo (the Sixth Amendment right against charges left for years neither tried nor dismissed), the ADA, Section 504 of the Rehabilitation Act and the Elder Justice Act.

OhioHealth would not be asked to adopt anything foreign. SEIU-M is simply OhioHealth's own mission, extended to the people falling through every other system in the country.

VI. The Resolution Gap

- There is a clear pathway for the person found incompetent and restorable.
- There is none for the person found incompetent and unrestorable.
- The first pathway is law. The second is silence.
- SEIU-M serves the purpose of ending that silence.

Behind that silence is an elderly person who cannot tell you what medication was withheld from them, who was arrested for behavior that medication should have prevented and who is now inside a system with no defined way out. That person is who this framework exists for.

For the unrestorable, those whose incapacity comes from dementia, brain injury, advanced decline or FND, charges stay open, civil commitment is unavailable because the patient has stabilized and no agency owns the resolution. The standard in Jackson v. Indiana (1972) is defeated not in principle but in practice, by the absence of a pathway. One figure conveys the scale: forensic patients now fill roughly nine of every ten state psychiatric beds in Ohio (Governor's Work Group on Competency Restoration and Diversion, 2024).

The Executive Briefing and Fact Sheet carry the rest , the rising guardianship caseload, the cost of forensic placement, the elder-abuse and adverse-drug-event data.

This is not theoretical. It is the reality COVID-19 exposed and did not resolve. And it is the reality SEIU-M proposes to begin closing, in Ohio first, replicably for the country after.

VII. Why OhioHealth and Why Now

I have asked myself many times which Ohio institution is the right clinical anchor for this work. The answer is always OhioHealth. Your mission is the mission. Your values are the values. Your history, founded in 1891 as a faith-based, not-for-profit ministry, with $444.2 million in charity care and community benefit in Fiscal Year 2024 alone, is 135 years of exactly the stewardship SEIU-M asks for. Your scale, 16 hospitals, 200-plus sites, a 50-county reach, 35,000 associates, is the clinical depth the framework needs. And you have already proven, in my father, that the model works.

OhioHealth would not be asked to become something it is not. It would be recognized for what it already is and presented an opportunity to let its mission, its model and its voice anchor a framework the country urgently needs and no single institution can build alone.

VIII. The Partnership

I believe the right pilot partnership for SEIU-M in Ohio is OhioHealth as clinical anchor, in collaboration with the Ohio Attorney General's Office (OAG), its Elder Justice Unit (EJU) and the Ohio Department of Behavioral Health (OhioDBH/OhioMHAS), the agencies proposed as the state's collaborative, coordinated ownership partner for the pilot. Under House Bill 96, effective October 1, 2025, that agency formally rebranded around the connection between mental and physical health, the very premise SEIU-M is built on.

OhioHealth would bring the multidisciplinary clinical depth no state agency can supply on its own. OhioDBH/OhioMHAS would bring the statutory authority, the regulatory framework, the relationships with the county ADAMHS boards, the Forensic Services pathway and coordination with the Ohio Attorney General's Elder Justice Unit, the Probate Courts and the federal partners. The Proposal contemplates formalizing this as a collaborative state contract, with clinical participation, including OhioHealth's, to be selected and approved through a contract process, should all parties be in agreement; OhioDBH/OhioMHAS as operational host, primary ownership vested in the OAG and its Elder Justice Unit and shared ownership across every participating authority so coordination is never concentrated in one office, with a participating health system (proposed to be OhioHealth) and a participating electronic health record platform, all within existing authority.

This asks OhioHealth to take on no new statutory authority, no new coercive power and no new unfunded burden. No new agency is created. The Proposal lays out a phased pathway and identifies existing federal and state funding, so no new funding category is required. And it pays for itself: resolving a single case in six months rather than three years produces more than $560,000 in direct taxpayer savings before associated judicial and administrative costs. The ask is review, consideration, and, if it fits your mission, leadership.

IX. One Trusted Anchor Per State

The larger principle this pilot is meant to demonstrate is simple: the justice system and policy reform should recognize, in each state, one trusted anchor medical organization as the clinical backbone of SEIU-M, paired with that state's behavioral health authority, coordinating with its Probate Courts and elder-services systems.

- One state. One anchor medical institution. One behavioral health partner. One pilot. Fifty replicable pilots. National readiness for a population the country has never been able to coordinate.

If OhioHealth and The Ohio Attorney General's Office (OAG), The Elder Justice Unit (EJU) and the Ohio Department of Behavioral Health (OhioDBH/OhioMHAS) pilot this and prove it works, Ohio becomes the proof case for the country. That is the opportunity I respectfully place before you.

X. What Accompanies This Letter and What I Humbly Request you to Consider

Accompanying this letter is the full SEIU-M package: the Fact Sheet, Executive Action Memo, Executive Briefing, Operational Implementation Framework (Proposal), White Paper and the Case Study and Systems-Impact Analysis. I have kept this letter free of the operational detail those documents carry, so the packet speaks for itself when you are ready to open it. The Case Study, in particular, names OhioHealth's physicians and programs with gratitude and, with the guardian's consent, is offered as the inaugural teaching and demonstration case study SEIU-M will need as it engages other states and federal partners.

I do not write to tell OhioHealth what to do. I write to share what your care has already produced and to humbly request your leadership and Board to consider, at whatever pace you find right: receiving the package; designating someone to review it; identifying clinical, legal and operational leads; and weighing whether the role of clinical anchor for an Ohio SEIU-M pilot is one OhioHealth would find consonant with its mission. Separately, I am sending parallel proposals to Ohio legislators, the Governor's office and federal authorities, asking that medical and treating-physician expertise carry greater weight in probate and competency matters involving wards of the state with a focus on elderly care, the population I believe most fragile in systemic oversight today.

XI. To Continue the Mission, Not Begin a New One

OhioHealth was built to improve the health of those it serves. This is not a request to abandon that mission for another. It is the same mission, extended into the coordination and policy domains the moment requires so that the next family does not depend on a daughter who happened to know what to ask.

Prevention is not only about sustainability. It is about preparedness. After COVID-19, every healthcare leader knows the next crisis is a question of when, not if. And I can tell you, from everything I have seen: we are not ready. We are not even close. This is the moment to build what the last crisis proved was missing before the next one arrives.

XII. With Gratitude

To The OhioHealth Executive Leadership, Board members and to every physician, nurse, therapist, chaplain and volunteer of OhioHealth I cannot fully say what your institution has meant to my father and to our family. You took an elder many systems had given up on and you treated him with compassion, expertise, patience and an unwavering recognition of his humanity. You restored him. We are grateful beyond what words can hold.

I share the SEIU-M package in the spirit it was written: humbly, in deference to the expertise and responsibility OhioHealth holds, as humble request rather than a prescription. I am hopeful that, reading it, you may feel, as I do, the moment calling for collaborative modernization and that OhioHealth may find a role in it that fits your mission, your voice and your pace.

It matters. It is making a real difference. And the country, I believe, needs OhioHealth in this conversation.

We build it not for one of us, but for all of us, in service of the greater good and of our shared humanity.

May God continue to bless you, the OhioHealth Physician Group, every hospital and every associate and the work you do each day for the most vulnerable among us.

God bless you all. God bless America and God bless all those entrusted to protect us all.

With deepest gratitude, respect, appreciation and unwavering faith,

Nebby

Nebiat Gebreziabher

Our Country. Our Constitution.

Compassion. Dignity. Due process. The protection of those who cannot protect themselves.
One unified stand, to protect the public and the best interest of us all.

Enclosure: The Full-Context and Outlined SEIU-M Proposal

Accompanying package:

1. SEIU-M - Fact Sheet
2. SEIU-M - Executive Action Memo
3. SEIU-M - Executive Briefing
4. SEIU-M Proposal
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6. SEIU-M - Case Study and Systems Impact Analysis, offered as the inaugural demonstration case study.
7. SEIU-M - Ownership Diagram (Pyramid).
8. SEIU-M - Distribution List
9. Guardian Testimony

Companion Letter: The proposed Ohio pilot vests primary ownership in the Office of the Ohio Attorney General and its Elder Justice Unit, with the Ohio Department of Behavioral Health (OhioDBH/OhioMHAS) as operational host and OhioHealth as the proposed clinical partner for the pilot, with clinical participation, including OhioHealth's, to be selected and approved through a contract process, should all parties be in agreement; companion letters have been directed to the Ohio Departments of Aging, Developmental Disabilities, Health and Medicaid, the Long-Term Care Ombudsman, the Office of the Governor, the Ohio Department of Rehabilitation and Correction (Bureau of Adult Detention) and the Ohio Association of Health Plans. The case and framework have also been submitted for federal review to the U.S. Department of Justice Civil Rights Division, the HHS Administration for Community Living, the Centers for Medicare and Medicaid Services and SAMHSA and reported to Disability Rights Ohio and Pro Seniors in their independent advocacy capacities. The framework has also been shared, as policy awareness, with Ohio's indigent-defense community (the Office of the Ohio Public Defender and the Ohio Public Defender's Association) and the Ohio Prosecuting Attorneys Association. The framework has also been shared, for professional-education awareness, with the Ohio State Bar Association.

May 25, 2026

CONFIDENTIAL INSTITUTIONAL SUBMISSION

Prepared for Legislative Review, Not for Public Distribution

To: The Members of the Ohio General Assembly

The leadership of the Ohio House of Representatives and the Ohio Senate; the chairs and members of the committees with jurisdiction over health, behavioral health, aging, the judiciary and Medicaid; and every Representative and Senator whose work shapes how this State protects its most vulnerable citizens.

RE: Request for legislative awareness and support of the SEIU-M / CIU-M framework, a coordinated, court-integrated medical-stabilization pathway addressing the constitutional Resolution Gap affecting incompetent, unrestorable wards adjudicated under Ohio Revised Code Chapter 2111, proposed as an Ohio pilot with a pathway to statewide scaling.

SUBMITTED BY: The Guardian, under Ohio Probate Court jurisdiction, by and on behalf of the ward and of every comparable family that cannot speak for itself.

Laws are how a people decide who they will protect. This framework asks Ohio to decide that the most vulnerable will be protected by design, not by accident.

To the Members of the General Assembly: some of you have heard the beginning of this before. The earliest version of the framework I bring before you today was first articulated in a letter I addressed to the Ohio House of Representatives in April 2026. What follows is that idea, now fully developed into a complete institutional framework and a respectful request that the legislature consider the role only it can play in making the reform real and lasting.

My name is Nebiat (Nebby) Gebreziabher. I am the court-appointed Guardian of the Person for my father, an Ethiopian Orthodox elder, a naturalized American citizen and a father of five known to his church as “Megabi Gebru”, “he who brings life to others.” Before a medical destabilization crisis that came through no fault of his own, he is a gentle, faith-centered Christian man with no history of violence, no psychiatric history and no criminal record. Today, by the grace of God and through coordinated medical care, he is alive, walking and stabilized, yet he remains, as of this writing, inside a system with no defined way out. His case is the documented foundation of the framework this submission presents. His case is the documented foundation of the framework this submission presents.

I. The Gap the Legislature Is Positioned to Close

There is a clear pathway for the person found incompetent and restorable. There is none for the person found incompetent and unrestorable. The first pathway is law. The second is silence. SEIU-M exists to end that silence.

There is also no clear pathway here for the lawyers on either side. For the defense attorney, there is no ethical road map for representing a client who has been found incompetent and unrestorable, a client who cannot meaningfully assist in their own defense and whose case the system offers no way to resolve. For the prosecutor, there is no clear pathway to discharge the duty to protect public safety while also doing justice, when a case can neither fairly proceed nor properly conclude. This is not sustainable and it is not sound as a matter of judicial, legislative or systemic design. A system that leaves both the defense and the prosecution without a framework serves no one: not the defendant, not the public and not the court.

There is no guidance because there is no pathway. We need policy reform that builds the pathway; the pathway becomes the guidance we, the public, are all desperately seeking. The SEIU-M framework not only creates an effective and efficient pathway but it produces a solution to a nationwide problem.

Behind that silence is an elderly person who cannot tell you what medication was withheld from them, who was arrested for behavior that medication should have prevented and who is now held inside a system with no way out. For the unrestorable, those whose incapacity arises from dementia, brain injury, advanced decline or Functional Neurological Disorder, charges remain open, civil commitment is unavailable because the patient has stabilized and no agency owns the resolution. This is not a gap any single agency can close on its own, because it lives in the space between them. It is, in the end, a question of how the State has structured its laws and its systems and that makes it, ultimately, a question for the legislature.

The scale is documented in the State's own data. Forensic patients now fill roughly nine of every ten state psychiatric beds in Ohio (Governor's Work Group on Competency Restoration and Diversion, 2024). Ohio's adult guardianship caseload has grown from roughly 42,000 to approximately 49,000, with thousands of new applications each year (Supreme Court of Ohio, Case Management Section). The accompanying package carries the rest of the empirical record. Behind every one of those numbers is a citizen and very often a family quietly breaking under a weight it was never trained to carry.

II. The Constitutional Stakes and Why Ohio Should Act First

The constitutional standard already exists; what is missing is the implementation. *Jackson v. Indiana* (1972) holds, on due-process and equal-protection grounds, that a person committed solely for incompetency cannot be held indefinitely and must be civilly committed or released where restoration is not possible. The Sixth Amendment speedy-trial right under *Barker v. Wingo* (1972) is implicated when charges sit for years. *Olmstead*, the Americans with Disabilities Act and Section 504 command the least-restrictive setting. In other states, these guarantees have been enforced only after federal litigation and years of harm, as in *Trueblood v. Washington DSHS* (2015). Ohio has the opportunity to act first, to build the pathway voluntarily, on its own terms, before the gap becomes the subject of a federal lawsuit rather than a state achievement.

III. What This Case Proves and What It Cost

This is not a theory. On April 21, 2023, a court released my father to guardian-supervised community care. Across the six months that followed, the record documents no violent incidents, no police interactions, no

emergency episodes and no safety concerns of any kind; he progressed from a wheelchair to unassisted walking. Stabilization was not only possible, it was achieved, under judicial supervision and documented. Yet he was returned to institutional placement, where he remains, because no pathway existed to carry that proven stabilization toward resolution. He had been adjudicated incompetent by the Probate Court six months before the incident that led to his arrest and that prior ruling was never integrated into what followed. Four separate systems each held one piece of him and not one of them held the whole man.

The fiscal cost of that failure is borne by the State. State forensic placement runs roughly $790 per bed per day; a single case resolved in six months rather than three years produces more than $560,000 in direct taxpayer savings before associated judicial and administrative costs. The Resolution Gap is, among everything else it is, a recurring and avoidable expense to the State's budget, the kind of structural inefficiency the legislature exists to correct.

IV. What the Framework Asks and What It Does Not

Stabilize before you escalate. Find the cause before you prosecute. Coordinate before you decide. Be a faithful steward before you continue.

SEIU-M is built on those four principles. It creates no new agency. It requests no new statutory authority during the pilot phase. It asks the systems Ohio already has, its hospitals, its behavioral health system, its Probate Courts, its Attorney General and Elder Justice Unit, its aging, developmental-disability, health and Medicaid agencies, to coordinate, in the correct order, the authority each already holds. Coordination, not coercion. Sequence, not new authority. The proposed Ohio pilot vests primary ownership in the Office of the Ohio Attorney General and its Elder Justice Unit, with the Ohio Department of Behavioral Health as operational host and OhioHealth as the proposed clinical partner for the pilot, with clinical participation, including OhioHealth's, to be selected and approved through a contract process, should all parties be in agreement, operating within existing federal and state authority.

The legislature's role is distinct from that of the agencies. Where they coordinate and operate, the General Assembly enables and scales. The framework's twelve-month action horizon contemplates exactly the work that is yours: evaluating the pilot's results, considering the funding feasibility and, if the pilot proves itself, developing the legislative and administrative pathway for regional expansion and statewide scaling. That is why I bring this to you not only for awareness, but as the body ultimately positioned to make a successful pilot permanent and statewide.

V. One Trusted Anchor Per State and Ohio as the Proof Case

The larger principle this pilot is built to demonstrate is straightforward and replicable: that each state recognize one trusted anchor medical organization as the clinical backbone, paired with its behavioral health authority as operational host and anchored by the constitutional and elder-justice authority of its Attorney General, coordinating with its Probate Courts and elder-services systems.

One state. One anchor medical institution. One behavioral health host. One elder-justice authority. One pilot. Fifty replicable pilots. National readiness for a population the country has never been able to coordinate.

Should Ohio pilot this framework and prove it works, Ohio becomes the proof case for the nation and the General Assembly becomes the legislature that showed the country how a state protects its most vulnerable not by accident, but by design. That is a legacy worthy of this body and it is within your reach.

What I Humbly Request

I humbly request your consideration of the following, at whatever pace the legislature finds appropriate: that Members and the relevant committees receive and review the accompanying package; that the General Assembly remain aware of the pilot as it develops among the participating agencies; and that, should the pilot demonstrate its value, the legislature consider the funding feasibility and the statutory pathway for regional expansion and statewide scaling that the framework's action horizon contemplates. I would be honored to provide any further information, testimony or documentation that would assist the legislature's consideration.

I write this on behalf of every person and every family who has lived this same reality or one like it or felt the weight of this gap and was not heard, for every vulnerable and voiceless person who went unheard or abandoned, every guardian who fought a system they were never trained to fight, every elder whose dignity was reduced to a case number, every patient returned again and again to the place that harmed them and for the ones still inside it tonight, waiting for a pathway that does not yet exist. I write it for every person still to come, who will live this same reality unless we choose, now, to build the pathway that would spare them. I write it so that the protection we could not always find will be built into the system itself, never again left to chance, to resources, to power or to whoever happens to have someone willing to fight for them. Let it protect every life, especially those with no one to fight for them, not by chance, but by design.

We build it not for one of us, but for all of us, in service of the greater good and of our shared humanity.

God bless you all. God bless America and God bless all those entrusted to protect us all.

With deepest gratitude, respect, appreciation and unwavering faith,

Nebby

Nebiat Gebreziabher

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One unified stand, to protect the public and the best interest of us all.

Enclosure: The Full-Context and Outlined SEIU-M Proposal

Presented by: The Guardian, Nebiat (Nebby) Gebru Gebreziabher, under Ohio Probate Court Jurisdiction
206.753.7910 • nebbyg@outlook.com • Columbus, Ohio

Accompanying package:

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