ATTACHMENT A

REPORT OF THE INDEPENDENT REVIEWER

In The Matter Of

United States of America v. The State of Georgia

Civil Action No. 1:10-CV-249-CAP

Submitted By: Elizabeth Jones, Independent Reviewer

September 15, 2014

INTRODUCTORY COMMENTS

This is the fourth Report issued on the status of compliance with the provisions of the Settlement Agreement in United States v. Georgia. The Report documents and discusses the State's efforts to meet obligations to be completed by July 1, 2014.

The Independent Reviewer and her expert consultants in supported housing, supported employment, Assertive Community Treatment (ACT), behavioral interventions and health care drew from multiple sources of information to form their professional judgments regarding compliance with the Settlement Agreement obligations for Georgia's individuals with mental illness and/or an intellectual disability. These sources included observations from multiple site visits in every Region of the State. (The Independent Reviewer spent forty-four days on site in Georgia.) In addition, the information and data contained in numerous documents were reviewed. There were discussions with the leadership and staff of the Department of Behavioral Health and Developmental Disabilities (DBHDD), and conversations with key stakeholders, including members of the target population, their families and their advocates. Parties' meetings and meetings with the Amici were held throughout the fourth year in order to collaborate on issues of mutual concern.

While there continue to be critical systemic matters to be addressed and resolved, including the under-representation of individuals with forensic histories, the uneven demonstration of the recovery model, and the gaps in continuity of care, it is evident that the State of Georgia has worked diligently and effectively throughout the fourth year to strengthen and expand the supports required by adults with a serious and persistent mental illness.

Despite competing demands for limited resources, the Governor and the State Legislature have continued to approve the funding requested for the implementation of the Settlement Agreement in the fourth year. The State has demonstrated a good faith effort to ensure that the terms of the Settlement Agreement are met.

At this time, with very limited exceptions, the transition of individuals with an intellectual disability from State hospitals to community-based settings is still suspended. The State remains out of compliance with key provisions of the Settlement Agreement regarding community placements, the implementation of individualized support plans and support coordination. However, there are promising plans to reform the system of supports throughout the State and credible efforts are now beginning to be initiated. The State has retained highly qualified expert consultants to assist with its transformation actions; their experiences in other States will be invaluable assets in the introduction of the necessary reforms. Although the delays in the design and development of community placements are of significant concern, the Commissioner's decision to twice stop community placements until health, safety and

habilitation could be assured was a wise one. There has been considerable support for his decision throughout the stakeholder community and there is confidence and hope in his leadership and that of the Deputy Commissioner.

As noted in the attached expert consultant reports, the public statements by Commissioner Berry and his leadership team have strongly underscored the importance of the recovery model and the principles of the Olmstead decision. Their commitment and conscientious, seemingly tireless, efforts are extremely important to the reform of the State's system. In the coming year, the fifth year of the Settlement Agreement, it will be critical to ensure that their understanding of and advocacy for the recovery model and for the meaningful integration of Georgia's residents with a mental or developmental disability are reflected throughout the network of clinicians and professional/paraprofessional staff who provide services and supports. The attached reports describing supported housing, supported employment and Assertive Community Treatment (ACT) document that this is not presently the case. Additional emphasis on these expectations, as well as training and oversight, is required.

The work of the Independent Reviewer and her consultants has been greatly aided and encouraged by the generous assistance of and access to Commissioner Berry, Deputy Commissioner Judith Fitzgerald, Settlement Agreement Director Pamela Schuble, and many Department (DBHDD) staff and consultants. Commissioner Berry and Deputy Commissioner Fitzgerald have invited the Independent Reviewer's perspective, and those of her expert consultants, on individual, programmatic and systemic issues. Ms. Schuble has joined the Independent Reviewer on many site visits and has taken the responsibility to follow-up on issues of concern.

It has also been invaluable to work with the State's counsel and the attorneys from the Department of Justice. This past year has required a high degree of collaboration and commitment to problem resolution. The willingness to convene periodic Parties' meetings and hold frank discussions about the implementation of the Settlement Agreement provisions has resulted in the identification and implementation of productive approaches to fact-finding and remedial actions. The Court's instruction to periodically include representatives of the Amici in discussions about the implementation of the Settlement Agreement provisions has been respected by the Parties and the Independent Reviewer. The advice and observations of the Amici have received serious consideration.

Each year, the State of Georgia's articulate and engaged community of peers and advocates has been acknowledged and applauded in these Reports to the Court. This year, the Independent Reviewer and her consultants had the privilege of visiting three Peer Wellness Centers in order to meet directly with men and women who are receiving supports related to their mental illness. (Two additional Centers have now been funded.) Although the Settlement Agreement

does not require these Centers, they are funded by State dollars and provide exemplary opportunities for companionship, respite, skill acquisition and encouragement. They are an indication of the State's commitment to client-directed supports in typical community settings. These Centers stood in contrast to three other sites, for ACT clients, visited very recently by the Independent Reviewer and her consultants in preparation for this Report. The disparities between these settings point to three substantial challenges that the State must continue to address in its mental health system in the fifth year of the Settlement Agreement:

- Implementation of a recovery-based model must be present throughout the system. All agencies should demonstrate knowledge of and commitment to these principles in order to receive State funding;
- There must be evidence of continuity of care. The mental health system must work as a whole rather than as a series of parts;
- Access to recovery-based supports must be available for each member of the target population, including those with a forensic history.

These challenges exist in parallel with the outstanding concerns still evident in the State's system of supports for individuals with a developmental disability. These identified concerns are known to the Parties and are the subject of intensive remedial efforts by the Department of Behavioral Health and Developmental Disabilities. They are clearly outlined in the Priority Plan adopted by the Department (DBHDD) and published on its website.

In summary, therefore, the State has continued to demonstrate continuing progress in the expansion and strengthening of its mental health system. Attention must now be directed towards under-represented members of the target population; ensuring continuity of care across the discrete parts of the system; and uniform application of recovery-based principles and practices. The system of supports for individuals with an intellectual/developmental disability is still seriously compromised. Substantive changes must be implemented as described in the Priority Plan submitted by the State. Timelines must be met.

Given the leadership strengths within the Department (DBHDD) and the advocacy community, the resources appropriated by the Governor and the Legislature, and the contemporary knowledge in the field of evidence-based practices available to the State, it is the Independent Reviewer's opinion and hope that this forthcoming year of the Settlement Agreement will build on the accomplishments of Year Four, continue to resolve identified weaknesses and demonstrate increased growth in Georgia's systems of care for individuals with a mental disability.

CURRENT STATUS OF MODIFICATIONS TO THE SETTLEMENT AGREEMENT LANGUAGE

The Settlement Agreement permits the Parties to seek approval from the Court for mutually agreed upon modifications:

> Any modification of this Settlement Agreement shall be executed in writing by the Parties, shall be filed with the Court, and shall not be effective until the Court enters the modified agreement and retains jurisdiction to enforce it. (VII, E)

On two occasions, August 29, 2012 and July 26, 2013, upon receipt of joint motions by the Parties, the Court approved modifications to the language of the Settlement Agreement. The requirements linked to the first modification were met by the State and were discussed in last year's Report. They involved the development of the Quality Management system and the review of the Assertive Community Treatment teams implemented under the Settlement Agreement. The issues linked to the second modification focused on the transitions from State hospitals to community-based settings for individuals with an intellectual/developmental disability. These latter issues are not resolved and have received continuing attention from the Parties and the Independent Reviewer. A Supplemental Report by the Independent Reviewer was filed with the Court on March 24, 2014. Subsequently, on the same date, the Parties filed a joint response to the Independent Reviewer's report.

The Parties' response requires the State to respond to the recommendations made by the Independent Reviewer in her Supplemental Report. These recommendations are:

1. Realign the responsibilities and competencies of support coordinators to include developing and implementing an individualized plan of supports, revising the plan to address changing needs, and oversight to ensure needed services are delivered and outcomes are achieved.
2. Strengthen the transition process from the State hospitals to community-based settings, including providing individualized and relevant competency based training for community providers.
3. Ensure competent and sufficient health practitioner oversight of medically fragile individuals including providing competency-based training on writing and implementing nursing plans of care, proper positioning techniques, and proper monitoring of food and fluid intakes.
4. Design and implement Intensive Support Coordination for high-risk individuals, including pursuing an amendment to the Home and Community-Based Services Waiver.
5. Restructure the roles and responsibilities of regional offices, including examining how the regional offices inter-relate with the DD Division and with community providers, including Support Coordination agencies.

6. Develop and implement sustainable strategies for the ongoing monitoring and evaluation of community placements to remedy issues such as lack of communication, information sharing, and feedback.
7. Recruit and retain provider agencies with requisite experience with individuals with medical and behavioral complexities.
8. Conduct independent mortality reviews of all deaths of individuals receiving Home and Community Based Services Waivers who meet the criteria for the target population of individuals with intellectual disabilities in the Settlement Agreement, § III.A.2.a.
9. Create exit criteria to enable the State to reach identifiable goals necessary to achieve compliance with the Settlement Agreement.

The joint response also requires the Independent Reviewer to comment on the Plan developed by the Department of Behavioral Health and Developmental Disabilities as it works to address acknowledged deficiencies in its system of supports for individuals with a developmental/intellectual disability.

On June 30, 2014, as agreed, the Department (DBHDD) submitted a draft Priority Plan to the Department of Justice and to the Independent Reviewer. This document was shared with the Amici on July 7, 2014. The Independent Reviewer, the Department of Justice and the Amici provided their comments to the Department (DBHDD) in a timely manner. On July 21, 2014, the Department (DBHDD) published its Plan on its website.

The Plan submitted by the Department (DBHDD) is comprehensive. It provides detailed attention to the essential ingredients of a well-functioning system of community-based supports, including the implementation of support coordination; the transition process from institutions; the development of residential and clinical resources as determined by Individual Support Plans; and the creation of oversight and Quality Management mechanisms.

The Plan is responsive to all but one of the Independent Reviewer's recommendations referenced above (9). As of this date, the exit criteria for the Plan have not been finalized, although they are reportedly in the process of being developed.

As noted by the Department of Justice and the Amici, the Plan will require additional resources and staffing in order to be implemented as written. The implementation timelines referenced in the Plan were of concern to the Department of Justice, the Amici and the Independent Reviewer; they appeared to be too concise to achieve the stated expectations for the requisite and wide-ranging programmatic and systemic reforms.

Since the issuance of the planning documents, the Department (DBHDD) and its expert consultants have continued to work with great seriousness to implement the initial stages of the Plan. On July 14, 2014, the Independent Reviewer met with the Department's (DBHDD)

leadership team, including its clinical consultants, to review its initiatives for transition planning and program development in Region 2. These initiatives have merit and will provide a template for similar initiatives in other Regions. Region 2 was an ideal choice to begin the new design of program supports since it is also the location of the Craig Center and Gracewood, two institutions that are the sites for future transitions.

The transitions from Craig Center are of immediate concern. The individuals who live here now are medically or psychiatrically compromised and will require residential settings with adequately trained staff and clinical supports. Unless there is Guardian opposition, the Department (DBHDD) has determined that individuals with an intellectual/developmental disability will be placed in appropriate community settings funded under the Home and Community-Based Services Waiver. However, there has not been sufficient planning to ensure appropriate community options for those individuals with both psychiatric and medical needs for support. The discussions with the Department of Community Health, a signatory to the Settlement Agreement, have not been fruitful regarding this important matter, despite assurances to the Independent Reviewer that were documented in last year's Report. It is the Independent Reviewer's opinion that the future placements for individuals who reside at the Craig Center must be addressed as part of the new Region 2 initiative. At the present time, individuals have been or are projected to be transferred to Georgia Regional Hospital in Atlanta and to Gracewood. Visits to both institutions by the Independent Reviewer, in July 2014, surfaced concerns about the lack of active treatment. In addition, there is virtually no privacy or individualization in either setting. During the site visits, nursing care at the Atlanta facility was noted to be caring and competent. (This State hospital is also the current placement for individuals transferred from Southwestern State hospital prior to its closure in December 2013. Two individuals were transferred to Gracewood. All of these men and women remain hospitalized although one is scheduled to move to a community placement.)

It is clear that the Department's (DBHDD) leadership and its expert consultants are very mindful of the responsibilities that must be implemented successfully in order to permit the transitions from State hospitals required under the provisions of the Settlement Agreement.

It is the Independent Reviewer's strong recommendation that another Supplemental Report on the status of the provisions related to transitions, support coordination and the implementation of Individual Support Plans be prepared and submitted to the Parties and then filed with the Court under the same timeframes and expectations as the first Supplemental Report filed in March 2014.

Summary of Compliance: Year Four

Settlement Agreement Reference	Provision	Rating	Comments
III	**Substantive Provisions**		
III.A.1.a	By July 1, 2011, the State shall cease all admissions to the State Hospitals of all individuals for whom the reason for admission is due to a primary diagnosis of a developmental disability.	Compliance	The State has complied with this provision. There is no evidence to indicate that individuals with a developmental disability have been transferred between State Hospitals in contradiction of the commitment to cease admissions. It is recommended that the Department's Quality Management system restructure its reporting of performance indicators related to the cessation of admissions.
III.A.1.b	The State will make any necessary changes to administrative regulations and take best efforts to amend any statutes that may require such admissions.	Compliance	In House Bill 324, the State Legislature amended Chapter 4 of Title 37 of the Official Code of Georgia Annotated.
III.A.2.b.i(A)	By July 1, 2011, the State shall move 150 individuals with developmental disabilities from the State Hospitals to the community and the State shall create 150 waivers to accomplish this transition. In addition, the State shall move from the State Hospitals to the community all individuals with an existing and active waiver as of the Effective Date of this Agreement, provided such placement is consistent with the individual's informed choice. The State shall provide family supports to a minimum of 400 families of people with developmental disabilities.	Compliance	By July 1, 2011, the Department placed more than 150 individuals with a developmental disability into community residential settings supported by the Home and Community-Based Waiver. A sample of 48 individuals was reviewed. Identified concerns were referred to the Department and corrective actions were initiated. Nine of the 11 individuals hospitalized with an existing Waiver were discharged to community settings. Two individuals remained hospitalized. Delays in placement were attributed to family objections or to provider-related issues. The Department continued to pursue appropriate community placements for these two individuals. More than 400 individuals were provided with family supports. Because there was substantial compliance with this provision, a positive rating was given.
III.A.2.b.i(B)	Between July 1, 2011, and July 1, 2012, the State shall move 150 individuals with developmental disabilities from the State Hospitals to the community. The State shall create 150 waivers to accomplish this transition. The State shall also create 100 additional waivers to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. The State shall provide family supports to an additional 450 families of people with developmental disabilities.	Compliance	The Department placed 164 individuals with a developmental disability into community residential settings supported by the Home and Community-Based Waiver. A statistically relevant sample of 48 individuals was reviewed. Identified concerns have been referred to the Department and corrective actions are being initiated. Although in compliance, it is recommended that the Department review its policies and guidance regarding expectations for community placement and to provide greater oversight of service coordination at the Regional level. The two hospitalized individuals referenced in the provision above have either been placed or have a placement in process. Two other individuals with existing and active Waivers at the time of the Settlement Agreement were rehospitalized. Those individuals were reviewed by a psychologist consulting with the Independent Reviewer. Community placements are being actively pursued; an experienced provider has been recruited. The Department issued 117 Waivers to avoid institutionalization of individuals with a developmental disability residing in the community. Family supports were provided for 2248 individuals through 38 provider agencies.

Settlement Agreement Reference	Provision	Rating	Comments
III.A.2.b.i(C)	Between July 1, 2012, and July 1, 2013, the State shall create at least 250 waivers to serve individuals with developmental disabilities in community settings. The State shall move up to 150 individuals with developmental disabilities from the State Hospitals to the community using those waivers. The remaining waivers shall be used to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. The State shall provide family supports to an additional 500 families of people with developmental disabilities.	Compliance	The Court's Order, dated July 26, 2013, modified the language of this provision. The Department has issued 597 waivers to serve individuals with developmental disabilities in community settings. These waivers have been used to prevent institutionalization and to sustain individuals with a developmental disability with their families. The number of individuals with a disability who have moved from state hospitals using these waivers will be reviewed in the Independent Reviewer's report to be issued in late Winter 2014. As of this date, seventy-nine individuals with a developmental disability have been transitioned from state hospitals to community residential settings.
III.A.2.b.i(D)	**Between July 1, 2013, and July 1, 2014, the State shall move 150 individuals with developmental disabilities from the State Hospitals to the community. The State shall create 150 waivers to accomplish this transition. The State shall also create 100 additional waivers to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. The State shall provide family supports to an additional 500 families of people with developmental disabilities.**	Non-compliance	**With few exceptions (three), placements from State Hospitals have been suspended. The Department is planning and developing remedial actions to permit the resumption of individualized community placements. A "pioneer" project is being initiated in Region 2 to demonstrate improved transition, support coordination and habilitation practices. In total, 46 individuals were transitioned from State Hospitals during this Fiscal Year. The State issued 100 additional waivers to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. In FY14, the State provided family supports to a total of 1155 families of people with developmental disabilities.**
III.A.2.b.ii(B)	Individuals in the target population shall not be served in a host home or a congregate community living setting unless such placement is consistent with the individual's informed choice. For individuals in the target population not served in their own home or their family's home, the number of individuals served in a host home as defined by Georgia law shall not exceed two, and the number of individuals served in any congregate community living setting shall not exceed four.	Compliance	**The Department remains in substantial compliance with this provision. All host homes reviewed to date have no more than two individuals. With one recently identified exception, the number of individuals served in any congregate community living setting has not exceeded four.**
III.A.2.b.iii(A)	Assembling professionals and non-professionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Service Plans, as required by the State's HCBS Waiver Program, that are individualized and person centered.	Non-compliance	**The rating of this provision was deferred initially by Court Order until January 2014. As of June 30, 2014, the Department has not achieved compliance with this provision.**

Settlement Agreement Reference	Provision	Rating	Comments
III.A.2.b.iii(B)	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, and other services identified in the Individual Service Plan.	**Non-compliance**	**The rating of this provision was deferred initially by Court Order until January 2014. As of June 30, 2014, the Department has not achieved compliance with this provision.**
III.A.2.b.iii(C)	Monitoring the Individual Service Plan to make additional referrals, service changes, and amendments to the plans as identified as needed.	**Non-compliance**	**The rating of this provision was deferred initially by Court Order until January 2014. As of June 30, 2014, the Department has not achieved compliance with this provision.**
III.A.2.b.iii(D)	The Independent Reviewer will not assess the provisions of this section, III.A.2.b.iii.(A)-(C), in her report for the period ending July 1, 2013. Instead, the review period for this section will be extended six months until January 1, 2014, after which the Independent Reviewer will report on this section pursuant to the draft, review, and comment deadlines enumerated in VI.A.	**Completed**	**The Independent Reviewer has complied with this requirement. Her supplemental report was filed with the Court on March 24, 2014.**
III.A.2.c.i(A)	By July 1, 2012, the State will have six mobile crisis teams for persons with developmental disabilities.	**Compliance**	**There are 12 mobile crisis teams for individuals with developmental disabilities.**
III.A.2.c.ii(B)(1)	By July 1, 2012, the State will have five Crisis Respite Homes for individuals with developmental disabilities.	**Compliance**	There are 11 Crisis Respite Homes, including one for children. One individual in the sample of 48 was reviewed in his crisis home; supports were adequate and individualized.
III.A.2.c.ii(B)(2)	By July 1, 2013, the State will establish an additional four Crisis Respite Homes for individuals with developmental disabilities.	**Compliance**	There are 11 Crisis Respite Homes across the State. There are 2 homes in each Region, except for Region 3 which has one Home. There were 270 individuals served in FY13.
III.A.2.c.ii(B)(3)	**By July 1, 2014, the State will establish an additional three Crisis Respite Homes for individuals with developmental disabilities.**	**Non-compliance**	**There are 11 Crisis Respite Homes. The contract for the twelfth home was cancelled and has not yet been re-issued.**
III.A.3.a	By July 1, 2013, the State shall create a program to educate judges and law enforcement officials about community supports and services for individuals with developmental disabilities and forensic status.	**Compliance**	**The Department has initiated a program to provide education to judges and law enforcement individuals. In FY14, training was provided to 1433 individuals, including 130 Judges, 1279 law enforcement officials and 24 attorneys.**
III.A.3.b	Individuals with developmental disabilities and forensic status shall be included in the target population and the waivers described in this Section, if the relevant court finds that community placement is appropriate. This paragraph shall not be interpreted as expanding the State's obligations under paragraph III.A.2.b.	**Compliance**	**There is evidence that individuals with a developmental disability and forensic status are included in the target population. However, with few exceptions, community placements are currently suspended.**

Settlement Agreement Reference	Provision	Rating	Comments
III.A.4.a	By July 1, 2013, the State will conduct an audit of community providers of waiver services.	**Compliance**	The Georgia Quality Management System (GQMS) contract with the Delmarva Foundation mandates that each provider rendering services through the Medicaid waivers to individuals with developmental disabilities has one annual review over the course of five years. Therefore, 40 providers are reviewed each year (39 service providers and one support coordinator agency). The providers are selected randomly. Findings from these reviews are summarized in the Quality Management reports issued by the Department.
III.A.4.b	By the Effective Date of this Agreement, the State shall use a CMS approved Quality Improvement Organization ("QIO") or QIO-like organization to assess the quality of services by community providers.	**Compliance**	**In FY14, the Department again utilized the services of the Delmarva Foundation to design and implement a quality assurance review process. Delmarva also assessed the quality of services by community providers. The Department participated in the National Core Indicator surveys.**
III.A.4.d	The State shall assess compliance on an annual basis and shall take appropriate action based on each assessment.	**Compliance**	**The Delmarva Foundation issues annual reports assessing the quality of services by community providers for individuals with a developmental disability. The most recent report was issued to the Independent Reviewer and the Department of Justice on August 1, 2014. Annual reports are posted on the Delmarva website. The State will need to continue its review of the quality of services to ensure that any remedial actions have occured in a timely manner. The Regions receive the information from Delmarva and are expected to take timely remedial action.**
III.B.1.c	Pursuant to the Voluntary Compliance Agreement with Health and Human Services, the State established a Mental Health Olmstead List. The State shall ensure that all individuals on the Mental Health Olmstead List as of the Effective Date of this Agreement will, if eligible for services, receive services in the community in accordance with this Settlement Agreement by July 1, 2011. The Parties acknowledge that some individuals on the Mental Health Olmstead List are required to register as sex offenders pursuant to O.C.G.A. § 42-1-12 et seq. The Parties further acknowledge that such registration makes placement in the community more difficult. The Parties may by written consent extend the application of the date set forth in this paragraph as it applies to such individuals. The written consent described in this paragraph will not require Court approval.	**Compliance**	At the time the Settlement Agreement was signed, there were 27 individuals on the Olmstead List. All of these individuals were discharged from the State Hospitals and were provided community services.

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.a.i(G)	All ACT teams will operate with fidelity to the Dartmouth Assertive Community Treatment model.	**Compliance**	**In FY12, The Parties, with concurrence by the Independent Reviewer, requested that the Court defer evaluation of this provision. The Court approved this request on August 29, 2012 with explicit instructions regarding reporting, root cause analysis and corrective action plans. These instructions were complied with by the Department with close involvement of the Independent Reviewer and her expert consultants. In FY14, this provision continues to be in compliance. All teams funded under this Agreement are expected to operate with fidelity to the Dartmouth model. Certain lower performing teams have been identified for additional oversight and review. The Department (DBHDD) has been asked to report progress to the Independent Reviewer for inclusion in her second Supplemental Report.**
III.B.2.a.i(H)(1)	By July 1, 2011, the State shall have 18 Assertive Community Treatment teams.	**Compliance**	The Department has funded 18 Assertive Community Treatment teams.
III.B.2.a.i(H)(2)	By July 1, 2012, the State shall have 20 Assertive Community Treatment teams.	**Compliance**	The State has funded 20 Assertive Community Treatment teams. However, change in the composition of the teams is underway. The Department is proceeding with remedial action as required by the Court's Order and with consultation by the Independent Reviewer, the Department of Justice and other interested stakeholders.
III.B.2.a.i(H)(3)	By July 1, 2013, the State shall have 22 Assertive Community Treatment teams.	**Compliance**	**The Department has funded 22 Assertive Community Treatment teams. They are distributed through all six Regions of the state. As of June 30, 2014, there were 1,409 individuals participating in services with the ACT teams. For a discussion of the ACT teams, see attached report by Angela Rollins.**
III.B.2.a.ii(C)(1)	By July 1, 2012, the State will have two Community Support Teams.	**Compliance**	The State has established two Community Support Teams. Although one team was transferred to another provider beginning in FY13, both teams functioned and provided services from the time of their contract. The two teams supported a total of 71 individuals in FY12.
III.B.2.a.ii(C)(2)	By July 1, 2013, the State will have four Community Support Teams.	**Compliance**	The Department has established four Community Support Teams (CSTs). They are located in four rural areas of the State. A total of 145 individuals received services from the CSTs in FY13. Under the terms of the Agreement, the Independent Reviewer must assess whether the Community Support Team model provides services that are sufficient to meet the needs of the members of the target population who receive these services. The Independent Reviewer's assessment and recommendations are due by October 30, 2013.

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.a.ii(C)(3)	**By July 1, 2014, the State will have eight Community Support Teams.**	**Compliance**	**There are 8 Community Support Teams operating within 5 of the 6 Regions. On June 30, 2014, the number of people participating in CST services was 265.**
III.B.2.a.iii(D)(1)	By July 1, 2011, the State will have one Intensive Case Management team.	**Compliance**	The Department has established two Intensive Case Management teams.
III.B.2.a.iii(D)(2)	By July 1, 2012, the State will have two Intensive Case Management teams.	**Compliance**	The Department has established two Intensive Case Management teams. The two teams supported a total of 387 individuals in FY12.
III.B.2.a.iii(D)(3)	By July 1, 2013, the State will have three Intensive Case Management teams.	**Compliance**	The Department has established three Intensive Case Management teams in Regions 1, 3 and 5. These three teams served a total of 235 individuals in FY13. The Independent Reviewer has requested additional information about the caseload in Region 3.
III.B.2.a.iii(D)(4)	**By July 1, 2014, the State will have eight Intensive Case Management teams.**	**Compliance**	**There are 8 Intensive Case Management teams throughout the 6 Regions. On June 30, 2014, the number of people participating in ICM services was 885.**
III.B.2.a.iv(C)(1)	By July 1, 2012, the State will have five Case Management service providers.	**Compliance**	The Department has established five Case Management service providers. Case Management services were provided to 257 individuals in FY12.
III.B.2.a.iv(C)(2)	By July 1, 2013, the State will have 15 Case Management service providers.	**Compliance**	The 15 case management positions funded by the Department supported 1,893 individuals throughout the six Regions. The Independent Reviewer has requested additional information regarding caseload expectations.
III.B.2.a.iv(C)(3)	**By July 1, 2014, the State will have 25 Case Management service providers.**	**Compliance**	**There are 25 Case Management service providers through the six Regions. On June 30, 2014, the number of people partipating in CM services was 761.**
III.B.2.b.i(B)(1)	By July 1, 2013, the State will establish one Crisis Service Center.	**Compliance**	The Department opened a 24-hour, walk-in Crisis Service Center on March 1, 2013. From March 1, 2013 through June 30, 2013, 177 individuals received services in this Center. This is not an unduplicated count and some individuals may have received more than one episode of care during this time period.
III.B.2.b.i(B)(2)	**By July 1, 2014, the State will establish an additional two Crisis Service Centers.**	**Compliance**	**There are four 24-hour Crisis Service Centers. Three are in Region 4; and one is in Region 6. During FY14, 3,309 people received CSC services.**
III.B.2.b.ii(B)(1)	The State will establish one Crisis Stabilization Program by July 1, 2012.	**Compliance**	The Department has established two Crisis Stabilization Programs.
III.B.2.b.ii(B)(2)	The State will establish an additional Crisis Stabilization Program by July 1, 2013.	**Compliance**	The Department's two Crisis Stabilization Programs have remained operational. They each have 16 beds.
III.B.2.b.ii(B)(3)	**The State will establish an additional Crisis Stabilization Program by July 1, 2014.**	**Compliance**	**A third 16-bed Crisis Stabilization Program was opened in Savannah on June 30, 2014.**
III.B.2.b.iii(A)	Beginning on July 1, 2011, the State shall retain funding for 35 beds in non-State community hospitals without regard as to whether such hospitals are freestanding psychiatric hospitals or general, acute care hospitals.	**Compliance**	**The Department has funded hospital bed days in five community hospitals. These beds remained available in FY14.**

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.b.iv(A)	The State shall operate a toll-free statewide telephone system for persons to access information about resources in the community to assist with a crisis ("Crisis Call Center"). Such assistance includes providing advice and facilitating the delivery of mental health services.	**Compliance**	**The Georgia Crisis and Access Line operated by Behavioral Health Link continued to provide these services in FY14.**
III.B.2.b.iv(B)	The Crisis Call Center shall be staffed by skilled professionals 24 hours per day, 7 days per week, to assess, make referrals, and dispatch available mobile services. The Crisis Call Center shall promptly answer and respond to all crisis calls.	**Compliance**	The Georgia Crisis and Access Line complied with these requirements.
III.B.2.b.v(A)	Mobile crisis services shall respond to crises anywhere in the community (e.g., homes or hospital emergency rooms) 24 hours per day, 7 days per week. The services shall be provided by clinical staff members trained to provide emergency services and shall include clinical staff members with substance abuse expertise and, when available, a peer specialist.	**Compliance**	**The mobile crisis services provided by the Department comply with these requirements. The Department continued to respond to requests that training for certified peer specialists be held outside of Atlanta in order to benefit more rural areas of the state.**
III.B.2.b.v(B)(1)	By July 1, 2013, the State shall have mobile crisis services within 91 of 159 counties, with an average annual response time of 1 hour and 10 minutes or less.	**Compliance**	Mobile crisis services have been established in 100 counties, exceeding the requirements of this provision. Statewide, there were 840 individuals served by these teams. The average response time ranged from 49 to 56 minutes, again exceeding the requirements of this provision. The disposition for the majority of individuals (230) served was involuntary inpatient hospitalization. The Independent Reviewer will work with the Department's staff to better understand the range of options investigated by the teams and whether the least restrictive measure was consistently employed by the teams.
III.B.2.b.v(B)(2)	**By July 1, 2014, the State shall have mobile crisis services within 126 of 159 counties, with an average annual response time of 1 hour and 5 minutes or less.**	**Compliance**	**There are two mobile crisis providers covering all 159 counties in the State. The average response time was 49 minutes in FY14. As of June 30, 2014, 14,981 people had received mobile crisis services.**
III.B.2.b.vi(A)	Crisis apartments, located in community settings off the grounds of the State Hospitals and staffed by paraprofessionals and, when available, peer specialists, shall serve as an alternative to crisis stabilization programs and to psychiatric hospitalization.	**Compliance**	The Department has complied with the staffing and location requirements of this provision.
III.B.2.b.vi(B)	Each crisis apartment will have capacity to serve two individuals with SPMI.	**Compliance**	**The Department has now complied with this provision. Crisis apartments have the capacity to serve two individuals with SPMI.**

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.b.vi(C)(1)	By July 1, 2013, the State will provide six crisis apartments.	**Non-compliance**	The Department has not complied with this provision. There were three apartments operational, for a total of six beds, at the end of FY13. A contract was executed on June 27, 2013 for an additional 4 apartments but they were not yet operational.
III.B.2.b.vi(C)(2)	**By July 1, 2014, the State will provide 12 crisis apartments.**	**Compliance**	**There are 13 crisis apartments with a total of 25 beds throughout four Regions. 159 individuals were served in FY14.**
III.B.2.c.ii(B)(1)	By July 1, 2011, the State will provide a total of 100 supported housing beds.	**Compliance**	Although the Department provided the requisite housing vouchers, concern was noted about the review of eligibility and access for hospitalized individuals.
III.B.2.c.ii(B)(2)	By July 1, 2012, the State will provide a total of 500 supported housing beds.	**Compliance**	The State has exceeded this obligation. (See Consultant's report.) The Department awarded 648 housing vouchers and reassessed its prioritization for these awards. Further collaboration is planned between the Independent Reviewer and the Department to further analyze referrals for the housing vouchers.
III.B.2.c.ii(B)(3)	By July 1, 2013, the State will provide a total of 800 supported housing beds.	**Compliance**	The State has exceeded this obligation. In FY13, it awarded a total of 1,002 housing vouchers. The Department made adjustments to its review policies and worked closely with its regional offices, service providers, DCA and other organizations to increase program effectiveness and expand housing resources. (See attached report of Martha Knisley.)
III.B.2.c.ii(B)(4)	**By July 1, 2014, the State will provide a total of 1,400 supported housing beds.**	**Compliance**	**By July 1, 2014, there were 1,649 individuals served in supported housing beds. (See attached report of Martha Knisley.)**
III.B.2.c.ii(C)(1)	By July 1, 2011, the State will provide Bridge Funding for 90 individuals with SPMI. The State will also commence taking reasonable efforts to assist persons with SPMI to qualify in a timely manner for eligible supplemental income.	**Compliance**	The Department provided Bridge Funding as required.
III.B.2.c.ii(C)(2)	By July 1, 2012, the State will provide Bridge Funding for 360 individuals with SPMI.	**Compliance**	The State has exceeded this obligation. (See Consultant's report.) The Department provided Bridge Funding for 568 individuals.
III.B.2.c.ii(C)(3)	By July 1, 2013, the State will provide Bridge Funding for 270 individuals with SPMI.	**Compliance**	The State has exceeded this obligation. In FY13, the Department provided Bridge Funding for 383 individuals with SPMI. (See attached report of Martha Knisley.)
III.B.2.c.ii(C)(4)	**By July 1, 2014, the State will provide Bridge Funding for 540 individuals with SPMI.**	**Compliance**	**Bridge Funding was provided for 709 participants in FY14. (See attached report of Martha Knisley.)**
III.B.2.d.iii(A)	By July 1, 2011, the State shall provide Supported Employment services to 70 individuals with SPMI.	**Compliance**	The Department provided Supported Employment services to more than 70 individuals with SPMI. Since individuals were assigned to the Supported Employment providers in May, only eight were employed by July, 2011. A higher rate of employment will be expected next year.

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.d.iii(B)	By July 1, 2012, the State shall provide Supported Employment services to 170 individuals with SPMI.	**Compliance**	The Department has met this obligation. Supported Employment services were provided to 181 individuals as of June 30, 2012. (See Consultant's report.) A Memorandum of Understanding has been signed between DBHDD and the Department of Vocational Services. The Department is in the process of preparing a written plan, with stakeholder involvement, regarding the provision of Supported Employment. In FY12, 51 individuals gained competitive employment.
III.B.2.d.iii(C)	By July 1, 2013, the State shall provide Supported Employment services to 440 individuals with SPMI.	**Compliance**	The State has exceeded this obligation. According to a report issued by the Department and reviewed by the Independent Reviewer's expert consultant, Supported Employment services, with strong adherence to the Dartmouth fidelity scale, were provided to 682 individuals during FY13. The monthly rate of employment was 42.1%. (See attached report of David Lynde.)
III.B.2.d.iii(D)	**By July 1, 2014, the State shall provide Supported Employment services to 500 individuals with SPMI.**	**Compliance**	**The State has exceeded this obligation. Supported Employment services were provided to 988 individuals during FY14. The monthly rate of employment was 47.3%. (See attached report of David Lynde.)**
III.B.2.e.ii(A)	By July 1, 2012, the State shall provide Peer Support services to up to 235 individuals with SPMI.	**Compliance**	There are 3000 consumers enrolled; there are 72 Peer Support sites in Georgia.
III.B.2.e.ii(B)	By July 1, 2013, the State shall provide Peer Support services to up to 535 individuals with SPMI.	**Compliance**	The Department has made a substantial commitment to the meaningful involvement of peer support services. The Department's commitment was confirmed by the leadership of the Georgia Mental Health Consumer Network during a July 2013 site visit by the Independent Reviewer. Reportedly, and verified by the submission of names, 571 individuals received peer support services provided by the Georgia Mental Health Consumer Network's three Peer Wellness and Respite Centers and through its Peer Mentoring program.
III.B.2.e.ii(C)	**By July 1, 2014, the State shall provide Peer Support services to up to 835 individuals with SPMI.**	**Compliance**	**Since January 1, 2011, a total of 1,583 individuals have received Peer Support services provided by Georgia Mental Health Consumer Network's three Peer Wellness and Respite Centers and through its Peer Mentoring program. In FY14, there was documentation of 767 discrete units of support.**
III.C.1	Individuals under the age of 18 shall not be admitted to, or otherwise served, in the State Hospitals or on State Hospital grounds, unless the individual meets the criteria for emancipated minor, as set forth in Article 6 of Title 15, Chapter 11 of the Georgia Code, O.C.G.A. §§ 15-11-200 et seq.	**Compliance**	**The Department has complied with this obligation.**

Settlement Agreement Reference	Provision	Rating	Comments
III.C.2	Individuals in the target population with developmental disabilities and/or serious and persistent mental illness shall not be transferred from one institutional setting to another or from a State Hospital to a skilled nursing facility, intermediate care facility, or assisted living facility unless consistent with the individual's informed choice or is warranted by the individual's medical condition. Provided, however, if the State is in the process of closing all units of a certain clinical service category at a State Hospital, the State may transfer an individual from one institutional setting to another if appropriate to that individual's needs. Further provided that the State may transfer individuals in State Hospitals with developmental disabilities who are on forensic status to another State Hospital if appropriate to that individual's needs. The State may not transfer an individual from one institutional setting to another more than once.	**Compliance**	**In FY14, the primary focus of institutional closures has been at Southwestern State Hospital and the Craig Center at Central State Hospital. Southwestern State Hospital closed on December 30, 2013. Currently, placements from the Craig Center are pending further review and approval. Individuals have been transferred to Gracewood and Georgia Regional Hospital in Atlanta. The Independent Reviewer has been closely tracking these transfers and has been conducting site visits to both of these institutions.**
III.C.3.a.i	By January 1, 2012, the State shall establish the responsibilities of community service boards and/or community providers through contract, letter of agreement, or other agreement, including but not limited to the community service boards' and/or community providers' responsibilities in developing and implementing transition plans.	**Compliance**	Contract language delineates responsibility for developing and implementing transition planning.
III.C.3.a.ii	By January 1, 2012, the State shall identify qualified providers through a certified vendor or request for proposal process or other manner consistent with DBHDD policy or State law, including providers in geographically diverse areas of the State consistent with the needs of the individuals covered by this Agreement.	**Compliance**	This provision has been implemented.
III.C.3.a.iii	By January 1, 2012, the State shall perform a cost rate study of provider reimbursement rates.	**Compliance**	**The cost rate study has been completed and is still under advisement by the Commissioner.**

Settlement Agreement Reference	Provision	Rating	Comments
III.C.3.a.iv	By January 1, 2012, the State shall require community service boards and/or community providers to develop written descriptions of services it can provide, in consultation with community stakeholders. The community stakeholders will be selected by the community services boards and/or community providers.	**Compliance**	Two websites have been developed to provide comprehensive information and description of statewide services. Individual community service boards have information on their websites regarding services. Stakeholders are included on the community services boards.
III.C.3.a.v	By January 1, 2012, the State shall require and/or provide training to community service boards and/or community providers so that services can be maintained in a manner consistent with this Agreement.	**Compliance**	There are bi-monthly provider meetings for each region. Additionally, the Department hosts two meetings per year; the Regional Offices provide technical assistance; Delmarva meets with providers and provides technical assistance.
III.C.3.a.vi	By January 1, 2012, the State shall utilize contract management and corrective action plans to achieve the goals of this Agreement and of State agencies.	**Compliance**	**The Independent Reviewer has been informed of actions taken to achieve the goals of this Agreement and of State agencies. Such actions include the termination of provider contracts. In FY14, nine provider contracts were terminated. Seven were providers of developmental disabilities services and two were providers for behavioral health services.**
III.C.3.b	Beginning on January 1, 2012 and on at least an annual basis, the State shall perform a network analysis to assess the availability of supports and services in the community.	**Compliance**	**This obligation continues to be met. The Independent Reviewer was provided a copy of the Regional Network Analysis completed this year.**
III.D.1	By July 1, 2011, the State shall have at least one case manager and by July 1, 2012, at least one transition specialist per State Hospital to review transition planning for individuals who have challenging behaviors or medical conditions that impede their transition to the community, including individuals whose transition planning team cannot agree on a transition plan or does not recommend that the individual be discharged. The transition specialists will also review all transition plans for individuals who have been in a State Hospital for more than 45 days.	**Non-compliance**	**Case Managers and Transition Specialists were assigned at each State Hospital. However, at this time, with limited exceptions, community placements have been suspended. The three most recent placements were for individuals with challenging behaviors. Transition planning remains under review at this time.**
III.D.3.a	For persons identified in the developmental disability and mental illness target populations of this Settlement Agreement, planning for transition to the community shall be the responsibility of the appropriate regional office and shall be carried out through collaborative engagement with the discharge planning process of the State Hospitals and provider(s) chosen by the individual or the individual's guardian where required.	**Non-compliance**	**At this time, the entire transition process is suspended pending careful review by the leadership of the Department.**

Settlement Agreement Reference	Provision	Rating	Comments
III.D.3.b	The regional office shall maintain and provide to the State Hospital a detailed list of all community providers, including all services offered by each provider, to be utilized to identify providers capable of meeting the needs of the individual in the community, and to provide each individual with a choice of providers when possible.	Compliance	The Regional Offices provided a list to the State Hospitals of all community providers. The Independent Reviewer has copies of this information.
III.D.3.c	The regional office shall assure that, once identified and selected by the individual, community service boards and/other community providers shall actively participate in the transition plan (to include the implementation of the plan for transition to the community).	Compliance	In the sample reviewed in FY12, there was evidence of participation by community providers. Although it is evident that community providers continue to participate actively in the transition process, this matter continues to be under review by the Department and the Independent Reviewer.
III.D.3.d	The community service boards and/or community providers shall be held accountable for the implementation of that portion of the transition plan for which they are responsible to support transition of the individual to the community.	Compliance	**Once problems were identified, community service boards and/or community providers were held accountable. There is continuing evidence of this accountability measure in FY14.**
IV	**Quality Management**		
IV.A	By January 1, 2012, the State shall institute a quality management system regarding community services for the target populations specified in this Agreement. The quality management system shall perform annual quality service reviews of samples of community providers, including face-to-face meetings with individuals, residents, and staff and reviews of treatment records, incident/injury data, and key-indicator performance data.	Compliance	**The Quality Management system plan and the report issued most recently on August 1, 2014 document the focus on the community services implemented for the target population specified in this Agreement. The reports substantiate that annual quality service reviews are conducted by the Delmarva Foundation and APS, the External Review Organizations. In addition, the Georgia Mental Health Consumer Network interviewed recipients of mental health services. Incident/injury data was maintained and reviewed for the community system and key-indicator performance data was referenced in the Quality Management system reports.**
IV.A.1	The system's review shall include the implementation of the plan regarding cessation of admissions for persons with developmental disabilities to the State Hospitals.	Compliance	**The Department tracks data related to the provision of alternatives to state hospital admissions for individuals with a developmental disability. These data focus on various forms of crisis services, including mobile crisis teams and crisis respite care. Since the Department routinely tracks these sets of information and reviews them on a regular basis in preparation of the Quality Management reports, this provision is rated in substantial compliance.**

Settlement Agreement Reference	Provision	Rating	Comments
IV.A.2	The system's review shall include the service requirements of this Agreement.	**Compliance**	The Quality Management reports issued by the Department document the review of the services provided under the terms of this Agreement. In addition, data regarding services/supports are maintained by the respective Divisions of the Department. The Independent Reviewer was provided with the data from these sources for the preparation of this report.
IV.A.3	The system's review shall include the contractual compliance of community service boards and/or community providers.	**Compliance**	The Quality Management revised plan and subsequent reports describe the oversight structure for key performance indicators and outcomes as well as the requirements for service providers. External Review Organizations (APS and Delmarva) conduct on-site reviews of provider agencies on an established periodic basis. The Department of Community Health audits community service boards every three years.
IV.A.4	The system's review shall include the network analysis.	**Compliance**	**A comprehensive network analysis was submitted to the Independent Reviewer on July 1, 2014. In this report, detailed information was provided about available services/supports in each of the six regions as well as the currently existing gaps in services. Detailed information was also provided about the demographics of each region and the target populations to be served.**
IV.B	The State's quality management system regarding community services shall analyze key indicator data relevant to the target population and services specified in this Agreement to measure compliance with the State's policies and procedures.	**Compliance**	The Quality Management reports submitted to date contain analyses of key performance indicators related to specific services required under this Settlement Agreement. For example, there are key performance indicators related to ACT, supported employment, case management, housing and community support teams.
IV.C	Beginning on February 1, 2013 and ending on February 1, 2015, the State's quality management system shall create a report at least once every six months summarizing quality assurance activities, findings, and recommendations. The State shall also provide an updated quality management plan by July 1, 2012, and a provisional quality management system report by October 1, 2012. The provisional quality management system report shall not be subject to review by the Independent Reviewer under Section VI.B of the Settlement Agreement. The State shall make all quality management reports publicly available on the DBHDD website.	**Compliance**	**The Department continues to be in compliance with this provision. Reports have been submitted in a timely manner to the Independent Reviewer and the Department of Justice.**

Settlement Agreement Reference	Provision	Rating	Comments
V	**Implementation of the Agreement**		
V.E	The State shall notify the Independent Reviewer(s) promptly upon the death of any individual actively receiving services pursuant to this Agreement. The State shall, via email, forward to the United States and the Independent Reviewer(s) electronic copies of all completed incident reports and final reports of investigations related to such incidents as well as any autopsies and death summaries in the State's possession.	**Compliance**	**Although there have been some issues with timeliness, the Department remains in substantial compliance with this provision. The Independent Reviewer and the United States are notified of deaths and the results of investigations. At this time, the Department's mortality review process is undergoing scrutiny and revision. The Independent Reviewer is working closely with the Department on this matter. The Department has agreed to allow further review of its policies regarding reporting and investigation; has expanded its Mortality Review Committee; and has retained a qualified independent entity to review the deaths of individuals transitioned from State Hospitals to community placement. In addition, the Department is in contract discussions with two consultants who will review all deaths by suicide. Furthermore, the Department is exploring formats for public reports on its death investigations. Recently, the Department of Justice provided the Department with an analysis by their expert consultant regarding the deaths by suicide of a sample of mental health clients. This analysis is under consideration by the Department.**

DISCUSSION OF COMPLIANCE FINDINGS
Methodology

For each compliance requirement, the Department of Behavioral Health and Developmental Disabilities was asked to provide data and documentation of its work. The Department's (DBHDD) progress in meeting the provisions of the Settlement Agreement was reviewed in work sessions and Parties' meetings throughout the year; through discussions with providers and community stakeholders; and through site visits to community residences, day programs, Supported Employment programs, supported apartments, Assertive Community Treatment team sites, county jails and shelters for homeless individuals. (The expert consultants on Supported Employment, Support Housing and Assertive Community Treatment spent a combined total of twenty-three days on site in Georgia.)

The Department leadership and the Independent Reviewer have agreed to work together to institute a reliable strategy for monitoring community placements of individuals with a developmental/intellectual disability. The Department (DBHDD) selected Regions 2 and 3 as the initial sites for this collaborative effort. Therefore, in the last three months, the Independent Reviewer, with the assistance of the Settlement Agreement Director, has trained reviewers in Region 3 and began to train reviewers in Region 2 in the latter part of August 2014. The reviewers are Regional staff with backgrounds in health care and psychology. They have been paired with two experienced health care specialists and one doctoral level Board certified behavioral analyst in the field of intellectual/developmental disabilities retained by the Independent Reviewer. A joint monitoring tool has been developed and tested for inter-rater reliability.

In preparation for her Supplemental Report, filed in March 2014, the Independent Reviewer and her consultants invested a substantial amount of time to review the placements of adults with a developmental disability transferred from State hospitals to community placements. Therefore, the reviews during the period for this Report are more limited in scope and are focused on a subset of individuals with challenging behaviors. The individuals randomly selected for review reside in Region 1.

At this point in time, thirteen Region 1 clients have been randomly selected and reviewed. Each of these individuals requires, to varying degrees, behavioral supports by trained residential and day staff. Eleven individuals, including one on the at-risk list, reside in group homes; one individual lives in a host home; and one gentleman lives with his family. In addition, in Region 2, the behavioral analyst retained by the Independent Reviewer conducted site visits to the three individuals most recently transferred, in June 2014, from institutional settings to community residences.

The reports issued from the reviews of the individuals in the sample have been distributed to the Parties. The Department of Behavioral Health and Developmental Disabilities is in the process of analyzing these reports and will instruct its Regional staff to take corrective actions, as appropriate.

The Independent Reviewer is mindful that the focus on individuals transitioned from State hospitals has precluded the review of individuals who have not been institutionalized. Actions are now underway to include such individuals in each sample selected for further review. The sample randomly selected for the upcoming reviews in Region 2 will be drawn entirely from the at-risk list of individuals who receive support under the terms of the Settlement Agreement.

As in past years, three expert consultants were retained to assist the Independent Reviewer in evaluating the Department's compliance with the Settlement Agreement provisions regarding Supported Employment, Supported Housing and Bridge Funding and Assertive Community Treatment (ACT). The State Health Authority Yardstick (SHAY), a tool developed at Dartmouth University, was used for the evaluation of Supported Employment and Assertive Community Treatment services provided under the Settlement Agreement. The reports from each of these evaluations have been provided to the Parties. As desired by the Parties and the Amici, the Independent Reviewer will convene meetings to discuss the findings from these reports.

Finally, the Independent Reviewer had expected to report substantially on the individualized outcomes accomplished through the provisions of the Settlement Agreement. Unfortunately, despite earnest discussions with the Department's staff, the data system employed by the Department (DBHDD) has not permitted access to the individualized data required for such reviews. As stated in the Department's recently released "Regional Network Analysis 2014," such data retrieval is not currently possible:

> There is currently no single data system to track individuals who enter the DBHDD system. It is common to have to cross reference as many as five data sources to track simple information. Tracking more complex data such as the number of ADA consumers and what services they receive across agency lines takes reviewing many data sources, making calls, and calculating by hand. This is costly as it takes many man hours to collect the data…Part of the need for technology includes a more sophisticated utilization management system. The State is moving towards an Administrative Services Organization and that will assist in more coordinated care once it is implemented in FY 2015.

To be clear, the Department (DBHDD) has provided data regarding the utilization of services and compliance with certain target measures, such as the number of individuals receiving Assertive Community Treatment who are housed rather than homeless. What has been difficult

to retrieve, for example, are data about individuals prior to receiving the designated treatment. This information is important in analyzing the success of program intervention.

The Independent Reviewer and her expert consultants are attempting to work with the Department (DBHDD) staff to determine reasonable methods to collect, analyze and report individualized outcome data. A discussion in this matter is scheduled for October 7, 2014. In the meantime, the Independent Reviewer must rely on the aggregate data reported by the Department.

Review of Obligations for Year Four

A. Serving People with Developmental Disabilities in the Community

The State documented that forty-six individuals with a developmental/intellectual disability were transferred from State hospitals during the past Fiscal Year. Forty-three of these placements occurred prior to the Commissioner's second decision to suspend community placements. In June 2014, three men were transferred into community residences; the Independent Reviewer's consultants examined the quality of their supports. Reports of the findings have been shared with the Parties. Her consultants have commended the work of the single agency supporting these three men.

Documentation was provided to confirm that additional Home and Community-Based Waiver Services were provided to 100 individuals with a developmental/intellectual disability and that 1155 individuals with a developmental/intellectual disability were provided family supports in order to avoid institutionalization.

The data and documentation provided confirm that the Department (DBHDD) has met or exceeded the numerical targets for the provision of Waivers to at-risk individuals and for family supports.

However, as expected, the Department (DBHDD) did not comply with the provision requiring the transfer of institutionalized adults to integrated community placements. Furthermore, for the reasons explained at length in the Supplemental Report filed with the Court in March 2014, the Department continued to be in non-compliance with the provisions requiring the implementation of Individualized Support Plans and Support Coordination. Hopefully, the timely implementation of the Priority Plan will begin to remedy these findings of non-compliance.

The Independent Reviewer has recommended that a second Supplemental Report be filed with the Court, in March 2015, in order to document the status of these Provisions.

The Department (DBHDD) provided data regarding the implementation of crisis services, as required by the Settlement Agreement. The data confirms that the Provision of the Settlement Agreement regarding the establishment of mobile crisis teams has been met. There are twelve mobile crisis teams. The data documents the use of in-home support and Crisis Respite Homes. However, the Provision requiring the establishment of Crisis Respite Homes is in non-compliance. There are eleven Homes, not the required twelve. The contract for the twelfth Home was cancelled and the plans for its replacement are not finalized. In addition, three individuals have been residing in a Crisis Home for more than one year because appropriate community placements are not yet available for them. The Independent Reviewer has been informed of the reasons for each of these circumstances and will track the status of each case.

The Independent Reviewer is concerned that there does not appear to be a concentrated focus on the crisis services provided to individuals with a developmental disability. The Priority Plan addresses crisis management only briefly (see Page 30). Therefore, the Independent Reviewer is in the process of retaining an expert consultant to assist her in the review of crisis services.

B. Serving Persons with Mental Illness in the Community

Since the first Annual Report, the Independent Reviewer has retained three consultants with nationally recognized expertise in supported housing, supported employment and Assertive Community Treatment (ACT). Their findings and recommendations for the current Report have been submitted to the Parties and are attached.

1. Housing Supports

In her report, Ms. Knisley has continued to caution that there must be attention to infrastructure, capacity building, and collaborative action with housing agency partners and community agencies, if future housing targets are to be achieved and sustained. This is especially important as the State enters the fifth year of the Settlement Agreement. During this year, by July 1, 2015, the Department must comply with the requirement " to have capacity to provide Supported Housing to any of the 9,000 individuals in the target population who need such support." In order to conceptualize strategies to satisfy that obligation, the Department (DBHDD) sought guidance from the Technical Assistance Collaborative (TAC). The report from this consultation is attached.

As of July 1, 2014, the State was to provide a total of 1400 supported housing beds for individuals with serious and persistent mental illness who are in the target population. Bridge Funding was to be provided to 540 individuals. As confirmed by the findings of the expert consultant to the Independent Reviewer, the State has more than exceeded these obligations.

Ms. Knisley's report outlines the reasons why the State's housing voucher program has been successful. These reasons include positive inter-agency relationships with the Department of Community Affairs (DCA), strong leadership and flexible approaches to the provision of housing supports. The report also cautions the Department (DBHDD) that it must take concerted action to enforce its "housing first" policy and to ensure the inclusion of under-represented members of the target population, including those who have forensic histories or who are dually diagnosed.

Her report includes a number of recommendations to promote access to housing and to ensure that the quality of housing options is consistent with desired practices. She was particularly concerned that some Assertive Community Treatment (ACT) Team staff remain committed to a "readiness" model. This approach is not consistent with either the stated values of the current Administration or the principles of this evidence-based practice. (It should be noted that Ms. Knisley's concerns about staff were immediately addressed by the Department. The staff were replaced.)

2. Supported Employment

As required in this phase of the Settlement Agreement, there were to be 500 individuals provided with supported employment opportunities in Year Four. The State provided such services to 998 individuals.

Over the last four years, the measures of the State Health Authority Yardstick (SHAY) have been applied to the supported employment services provided under the Settlement Agreement. Scores have progressively increased. This year, the Department achieved a summary rating of 4.4 out of 5.0.

The report by Mr. Lynde is attached. In addition to his analysis of the strengths of the supported employment program, including leadership, training, policy development and planning, he cautions that successful outcomes are at risk of compromise by programs that fail to work to achieve continuity of care for their clients. He is particularly concerned that the employment specialists on some Assertive Community Treatment (ACT) Teams do not follow the standards and practices of evidence-based supported employment. He also has articulated the concerns voiced by some providers that resources will not be sustained after the conclusion of the Settlement Agreement. His concerns merit further discussion by the Parties.

3. Assertive Community Treatment (ACT):

The Settlement Agreement requires that all Assertive Community Treatment (ACT) teams will operate with fidelity to the Dartmouth Assertive Community Treatment model. In addition, by July 1, 2014, there were to be twenty-two ACT teams operating throughout Georgia.

The State now has established twenty-two ACT teams and has mandated that they operate with fidelity to the model required by the Settlement Agreement.

The ACT teams are measured for compliance with the Dartmouth Assertive Community Treatment Scale (DACTS).

At the request of the Independent Reviewer, her expert consultant, Dr. Angela Rollins, again reviewed the ACT teams' compliance with these Provisions of the Settlement Agreement.

The DACTS is a 28-item scale that assesses the degree of fidelity to the ACT model. Each item is rated on a 5-point behaviorally anchored scale, ranging from 1 = Not Implemented to 5 = Fully Implemented. The full implementation anchors are item-specific and were determined through a variety of expert sources, including published reports from the ACT model developers and from an expert panel.

Although cut-off scores for defining a minimum adherence to ACT are desirable, very little evidence exists for a particular cut-off score. McHugo and colleagues (2007) refer to 4.0 and above as "High Fidelity," 3.0-3.9 as "Moderate Fidelity," and below 3.0 as "Low Fidelity" in the National Evidence-Based Practices Project studying several practices, including ACT. Some helpful work to address this gap for ACT in particular did identify several empirical approaches to defining ACT using DACTS scores or subsets of scores (Salyers et al., 2003). Trials of item-level pass-fail criteria were found to be unattainable by the ACT programs in the study and, therefore, not helpful in distinguishing ACT from other services.

In FY 2014, the twenty-two ACT teams established under the Settlement Agreement scored an average of 4.1 on all 28 DACTS items (with no modified scoring; i.e., using the usual, stringent criteria in the DACTS protocol and scale). Seven of the twenty-two teams scored below 4.0, but still scored a 3.8 or 3.9, the upper range of what Salyers and colleagues (2003) refer to as a "C," in their model using 26 of 28 DACT items, indicating a need for improvement but certainly not out of the realm of ACT team scores in most implementation efforts.

Another approach to examining Georgia ACT teams' performance is to look at individual team scores over time. Dr. Rollins noted that only one team scored below 4.0 in both FY 2013 and FY 2014. That team scored 3.9 in one year and 3.8 in the next, both relatively close to the 4.0 mark. This team primarily struggled with staff turnover, which is scored relative to the last two years, so the turnover experienced in FY 2013 would still "count" and, thus, influence FY 2014 scores. (Some states have excluded the H5 Staff turnover item in state certification efforts in order to avoid "punishing" teams for staff turnover that sometimes is out of the agency's control.)

Dr. Rollins concluded that the ACT teams in Georgia are scoring comparably, if not better, than other ACT teams in the published literature, including some data derived from randomized controlled trials which are often difficult to replicate in real-world implementation efforts (Drake et al., 2001). In her opinion, using criteria that are either too stringent at the total DACTS score level or requiring item-level pass-fail criteria that are difficult to meet will likely result in a chaotic service environment where the State will be forced to pull contracts and rapidly reassign Georgia ACT consumers to new ACT providers in order to remain in compliance.

However, Dr. Rollins supported the Department (DBHDD)'s continued use of scores lower than 4.0 on the total DACTS score and individual item scores of 1 or 2 as indicators of the need for corrective action plans; teams scoring a "C" are expected to improve. She has urged the Department (DBHDD) to do better follow-up on progress on those corrective action plans so that improvements actually materialize in well-documented ways. She also urged the Department DBHDD to increase attention to other elements of ACT program quality that are not captured by the DACTS (e.g., recovery-orientation, employment services). Although it has not been an issue to date, she also recommended that the Department (DBHDD) prepare for any incidence where an ACT team scores a 3.4 or below on the DACTS.

In light of the findings by Dr. Rollins, the Department (DBHDD) has been advised of ACT teams with deficits in certain areas of performance. The Independent Reviewer has recommended that these teams receive increased oversight and technical assistance. The Department (DBHDD) has been asked to provide additional data regarding the ongoing performance of these teams. The progress of these teams will be discussed in the Independent Reviewer's proposed second Supplemental Report to be filed with the Court in March 2015.

CONCLUSIONS

The Settlement Agreement has required the structural reform of the State's systems of support for individuals with a developmental/intellectual disability and/or a mental illness. As recognized in this Report, there have been important achievements in the mental health system over the past four years. These achievements have been recognized and applauded by the stakeholders invested in evidence-based practices and the full implementation of the recovery model. While it has not been possible to quantify individual outcomes, there is documentation of increased access to affordable housing, competitive employment, clinical and peer supports and crisis services.

Although the expert reports describe the strengths and challenges of the mental health system in greater detail, it is important to note here the recurrent concern about three major findings:

- Individuals with forensic histories are not obtaining adequate access to community-based supports. As a result, they remain confined in institutions or are at risk of recidivism upon their release from custodial care. A significant part of this problem rests with discharge practices in jails and other forensic settings. Forensic facility clinicians have either limited available resources or have limited knowledge/experience with community-based alternatives as part of discharge planning. The latter requires a somewhat sophisticated understanding of community mental health services as well as knowledge of the actual services/supports available throughout the various Regions of the State. Regular in-reach by community providers and a vastly expanded community transition process would improve this situation but a coordinated approach must be created and implemented by the Department (DBHDD) and its sister agencies. The unfortunate consequence of this lack of coordination and strategic planning is that individuals are confined for longer periods of time, regardless of the nature of their crime.
- As described above, the State is extremely fortunate to have a well-respected and well-developed array of peer supports. These practices reflect a recovery-orientation and the use of integrated community resources. The failure of certain Assertive Community Treatment Teams to embrace a similar orientation is of considerable concern. Increased effort to ensure a recovery-model rather than a "readiness" model is critically important at this stage of the Settlement Agreement.
- Although substantial progress has been made in implementing the foundation of the mental health system, there is evidence of inconsistency in continuity of care. That is, the discrete parts of the mental health system do not always interact consistently and harmoniously. Further concerted action is required by the Department (DBHDD) to promote the integration of services/supports so that the consumers' experience is not

fragmented. Examples of strategies successfully used by the Department include training opportunities that blend staff from different types of programs, such as Assertive Community Treatment (ACT) and Supported Employment. These strategies should be expanded. The employment specialist on the ACT Team should implement his/her responsibilities in the same way as his/her colleague in Supported Employment.

The system of community-based supports for individuals with an intellectual/developmental disability has fallen seriously short of expected practice despite earnest attempts to improve the quality of residential programs and other critical services. The State's Plan for remedial actions is very promising but remain unfulfilled at this time. As universally recognized, the next few months will be extremely important in determining whether sufficient reform can be realized and whether resources and skills are adequate for the serious tasks ahead.

SUMMARY OF YEAR FOUR RECOMMENDATIONS

The subject matter experts working with the Independent Reviewer have included recommendations in their attached reports on Supported Housing, Supported Employment and Assertive Community Treatment. Those recommendations will not be repeated here. However, the recommendations described below draw from the findings of the expert consultants as well as from the Independent Reviewer's own observations and experiences.

Recommendation One:

It is strongly recommended that the Independent Reviewer prepare a second Supplemental Report under the same timeframes and expectations as the first Supplemental Report filed in March 2014. The second Supplemental Report should be filed with the Court.

The second Supplemental Report should address the status of the provisions related to transitions, support coordination and the implementation of Individual Support Plans for individuals with a developmental disability, including those placed from State hospitals and those receiving Home and Community-Based Waiver Services under the terms of the Settlement Agreement.

In addition, the next Supplemental Report should address the actions taken by the Department (DBHDD) to improve the performance and outcomes of the lower-performing Assertive Community Treatment (ACT) teams identified by the Independent Reviewer and her expert consultants. For each of the limited number of teams, the Department should report on the progress that has been made to improve DACTS scores, especially those related to intensity of service, frequency of contact, and informal supports.

The Independent Reviewer will consult with the Parties to this Agreement to determine whether other provisions should be reviewed and included in the second Supplemental Report.

Recommendation Two:

Although there has been some progress documented in the referral of individuals with forensic histories to Assertive Community Treatment (ACT) teams and to supported independent housing, this group of adults remain seriously under-represented in the implementation of the provisions of the Settlement Agreement. Therefore, substantial effort and evidence of inclusion must be confirmed in Year Five.

The Independent Reviewer is in the process of retaining an expert consultant to assist her in the review of community-based housing and other programmatic supports for individuals with forensic histories. She requests that the Department (DBHDD) identify the appropriate staff to work with her as she plans and implements her work related to forensic clients.

Recommendation Three:

The review of crisis services requires ongoing attention by both the Department (DBHDD) and by the Independent Reviewer. The need for this review was referenced in FY 2013.

In particular, the Independent Reviewer is concerned that there does not appear to be a concentrated focus on the crisis services provided to individuals with a developmental disability. The Priority Plan addresses crisis management only briefly (see page 30).

It is recommended that the Independent Reviewer continue to work with the Department (DBHDD) as it implements its "Community Behavioral Health Crisis Continuum Strategic Plan." Reports from the quarterly meetings of the Behavioral Health Crisis Continuum workgroup should be provided to the Independent Reviewer.

The Independent Reviewer is in the process of retaining an expert consultant to assist her in the review of crisis services for individuals included in the target population for the Settlement Agreement. She requests that the Department (DBHDD) identify the appropriate staff to work with her as she plans and implements her work related to crisis services.

Recommendation Four:

The Settlement Agreement requires that "By July 1, 2015, the State will have capacity to provide Supported Housing to any of the 9,000 persons in the target population who need such support." (See Provision III. B. 2. c. ii. (A).)

As evidenced by the attached report prepared for the Department (DBHDD) by the Technical Assistance Collaborative, efforts have been initiated to identify the sources of available housing that will be essential to compliance with this Provision.

It is recommended that the Parties prioritize their attention to the requirements of this Provision and to the resources and timelines that will be needed for compliance.

An initial discussion is scheduled with the Parties for October 7, 2014. The Independent Reviewer's expert consultant on Supported Housing will be present.

Recommendation Five:

As referenced in the review of recommendations for 2013, the Department has taken steps to educate providers of Assertive Community Treatment (ACT), Intensive Case Management, Supported Employment and Community Support Teams about the resources available to them from other components of the behavioral health system. These efforts are important to increasing collaboration across all parts of the mental health system. It is recommended that they be intensified in Year Five. In particular, added emphasis on the principles and practices of

a recovery-orientation would be important to ensuring consistency of performance across all provider agencies.

In this previous year, in an effort to evaluate the mental health system as a whole, the Independent Reviewer has asked her expert consultants to conduct site visits together and to discuss their respective observations. This collaboration has been very useful and will be continued into the next year.

STATUS OF YEAR THREE RECOMMENDATIONS

The following recommendations were included in the Independent Reviewer's FY 2013 Report. A brief update of the status of each recommendation is noted below:

1. In the professional judgment of the Independent Reviewer, it is critical that there be a more concentrated focus on the analysis and reporting of the effects from the above-referenced cessation of admissions to the state hospitals of people with developmental disabilities. For example, the Department could track the admission of individuals with both an intellectual disability and a mental illness to its psychiatric hospitals in order to evaluate the effectiveness of its crisis system.

Although the Department reported that it tracks this information, the data are not currently used to assess its system or its crisis services. The forthcoming implementation of the Administrative Services Organization (ASO) may affect the utilization of these data.

2. In concert with the Independent Reviewer, it is recommended that the Department review the components of the crisis services system to determine if they are organized and coordinated as effectively as possible.

The Independent Reviewer and the Department discussed this recommendation. The Department had recognized that "crisis services are often the first point of encounter with the behavioral health delivery system for an individual or family, and can, therefore, set the future course of the individual's or family's attitude toward, and relationship with, the system." Stakeholder meetings held in October and December 2012 were followed by the formation of a Steering Committee that met from February to June 2013. Over the period of August 2013 through April 2014, a "Community Behavioral Health Crisis Continuum Strategic Plan" was developed by a Departmental workgroup that included staff from adult mental health, child and adolescent mental health, addictive diseases, suicide prevention and the Office of Recovery. The Strategic Plan was based on the findings and recommendations of the Steering Committee. The Departmental workgroup has continued to meet quarterly to move forward the work required for the implementation of the Strategic Plan. The Independent Reviewer was provided a copy of the Strategic Plan. It outlines goals and timelines that extend until June 30, 2016. The Independent Reviewer and Departmental staff intend to meet periodically to ascertain progress towards these goals.

The above initiative did not include the crisis services provided to individuals with a developmental disability. The Independent Reviewer has recommended that a concerted effort be made to pinpoint the responsibility for implementing a similar analysis and developing a strategic plan with measurable goals and objectives.

The Independent Reviewer is in the process of retaining a subject matter expert to assist in her continuing review of crisis services.

3. Attention must be given to infrastructure capacity and collaboration with housing agency partners and community agencies, if future housing targets are to be achieved. While the state met the targets again this year, it was agreed that meeting future targets would be more difficult because the expectations are greater. Similarly, maintaining the program at the level required by this Settlement Agreement requires "sustained" capacity at the provider, Regional and state level. It will be important to give further attention to “turnover” and sustaining provider capacity.

The attached report by the Independent Reviewer’s expert consultant, Martha Knisley, discusses the Department’s efforts to determine and sustain adequate capacity through collaboration with other State and Federal agencies. This issue is the subject of ongoing discussion between the Department and the Independent Reviewer and her expert consultant. The next discussion with the Parties about the status of housing for the Settlement Agreement’s target population is scheduled for October 7, 2014.

4. Collaboration must be strengthened with the DCA HCV program staff, Continuums of Care, local jails and prisons, the Veterans Administration and local Public Housing Authorities. It is strongly recommended that action steps and outcomes for these collaborations include, for example, formal referral agreements, interagency training, the DCA-DBHDD-provider "boot camps" and activities, and relationship building events. The development of a work plan would help "size" the planning process and make clear expectations for these activities.

As documented in the attached report by Ms. Knisley, the Department has initiated and implemented numerous positive actions to increase collaboration with its partners in the provision of housing. This issue also continues to be the subject of ongoing discussion between the Department and the Independent Reviewer and her expert consultant.

5. For Assertive Community Treatment programs and Supported Housing programs, the Department should assess the potential for increasing referrals from hospitals and intensive residential programs.

6. For Assertive Community Treatment and Supported Housing programs, the Department should take concrete steps to increase referrals from jails and prisons. These steps include building relationships and working agreements between Regional staff, local providers/community service boards and local Sheriffs and other officials for access, screening and referral arrangements.

Although more work will be required to address both of these recommendations, progress has been documented in the efforts to increase referrals from hospitals, intensive residential programs, jails and prisons. However, as discussed in both the Independent Reviewer's narrative summary and the attached reports by her experts, Ms. Knisley and Dr. Rollins, substantial work remains to be planned and implemented in the Fifth Year, if these provisions of the Settlement Agreement are to be fully satisfied.

7. The Department should intensify its efforts to make provisions for supported housing for individuals with developmental disabilities and those with co-occurring mental illness and developmental disabilities.

There has been virtually no progress made towards addressing this recommendation. The Independent Reviewer will continue to discuss this recommendation with the Department as it implements its reform efforts, especially those now beginning in Region 2.

8. The Department should consider ways in which to further refine, expand and improve Supported Housing, Assertive Community Treatment, Intensive Case Management and Supported Employment as interconnected initiatives. A simple crosswalk of the initiatives would reveal many opportunities for connecting the programs. As noted, providing opportunities for peers to be a part of these processes will add incredible value.

There is documentation that confirms the Department's efforts to increase collaboration between the programmatic components of its behavioral health system. For example, the agendas for monthly meetings/teleconferences with providers responsible for Supported Employment, Assertive Community Treatment, and Community Support consistently reflect discussion about understanding and using resources, including housing vouchers, available throughout the State's system. On January 15, 2014, providers responsible for these services as well as those responsible for crisis services and Intensive Case Management held a combined meeting/retreat to strengthen their collaboration. On February 20, 2014, providers of Assertive Community Treatment and Community Support met for joint training. On February 25, 2014, a training session on "Recovery-Oriented Engagement and Service Delivery" was held in Macon, Georgia. Further, the Quality Councils for Behavioral Health review the data, discuss the findings and issue recommendations. These efforts are positive and are commended. Nonetheless, continuing and expanded efforts are strongly recommended, especially in the area of recovery-oriented training. As discussed in the attached reports by Ms. Knisley, Mr. Lynde and Dr. Rollins, the understanding of recovery-oriented principles and practices appears to be uneven and some providers are in need of more intense support and supervision.

This recommendation by the Independent Reviewer and her expert consultants is repeated and will be reviewed in future reports.

ATTACHMENT B

State Health Authority Yardstick (SHAY) Report for Georgia Assertive Community Treatment (ACT) Services

Angela L. Rollins, PhD
September 11, 2014

Introduction

The State Health Authority Yardstick (SHAY) was designed by a group of mental health researchers and implementers who were interested in assessing the facilitating conditions for the adoption of Evidence-Based Practices (EBPs) created by the state's (mental) health authority. The focus of this report is the state's implementation of assertive community treatment (ACT) services.

The SHAY is a tool for assessing the state health authority responsible for mental health policy in a given state. For the purposes of this assessment, Georgia DBHDD has been identified as the "State Health Authority."

The author of this report spent four days in July 2014 completing a series of interviews with a variety of stakeholders in the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) system, including:

- Commissioner and Deputy Commissioner for Programs, DBHDD
- Assistant Commissioner of Behavioral Health, DBHDD
- Director, Adult Mental Health, DBHDD
- DOJ ADA Settlement Coordinator
- ACT fidelity assessment team, DBHDD
- Supported Housing Director, DBHDD
- APS (external Medicaid monitoring agency) care managers for ACT services, their team leader, and DBHDD liaison
- External trainers who provided ACT-specific trainings during the course of the last year
- DBHDD social worker from Georgia Regional Atlanta
- Community stakeholders including representatives from a number of mental health advocacy organizations and criminal justice system representatives (e.g., public defender's office)

The author also reviewed relevant documentation provided, including:

- State Plan for ACT (from last year)
- ACT service definition
- ACT fidelity reports and fidelity score tracking tables, ACT team plans of correction for low fidelity, ACT consumer census tables
- Log of all ACT-related trainings (with sign-in sheets) and some ACT training materials
- ACT client outcomes reporting templates and reports
- APS audit tool items and sample reports; reports on ACT authorization approval rates
- Minutes for each ACT Coalition meeting held during the last fiscal year
- Memos documenting ACT policy changes during the last fiscal year
- Georgia Housing Voucher slides and some statistics on referral sources and outcomes

During the July 2014 visit, the author visited team leaders and managers for four ACT teams in Region 3 and reviewed charts at one agency. The author also visited three teams in southern Georgia in May 2014 and visited CST and Peer Support and Wellness Centers in October 2013.

Region 3 teams received increased attention during this trip because of community stakeholder concerns about a particular team in that region. As you will see noted later in this report, many concerns identified with regards to this team and their operations have not been observed universally throughout the State. It is important for stakeholders to keep in mind that we ideally weight concerns and prioritize recommendations based on patterns of negative performance (i.e., observed across multiple teams or across time without correction in fewer teams). To provide perspective, this particular team serves only 14% of Region 3 ACT consumers and only 4% of ACT consumers in the state.

Although the author had hoped to report more specifically on the impact of ACT on key consumer outcomes relevant to the Settlement Agreement, we are still somewhat limited in our ability to draw strong conclusions about the impact of ACT. DBHDD does collect a range of outcomes from ACT teams in the aggregate each month ("X% of the caseload of Team A was hospitalized this month") for quality improvement purposes. Further, some consumers are part of a cohort that is followed monthly over time, starting with ACT enrollment, with respect to these outcomes ("X% were employed in Month 6 of ACT and Y% were employed in Month 12 of ACT"). As far as I can tell, the data collection lacks a reliable system for tracking client-specific outcomes both pre and post ACT service or an ability to mark the beginning of an ACT episode of care for a particular consumer so that those comparison data could be mined from any existing data sets (e.g., Medicaid claims data). For instance, to know whether a 7% hospitalization rate is an improvement, we would need to know what rate of hospitalization was experienced prior to ACT. My understanding is that we can certainly get a rough idea of how teams are doing from one month to the next, but we cannot really say with certainty whether these are reductions in negative outcomes from pre-ACT functioning for these consumers.

The interviews throughout the year and during this July 2014 visit were rich and open about progress and struggles in ACT implementation. Because basic policy and infrastructure supports for ACT have been in place starting around 2012 and many positive refinements were made in 2013, the focus in this year's assessment was on improving recovery orientation of ACT, making sure ACT serves key settlement populations adequately (i.e., keeping consumers out of hospital and other institutions), and improving sustainability for ACT.

The State of Georgia is in compliance with the Settlement Agreement requirement to establish twenty-two ACT teams by July 1, 2013. As of the end of June 2014, the twenty-two teams collectively were serving 1,409

consumers, a net increase of 146 consumers since June 2013. The State is also in compliance with regards to additional requirements related to the composition of ACT teams with multidisciplinary staff, including a dedicated team leader, and the range of services to be provided by the team, including the availability of 24/7 crisis services. However, this year's fidelity records indicate six of twenty-two teams have struggled with covering the required nursing time required for ACT. Frequency of contact across the teams was also low with only one team attaining a fidelity score of 5, and eight teams scoring a 1 or 2. Across all twenty-two teams, the mean score for this item was 2.8 (out of possible 5). As noted below, I also have become concerned that current Corrective Action Plans and processes do not require teams to demonstrate progress in fidelity ratings.

For some context on Georgia DBHDD ACT team fidelity performance, I did some additional analyses of their scores. The Dartmouth Assertive Community Treatment Scale (DACTS; Teague, Bond, & Drake, 1998) is a 28-item scale that assesses the degree of fidelity to the ACT model.[1] Each item is rated on a 5-point behaviorally anchored scale, ranging from 1 = not implemented to 5 = fully implemented. The full implementation anchors are item-specific and were determined through a variety of expert sources, including published reports from the ACT model developers and from an expert panel (McGrew & Bond, 1995). The DACTS has been shown to discriminate between four types of services (Teague et al., 1998), is sensitive to change over time in implementation efforts (McHugo et al., 2007), and a precursor to the DACTS predicted consumer outcomes (i.e., r=.60 for total score related to reductions in hospitalizations) (McGrew, Bond, Dietzen, & Salyers, 1994).

Although cut-off scores for defining a minimum adherence to ACT is desirable, very little evidence exists for a particular cut-off score. McHugo and colleagues (2007) refer to 4.0 and above as "high fidelity", 3.0-3.9 as "moderate fidelity", and below 3.0 as "low fidelity" in the National Evidence-Based Practices Project studying several practices, including ACT. Georgia ACT teams also scored similarly in both FY13 and FY14 (DACTS mean across 22 teams and all 28 items of 4.1) to longer-term data from Indiana in FY01-09 (also 4.1 taking a statewide average across teams for all years, where some teams were quite experienced by 2009). Some additional helpful work to address this gap regarding cut-points for ACT in particular did identify several empirical approaches to defining ACT

[1] The Tool for Measuring Fidelity to Assertive Community Treatment (TMACT; Monroe-Devita, Teague, and Moser, 2011) is a new measure of ACT fidelity that includes 47 items and 6 subscales. Similar to DACTS, items are rated on a 5-point behaviorally anchored scale, 1 to 5. In addition to core ACT components and structures also measured in the DACTS, the TMACT also measures implementation of other evidence-based practices within ACT, scores the function of specialist positions (as opposed to just scoring a qualifying person occupying a position on ACT), and has items covering recovery-oriented practice and person-centered planning. Unfortunately, because the TMACT is a newer instrument, methods for using its scores to discriminate ACT from other services are not yet established.

using DACTS scores or subsets of scores (Salyers et al., 2003). Trials of item-level pass-fail criteria were found to be unattainable by the ACT programs in the study and, therefore, not helpful in distinguishing ACT from other services. The most promising approach offered to discriminate ACT from intensive case management (ICM) and brokered case management was using the mean for a subset of 21 items (excluding H5, H6, H10, H11, S8, S9, S10) and using recalibrated scoring methods for 9 items (meaning they inflated the DACTS scoring methods for these items because a 5 was so difficult to attain, even for ACT teams). Using this approach, about 20% of the ACT programs still scored a 3.9 or below on the total for these 21 items (using the inflation method -- Georgia DBHDD data use the usual stringent DACTS scoring criteria). Conversely, 84% of ICM teams scored 3.4 or below and 91% of brokered case management programs scored 2.9 or below.

In FY14, the 22 ACT teams scored an average of 4.1 on all 28 DACTS items (with no modified scoring; i.e., using the usual, stringent criteria in the DACTS protocol and scale). Seven of the 22 teams scored below 4.0 but still scored a 3.8 or 3.9, the upper range of what Salyers and colleagues (2003) refer to as a "C" in their model using 26 of 28 DACT items, indicating a need for improvement but certainly not out of the realm of ACT team scores in most implementation efforts. To most accurately compare the performance of the 22 Georgia ACT teams to the performance of ACT, ICM, and brokered case management teams in the Salyers paper (2003), we recalculated Georgia teams' scores using the same 26-item and 21-item means used in the paper. As you will see in Figure 1 (26-items) and Figure 2 (21-items) below, the distribution of the Georgia ACT teams' shows more teams performing at higher DACTS "grades" (A and B) than the other ACT benchmark teams in the published paper. Similarly, a lower percentage of Georgia ACT teams scored in the C range, compared to the benchmark ACT samples Salyers et al. (2003), and no Georgia ACT teams scored a D or F, which is where the majority of ICM and brokered case management teams tend to score.

Another angle to examine Georgia ACT teams' performance is to look at individual team scores over time. I noted that only one team scored below 4.0 in both FY13 and FY14. That team scored 3.9 in one year and 3.8 in the next, both relatively close to the 4.0 mark. This team primarily struggled with staff turnover, which is scored relative to the last 2 years, so the turnover experienced in FY13 would still "count" and, thus, influence FY14 scores. Some states have excluded the H5 Staff turnover item in state certification efforts in order to avoid "punishing" teams for staff turnover that sometimes is out of the agency's control.

From these analyses, the ACT teams in Georgia are scoring comparably, if not better, than other ACT teams in the published literature, including some data derived from randomized controlled trials which are often difficult to replicate in real-world implementation efforts (Drake et al., 2001). Using criteria that are either too stringent at the total DACTS score level or requiring item-level pass-fail

criteria that are difficult to meet will likely result in a chaotic service environment where the state will be forced to pull contracts and rapidly reassign Georgia ACT consumers to new ACT providers in order to remain in compliance. However, I support Georgia DBHDD's continued use of scores lower than 4.0 on the total DACTS score and individual item scores of 1 or 2 as indicators of the need for corrective action plans so that teams scoring a below a 4 are expected to improve. In an earlier year of monitoring ACT implementation and discussing where to set the contracting benchmark (ie., the benchmark referred to in the state's QM report), I urged DBHDD staff to set the bar high at 4.0, so that there would be leverage to work with teams on improvement before scores became truly problematic. I urge DBHDD to do better follow-up on progress on those corrective action plans so that improvements actually materialize in well-documented ways. I also urge Georgia DBHDD's to increase attention on other elements of ACT program quality that are not captured by the DACTS (e.g., recovery-orientation, employment services). Although it has not been an issue to date, I do recommend that Georgia DBHDD prepare for any incidence where an ACT team scores a 3.4 or below on the DACTS, as this would be a DACTS score more indicative of ICM or brokered case management.

Figure 1. Distribution of ACT teams achieving each "grade" on DACTS, using 26-items (excludes H11 and S10)

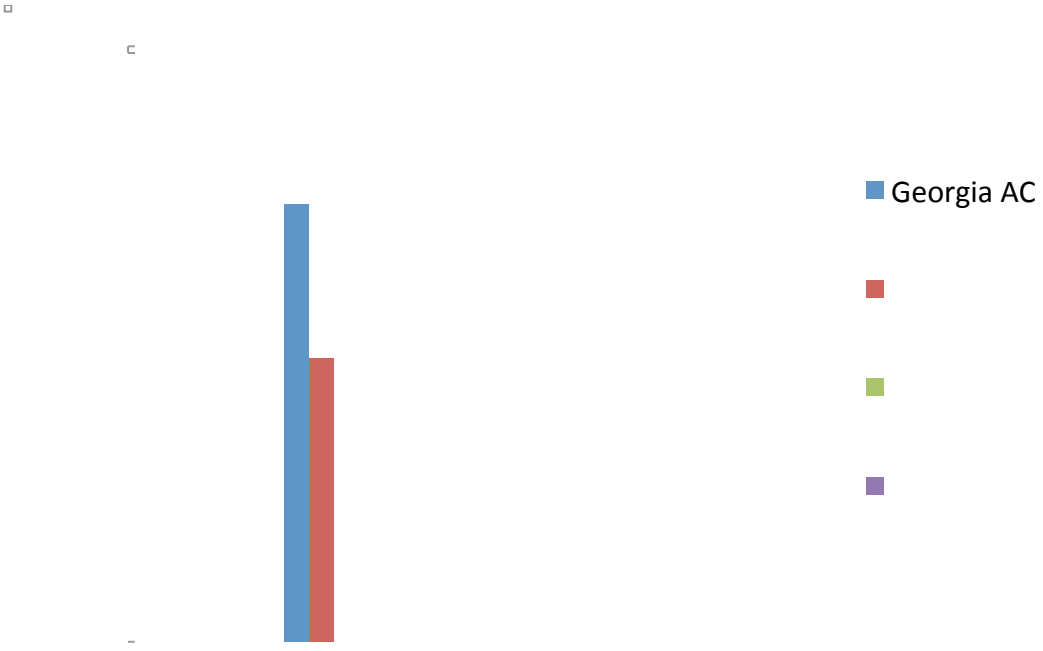
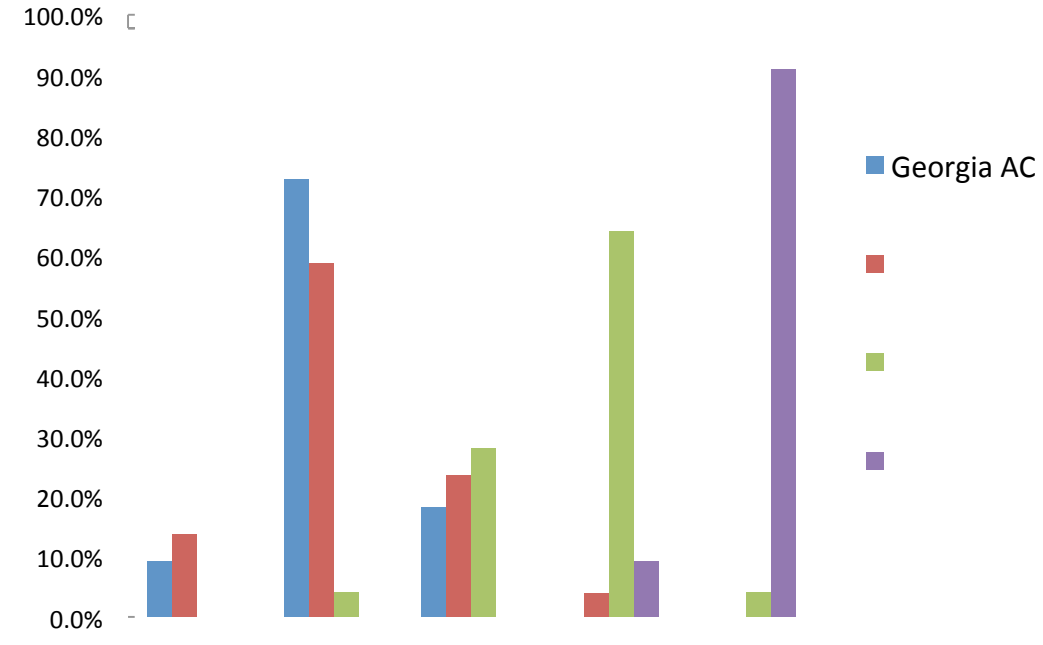


Figure 2. Distribution of ACT teams achieving each “grade” on DACTS, using 21-items (excludes H5, H6, H10, H11, S8, S9, and S10)



receiving Medicaid, though other factors should also be explored. Increasing Medicaid billing is a key strategy for financially sustaining ACT services. A multi-pronged approach that addresses both improving Medicaid application success rates and timelines and making sure teams provide intensive care and bill appropriately for that care are both needed.

- In 2013, one of my recommendations was that some ACT teams need more encouragement from DBHDD in the form of policies, fidelity review feedback, or other methods to consider independent living options for their consumers. This remains an issue, though it is not systematically needed across all teams. In addition to ACT team preferences for more structured housing settings, some staff in institutions may be hesitant to release consumers who will reside in independent living settings with housing vouchers because they fear ACT teams will not provide the high frequency of contact for those consumers to maintain an independent apartment. Low scores on the ACT fidelity item for frequency of contact substantiate this fear. Each case may be different, but it is clear that Georgia teams are at a critical stage for developing and maintaining trust between providers and community stakeholders and institutions. Certainly ACT teams should be capable of making daily contact with consumers who are released from hospitals or jails and placed in independent housing. This is why ACT fidelity standards dictate low intake rates – to allow ample staff time for contact with newly enrolled ACT consumers.
- Improve recovery potential for ACT consumers by providing technical assistance (some onsite) to help teams use specialist positions to maximum advantage, such as helping supported employment specialists, substance abuse specialists, peer specialists, and nurses focus on their unique roles on the ACT team.
- Strengthen the consequences within corrective action plans, asking for agencies to demonstrate progress on the DACTS item that is deficient.

Findings

Based on the information gathered, the author assessed each category of the SHAY as follows.

1. EBP Plan

The SMHA has an EBP plan to address the following: (Use boxes to identify which components are included in the plan) *Note: The plan does not have to be a written document, or if written, does not have to be distinct document, but could be part of the state's overall strategic plan. However if not written the plan must be common knowledge among state employees, e.g. if several different staff are asked, they are able to communicate the plan clearly and consistently.*	
X	1) A defined scope for initial and future implementation efforts,

X	2) Strategy for outreach, education, and consensus building among providers and other stakeholders,
X	3) Identification of partners and community champions,
X	4) Sources of funding,
X	5) Training resources,
X	6) Identification of policy and regulatory levers to support EBP,
X	7) Role of other state agencies in supporting and/or implementing the EBP,
X	8) Defines how EBP interfaces with other SMHA priorities and supports SMHA mission
X	9) Evaluation for implementation and outcomes of the EBP
X	10) The plan is a written document, endorsed by the SMHA

Score

	1. No planning activities
	2. 1 – 3 components of planning
	3. 4 – 6 components of planning
	4. 7 – 9 components
X	5. 10 components

Comments:

The State Plan for ACT (written in 2013) is thorough and includes substantive policies supportive of ACT.

2. Financing: Adequacy

Is the funding model for the EBP adequate to cover costs, including direct service, supervision, and reasonable overhead? Are all EBP sites funded at the same level? Do sites have adequate funding so that practice pays for itself? *Note: Consider all sources of funding for the EBP that apply (Medicaid fee-for-service, Medicaid waiver, insurance, special grant funds, vocational rehabilitation funds, department of education funds, etc.) Adequate funding (score of 4 or 5) would mean that the practice pays for itself; all components of the practice financed adequately, or funding of covered components is sufficient to compensate for non-covered components (e.g. Medicaid reimbursement for covered supported employment services compensates for non-covered on inadequately covered services, e.g. job development in absence of consumer). Sources: state operations and budget, site program managers. If financing is variable among sites, estimate average.*

Score:

X
2013

1. No components of services are reimbursable
2. Some costs are covered
3. Most costs are covered
4. Services pays for itself (e.g. all costs covered adequately, or finding of covered components compensates for non-covered components)
5. Service pays for itself and reimbursement rates are attractive relative to competing non-EBP services.

Comments:

As I had mentioned in last year's report, the removal of Tier 3 DBHDD ACT contract funding so that all teams go from a maximum $870,000 in Year 1 to $780,000 each year thereafter was a positive policy change to account for lower than expected rates of Medicaid coverage for ACT consumers being noted throughout the state. On top of the state contract money, teams also bill Medicaid ACT rates ($32.46 per 15 minute unit). Other significant improvements in years past included increasing ACT authorization length from 90 days to 6 months and then a further lengthening of the initial ACT authorization to a full year, bringing ACT authorization length much closer to the ACT principle of providing services with no arbitrary time limits. Other improvements included allowing collateral contact billing under the ACT Medicaid rate and the allowance of dual authorizations for ACT consumers who are transitioning from ACT to less intensive services (so both ACT and other service programs can bill during the planned transition period). Providers and other stakeholders across the State openly expressed gratitude for these important policy changes, particularly the lengthening of ACT authorization periods. It was also noted that APS and DBHDD worked to address barriers related to communication and transmission of ACT authorization documentation between APS and providers. Most providers report a much smoother process for ACT authorizations with APS. One provider did state that APS's ACT authorization categories of "denials" vs "closed" cases is one of semantics since closed cases are often those where a provider simply "gives up" pursuing the ACT authorization. I recommend DBHDD follow up on ACT consumers who leave ACT care because the authorization cannot be obtained. If these consumers return to institutions, homelessness, or experience other poor outcomes, this is an indication to me that ACT authorization policy changes could be considered, such as modifying continuing stay criteria, lengthening authorization periods, or lengthening transition authorization periods so that ACT teams can watch for regression in the consumer when services are decreased before officially discharging the consumer.

Unfortunately, agency leaders from two Region 3 agencies operating five ACT teams all reported financial losses on their ACT teams in FY13. According to

both agencies, one key factor in this deficit appears to be low rates of ACT consumers receiving Medicaid, though other factors should also be explored (including team staffing composition and related costs and frequency of contacts, which appear to be lower than expected across the state). For FY14, one agency reported losing over $200,000 on one team (where 31% of consumers on current caseload are currently receiving Medicaid) and over $100,000 (where 38% of consumers on current caseload are currently receiving Medicaid) on another. These figures did not include additional staff positions created to work with DeKalb county public defenders and jail to coordinate placement upon release, so they are likely to be conservative estimates of actual losses. The other agency reported that it takes about $1.3 Million to run each of their ACT teams annually, and these expenses are not fully covered by available funding. In southern Georgia, one CFO interviewed reported anecdotally that they can break even with ACT funding but would never be able to support ACT on Medicaid rates alone. In order to serve consumers well, this team stated that their team has to have more staffing than that required by the Statement of Need. This particular team was one that reported being able to send some staff to all offered trainings (and changed practice because of this), work extensively with hospitals and jails to engage consumers prior to discharge (at least weekly with some visits from ACT psychiatrist as well), and work creatively with pharmacies and patient assistance programs to cover medication costs when consumers are without insurance.

I consider the existing state contract maximums and Medicaid rates to be attractive rates in and of themselves. For example, I had not heard that ACT teams specifically state they were taking losses in previous years. Some teams in previous years certainly expressed apprehension that they would be able to break even on ACT once fully staffed and they reached lower tiers of state contract funding. But this was the first year that teams flatly told me they lost money on ACT. I recommend that DBHDD find out if other agencies operating in Year 2 and beyond are reporting losses as well to identify the extent of the issue. The logical first step in addressing this issue is increasing Medicaid billing and perhaps starting with the issue of securing Medicaid benefits for ACT consumers, many of whom enroll in ACT without Medicaid. Larger state contracts, for instance, may be very difficult to sustain beyond the settlement period. Obtaining Medicaid and social security benefits is particularly challenging for consumers being released from incarceration because they are often without identification and other basic required documentation that delays the application process. Conversely, one agency reported much higher rates of obtaining Medicaid when application was made within Georgia Regional prior to discharge. A multi-pronged approach that addresses both improving Medicaid application success rates and timelines and making sure teams provide intensive care and bill appropriately for that care are both needed. Both agencies visited in July and a few other agencies visited in the past indicated that, although they actively pursue Medicaid applications for ACT consumers without coverage, the process (usually multiple denials and appeals) is so long that many of these consumers

are getting Medicaid right about the time that they no longer qualify for ACT services according to APS. Medicaid's allowance for 180 days of back billing is certainly helpful, but the "uncovered" time on ACT often exceeds this amount. With DBHDD, I discussed the notion of some kind of presumptive Medicaid eligibility for ACT consumers. DBHDD indicated that this may be possible and will look into the issue further. Increasing Medicaid coverage also has the added benefit of reinforcing teams' provision of frequent, intensive services to support consumers to remain out of hospitals, jails, and supervised living settings.

Last year, DBHDD hired a Medicaid Eligibility Specialist in each region to help with increasing the portion of consumers with Medicaid. A staff person from DBHDD also performs SOAR training for staff around the state to increase rapid application for social security benefits for eligible persons. These were all positive developments. One community stakeholder asked if there was room to hire more of these types of individuals since they are very helpful in addressing this Medicaid issue.

3. Financing: Start-Up & Conversion Costs

Are costs of start up and or conversion covered, including: 1) Lost productivity for staff training, 2) hiring staff before clients enrolled (e.g. ACT), 3) any costs associated with agency planning and meetings, 4) changing medical records if necessary, 5) computer hardware and/or software if necessary, etc. *Note: If overall fiscal model is adequate to cover start-up costs then can rate 5. If financing is variable among sites, estimate average. Important to verify with community EBP program leaders/ site program managers.*

	Score:
	1. No costs of start-up are covered
	2. Few costs are covered
	3. Some costs are covered
	4. Majority of costs are covered
X	5. Programs are fully compensated for costs of conversion

Comments:

As mentioned in previous reports, ACT start-up costs appear to be covered with larger state contracts in Year 1 supplemented by ACT Medicaid reimbursement. The teams reporting losses were in second year and beyond.

4. Training: Ongoing consultation and technical support

Is there ongoing training, supervision and consultation for the program leader and clinical staff to support implementation of the EBP and clinical skills:
(Use boxes to indicate criteria met.)
Note: If there is variability among sites, then calculate/estimate the average visits per site.

X	1) Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training)
X	2) Initial agency consultation re. implementation strategies, policies and procedures, etc. (e.g. 1 - 3 meetings with leadership prior to implementation or during initial training)
Needs emerging here in 2014	3) Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (minimum of 3 months, e.g. monthly x 12 months)
Some added this year	4) On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months)
X (ACT Coalition)	5) Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (minimum of 3 months, e.g. monthly X 12 months)

Score

	1. 0-1 components
	2. 2 components
	3. 3 components
X	4. 4 components
	5. 5 components

Comments:

Strengths of training structures have been covered in previous reports. DBHDD added and documented more extensive onsite consultation by fidelity assessors on the wrap-up day for each fidelity assessment which is a positive improvement, but could be focused on emerging areas of weakness for teams.

I recommend a continued emphasis on strengthening recovery orientation of ACT and helping teams understand how to engage consumers well before and during their initial weeks with ACT. To improve recovery orientation of ACT teams, I encourage training and shadowing experiences that bolster the critical roles of supported employment specialists and peer specialists, as well as emphasize the role of ACT in supporting consumers in independent housing arrangements.

For employment, I hope training emphasizes that ACT supported employment specialists work in all phases of supported employment work, from engagement and assessment of skills to job development to follow-along supports. I was troubled to hear one consumer this year state that her ACT supported employment worker would help her get a job but that an outside vocational provider would do her job coaching after placement. (This was a consumer with employment history and who presented herself very well). When I inquired with the team, the leader stated that the employment specialist on their team would not be able to job coach her for eight hours each day. This showed a clear lack of understanding of supported employment and finding jobs that fit a consumer's strengths. I also fear some teams are working on employment only for consumers who they see as "stable" and "ready" for employment while missing opportunities to engage consumers early in their ACT services around expressed employment goals. For instance, I visited another consumer recently released from jail who was so motivated to work that she was going to go out on her own to a downtown office to apply. This particular consumer was not aware that the ACT team could help her with her employment goals. I recommend working with the supported employment technical assistance providers to improve ACT teams' adherence to supported employment principles. Team leaders should also be exposed to these principles in order to manage team functions to support quality SE work.

For housing, I would recommend even basic ACT trainings continue to emphasize that ACT teams are specifically equipped to provide frequent and intensive services that help consumers live independently. I continue to see what I view as an overreliance on personal care homes and other supervised housing options on teams (e.g., many teams are being scored as brokering housing support on their DACTS assessments though this is a relatively small penalty to the item score). Sometimes this is legitimately because housing choices are limited or, as one team reported in southern Georgia: "our judges often want them to live in residential settings upon release." However, in other instances, the ACT team wants to see that consumers prove they are "ready" for independent housing with a trial in supervised housing. More recovery-oriented teams lean away from putting this burden of "readiness" on consumers and instead use their intensive and flexible services to support consumer goals. For a consumer who clearly wants independent housing and is told the team disagrees, this could increase resistance from the consumer and drive them to avoid the team because they are not hearing the consumer's goals.

Peer specialists on the teams are a great resource for engaging consumers who may otherwise be skeptical or resistant to mental health services. I recommend working with Mark Baker and his office at DBHDD or other consumer advocacy groups in Georgia to strategize how to effectively make good use of peer specialists. Another idea would be to incorporate consumer speakers from the

Respect Institute in existing trainings to infuse a more person-centered consumer perspective on ACT teams.

I noticed some teams this year where there is a real deficit in recovery-orientation. Some teams allowed their staff to talk pejoratively about consumers, repeatedly stating that consumers were unmotivated or untrustworthy or unable to make decisions about their own care. There are some consumers on ACT teams who are clearly difficult to engage and serve, but when I hear staff say this about the majority of their caseload, then I suspect that this is a team bias and probably does not reflect the capacity of their consumers. I struggle with how to advise DBHDD to address some of these issues because training events are certainly limited in their ability to bring about changes in staff attitudes and beliefs, which is the central goal in improving recovery orientation. One provider (a nurse) told me that Motivational interviewing, Integrated Dual Disorders Training, and Illness Management and Recovery trainings offered by DBHDD for ACT staff were very helpful: “That really helped us rethink how to handle tough customers who are difficult to engage. They don’t want to hear about meds.” Recovery-oriented engagement training was another good example. Person-centered planning is another training where teams would learn how to engage consumers around their own personal goals and tailor services to support those goals. So my only advice with respect to trainings is to keep offering them, know which teams need them the most, and target them so that those teams can send key staff.

What may work better for improving recovery-orientation is continued emphasis on detecting these attitudes and corresponding behaviors while on fidelity reviews, pointing them out to staff and leadership while onsite and having honest, frank, respectful discussions about how recovery-oriented ACT contrasts their current practice. Using real examples from an ACT team has the advantage of bringing recovery-oriented care discussions beyond theory and into practice -- helping teams make better choices with specific consumers. When teams have a long way to go towards recovery-oriented care, I personally avoid talking about these issues as “black and white” and instead try to reinforce modest changes in how the team chooses to function to move them along the continuum of recovery.

Offering some low recovery-oriented teams or staff the opportunity to shadow teams that do well with employment housing, person-centered planning, or motivational approaches is another way to improve recovery-oriented care. Sometimes a message is more powerful when it comes from a colleague doing this same kind of work and not from a centralized DBHDD staff member or trainer. The new ACT fidelity assessor who was hired and recently worked as an ACT team leader may also be a helpful asset at DBHDD for this reason – he has done this work very recently.

Recovery-oriented ACT should be a priority topic at this year's ACT team leader retreat as well, since leadership on these issues is critical in changing team culture. Team leaders can recognize language and attitudes and set the standard for team performance in these areas. For some teams where the ACT team leader does not embrace recovery-oriented care, measures may need to be more drastic to get the right personnel in a leadership position with the team.

5. Training: Quality

Is high quality training delivered to each site? High quality training should include the following:
(Use boxes to indicate which components are in place.
Note: If there is variation among sites calculate/estimate the average number of components of training across sites.)

X	1) credible and expert trainer
X	2) active learning strategies (e.g. role play, group work, feedback
X	3) good quality manual, e.g. SAMHSA Toolkit
X	4) comprehensively addresses all elements of the EBP
On demand only	5) modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered
X	6) high quality teaching aides/materials including workbooks/work sheets, slides, videos, handouts, etc., e.g. SAMHSA Toolkit/ West Institute

Score

	1. 0 components
	2. 1 – 2 components
	3. 3 – 4 components
X	4. 5 components
	5. All 6 components of high quality training

Comments:

Providers continue to report that training is high quality and covers relevant, important content for good ACT functioning. I hear this both anecdotally during team visits and see these reports in DBHDD surveys of providers. Although shadowing is still technically on-demand, DBHDD did make progress in this area by offering some reimbursement to agencies whose teams have a strength area for shadowing which should increase the shadowing opportunity capacity. DBHDD is determining strengths and weaknesses of various teams and suggesting teams with weak areas of ACT functioning shadow a team that does well in that area. This is a worthwhile approach since some teams will different strengths than others.

6. Training: Infrastructure / Sustainability

Has the state established a mechanism to allow for continuation and expansion of training activities related to this EBP, for example relationship with a university training and research center, establishing a center for excellence, establishing a learning network or learning collaborative. This mechanism should include the following components:
(Use boxes to indicate which components are in place)

X	1) offers skills training in the EBP
X	2) offers ongoing supervision and consultation to clinicians to support implementation in new sites
X	3) offer ongoing consultation and training for program EBP leaders to support their role as clinical supervisors and leaders of the EBP
Variable	4) build site capacity to train and supervise their own staff in the EBP
Offered but needs more attention	5) offers technical assistance and booster trainings in existing EBP sites as needed
Medicaid only sites	6) expansion plan beyond currently identified EBP sites
X (new)	7) one or more identified model programs with documented high fidelity that offer shadowing opportunities for new programs
Some	8) SMHA commitment to sustain mechanism (e.g. center of excellence, university contracts) for foreseeable future, and a method for funding has been identified

Score

	1. No mechanism
	2. 1 – 2 components
	3. 3 – 4 components of planning
X	4. 5 – 6 components
	5. 7 – 8 components

Comments:

As was the case last year, current training infrastructure is an area of strength and improvements were made this year in DBHDD's capacity to offer shadowing for teams (i.e., reimbursement for teams as shadow sites and a shadowing experience template to set goals and expectations). DBHDD also offered a team leader retreat this year that should be offered at least annually since many issues related to recovery-oriented ACT are often best resolved with good ACT team leadership. The fidelity assessment team has been offering some technical assistance in their wrap-up day of the fidelity visit, but I am seeing emerging needs regarding a lack of understanding of specialist roles (particularly the SE specialist often being used as a gatekeeper to the agency's VR program), an overreliance on structured housing and a lack of consumer choice in housing and

other services, and general problems with recovery-orientation of teams. Even if a team scores well on a fidelity item, there is a lot of feedback and technical assistance that could be infused in these visits that improve quality above and beyond the basic DACTS requirements.

I do continue to be concerned about the ability of DBHDD to sustain the current technical assistance and training infrastructure in future years.

Although the Settlement Agreement only requires 22 ACT teams, the State does offer Medicaid funding to other programs that might be considered the expansion element in this item.

7. Training: Penetration

What percent of sites have been provided high quality training (score of 3 or better on question #5, see note below), and ongoing training (score of 3 or better on question #4, see note below).
Note: *If both criteria are not met, does not count for penetration. Refers to designated EBP sites only.*
High quality training should include 3 or more of the following components:

1) *credible and expert trainer,*
2) *active learning strategies (e.g. role play, group work, feedback),*
3) *good quality manual (e.g. SAMHSA toolkit),*
4) *comprehensively addresses all elements of the EBP,*
5) *modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered,*
6) *high quality teaching aids/ materials including workbooks/ work sheets, slides, videos, handouts, etc. e.g. SAMHSA toolkit/ West Institute.*

Ongoing training should include 3 or more of the following components:

1) *Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training),*
2) *Initial agency consultation re. implementation strategies, policies and procedures, etc. (e.g. 1 - 3 meetings with leadership prior to implementation or during initial training),*
3) *Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (minimum of 3 months, e.g. monthly x 12 months),*
4) *On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months),*
5) *Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (minimum of 3 months, e.g. monthly X 12 months).*

	Score:
	1. 0-20%
	2. 20-40%
	3. 40-60%
	4. 60-80%
X	5. 80-100%

Comments:

DBHDD requires new staff to attend ACT trainings, but the penetration of ACT staff receiving other trainings is much lower. This is understandable to a certain degree, but lower functioning teams or teams who struggle with certain recovery concepts (e.g., motivational interviewing) should be specifically targeted to send key staff to relevant trainings.

8. SMHA Leadership: Commissioner Level

Commissioner is perceived as an effective leader (influence, authority, persistence, knows how to get things done) concerning EBP implementation and who has established EBPs among the top priorities of the SMHA as manifested by:
(Use boxes to indicate components in place.)
Note: Rate existing Commissioner, even if new to post.

Yes	1) EBP initiative is incorporated in the state plan, and or other state documents that establish SMHA priorities,
Yes	2) Allocating one or more staff to EBP, including identifying and delegating necessary authority to an EBP leader for the SMHA,
Yes	3) Allocation of non-personnel resources to EBP (e.g. money, IT resources, etc.),
Yes	4) Uses internal and external meetings, including meetings with stakeholders, to express support for, focus attention on, and move EBP agenda,
Notably strong throughout the year	5) Can cite successful examples of removing policy barriers or establishing new policy supports for EBP.

	Score
	1. 0-1 component
	2. 2 components
	3. 3 components
	4. 4 components
X	5. All 5 components

Comments:

As in past evaluations, I was able to speak with the Commissioner and Deputy Commissioner of DBHDD and heard from a variety of community stakeholders who feel they are committed to supporting quality ACT services. Both leaders continue to understand the importance of and challenges to implementing ACT in Georgia. When I mentioned my concerns regarding the need to improve recovery-orientation for some ACT teams, the Medicaid eligibility challenges for some ACT consumers, and statewide concerns about the sustainability for ACT beyond the Settlement Agreement period, they immediately understood the critical issues. We talked at length about sustainability and the need to maximize federal revenue for both ACT and SE, reinvest hospital funding for community-based mental health programs, and to demonstrate critical outcomes in commonsense ways that give state legislators trust and confidence in investing in intensive community-based mental health programs.

9. SMHA Leadership: Central Office (GA DMH) EBP Leader

There is an identified EBP leader (or coordinating team) that is characterized by the following:
(Use boxes to indicate which components in place.)
Note: Rate current EBP leader, even if new to post.

X	1) EBP leader has adequate dedicated time for EBP implementation (min 10%), and time is protected from distractions, conflicting priorities, and crises,
X	2) There is evidence that the EBP leader has necessary authority to run the implementation,
X	3) There is evidence that the EBP leader has good relationships with community programs,
Strong	4) Is viewed as an effective leader (influence, authority, persistence, knows how to get things done) for the EBP, and can site examples of overcoming implementation barriers or establishing new EBP supports.

Score

	1. No EBP leader
	2. 1 components
	3. 2 components
	4. 3 components
X	5. All 4 components

Comments:

As indicated in years past, the DBHDD Director of Adult Mental Health is a strong leader for ACT, devotes more than 10% effort to ACT, has and exercises her authority to make policy changes related to ACT, and is observed to be very responsive to consumer, provider, and other community stakeholders with regard to ACT. My only concern at this point is that, as the basics of ACT have become more manageable, it would be beneficial to see more DBHDD central office personnel going out and making contact with teams on site in the field. Perhaps if reports from others come in about high or low functioning teams, then a site visit might be warranted to reinforce good practice or to provide recommendations on poor practices. To strike a balance with the myriad of other site visits and audits with which ACT teams must comply with, I would recommend removing the APS program audit for ACT because that audit appears to duplicate fidelity audits and is a source of frustration rather than true quality assurance.

10. Policy and Regulations: Non SMHA State Agencies

The SMHA has developed effective interagency relations (other state agencies, counties, governor's office, state legislature) to support and promote the EBP as necessary/appropriate, identifying and removing or mitigating any barriers to EBP implementation, and has introduced new key facilitating regulations as necessary to support the EBP.

Ask SMHA staff and site leadership: What regulations or policies support the EBP implementation? What regulations or policies get in the way? Note: give most weight to policies that impact funding.

Examples of supporting policies:

- Medicaid agency provides reimbursement for the EBP (If Medicaid not under the SMHA)
- The state's vocational rehabilitation agency pays for supported employment programs
- The state's substance abuse agency pays for integrated treatment for dual disorders
- Department of Professional Licensing requires EBP training for MH professionals

Examples of policies that create barriers:

- Medicaid agency excludes EBP, or critical component, e.g. disallows any services delivered in the community (If Medicaid agency not under the SMHA)
- State substance abuse agency prohibits integrated treatment, or will not reimburse for integrated treatment
- State substance abuse agency and state mental health authority are divided, and create obstacles for programs attempting to develop integrated service programs
- State vocational rehabilitation agency does not allow all clients looking for work access to services, or prohibits delivery of other aspects of the supported employment model
- Department of Corrections policies that create barriers to implementation

of EBPs

Score	
	1. Virtually all policies and regulations impacting the EBP act as barriers.
	2. On balance, policies that create barriers outweigh policies that support/promote EBP.
	3. Policies that support/promote are approximately equally balanced by policies that create barriers.
X	4. On balance, policies that support/promote the EBP outweigh policies that create barriers.
	5. Virtually all policies and regulations impacting the EBP support/promote the EBP.

Comments:

Many of the barriers related to use of the housing vouchers are less of an issue than in the past two years. As discussed in an earlier section, other housing barriers (having nothing to do with vouchers) still exist such as team or community stakeholders who resist the idea of consumers living independently when coming out of institutions. As one Georgia Regional social worker clarified to me, some of her own colleagues hesitate to endorse independent living in the discharge plan because they doubt the ACT teams will see consumers frequently enough to support the consumer in independent living. Other barriers exist just related to the availability of rental stock or barriers for certain consumers related to criminal histories.

The Medicaid office has worked well with DBHDD in the past. As noted above, I did hear teams report struggles with getting ACT consumers on Medicaid, particularly consumers with substance use disorders or legal histories. I recommend doing more fact finding into this issue to see the depth and breadth of the issue across the state. For instance, the rates of ACT consumers with Medicaid seemed to vary widely in the teams I visited this year (31% to 90% with most in the 50-70% range). Some of the barriers might be traced to specific social security offices (county level) that hesitate to grant disability to consumers with mental illness or substance use disorders. Conversely, one team reported that when the Medicaid application is started at Georgia Regional, those consumers definitely get disability status and have no problems getting Medicaid. During one of my interviews with DBHDD staff, I mentioned the notion of presumptive Medicaid eligibility for ACT consumers and DBHDD agreed to look into this option. Presumptive eligibility would certainly relieve some of the financial pressure I am now hearing about and help provide tools to sustain ACT in Georgia. Other ideas suggested by stakeholders included hiring more SOAR-trained DBHDD staff or finding out how state hospital doctors write successful disability applications. Increasing emphasis on revenue from Medicaid also would

reinforce frequent, intensive service provision for ACT consumers that could help to engage consumers early in treatment and support consumers in independent living.

11. Policies and Regulations: SMHA

The SMHA has reviewed its own regulations, policies and procedures to identify and remove or mitigate any barriers to EBP implementation, and has introduced new key regulations as necessary to support and promote the EBP.
Ask SMHA staff and site leadership: What regulations or policies support the EBP implementation? What regulations or policies get in the way?
Examples of supporting policies:
- *SMHA ties EBP delivery to contracts*
- *SMHA ties EBP to licensing/ certification/ regulation*
- *SMHA develops EBP standards consistent with the EBP model*
- *SMHA develops clinical guidelines or fiscal model designed to support model EBP implementation*

Examples of policies that create barriers:
- *SMHA develops a fiscal model or clinical guidelines that directly conflict with EBP model, e.g. ACT staffing model with 1:20 ratio*
- *SMHA licensing/ certification/ regulations directly interfere with programs ability to implement EBP*

X

Score:
1. Virtually all policies and regulations impacting the EBP act as barriers.
2. On balance, policies that create barriers outweigh policies that support/promote the EBP.
3. Policies that are support/promote the EBP are approximately equally balanced by policies that create barriers.
4. On balance, policies that support/promote the EBP outweigh policies that create barriers.
5. Virtually all policies and regulations impacting the EBP support/promote the EBP.

Comments:

Although most of these policy updates occurred in 2012 and 2013, I will reiterate these positive policies below to emphasize DBHDD progress in ACT implementation:
- Establishing systematic fidelity monitoring system and tying contracts to ACT standards.
- Changing the ACT authorization periods to six months and later extending the initial authorization to one year to more closely fit with the longer-term nature of ACT services.

- Streamlining regulatory documents to avoid confusion (e.g., making operations manual align with service definitions and designating the operations manual as a guide rather than a regulatory document).
- Modifying ACT admission criteria.
- Modifying APS authorization and audit processes and tools to eliminate conflicts with the model (there are still a few audit tool items best. assessed at the program level rather than the record level).
- Allowing dual authorizations for ACT and other services to allow for a coordinated graduation from ACT to less intensive services.
- Allowing collateral contact billing.
- Eliminating an overly strict policy that demanded ACT psychiatrists deliver services in the field (i.e., allowing the metrics of the fidelity item for this standard to determine if services are too office-based).
- Removal of the Tier 3 (lowest) funding so that teams now can bill state contract amounts up to $780,000 per year starting in their second year and continuing on while under contract.

12. Policies and Regulations: SMHA EBP Program Standards

The SMHA has developed and implemented EBP standards consistent with the EBP model with the following components:
(Use boxes to identify which criteria have been met)

X	1) Explicit EBP program standards and expectations, consonant with all EBP principles and fidelity components, for delivery of EBP services. *(Note: fidelity scale may be considered EBP program standards, e.g. contract requires fidelity assessment with performance expectation)*
X	2) SMHA has incorporated EBP standards into contracts, criteria for grant awards, licensing, certification, accreditation processes and/or other mechanisms
X	3) Monitors whether EBP standards have been met,
Needs more work	4) Defines explicit consequences if EBP standards not met (e.g. contracts require delivery of model ACT services, and contract penalties or non-renewal if standards not met; or licensing/accreditation standards if not met result in consequences for program license.)

Score

	1. No components (e.g., no standards and not using available mechanisms at this time).
	2. 1 components
	3. 2 components
X	4. 3 components
	5. 4 components

Comments:

With two years of consistent fidelity monitoring in place, I do have a concern that some teams appear to be scoring low on some items in consecutive years and consequences are not sufficient to change behavior. For instance, if a required staff position is vacant two years in a row, did the corrective action plan serve its purpose of providing a real consequence for low performance on that standard? Simply encouraging a team to consult resources to help hire the missing staff is not a sufficient tool if there is no reassessment of whether the hire has been made. I recommend that corrective action plans require a concrete outcome related to improving that DACTS item score. So for staff positions, you would have to see that an appropriate person was hired or assigned to the team, even if part-time, to improve the score and coverage for ACT consumers. For low frequency of contact, a fidelity assessor may need to perform another chart review or the team might be required to report on weekly face to face contacts made per consumer using data from the entire team's caseload (if a report can be generated). The only exception to that could be the informal support item, although I think the DACTS standard is unrealistically high. Even on that item though, I would expect teams who score a 1 or 2 to make strides to increase their informal support contacts, even if it means simply that they went from a score of 1 to 2, or 2 to 3.

13. Quality Improvement: Fidelity Assessment

There is a system in place for conducting ongoing fidelity reviews by trained reviewers characterized by the following components: (Use boxes to indicate criteria met.) *Note: If fidelity is measured in some but not all sites, answer for the typical site.*	
X	1) EBP fidelity (*or functional equivalent designed to assess adherence to all critical components of the EBP model) is measured at defined intervals,*
	2) GOI fidelity (*or functional equivalent designed to assess adherence to all critical components required to implement and sustain delivery of EBP) is measured at defined intervals,*
X	3) Fidelity assessment is measured independently – i.e. not assessed by program itself, *but by SMHA or contracted agency,*
X	4) Fidelity is measured a minimum of annually,
X	5) Fidelity performance data is given to programs and used for purposes of quality improvement,
X	6) Fidelity performance data is reviewed by the SMHA +/- local MHA,
X	7) The SMHA routinely uses fidelity performance data for

	purposes of quality improvement, to identify and respond to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.),
X (new)	8) The fidelity performance data is made public (e.g. website, published in newspaper, etc.).

Score

	1. 0-1 components
	2. 2-3 components
	3. 4-5 components
X	4. 6-7 components
	5. All 8 components

Comments:

Although the score on this item did not change this year, DBHDD is posting ACT fidelity reviews on their public website. As noted in previous reports, the fidelity review process itself is thorough and only missing the General Organizational Index. (I would prefer to see more attention paid to recovery-orientation of ACT teams, even if they "technically" meet DACTS fidelity, rather than focusing any energy on the GOI). I do want to include a few small notes for the fidelity assessors. I recommend generous calculation of direct contact for the Practicing team leader item. Many of your explanations refer only to billable productivity reports. I would add to that total any phone contacts with consumers (many non-billable in Georgia Medicaid for ACT) or any shadowing contacts or field mentoring. I also inquire about the last ten hospitalizations verbally with teams or team leaders to determine the team's involvement in admissions and discharges. I saw many reports referred to far less than ten hospitalizations. When the number examined is fewer than ten, the sample is so small that one omission and the percentage varies widely. Also, as we discussed while I was onsite with the APS staff, I typically do not exclude charts for review just because someone is in jail or the hospital. (In fact, this is one way to reinforce continued engagement with those consumers.) Certainly if a team says they are about to discharge the person but have not formally closed the chart, I would omit the chart at that point. I do realize that consumers hospitalized far away from the team are another special case as well since face to face visits will be less frequent. I am happy to leave those sorts of decisions up to the assessors to judge individually. There are no formal protocol "rules" on this, but I tend to think of the median chart on all these figures as accounting for some outliers.

14. Quality Improvement: Client Outcomes

A mechanism is in place for collecting and using client outcome data characterized by the following:

(Use boxes to indicate criteria met.)
Note: Client outcomes must be appropriate for the EBP, e.g. Supported employment outcome is persons in competitive employment, and excludes prevoc work, transitional employment, and shelter workshops. If outcome measurement is variable among sites, consider typical site.

X	1) Outcome measures, or indicators are standardized statewide, AND the outcome measures have documented reliability/validity, or indicators are nationally developed/recognized,
X	2) Client outcomes are measured every 6 months at a minimum,
X	3) Client outcome data are used routinely to develop reports on agency performance,
	4) Client specific outcome data are given to programs and practitioners to support clinical decision making and treatment planning,
X	5) Agency performance data are given to programs and used for purposes of quality improvement,
X	6) Agency performance data are reviewed by the SMHA +/- local MHA,
X	7) The SMHA routinely uses agency performance data for purposes of quality improvement; performance data trigger state action. Client outcome data are used as a mechanism for identification and response to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.),
	8) The agency performance data are made public (e.g. website, published in newspaper, etc.).

Score

	1. 0-1 components
	2. 2-3 components
	3. 4-5 components
X	4. 6-7 components
	5. All 8 components

Comments:

DBHDD collects, aggregates, and reports back key ACT outcomes to providers aggregated each month and collated into quarterly reports. DBHDD also tracks some ACT consumers prospectively over time so that they can report on ACT consumer progress in relation to tenure on ACT. What is missing from that report is the ability to tell legislators and other stakeholders that ACT is reducing negative outcomes (e.g., hospitalization or incarcerations) or increasing positive

outcomes (e.g., employment or independent living) and in what quantities, if improvements are being observed. Several stakeholders asked me if Georgia's ACT programs were achieving these outcomes. Unfortunately, my answer was that I am not sure. I certainly could say that I saw the employment rate rise very slowly in the consumer cohort that is being followed over time, but I saw the rate drop at the 12-month mark. I assume this drop probably means a large number of employed consumers were discharged at the 12-month mark, but without better tracking, I cannot state this with absolute certainty. For outcomes like hospitalizations, it would be helpful to have information about a consumer's number of hospitalizations and hospital days prior to ACT enrollment to track statistical improvements over time. It might also help the State to assess how other important factors such as what is the critical length of time on ACT that it takes to see improvements in key outcomes. The State consistently talks about the outcomes at ACT coalition meetings and has started using the reports to think about program development.

Consumer-level outcomes tracking is not currently available. Some key performance indicators for ACT (e.g., hospitalizations) are publicly available on the DBHDD webpage. The Director of Adult Mental Health shares the outcome reports at a number of stakeholder meetings, including Georgia Mental Health Consumer Network, the Behavioral Health Services Coalition, and the provider network.

DBHDD currently plans to use their new ASO to do more outcomes monitoring, including some of the ideas noted above. Having a field in the state data system noting when an episode of ACT services starts and stops will be a key element of any new tracking system.

Answering "simple" questions about the impact of ACT is a key strategy for justifying sustainment of ACT.

15. Stakeholders

The degree to which consumers, families, and providers are opposed or supportive of EBP implementation. *Note: Ask - Did stakeholders initially have concerns about or oppose EBPs? Why? What steps were taken to reassure/engage/partner with stakeholders? Were these efforts successful? To what extent are stakeholders currently supportive this EBP? Opposed? In what ways are stakeholders currently supporting/ advocating against this EBP? Rate only <u>current</u> opposition/support.*

Scores:

1. Active, ongoing opposition to the EBP,
2. Opposition outweighs support, or opinion is evenly split, but no active campaigning against EBP,
3. Stakeholder is generally indifferent,

4. Generally supportive, but no partnerships, or active proponents,
5. Stakeholder advocacy organization leadership/opinion leaders currently offer active, ongoing support for the EBP. Evidence of partnering on initiative.

4.3	15. Summary Stakeholder Score: (Average of 3 scores below)
4	15.a Consumers Stakeholders Score
4	15.b Family Stakeholders Score
5	15.c Providers Stakeholders Score

Comments:

As was the case in FY13, most providers express a sense of strong partnership with DBHDD staff in providing high quality ACT services following the Dartmouth Assertive Community Treatment Scale. Consumer and family advocacy groups express support for ACT, although there was more of a sense of impatience this year in wanting DBHDD and ACT teams to do better or adhere more closely with ACT. I agree with some stakeholders in their hopes that ACT teams would focus on recovery goals for ACT consumers (e.g., employment and independent living) and making better use of peer specialists. In some cases though, I wonder if some stakeholder groups want more consumers to receive ACT than the system is currently capable of enrolling. For instance, Fulton and DeKalb county jail discharge referrals alone could probably fill up the majority of Region 3's available ACT intake slots each month, leaving little room for referrals from other jails, prisons, state hospitals, private hospitals, internal agency referrals, or other important referral sources. The discrepancy between ACT capacity and perceived need produces frustrations on multiple levels for both providers and some of these community stakeholders. Certainly, some ACT teams might be able to do better in taking on referrals. Certainly, some stakeholders need to have more realistic expectations about referral and engagement and client choice in signing onto community mental health programming. I hope the ongoing discourse can be improved in terms of professionalism and more of a sense of partnership between these ACT teams and stakeholders. To help address this lack of partnership, I suggested that some advocates attend similar discharge planning meetings in Fulton county and in Gwinnett to see what was reported by ACT teams as a more collegial working relationship between ACT providers and advocates. It is also important to note that these struggles are not universally experienced across the state. As one example, a team in southern Georgia specifically mentioned having good relationships with jail and probation staff to move consumers out of jail more quickly. This particular team said they make ample use of Community Transition Plan funding to engage with consumers at least weekly in preparation for release, including some visits by the ACT psychiatrist.

Generally, it sounds like most advocates feel they have a strong partnership with DBHDD around ACT but perhaps not as strong a partnership with some ACT providers. A few stakeholders did express some impatience with DBHDD in not collecting outcomes that depict ACT's impact and not addressing what they see as weak ACT providers. However, none of their frustration extends from opposition to ACT. In fact, they want ACT teams to adhere more closely to ACT ideals.

Summary of SHAY Scores Over Time

	2012	2013	2014
1. EBP Plan	3	5	5
2. Financing: Adequacy	5	5	3
3. Financing: Start-up and Conversion Costs	3	5	5
4. Training: Ongoing Consultation & Technical Support	2	4	4
5. Training: Quality	3	4	4
6. Training: Infrastructure / Sustainability	1	4	4
7. Training: Penetration	4	5	5
8. SMHA Leadership: Commissioner Level	5	5	5
9. SMHA Leadership: EBP Leader	3	5	5
10. Policy and Regulations: Non-SMHA	3	4	4
11. Policy and Regulations: SMHA	2	5	5
12. Policy and Regulations: SMHA EBP Program Standards	3	5	4
13. Quality Improvement: Fidelity Assessment	1	4	4
14. Quality Improvement: Client Outcome	1	4	4
15. Stakeholders: Aver. Score (Consumer, Family, Provider)	4	4	4
SHAY average = average over all 15 items	3.58	4.53	4.33

*For information on the specific numeric scoring methods for each item, please see the SHAY Rating Scale

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2014 Review

Georgia Supported Housing and Bridge Funding

United States of America v the State of Georgia

(Civil Action No. 1:10---CV---249---CAP)

Martha Knisley
Technical Assistance Collaborative, Inc.

August 15, 2014

Introduction

This report to the Independent Reviewer summarizes the progress of the Supported Housing and Bridge Funding programs required by the Settlement Agreement in United States of America v the State of Georgia (Civil Action No. 1:10---CV---249---CAP), referred to hereafter as the Settlement Agreement, for the period of July 1, 2013 through June 30, 2014.

Information analyzed for this report was obtained from written documents provided by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Georgia Department of Community Affairs (DCA); key informant interviews with the amici; DBHDD staff, including interviews with Commissioner Berry, Chief of Staff Judy Fitzgerald and Assistant Commissioner Chris Gault; Department of Community Affairs (DCA) Commissioner Gretchen Corbin and Deputy Commissioner Carmen Chubb and her staff; a meeting with Monica Parker, Director of the DBHDD Division of Community Mental Health, Doug Scott, Director of Housing and five Regional Transitional (housing) Coordinators (Sam Page, Troy McQueen, Sharon Pratt, Jose Lopez and June Stewart) on July 22, 2014 in Macon; and five home visits (randomly selected) with ACT team staff of the Georgia Rehabilitation Outreach (GRO), Grady and Viewpoint in Fulton County on August 6 and 7, 2014.

This report focuses on the State's progress in three areas: 1.) meeting the Georgia Housing Voucher Program (GHVP, sometimes referred to as GHVs or GHV) and Bridge Funding targets by type of housing, number of subsidies funded, target population requirements and bridge funding requirements for the year ending June 30, 2014; 2.) supported housing program implementation for priority target populations, including the state's ability to implement the proposed program for the target population as contemplated in the Settlement Agreement; and 3.) program expansion including the state's progress to meet the July 1, 2015 requirement to "have capacity to provide Supported Housing to any of the 9,000 individuals in the target population who need such support."

Observations and Findings:

1. Housing (GHVP) and Bridge

Funding Georgia Housing Voucher

Program

The DBHDD continues to exceed GHVP numerical targets. DBHDD was required to serve 1,400 individuals by July 1, 2014 and served 1,649[1] or 123% of the goal. As of July 1, 2014, 1,094 participants had signed leases and another 241 were in housing search. This is the fourth year the DBHDD has surpassed 110% of the goal.

[1] Georgia Department of Behavioral Health and Developmental Disabilities, Georgia Housing Voucher and Bridge Funding Programs SFY 2014 Year in Review (July, 2014). Georgia DBHDD revised their final number of persons served by July 1, 2014 to 1,649 or 123% of goal on September 9, 2014.

Over 661 properties were under contract and sixty---four providers were actively serving participants. Participants are living in GHVP arrangements in seventy---four different counties. The number of properties under contract nearly doubled in the past year increasing from 350 to 661 and the number of providers actively serving participants grew substantially increasing from forty---five to sixty---four (30%).

The DBHDD keeps records on referrals from point of "notice to proceed," which is basically the DBHDD Supported Housing Director verifying an individual is eligible for the program and the individual can proceed with housing search. In FY 14, 69% of individuals with a "notice to proceed" had signed leases before the end of the fiscal year[2]. Data is not reported on time from referral to "notice to proceed" but the pace of "notice to proceed" to leases being signed seems within normal range. There were approximately 8% of the leases cancelled, which is slightly lower than the 12% cancelled in the previous year. Not all referrals resulted in individuals getting housing and some individuals were terminated or chose to leave the program during the year. This is typical but it is also important to assess the "churn" rate[3] to fully assess the number of individuals seeking or leaving housing at any given time, the costs associated with the churn rate over time and the program's capacity to manage and reduce the churn rate.

DBHDD met its goal of providing 1,400 supported housing beds. DBHDD exceeded their goal with 1,574 beds available but only 1,141 were reported as occupied on July 23, 2014 which means that, on July 23rd (date of last report), 28% of the beds were reported as not being occupied------either because they were new or were in turnover. Evaluating a churn rate is somewhat complicated when a program is required to establish new leases at the level required in this program. However it is a significant issue and will be discussed further in the recommendations section of this Report.

In FY 14, 45%[4] of participants had zero income at entry and the monthly average rental payment was $447.87 down slightly from the previous year; this is a positive step because lower rental payments over time enables the program to increase the number of units that can be leased. Bridge funding was provided to 709 participants in the third year of this Settlement Agreement, which is 169 above the goal of 540 for the year[5]. The average "bridge" cost per participant was preliminarily calculated at $2,347, the same as the year before. Furnishings and first and second month rent account for 50% of this cost and provider fees account for 20%. The remaining funds (30%) are allocated for household items, food, transportation, medications, moving expenses, utility and security deposits and other expenses.

This program's success in meeting targets appears to be the result of a combination of at least five factors, including the continued allocation of funds for this program necessary to meet

[2] The primary reason that only 71% had signed leases is that "notices to proceed" can be issued until the end of the fiscal year and the individual was then signing a lease the following month or in the new fiscal year

[3] number of units being leased (new and turnover) and vacated during the year

[4] Georgia Housing Voucher and Bridge Funding Program Summary (7/23/14).

[5] Georgia DBHDD revised their final number of bridge funding participants to 709 which is 169 above the goal of 540 for the year on September 9, 2014.

targets, leadership at DBHDD allocating resources for its management at the state and regional level and forging and improving cross systems partnerships including strong relationships with potential referral sources, service providers adopting the supported housing model and improving their skills and the Supported Housing Director and Regional Transitional Coordinators' diligence and understanding of rental housing operations and supported housing requirements. Meeting this target is also related to the well---documented need for affordable rental housing for individuals who have severe and persistent mental illness and are the target population for this Settlement Agreement.

DBHDD with assistance from DCA methodically tracks their required targets and collect additional data in a timely manner, which enables DBHDD to self---monitor their performance and better grasp their challenges. From talking with participants at their homes as well as local, regional and state staff on site over the last three years, the DBHDD and their local service agency partners are increasingly informed about the local affordable rental markets, fair housing requirements, consumer choice and accessibility features, which is typically related to success in meeting leasing targets.

In looking forward, the Settlement Agreement requires the program to be expanded by 600 slots by July 1, 2015, which is the same level of expansion that was required in FY 14. This means that next year the program is required to grow by approximately 25% of its present capacity. This also means the program will have doubled in size in two years, if the state meets its 2015 target.

Bridge Funding
Making Bridge Funding available to participants is crucial to the success of this program as without this resource many individuals could not get into housing. In FY 14, over $1.9 million was spent on furnishings, first and second month's rent, deposits and household items. Furnishings and rent accounted for 51% of these costs. In addition, over $407,000 was spent on provider fees for managing these funds at the participant level. Seven hundred and nine (709) individuals or 124% of the goal received bridge funding assistance in FY 14. This is $3,140 on average for the number of people who signed leases in FY 14. Bridge funding availability is essential to this program; without it progress would be much slower---------over 40% of applicants had no income at time of referral.

2. Program Implementation

Program implementation refers to the State's ability to assist individuals in the target population to get referred for housing, get the services and resources they need to access available housing, live in their own homes and become fully integrated into the community. As referenced in last year's report, this task is very challenging. Historically, individuals in the target population haven't gotten opportunities to move into their own home which means staff may not be fully knowledgeable or familiar with supported housing. Likewise, individuals with a severe and persistent mental illness are often labeled “not ready,” “needing structure” or incapable of living on their own. This is true generally not just in Georgia. Or, if given the opportunity, they may get housing but may not be successful in retaining their housing and/or

remain very isolated in their community. Some referral sources such as PATH teams and some discharge planners have this type of planning built into their job requirements, are more adept and/or cognizant of assisting with transitions; for others, such as correctional personnel, this may be more difficult. Likewise, there are significant barriers to accessing affordable housing at this scale for this target population.

For this review, program implementation was measured quantitatively with program documents (DBHDD and DCA), referral information and housing stability outcomes, other information prepared by the DBHDD and DCA staff and qualitatively through key informant interviews and home visits.

Referrals

Referral patterns for the GHVP have remained consistent with patterns from the three earlier years even as the overall number of referrals has increased substantially: from 589 in FY 13 to 921 in FY 14. Individuals who were homeless at the time of referral comprise 47% of all referrals. Referrals from hospitals increased numerically (from 196 in FY 13 to 304 in FY 14) and remained essentially the same as a percentage of the total (from 17% in FY 13 to 16% in FY 14); referrals from intensive residential settings were down significantly as a percentage (16% to 8% from FY 13 to FY 14) but numerically remained essentially the same, 156 referrals from FY 13 to 155 in FY 14. Referrals from families also increased from 8% in FY 13 to 13% in FY 14. As expected, Region 3 had the highest number of referrals (581 or 30%). Referrals of individuals who are homeless from Region 3 accounted for 70% of Region 3's referrals and this number represents 40% of referrals of individuals who are homeless across all regions. Regions 1,2, 4 and 5 have a much higher percentage of referrals from family and friends, 87% of all referrals in this category, and 91% of all referrals in the rent burdened category. Referrals from CSUs (and CAs) and PCHs and GHs remain low, 1% and 6% respectively.

Referrals from jails and prisons increased from "5" over a three year period to twenty---six in FY 14. But this number is only part of the story. It is difficult for individuals who are incarcerated to get referred, get an ID upon release, make a housing choice, go through an eligibility process(es) and move before release from a correctional facility or jail. For jail releases, the issue is often related to how quickly release decisions are made by the court and often with little or no notice. For prisons, the difficulty is more often related to the reality that individuals are not routinely sent to prisons near their home so it is more difficult to make discharge arrangements if a person is moving across the state when released. Regional Transition Coordinators estimate an additional ninety---eight individuals (above the number listed above) were released from jails and prisons in FY 14 and were referred to the GHVP within thirty days.

This increase appears to be directly related to the emphasis the DBHDD has placed on these referrals, including DBHDD's work with Behavioral Health Coordinating Council (BHCC) and work at the regional and local level with Sheriffs and Judges, jail and correction personnel and diversion staff in selected jails to develop better transition protocols and referrals. Specifically, Regional Transition Coordinators are forming stronger relationships with Department of Corrections personnel at Valdosta and Zebulon and in the Fulton and DeKalb jails along with Atlanta Legal Aid. Regional Transition Coordinators and providers have become very

resourceful first in getting referrals so individuals can move directly into housing when released. The Coordinators tell individuals who qualify for the program or corrections personnel know to call them as soon as a person is released (in situations where they know they may not be able to make a direct referral) so they can at least complete the referral process at that point. Sometimes providers also help individuals find a place to stay while supported housing arrangements can be made.

DBHDD is employing a "housing first" approach for many individuals being referred, meaning referrals come directly from homeless outreach, from hospitals, CSUs or intensive residential programs without first being "transitioned" through group living arrangements. As referenced last year, DBHDD has not made a policy decision that people need to live in "structured" settings first before moving into supported housing arrangements. However, a "brief" transition may have long term benefits especially for jail and prison referrals. In addition, DBHDD should continuously re---evaluate if any sub---population or "status" group is being under referred consistently such as individuals with a forensic status at admission to a state psychiatric hospital. This item will be discussed later in the Recommendations section.

The second group of referrals are individuals residing in group or personal care homes. Combined, these groups only represent 7% of the referrals to the program. While it is true these settings are more community like than larger institutions, they have often been referred to as “transitional” when in reality people stay there because they or their providers do not believe they are capable of living in their own home.

The DBHDD has entered into a working relationship with the VA Homeless Veterans programs to assist individuals in the Settlement target population who qualify for VASH vouchers to get a VASH voucher rather than having to use limited GHVP resources. However, most homeless veterans could also qualify for Support Services for Low---income Families (SSVF) thus gaining access to resources including security deposits and back rent. In FY 13, five organizations in Georgia were awarded over $5.5 million combined in SSVF funds and these resources are expanding each year. In FY 14, fifty---three individuals got $24,672 in Bridge funding. In FY 15, DBHDD should explore the potential to reduce this funding to only individuals who do not qualify for SSVF funds. The DBHDD has consistently maintained good working relationships with CoCs. CoCs and local homeless programs have benefitted from the GHVP because otherwise they would have had to tap their scarce resources for rental assistance (when available) for individuals who were homeless. In FY 14, 880 individuals who were homeless were referred for a GHV.

Section III.B.2.c.ii(B5) of the Settlement Agreement requires the state to "provide housing supports for approximately 2,000 individuals in the target population with Severe and Persistent Mental Illness (SPMI) (by July 2015) *that are deemed ineligible for any other benefits...*" This section has been repeatedly referenced in earlier reports, as many individuals in the program are eligible for other benefits. Individuals not having benefits when referred is not the same as their being ineligible for benefits. It is also the case that getting into the GHVP helps a person be in a better position to get benefits, in part, because if a person isn't stably housed, their getting through the eligibility and award process is often more difficult.

It is to DBHDD's benefit to build strong reciprocal working relationships across systems, even those with housing resources. However, the state may want to consider a policy that the GHVP is always the last not first option, thus assuring GVHP resources are available to those who are going to be deemed ineligible for other benefits.

Housing Access and Stability

Housing stability is measured by DBHDD at the six month mark, which is the same measure HUD uses to measure housing stability (# < 6 mos leaving/ # > 6 mos in housing). HUD's standard is 77% at that mark and the state was at 92% or 15% above that mark for new tenants in each of the first four years of implementation. DBHDD also set their own standard for reengagement of "negative leavers" at 10% and has exceeded that standard by 7% with 17% of negative leavers being reengaged in FY 14. HUD uses this standard to measure Public Housing Authority performance but not necessarily to measure stability of renters. In addition to measuring tenure, it is also essential to monitor negative leavers for trends.

As previously referenced for purposes of this Settlement Agreement, it would be helpful to measure stability for the short term but to assess tenure over the long term and measure the performance of the program. In FY 14, DBHDD reported on longer term housing stability as follows:

FY 2011 Program Participants:	89 out of 117	76%
FY 2012 Program Participants:	384 out of 505	76%
FY 2013 Program Participants:	318 out of 375	85%
FY 2014 Program Participants:	548 out of 577	95%
Total Placed:	1,339 out of 1,574	85%

Even though it is difficult to make comparisons across states, these longer term percentages are within the acceptable range for a state funded housing first supported housing program. With transitions to the DCA HCV program, the GHVP percentage dips to 85% when it is actually closer to 90% over four years. Maintaining 85% is a desirable long term goal.

Taking supported housing programs to scale across an entire state is a very daunting task. It becomes an even greater challenge if the program experiences a great deal of turnover or if referrals are slow, which can happen if referring organizations are either not well organized or not convinced the program can work for the target population. Or this may happen because of the paucity of quality affordable housing in many communities, many individuals not meeting background requirements for leasing their own apartments or some owners not being willing to include utilities in rent which would enable more individuals with "zero income" to get into units under the Fair Market Rent (FMR) rent threshold.

DBHDD reports that nearly 45% of participants have zero income at time of entry into the program. Some owners will rent to GHVP participants but only if they can get rent above FMR and in some communities there is a limited stock of acceptable multi---family rental units. As stated above, DBHDD is firmly committed to "housing first" and is making a good faith effort to make this work but housing supply and zero income obstacles have to be overcome to make

this happen even when DBHDD and providers are willing to transform their approach to make "housing first" more real.

Providers are challenged with shifting their staff's skills to supporting individuals in their own home. This is a result of their not having done much of that type of work before or because they are much more accustomed to operating group residences, which requires different skills sets, approaches and knowledge. Often this is described as providers having a different philosophy, believing in a continuum approach, where people move from institutions or homelessness to group residences where they are "supervised" or need "structure" before moving on their own. Regardless of the reasons, skills and knowledge or philosophy, the need for a consistent presence (DBHDD Regional and state staff), training and coaching can close the gap between the desired outcomes of this program and current provider knowledge, skill and philosophical differences with this approach.

One reliable qualitative measure for assessing program implementation comes from interviews and site visits. In 2013, this reviewer made three home visits with three relatively new GHVP residents in the Savannah area served by a Gateway ICM team. This year, five home visits were conducted in Fulton County; participants selected are served by three different agencies providing ACT services in Fulton County: Grady, Viewpoint and GRO. In 2013, the DBHDD arranged the home visits. This year participants were randomly selected. The selection was stratified to assure visits would be conducted with at least one person who had been referred from a jail or prison, one who was homeless and one referred from a hospital. Selection was also stratified by agency and by gender. Chris Gault, Assistant Commissioner at DBHDD accompanied the reviewer on each visit and at least one staff person from Viewpoint, GRO or Grady met the reviewer at the person's home. The 2013 visits revealed important essentials about the program described through the narratives of the participants; the same occurred with this sample.

The participant's life situations were highly individualized but participants expressed common goals and challenges and their histories had common themes. There were also similarities to the 2013 sample:

- All five participants had multiple periods or an extended period of homelessness, hospitalizations and/or residential treatment. Three out of five were either jail referrals or had been incarcerated in the recent past.

- Several self reported histories of drug and alcohol abuse and recovery were an essential element of their recovery. In both years, one of the participants was relying on AA and/or NA for their major support system.

- Most had few possessions and had lost their possessions. They were all improvising and problem solving to survive and get on with their lives despite a lack of resources; several having to struggle to get an i.d., appealing to get SSI or, in one situation, having to report to a jail release program daily after being convicted of two felonies and

several misdemeanors. MARTA was their major transportation source and all reported getting "rides" from an ACT team member or, in one case, family.

- All mentioned they were cooking for themselves although their diets seemed limited; two individuals were living at Welcome House where there was a shared kitchen and one found a way to get some meals while attending several programs.

- Getting a job was a high priority for three of the individuals as it had been for two participants in the group seen last year. Losing SSI benefits did not appear to be a deterrent. Several reported either getting help from the ACT Team's job specialist or knowing help was available and one participant was hoping to get certified as a Peer Specialist.

- Most described acquaintances but nearly all appeared isolated either by choice or necessity. While there wasn't time in the interview nor would it have been appropriate to explore in depth, several participants in both this and last year's group had likely experienced highly abusive situations and/or had suffered trauma.

- Two individuals were living at Welcome House, a 209 single and double "room" unit building with shared kitchens and bathrooms located in downtown Atlanta for very low income single adults. Welcome House does not meet all of the desired characteristics of supported housing as referenced in the Settlement Agreement or any standard definition of supported housing although it does fill a niche for "short term transitions" for individuals who have been homeless, in jail or shelters for a short period of time.

  Welcome House is staffed 24 hours a day with some limited programs. The facility is well maintained and operated by Project Interconnections. The two gentlemen we visited were there primarily because they could not yet qualify for GHVP. One was having difficulty getting documentation but a Judge denied his request to change residence. Welcome House is a safe decent place where people can live temporarily until they can get access to Supported Housing, it fills a niche for short term rental housing and seems appropriate that individuals can live there for a limited period of time particularly if they are transitioning quickly into the GHVP. However, a "single room" is not an apartment. It is recommended that an exception policy be developed for use of GHVP funds for rent at any facility similar to Welcome House that doesn't fully meet the Settlement Agreement definition of Supported Housing. It is further recommended that criteria for what type of housing qualifies for this purpose be developed.

The individuals we visited have experienced failure and either periods of homelessness, hospitalization, residential treatment and/or incarceration. They clearly fall into the target population and without help and support------both formal and informal------ they will experience many more difficulties and life challenges. For different reasons, they are all good candidates for supported housing; they would not likely succeed or stay long in more traditional group

residential living. Perhaps the most isolated and least verbal participant was clear about not liking attending a day program previously. However, all five will need expert medical and psychiatric treatment, recovery and personal support. At least one individual could benefit from psychotherapy. Most are good candidates for peer support and one could be a good candidate to provide support in a "wellness" setting.

As reported in 2013, peer support would need to be tailored because while one person we visited needs support to maintain sobriety, one participant needs support from someone who can help him overcome traumatic life events and another wants to be active with the Wellness Center in Decatur. In each of their situations, housing is a stabilizer but won't be enough for them to succeed. Only one of the five appears to have a major chronic medical condition.

One other issue surfaced during the site visits. Staff, including a program supervisor, of one of the Fulton County ACT providers were significantly challenged with understanding and being able or perhaps interested in incorporating basic recovery, person centered planning core principles and best practice supported housing interventions into practice. Staff repeatedly referenced a person we were visiting as needing "structure" before he would be "ready" to move into housing. During a discussion before we met the person served by this provider, staff referenced the person as not making any progress with hygiene and "ADLs", not being safe to "live on his on" nor ready because he apparently gave food away when living on his own earlier. The staff's approach to the person revealed that staff had done little to build a trusting relationship or to understand what assistance he needs to transition from being incarcerated for ten years. The consumer's hygiene appeared satisfactory and, when given the opportunity, he was able to verbalize some simple goals. If explored, these goals could form the basis of his recovery plan. It has been reported that this provider is meeting basic ACT requirements (DACTs). However, DBHDD should determine if this provider's performance meets basic provider expectations going forward and determine if consumers being served by this provider are being provided an acceptable level of service.

This incident, coupled with this reviewer's overall impression, points to DBHDD needing to take additional steps to monitor supported housing provider performance beginning with doing supported housing fidelity and quality reviews that include routine site visits. This type of review should not be done separately from an ACT, ICM or Supported Employment review as these services are inter---connected. For example, person centered planning, motivational learning, community skills development don't have service boundaries------interventions are approached the same across three different services, only the specific tasks or points of reference change. This is also covered under the Recommendations section of this report.

Provider Capacity

As referenced above, the behavioral health care system must have the capacity to provide recovery---oriented services and in---vivo supports that are focused, highly individualized and well organized. If the system has this capacity, supported housing is a means for consumers to meet their life goals. ACT provider capacity is complicated because by definition, individuals qualifying for ACT services have likely not been as willing to be engaged in treatment, have had

more prolonged and severe psychiatric symptoms, experienced more catastrophic life events and whose recovery is more challenging because they lost so much in their lives, in some cases their cognitive skills or often their health, and often are alienated from their families. Recovery is a long and sometimes uneven process which is why ACT services are designed and reimbursed to serve people with higher levels of need. This does not mean ACT clients should not be referred for Supported Housing---------just the opposite is true.

ACT staff must apply their engagement, motivational and cognitive re---structuring skills among other skills to assisting a person to get and keep their housing. Individuals served by ACT are less likely to have funds, will need assistance to get disentangled from the criminal justice system, need assistance to restore their identify and re---gain their motivation if they have been homeless, incarcerated or institutionalized.

As referenced in 2013, DBHDD recognizes the need for providers to receive ongoing training and support to be successful. Supported housing practice and skills training needs to be embedded into training planned for ACT, ICM and CM------not compartmentalized and separated. If supported housing is considered "outside" or an "add on" rather than an integral part of their work, it will be less effectively implemented. ACT, ICM and CM providers will need to consider what "practice changes" they need to make to successfully assist people to move into housing, get jobs and keep them. It is even more apparent now that DBHDD's supported housing program can not be so separated organizationally or in its operations, provider expectations, including performance, and quality review approaches.

3. Program Expansion

Perhaps the greatest challenge in meeting and sustaining Settlement Agreement supported housing targets is taking supported housing to scale so individuals with SPMI who need supported housing will have access to it. Georgia's obligation in the Settlement Agreement is that "By July 1, 2015, the State will have the capacity to provide Supported Housing to any of the 9,000 individuals in the target population who need such support. The Supported Housing required by this provision may be in the form of assistance from the Georgia Department of Community Affairs, the federal Department of Housing and Urban Development, and from any other governmental or private source."

This section includes a summary of program expansion in FY 14 and a summary of Georgia's progress and plans to meet the above referenced obligation. It includes references to a "Supported Housing Capacity Report to the Georgia Department of Behavioral Health and Developmental Disabilities " conducted by the Technical Assistance Collaborative at the request of DBHDD[6] to assist the DBHDD to assess the "State's capacity to provide supported housing to the target population in the settlement Agreement", "how to define who" is in need of

[6] This reviewer is employed by the Technical Assistance Collaborative but did not participate or contribute to this report, reading it only after it was submitted to the DBHDD. The reviewer did participate with the Independent Reviewer in recommending the scope of the review.

supported housing and "define areas for training for DBHDD Regional staff and providers on issues related to permanency and preservation for the Settlement population"[7]. The Report does not estimate need but rather what needs to be considered and defined to assess and determine need. References to information and recommendations of the report will be noted as such. A copy of this report is attached.

Additionally it is important to recognize that Georgia, like most states, is experiencing challenges in the availability of decent, affordable, accessible multi---family rental housing. PHA budgets remain tight and, as reported last year, rental housing prices are continuing to rise. The monthly cost for a one bedroom market rate rental unit in Georgia is equal to 93% of an individual's SSI monthly check and in the Atlanta and Savannah Metropolitan Statistical Areas exceeds 100% of an individual's SSI check.[8] In many rural Georgia communities, Regional Transitional Coordinators report there is simply not available affordable, decent multi---family rental stock. These issues have to be carefully considered when measuring the state's ability to secure affordable housing for the target population.

Housing Resources

The DCA Housing Choice Voucher Program (DCA HCVP or HCV) expansion began two years ago and provides needed housing resources in areas of the state where these resources are the primary HCVs available. In 2012, the Georgia Department of Community Affairs (DCA) received approval from the US Department of Housing and Urban Development (HUD) to provide preferences in the HCVP for individuals with "specific disabilities" identified in this Agreement. This approval is in force until July 1, 2015 and DCA has agreed to allow this preference for up to 50% of their turnover units (DCA's total HCV capacity is 16,936) during this period of time. This is a significant opportunity but comes with several challenges. One, the DCA HCV program operates mostly in rural areas. Rural counties have both fewer staff resources to undertake such a program and during the past two years had lower turnover than anticipated. By the end of FY 2014, only 113 individuals had been transitioned to this new program and, at this rate, less than 250 people would be able to take advantage of this program by July 2015. The program is more complex to operate and access than the GHVP. As a federally funded rental program, it has more requirements than the GHVP and is more cumbersome to navigate, regardless of current attempts to simplify for this Settlement Agreement. But both DCA and the DBHDD had hoped for a much higher number of referrals.

Initially, the number of GHVP rental units were not meeting required Housing Quality Inspections (HQS) at the time the units were to be transitioned from the GHVP to the DCA GHVP as required by HUD for HCVs. There was a problem with the number of units that were being rented in the GHVP above maximum (110% of Fair Market Rent) rent payment standards. Both of these problems have been reduced; however, the HCV transitions have been slower than expected. Historically, providers have conducted the GHVP housing inspections rather

[7] "Supported Housing Capacity Report to the Georgia Department of Behavioral Health and Developmental Disabilities": The Technical Assistance Collaborative, July 2014.
[8] *Priced Out* , The Technical Assistance Collaborative, 2012

than trained, certified HQS inspectors. DCA reports that the inspection process has improved but with the increase of providers and property managers/landlords, it is recommended the housing inspections for the GHVP and the DCA HCV be managed by the DCA. Paying higher rents helped the DBHDD lease up the GHVP faster but it came with a downside when attempting the transition. Other steps have been taken to intensify the referral process and to ensure that Regional Transition Coordinators and service provider staff are fully cognizant of the HCV requirements and able to make timely successful referrals.

The June 2014 GHVP---HCVP summary revealed that, in some months as few as one to two applications were submitted but there were 26 applications submitted in June 2014. The number converted was six or less each month for the past eight months. More referrals have been submitted from Region 1, 2, 5 and 6 where the DCA HCVs are more available. The summary reveals that HCV applications are submitted very slowly and that there is a fifty day gap between when a HCV application is signed by an applicant and when DCA receives the application from a provider. It takes on average another twenty---seven days for a voucher to be issued by DCA. At the time of the June report, 198 applications had been received by DCA with thirty---one being processed and fifty---one either having been withdrawn or terminated. DBHDD and DCA held a "boot camp" in FY 14 for Region 4 providers, regional staff and DCA staff to map out responsibilities and action steps and set targets for leasing within a specific time frame------ their referrals increased dramatically thereafter. DBHDD is planning a second "boot camp" in FY 15.

Working agreements with CoCs, PHAs, the DCA and the VA
Four groups, Continuums of Care (CoCs), which are homeless services planning consortiums, Public Housing Authorities (PHAs), the Veterans Administration (VA) and the DCA, have access to plan, plan for and/or fund affordable housing. DBHDD and DCA are working jointly on CoC partnerships and DBHDD has taken significant steps to increase referrals to the VA's VASH program. As referenced above, the DBHDD made an agreement with the VA to use Bridge funding for some VASH referrals. Both the DCA and DBHDD work with local CoCs to create more housing opportunities. The DBHDD and DCA have also agreed to step up their efforts to engage local PHAs to also enter into "preference" agreements with HUD to access HCVs. This would likely need to happen on turnover in the same manner the DCA HCV program is operating. DCA has considerable leverage with PHAs and should take the lead in this endeavor. HUD is more likely to agree to this type of arrangement while Georgia is still under a remedial agreement with the Department of Justice so the initiative should be a priority for FY 15.

In FY 2013, Georgia was one of the first thirteen states to be awarded an 811 PRA Demo award. This program will be managed by the DCA but DBHDD is a full partner in this new modernized 811 program. The program is slated to get started this fall. DCA will receive funds for 150 permanent project based rental subsidies. Therefore, individuals in the target population will have access to project based rental assistance in selected tax credit properties through a partnership agreement with DCA. While the 811 PRA program is a great opportunity, it is also somewhat complicated to implement, especially to ensure that referrals of individuals covered by the Settlement Agreement are made in a timely manner. DCA projects this target

population will get 50% of the PRA 811 assistance. After a review of the application protocols, this percentage appears highly doable, but not without a great deal of work by DBHDD at all levels. It is also important that the criteria for the referral process requirements be communicated to owners and property management in sufficient detail to ensure that consumers have a choice of provider, that services are not mandatory and that they are delivered consistent with Settlement Agreement requirements.

Infrastructure and Program Capacity

DBHDD has built a solid infrastructure for the GHVP and Bridge Funding program. Sixty four contract providers are delivering services to people moving into newly developed (or turnover) housing arrangements in 661 different properties. The state is required to expand the program by another 600 units in FY 15. Taking these programs to scale, sustaining them is requiring expanded infrastructure, increased provider capacity and performance, the ability to secure additional safe, decent affordable rental units. The infrastructure issues and overall scalability of the program is heightened exponentially when the state begins adding additional housing resources including, but not limited to, the DCA HCV, additional PHA HCVs and 811 PRA.

DBHDD staff recognize that their current Supported Housing program needs to evolve and expand to meet the demands of the program and the Settlement Agreement. DBHDD housing staff, as reported previously, carry out duties ranging from filing, assuring monthly rent obligations are paid, working with staff in each region------both Regional staff and providers on routine matters ------ plus trying to make and manage new housing connections to enable the program to grow. The GHVP doubled in size in the last fiscal year and is required to do the same again this year. In addition, DBHDD and providers are required to do housing eligibility re---determinations annually, which adds to the ever expanding workload. A staff person has been added to the DBHDD program to assist with this effort.

Perhaps the most encouraging sign of the DBHDD capacity to achieve its targets and sustain the program is the increasing capacity and performance of the Regional Transition Coordinators. They were key to DBHDD successfully managing the GHVP growth over the past year, increasing jail and prison referrals and building stronger ties with landlords and property managers. They are cognizant of housing specific matters such as the variance in quality and availability of multi---family housing in their region, the steps that need to be taken to transition a person from a GHV to a DCA Housing Choice Voucher. They are adept at handling eligibility requirements, working with providers to improve their performance and working with referral sources to solicit their support in transition plans. Although there isn't quantitative data to back up this assertion, they appear to be one, if not the primary, reason for the program exceeding at this higher level of performance, especially in Regions with fewer resources and the greater need for more "creativity" to make the program successful.

Achieving a higher level of supported housing capacity requires constant relationship building, and a well organized and executed cross service initiatives, cross systems plan. Each group/ organization has different requirements (statutory, regulatory and local), management staff at the state and local levels, mandates and housing contract arrangements. As referenced in last

year's report, tracking and ensuring people get routed to programs that they qualify for and that match their needs will likely require even more sophisticated technology and staff support at the state and regional level than is currently in place even with the current program operating at a very high level. The Regional Transitional Coordinators already play a huge role in this endeavor. Supported Housing cannot be an insular operation. Based on this review, service providers need to perform their tasks at the highest level possible with less separation across ACT, ICM, Supported Employment, Peer Support and Supported Housing and DBHDD leadership will need to continue to embrace cross system partnerships and operations. There are limits to the success of in---house operations.

Recommendations

The findings section of this report refers to a number of issues that merit recommendations. There are a number of recommendations embedded in the findings section. Below is a summary of seven broad recommendations:

1. Further develop and sustain Supported Housing capacity through the DCA---DBHDD Partnership: The state has made good progress to develop capacity but creating capacity for up to 9,000 individuals in the target population who are in need of supported housing is a daunting task that requires multiple strategies. It begins with sustaining the program at the level required by this Settlement Agreement in 2015.

   There are many small or incremental steps DBHDD and DCA can take to achieve capacity. This reviewer discussed those with DBHDD and DCA during two site visits in July and August 2014. Below are recommendations for the two agencies to increase housing resources for the target population and to sustain capacity to the highest attainable level possible:

   A. DBHDD and DCA should establish a broad written memorandum of agreement to include a set of "actionable" goals to take effect prior to June 30, 2015 to meet current commitments and expand Supported Housing resources in at least six areas as follows:

      1.) DCA should request an extension of the HUD approved Remedial Tenant Selection Preference Agreement to enable the state to meet their future *Olmstead* obligations including meeting capacity of up to 9,000 individuals with SPMI as defined in the current Settlement Agreement. The DCA and DBHDD should set targets for this extension.

      2.) DCA should request Public Housing Authorities to consider a modest set aside of turnover HCVs over a three year period per the TAC report (in addition to the preference arrangement referenced in the 2014 DCA QAP) to further the state's ability to meet its *Olmstead* obligation and goals.

      3.) DBHDD should examine their current working agreements (across each initiative) and refine them to assure adequate resources are in place to maximize the HUD approved Selection Preference Agreement, to meet the 2013 811 PRA and the 2014 811 PRA (if

awarded) requirements and to meet any additional arrangements to implement the 2014 LIHTC program Integrated Supported Housing and Target Population Preference.

4.) DCA should assure that each project awarded Low Income Housing Tax Credits implements an Affirmatively Furthering Fair Housing Marketing Plan that meets the intent of the DCA policy for owners/property managers to affirmatively market units to the SPMI population as "tenants with special needs." This includes each selected LIHTC Applicant providing reasonable accommodations for tenants with special needs who are also in the Settlement target population.

5.) DCA and DBHDD should continuously evaluate the need for expanding housing resources. For example, the number of projected units that can be set aside or targeted for the target population following the awarding of 2014 LIHTCs and HUD's awarding 2014 811 PRA will be known later this fall. This will give the DCA and DBHDD a more precise idea of their potential expanded capacity for at least the next 24---36 months depending on award and production schedules. At that time, DCA and DBHDD should examine what additional options they could pursue with the LIHTC or other programs.

6.) The DCA should assume responsibility for GHVP inspections, which consolidates this function in one place. There may be other functions that need to be consolidated across agencies to maximize sustainability as the program continues to grow. For example, 811 PRA referral processes should be the same or as similar as possible with HCV referrals; DCA and DBHDD should work out how housing search will work simultaneously across these two programs.

2. DBHDD should request an expansion of the GHVP and Bridge funding for FY 2016 to narrow the gap between projected need and the capacity to sustain the Settlement Agreement gains.

3. DBHDD should assess the potential for increasing referrals from hospitals, intensive residential settings, group homes and personal care homes. The number of referrals from hospitals and intensive residential settings has increased but the DBHDD depends on referrals from discharge planners and may be unaware of the potential for more referrals. DBHDD should be constantly targeting these settings for referrals. The same is true for personal care and group homes where low numbers of individuals being referred may or may not reflect the true need or that consumers are given a choice to move. It may be more a reflection of perceived "readiness" or concern on the part of providers that they may lose revenue. Arguably, individuals living in stable living situations would be lower priority in most systems; however, to not provide the opportunity is denying a person a choice of living situations. Therefore, reviewing the potential for more referrals based on true need and choice as well as the long term potential for conversion of resources is recommended.

4. DBHDD should assess need. Assessing need for supported housing is a complex process and many factors need to be taken into consideration. These include: a.) the extent to which individuals are already living in supported housing or stable housing integrated into the community; b.) the number of individuals who qualify for supported housing actually choosing housing options such as living at home with family or finding a place of their own to live; c.) the extent to which individuals are routinely given the opportunity to choose supported housing rather than a more segregated option including remaining where they are living; and d.) the extent to which providers are skilled and knowledgeable about assisting individuals to learn how to access housing and live successfully in their own home "after" not "before" they move in. Sometimes opportunity is related to a person's "perceived" need by a referral sources or their provider and sometimes it is related to a person refusing services and not being aware of this opportunity.

   TAC explored these issues with DBHDD. TAC's assessment of these issues was thorough and provocative in a positive sense. DBHDD must now decide how they will proceed with determining need. DBHDD will have to put a system in place to assess housing need routinely, keeping four issues in mind. One is that individuals be given "informed choice" in selecting among options of where to live on an ongoing basis beginning when individuals are identified for services whether they be hospitalized, in an CSU, are homeless, incarcerated or living in a group or personal care home. This will require DBHDD to establish a process whereby individuals living in group settings are given the option for supported housing.

   The second is to establish objective criteria for determining the need to reduce potential bias toward individuals being placed or having to stay in more segregated settings longer than necessary. TAC provided a method and a criteria based approach. Experience would indicated that individuals across four LOCUS levels of care (1---4) could be successful in their own home given the right level and type of support. It is also assumed a number of individuals at Level 1 would not need supported housing but could live successfully on their own.

   Third, supported housing should be voluntary and made available to individuals regardless of their willingness to participate in any services program and housing opportunities should not be tied to any one provider. From experience it is assumed that well over half of the 9,000 individuals will qualify for supported housing but likely fewer in the 40---50% range will choose options other than supported housing.

   Fourth, a review and ongoing process will need to be established to determine a more precise estimate over time. Until actual supported housing choices are available and housing offers made, the actual need will not be fully known. Even then, there may be mis---matches between available housing (especially with such geographic differences in available, quality rental stock) and consumer choice. Needed capacity may always be somewhat of a theoretical construct even when resources are increased to match the perceived need.

According to DBHDD 4,500 individuals have accessed Settlement services to date. Estimates vary slightly between DCA and TAC on what supported housing resources are currently available but the number is approximately 4,700 when counting the GHVP, the DCA HCV, S+C and HOME programs, not including individuals with local PHA HCVs or individuals with VASH vouchers or HOWPA assistance. Assessing the projected program growth conservatively, it appears that with 811 PRA, GHVP FY 15 and DCA HCV additions capacity will definitely increase by 825 in FY 15 (assuming 811 PRA is implemented within that time period) bringing the total capacity to 5,525. If DCA and DBHDD are successful in securing additional remedial DCA and local PHA preferences, 811 PRA, VASH expands in FY 16 and FY 17, capacity could increase to approximately 6,000. With a 5% turnover annually, another 100 to 200 individuals could access housing although this does not increase net capacity.

5. Quality and Performance Improvements. This report provides relevant touch points for success of this initiative. These can be addressed individually but it is recommended the DBHDD put a quality management plan structure in place that includes performance goals and targets. The DBHDD Supported Housing program already complies data and tracks leasing performance, sustainability and referrals but this plan should not be isolated to the DBHDD Supported Housing unit or to DBHDD functions. It should include either service provider fidelity or quality reviews that include random routine site visits. Some items such as shortening the length of time from referral to "move in" should be done jointly with DCA, targeting an increase in the number and type of referrals or successful implementation of the PRA 811 initiative are examples of other options. Developing this type of approach is also a good vehicle for an annual review of the program's progress and for assessing and demonstrating substantial compliance with the Settlement Agreement.

6. DBHDD should establish a process for supported housing referrals for individuals with developmental disabilities and those with co---occurring mental illness and developmental disabilities. Many individuals with a developmental or intellectual disability are good candidates for supported housing and it is recommended a plan be made for these referrals in FY 15.

7. Make certain GHVP is a resource of last resort. The state has made reasonable efforts to assist individuals to qualify timely for benefits including SSI. However, as referenced above, there have not been any specific steps taken to assure that individuals being provided housing support have been "deemed ineligible for any other benefits." Individuals may not have been enrolled or made eligible at the time of referral, which is a different but important distinction, and steps the state has taken to ensure individuals get enrolled should not be overlooked as an important step to making Supported Housing possible for more individuals with SPMI. However, it is also important that individuals not going to be made eligible under any circumstance be given the first opportunity for supported housing assistance. Housing resources are limited and it is possible, not always easily, for individuals who are eligible for SPC, VASH or HCVs to get access to those other resources. The GHVP should always be "last dollar" unless getting into a stable housing setting is necessary to get

a HCV. DBHDD should create and promulgate a policy to adhere to this requirement.

8. Develop stronger ties across DBHDD programs. In last year's report, a recommendation was made to link the ACT, Supported Employment and Supported Housing strategies, operations, requirements, care management, fidelity or other reviews, expectations and/or training to build stronger ties among these initiatives to improve overall performance and outcomes. This year's site visits amplify the urgent need for stronger ties across these initiatives. The Assistant Commissioner's office at DBHDD should be the focal point for this work.

   In addition to combining the above referenced initiatives, it also is important to include Peer Support and Wellness opportunities in this mix. Individuals moving into their home are continuously making decisions about how they will organize their day, find ways to integrate back into their community, establish relationships and a support network. Some may be leaving very structured settings where decisions and daily routines were established for them or exiting homelessness where few if any opportunities existed. Most individuals express wanting more flexibility and opportunities in their lives but are challenged to make this happen------peer support is often the most effective, least obtrusive means for helping people sustain their housing and lead even more successful lives in the community.

Lastly, perhaps the most revealing information from this review was the uniform response from staff and participants of the value of Georgia's Supported Housing Program. This resource is viewed by consumers as not just a rental program but a raison d'être for optimism for their future, often even after many failed attempts to live on their own in the community. Staff share this optimism. In July 2013, this reviewer visited three men in the Savannah area, all with significant disabilities; all three are still living in their home, doing well and at least one has a job. Their hope for their future becoming real. Georgia is setting high goals for this program, they are methodically achieving their goals all the while recognizing that instilling hope is the highest goal of them all.

Supported Housing Capacity Report to the Georgia Department of Behavioral Health and Developmental Disabilities

Final Report July 2014

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Georgia Department of Behavioral Health and Developmental Disabilities

TAC
TECHNICAL ASSISTANCE COLLABORATIVE

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Executive Summary

Background

In October 2010, the State of Georgia and the U.S. Department of Justice entered into a Settlement Agreement. Conditions of the Settlement Agreement require the State of Georgia to assist 9,000 people with mental illness who have co-existing medical, behavioral health, and/or co-occurring substance use disorders who are currently served in the State's hospitals, frequently admitted to state hospitals, frequently seen in hospital emergency rooms, chronically homeless, and/or being released from jails and prisons and people with developmental disabilities transitioning from institutions or who are at risk of institutionalization.

To assist the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) in its on-going efforts to help the State meet the terms of the Settlement Agreement, DBHDD contracted with the Technical Assistance Collaborative (TAC) to undertake an assessment of the State's capacity to provide supported housing to adults with serious and persistent mental illness (SPMI) who are part of the target population in the settlement agreement. As part of the engagement, TAC proposed to provide consultation to DBHDD regarding how to define who among those accessing settlement services is in need of supported housing and identify areas of training for DBHDD Regional Staff and providers on issues pertaining to housing permanency and preservation for the settlement population. TAC's scope of work for DBHDD under this contract was limited to assisting DBHDD in defining "in need of supported housing". It was not intended to estimate numbers of consumers covered through the settlement who are in need of supported housing.

Review of federal and state housing resources in Georgia

Through strategic planning and interagency collaboration, the State of Georgia has been successful in securing supported housing capacity available to meet the needs of individuals served by the settlement agreement, and it appears that many settlement class individuals are already accessing supported housing. The report identifies a potential pool of approximately 6,910 affordable housing units that could provide housing for eligible settlement class individuals "in need of" supported housing.

In the next three years it is estimated that over 4,000 persons will have access to affordable housing made available through rental assistance provided through the Georgia Housing Voucher Program (GHVP), a Department of Community Affairs (DCA) Housing Choice Voucher, DCA HOME Tenant Base Rental Assistance (TBRA), or U.S. Department of Housing and Urban Development (HUD) Section 811 Project Rental Assistance (PRA) in a DCA-financed Low Income Housing Tax Credit project. In addition, eligibility requirements for existing programs indicate a high likelihood that these resources are already housing a certain number of persons covered by the Settlement Agreement. With turnover and continued collaboration, it is likely that these resources will continue to be available for individuals in the settlement class.

Given the overlap in eligibility criteria for existing programs and units, TAC estimates that over the next three years approximately 1,300 persons covered by the Settlement Agreement will be

housed by the HUD Continuum of Care (CoC) Program for homeless persons with disabilities, existing HUD Section 811 housing for persons with disabilities or HUD Section 202 housing units for elderly and disabled individuals. Finally, with strategic and targeted outreach and engagement, the State could secure additional set asides or preferences with other Public Housing Authorities (PHAs) or Participating Jurisdictions (PJs). For example, the report suggests that by working with only three PHAs and two PJs, it is estimated that an additional 1,470 units could be secured.

The following chart summarizes the Supported Housing potential capacity in Georgia over the next three years. A more detailed analysis and description of each available affordable housing program is discussed in Sections One and Two.

TOTAL SUPPORTED HOUSING CAPACITY

	Current	Year 1	Year 2	Year 3	Total
Existing resources dedicated to settlement population	1660	1,115	656	633	4,064
Estimated capacity of supported housing currently housing individuals covered by settlement		1,250	63	63	1,376
Potential additional capacity through additional preferences		510*	480	480	1,470
Total Capacity	1660	2,875	1,199	1,176	6,910

*** INCLUDES 30 UNITS THROUGH HOME FUNDS, TABLE 15, PG. 26**

Despite the fact that there is supported housing capacity, however, much of the supply is occupied and timing access to existing or new housing for individuals who are in need of supported housing can take time. The report goes on to recommend ways that Georgia can increase its capacity of supported housing through HCVs, Section 811 funding or reallocation of existing state funds. For example, DBHDD could increase its supported housing capacity further by converting state-only resources in residential services into Medicaid funded services. DBHDD currently spends approximately $24 million in non-matched resources in residential programs. DBHDD has the Medicaid state plan in place to do this, and is beginning to address this. State funds saved as a result of additional federal financial participation could be re-allocated to support housing capacity, support non-Medicaid eligible individuals, or fund non-eligible housing support services.

Defining In Need of PSH

The Settlement Agreement requires DBHDD to determine who among the 9,000 individuals identified as part of the settlement class is in need of supported housing. Supported housing is defined in the settlement agreement as deeply subsidized, affordable housing that provides

tenancy rights, and an array of flexible community based services that are available (but not mandatory) to assist the individuals with accessing and maintaining housing.

TAC recommends DBHDD utilize the following criteria to determine who in the settlement class is "In Need of Supported Housing:"

1. Eligibility for Settlement Services:

    a. Core customer eligibility criteria;
    b. LOCUS scores of 1, 2, 3 and many with a score of 4 (with adequate support services) could live in supported housing. LOCUS scores of 5, 6 and some with a 4 would need other settings;
    c. Presence of functional limitations;
    d. Specific indicators of continuous high-service needs (ACT)

2. Preference: Consumer has indicated a preference to live in supported housing.

3. Prioritization

    a. Homeless or At-risk of homelessness (i.e. discharge from an institution such as hospital, nursing facility, ICF/DD, or jail with no placement option), those living in uninhabitable or substandard housing)
    b. Those living in short term or transitional housing with no tenancy rights or other discharge options

4. Exclusionary Criteria

    a. Choosing and able to live with family and/or friends;
    b. LOCUS score of 5 and 6 unless the supports needed as developed in a person-centered planning process can be provided.

DBHDD applies eligibility criteria for determining level of service needs for each of the settlement services. These include meeting Core customer eligibility criteria, use of the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS), presence of functional limitations, and specific indicators of continuous high-service needs in the case of Assertive Community Treatment (ACT). Additionally, DBHDD specifies a LOCUS score range (2-6) and documented financial need as eligibility criteria for Housing Supplement assistance.

Combined, meeting specific level of service needs (as determined through the LOCUS and resulting composite score) and meeting the criteria for Housing Supplement assistance constitute basic eligibility for supported housing using a DBHDD funded rental subsidy (GVHP). Individuals may access other supported housing opportunities which are not funded by DBHDD and are described in Sections One and Two. Each of these state or federal housing programs provide leased based housing with tenant rights and most of these opportunities meet the supportive housing setting requirements as described in the Settlement Agreement.

Approximately 4,500 individuals have accessed settlement services to date. DBHDD reports that 84% are housed. It is not expected that all of the individuals will need supported housing. Most will choose to live with family or have other desired and acceptable housing arrangements. Depending on the availability of affordable housing resources in a given region, DBHDD may need to further prioritize to ensure those most in need gain access to supported housing.

Among all of those who are eligible, those most in need of supported housing are individuals who are homeless or at imminent risk of homelessness. At risk of homelessness includes individuals soon to be discharged from an institution (including hospital, nursing facility, ICF/DD facility or jail) with no home or other discharge placement, and those living in uninhabitable or substandard housing. These individuals should be prioritized for available supported housing opportunities. Other individuals in need of supported housing are those living in short term or transitional housing with no tenancy rights and no other options upon discharge.

Through the data reported on the Monthly Programmatic Reports, DBHDD can identify the current housing arrangements of those actively receiving settlement services and note trends to project possible estimates of those in need of supported housing, and those who will not need it. Data on living arrangements for individuals receiving services for 30 days or more are captured through Sections C or D (Living Arrangements) of the Monthly Programmatic Report. As such, data will only capture those individuals who are still receiving one of the settlement services, and not include those who have accessed one of the settlement services in the past and are no longer engaged with the service.

Training to maximize housing permanency and preservation

Through the facilitated focus group and discussion with DBHDD leadership, an important area for training emerged. The current system relies on functional assessment at the time of intake in directing placement whereas the role of choice should have increased importance in determining housing needs and options.

Common practice when deciding what housing option to pursue seems to be based on assessed or perceived competence in general skill areas associated with independent living (most mentioned basic ADLs, safety related issues, and taking medications). From this assessment, a determination is made as to what type of housing is most appropriate and whether a referral is made to supervised residential services or the GHVP. A person's choice or preference was not referenced as a primary factor in making housing referrals.

The assessment process described by most participants in the focus group emphasized staff determining an individual's "housing readiness" to live independently in the community. This type of approach potentially screens out individuals who, with support, could live in supported housing. Individuals assessed as not having the skills necessary to live independently at the time of intake are determined to need more supervised residential services. Yet, the support needed to live successfully in community based supported housing is available through the array of settlement services. This includes the level of assistance needed by individuals with challenging and complex clinical profiles and functional limitations. Competencies necessary to live independently can be accommodated or taught through various psychosocial and evidence

based interventions. The addition of crisis services further enhances the system's capacity to adequately support many individuals in supported housing who may be assessed as lacking in housing readiness.

Section One: Background and Approach

In October 2010, the State of Georgia and the U.S. Department of Justice entered into a Settlement Agreement. Conditions of the Settlement Agreement require the State of Georgia to assist 9,000 people with mental illness who have co-existing medical, behavioral health, and/or co-occurring substance use disorders who are currently served in the State's hospitals, frequently admitted to state hospitals, frequently seen in hospital emergency rooms, chronically homeless, and/or being released from jails and prisons and people with developmental disabilities transitioning from institutions or who are at risk of institutionalization.

To assist the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) in its on-going efforts to help the State meet the terms of the Settlement Agreement, DBHDD contracted with the Technical Assistance Collaborative (TAC) to undertake an assessment of the State's capacity to provide supported housing to adults with serious and persistent mental illness (SPMI) who are part of the target population in the settlement agreement. As part of the engagement, TAC proposed to provide consultation to DBHDD regarding how to define who among those accessing settlement services is in need of supported housing and identify areas of training for DBHDD Regional Staff and providers on issues pertaining to housing permanency and preservation for the settlement population. TAC's scope of work for DBHDD under this contract was limited to assisting DBHDD in defining "in need of supported housing". It was not intended to estimate numbers of consumers covered through the settlement who are in need of supported housing.

TAC conducted a review of the federal and state housing resources available in Georgia as well as telephone interviews with key stakeholders regarding access to these resources, availability of additional resources, and common access points to affordable housing resources. This review included participation in a focus group with DBHDD Regional Staff and DBHDD funded ACT teams. To assist DBHDD to identify who in the settlement class may be in need of supported housing and to identify areas for training, TAC reviewed settlement documents and existing service description and programmatic reporting forms, met with DBHDD leadership, and facilitated a focus group with DBHDD Regional Staff and ACT provider staff to learn about processes and practices related to referral for services, housing needs assessment, housing referral and assisting consumers to access and maintain housing. TAC also discussed with DBHDD opportunities that may be present within the existing residential services system to create movement through these programs and maximize existing DBHDD funds within that system to best meet the permanent housing and community based services needs of individuals.

Section Two: Housing Capacity Assessment

Essential Elements of Housing

Many people with significant and complex disabilities, including those covered by the Settlement Agreement, can live in integrated, community settings. To ensure community living is successful the housing needs to be: (1) affordable; (2) meet acceptable standards of quality; and (3) be located in communities that provide needed systems of care and community supports.

Affordability

Nationally, people with disabilities have disproportionately extremely low incomes. In Georgia, this gap between income of people with disabilities and likely rent for a housing unit reflects the national situation. In 2014, an individual with a disability in Georgia receiving Social Security Income (SSI) benefits is equal to $721 per month. The generally accepted standard for housing affordability is to pay 30% of income toward housing costs. On a statewide average in Georgia, people with a disability receiving SSI benefits would have to pay 85% of their monthly income to rent an efficiency unit and 93% of their monthly income to rent a one-bedroom at the Fair Market Rent (FMR), published by the U.S. Department of Housing and Urban Development (HUD).[1]

As documented in Table 1, within Georgia's federally defined housing market areas the cost of a one-bedroom rental unit ranged from a low of 65% of SSI payments in the Haralson County housing market area to a high of 104% in the Atlanta/Sandy Springs/Marietta housing market area.

TABLE 1: HOUSING NEEDS DATA FOR THE STATE OF GEORGIA

State and Metropolitan Statistical Area	SSI Monthly Payment	SSI as % Median Income	% SSI for Efficiency Apt.	% SSI for 1-Bdrm
Albany	$721.00	26%	71%	81%
Athens/Clarke County	$721.00	22%	74%	82%
Atlanta/Sandy	$721.00	19%	96%	104%
Augusta/Richmond	$721.00	22%	75%	85%
Brunswick	$721.00	23%	68%	69%
Butts County	$721.00	19%	78%	79%
Chattanooga*	$721.00	22%	63%	76%
Columbus*	$721.00	24%	70%	83%
Dalton	$721.00	26%	73%	79%
Gainesville	$721.00	22%	89%	89%
Haralson County	$721.00	27%	65%	65%
Hinesville/Fort Stewart	$721.00	25%	80%	83%

[1] *HUD updates Fair Market Rents each October 1st.*

State and Metropolitan Statistical Area	SSI Monthly Payment	SSI as % Median Income	% SSI for Efficiency Apt.	% SSI for 1-Bdrm
Lamar County	$721.00	26%	68%	74%
Long County	$721.00	25%	68%	71%
Macon	$721.00	24%	71%	85%
Meriwether County	$721.00	26%	68%	74%
Monroe County	$721.00	20%	63%	76%
Murray County	$721.00	27%	68%	69%
Rome	$721.00	24%	69%	69%
Savannah	$721.00	21%	82%	101%
Valdosta	$721.00	27%	80%	80%
Warner Robins	$721.00	19%	83%	85%
Non-Metropolitan Areas	$721.00	27%	70%	72%
Statewide	**$721.00**	**22%**	**85%**	**93%**

* Indicates a housing market area that crosses state boundaries

In lieu of SSI benefits, a person with a disability could have income from employment sources. In 2014, a person would have to have earned on average $12.88 per hour to be able to afford a one-bedroom rental unit based on HUD's Fair Market Rent (referred to by the National Low Income Housing Coalition as the Housing Wage). Table 2 lists the NLIHC Housing Wage by area in Georgia.

TABLE 2: 2014 SSI PAYMENTS AS AN HOURLY WAGE

Housing Market Area	NLIHC Housing Wage
Albany	$11.17
Athens/Clarke	$11.35
Atlanta/Sandy	$14.54
Augusta/Richmond	$11.77
Brunswick	$9.52
Butts County	$10.92
Chattanooga*	$10.50
Columbus*	$11.44
Dalton	$11.00
Gainesville	$12.38
Haralson County	$9.04
Hinesville/Fort	$11.50

Housing Market Area	NLIHC Housing Wage
Lamar County	$10.31
Long County	$9.79
Macon	$11.85
Meriwether County	$10.31
Monroe County	$10.56
Murray County	$9.52
Rome	$9.58
Savannah	$13.94
Valdosta	$11.13
Warner Robins	$11.85
Non-Metropolitan	$10.02
Statewide	$12.88

Given the gap between average rents and possible SSI or earned income, most people covered by the Settlement Agreement will need assistance covering housing costs by either living with family or friends or obtaining a subsidized housing unit or a rental subsidy.

Housing Standards

Most federal and state housing programs require that the housing units funded with their resources meet certain minimum housing standards. The primary standard for HUD-funded housing is Housing Quality Standards (HQS). The Housing Choice Voucher Program, HOME tenant-based rental assistance, and CoC Interim Rule leasing and rental assistance funded units must all meet HQS. HUD also has other housing programs (Neighborhood Stabilization Program, former Supportive Housing Program) that require units to meet Habitability Standards. HQS establishes the minimum criteria for the health and safety of program participants residing in these HUD-funded housing units.

Access to Quality Services

Access to quality services is essential to ensuring integration into the community for persons with disabilities. These services could include basic amenities such as shopping, social opportunities, recreational activities as well as quality supportive services. Having needed services in close proximity to affordable housing is the cornerstone for building and maintaining community-based integrated housing for persons with disabilities covered by the Settlement Agreement. Task 2 of TAC's work with DBHDD will focus on helping DBHDD define in need of supportive housing.

Available Housing Resources

The federal government is the prime funder of affordable housing resources. In addition, the State of Georgia has additional state-specific resources available to support the creation of affordable housing units. This next section highlights some of the significant resources available to create affordable housing.

U.S. Department of Housing and Urban Development (HUD)

HUD provides a variety of resources to states, local governments, and non-profit housing agencies to provide access to or to develop affordable housing. These resources include:

- Housing Choice Vouchers, including special purpose vouchers
- Federal Public Housing Units
- HOME Investments Partnership Program
- Continuum of Care Homeless Programs
- Section 811 Supportive Housing for Persons with Disabilities Program
- Community Development Block Grant (CDBG)
- Emergency Solutions Grant (ESG)
- Housing Opportunities for Persons with AIDS
- Section 202 Supportive Housing for the Elderly Program

a. Housing Choice Vouchers

The first two programs on the list above are administered by Public Housing Agencies (PHAs).

The Housing Choice Voucher (HCV) program is the major federal program for assisting low-income families, the elderly, and people with disabilities to obtain decent, safe, and affordable housing in the community. HCVs are commonly referred to as tenant-based rent subsidies because they are provided to eligible applicants to use in private market rental housing of their choice that meets the HCV program requirements. The HCV household pays a portion of monthly housing costs that is based on the income of the household. The household's portion is usually – but not always – equal to 30-40% of its monthly-adjusted income. This subsidy is based on the cost of moderately priced rental housing in the community and is provided by a PHA under a contract with HUD.

Federal public housing was established to provide decent and safe rental housing for eligible low-income families, the elderly, and persons with disabilities. Public housing comes in all sizes and types, from scattered single family houses to high rise apartments for elderly families. Public housing is site specific meaning eligible applicants only benefit from the resource if they live in the specific public housing unit.

At the present time, there are 188 PHAs operating in Georgia. Of these, three PHAs administer only a HCV program, 166 PHAs administer only public housing units, and 19 PHAs administer both a HCV and public housing program. In total, these PHAs administer a total of 63,118 vouchers and own and manage a total of 47,929 units of federally funded public housing. A list of these PHAs and the number of vouchers and public housing units they administer is included in Appendix A.

In addition to regular Housing Choice Vouchers, there are special purpose vouchers that have been appropriated by Congress exclusively for people with disabilities. Because of various requirements imposed on these vouchers by law and by Congressional appropriations language, these vouchers are an invaluable resource for meeting the housing needs of people with disabilities since they must continue to be set aside for people with disabilities even when they turnover and are re-issued. As documented below some vouchers administered by PHAs in Georgia are targeted exclusively to people with disabilities including:

- Five-Year Mainstream Housing Opportunities for Persons with Disabilities
- Rental Assistance for Non-Elderly Persons with Disabilities ("NED" Vouchers)

NED Category 1: vouchers for non-elderly disabled households on PHA waiting lists; and

NED Category 2: vouchers to enable non-elderly households with disabilities to transition from nursing homes and other health care institutions into the community. PHAs must partner with a state-level Medicaid or health and human services agency responsible for the state's institutional transfer program.

As seen in Table 3, five PHAs in Georgia currently administer a total of 488 vouchers for people with disabilities- 278 Five-Year Mainstream Vouchers and 210 NED vouchers. These vouchers represent less than 1% of the total number of HCVs administered by PHAs in Georgia.

TABLE 3: PHAS IN GEORGIA WITH SPECIAL PURPOSE VOUCHERS

PHA	Mainstream 5-Year Vouchers	NED Category 1	NED Category 2
Atlanta HA	50	175	0
Decatur HA	75	0	35
GA Dept. of Community Affairs	75	0	0
NW Georgia HA	20	0	0
Rockmart HA	58	0	0
Total	**278**	**175**	**35**

On June 14, 2011, HUD published *PIH Notice 2011-32*, a critical document for ensuring the effective utilization of all the vouchers described above targeted to non-elderly people with disabilities (now collectively referred to as NED vouchers). All PHAs will now be clear that, upon turnover, those vouchers must continue to be provided ONLY to non-elderly disabled households.

In addition to the special purpose vouchers described above, between 2000 and 2002 HUD awarded conventional vouchers (i.e., not targeted to any particular group) to PHAs that applied through a national competition. As part of the competition, HUD awarded extra points to PHAs that agreed to use at least 15% of the vouchers for people with disabilities and/or at least 3% of the vouchers for people with disabilities with Medicaid Home and Community Based Waivers. Table 6 documents the PHAs in Georgia that received extra points for these assurances.

TABLE 4: PHAS IN GEORGIA WITH FAIR SHARE SET-ASIDES

PHA	Fair Share HCVs for People with Disabilities	Fair Share HCVs for People with Medicaid HCB Waivers
HA of the City of Augusta	96	20
HA of the City of Columbus	42	0
HA of the City of Atlanta	48	10
HA of the City of Macon	100	20
HA of the City of Decatur	11	0
HA of the City of Albany	2	0
HA of Fulton County	20	0
City of Marietta	4	0
GA Dept. of Community Affairs	66	0
TOTAL	**389**	**50**

Housing utilization rates, as reported by PHAs, provide the percentage of all Housing Choice Vouchers that are being used by certain categories of tenants. As illustrated in Table 5, the rate of voucher assistance for non-elderly disabled households was lower than the national average of 20% in all but two of the PHA programs. Others were lower than the statewide average of 13% (Carollton HA and Newnan HA). The two PHAs with a utilization rate that was higher than the national average were Decatur HA and NW George HA at 24%.

TABLE 5: HOUSING CHOICE VOUCHER UTILIZATION RATES BY NON-ELDERLY DISABLED AND DISABLED HOUSEHOLDS

PHA	Non-elderly people with disabilities	Elderly people with disabilities
Albany HA	15%	7%
Americus HA	9%	3%
Augusta HA	11%	6%
Brunswick HA	8%	8%
Carrollton HA	7%	4%
College Park HA	12%	5%
Columbus HA	13%	8%
Decatur HA	24%	10%
Dekalb County HA	16%	9%
East Point HA	15%	6%
Fulton County HA	8%	5%
GA Dept. of Community Affairs	12%	9%
Jonesboro HA	11%	8%
Lithonia HA	11%	15%
Macon HA	18%	11%
City of Marietta	14%	10%
Newnan HA	7%	5%
NW Georgia HA	24%	18%
Savannah HA	8%	7%
Statewide	**13%**	**9%**
National	**20%**	**14%**

While there are a significant number of PHAs in Georgia and a large portfolio of HCVs and public housing units, the total amount of these resources being available is increasingly limited. While these HCV resources have always been in great demand, the impact of the March 2013 sequestration of the federal budget has meant a significant decline in the number of vouchers PHAs are able to issue to new individuals and families. Nationally, HUD estimated that as a result of sequestration, 125,000 individuals and families, more than half of whom are elderly or disabled will lose assistance provided to them through the HCV program. Others will not have

the opportunity to access the program since local PHAs, including Georgia's Department of Community Affairs, must suspend reissuing vouchers to new participants.

TAC conducted a review of the PHAs with over 400 HCVs in Georgia to see if they were accepting new applications for HCVs and the status of their waiting lists.

Table 6 shows that of the 15 PHAs surveyed, two did not respond and only one was accepting new applications. *(The Georgia Department of Community Affairs has the second most vouchers in the State, however, since DCA has developed a Strategic Housing Plan to address the Olmstead Settlement Agreement they are not included in the following chart but are discussed separately.)*

TABLE 6: PUBLIC HOUSING AGENCY HCV WAITLIST STATUS

Public Housing Agency	# HCV	Accepting Applications
Americus HA	716	no
Atlanta HA	19804	no
Augusta HA	4114	yes
Brunswick HA	750	no
City Of Marietta HA	657	*
Columbus HA	2333	no
Decatur HA	868	no
Dekalb County Ha	4383	no
East Point HA	455	no
Fulton County HA	847	no
Jonesboro HA	1840	*
Macon HA	2954	no
Marietta HA	1992	no
NW Georgia HA	620	no
Savannah HA	2992	no

* no response

PHAs are given the flexibility by HUD to establish policies for their Housing Choice Voucher Program that reflects the specific housing needs of their communities. This flexibility can range from how and when it accepts new applications for assistance, to setting local payment standards, to establishing waiting list preferences.

Under the Section 8 rules, the PHA establishes payment standards for its HCV program. These payment standards are used to calculate the maximum amount of the Section 8 rent subsidy the PHA will pay for the units rented through the program. PHAs have flexibility to establish their payment standards. Payment standards are based on the HUD determined Fair Market Rents (FMRs) that are set each October and reflect the cost to rent a modestly priced housing unit in a certain housing market. PHAs have the discretion to set their HCV payment standard at an amount between 90 and 110 percent of the FMR. In addition, a PHA can use an "exception" or higher payment standard on a case-by-case basis as a reasonable accommodation for a person

with a disability. This opportunity to request higher payment standards as a reasonable accommodation can be an important tool in serving persons with disabilities.

In addition, HUD allows each PHA to implement preferences for their Section 8 waiting list. These preferences can allow households with certain characteristics or circumstances, such as local residents, people with disabilities, people who are homeless, to receive HCV assistance before others. PHAs are not required to use preferences, but they may choose to do so with HUD approval.

b. Resources Administered by State and Local Community Development Officials

Each year, Congress appropriates billions of dollars (slightly over $6 billion for federal Fiscal Year 2013) that go directly to all states, most urban counties, and communities "entitled" to receive federal funds directly from HUD. Before states and communities can receive these funds they must have a HUD-approved Consolidated Plan (Con Plan). In Georgia, there are 25 localities and the State that develop Consolidated (Con) Plans and receive related federal resources. The allocations are itemized below in Table 8 by program including:

- Community Development Block Grant (CDBG):
- HOME Investments Partnerships Program (HOME)
- Emergency Solutions Grant (ESG); and
- Housing Opportunities for Persons with AIDS (HOPWA)

TABLE 7

FY2014 CONPLAN RESOURCES FOR GEORGIA

AREA	CDBG	HOME	ESG	HOPWA	TOTAL
ALBANY	$882,403	$408,309	$0	$0	**$1,290,712**
ATHENS-CLARKE	$1,269,701	$244,250	$0	$0	**$1,513,951**
ATLANTA	$6,861,534	$1,648,209	$579,189	$14,242,883	**$23,331,815**
AUGUSTA	$1,703,221	$733,800	$142,880	$937,957	**$3,517,858**
BRUNSWICK	$345,773	$0	$0	$0	**$345,773**
COLUMBUS-MUSCOGEE	$1,341,715	$691,389	$0	$0	**$2,033,104**
DALTON	$379,015	$0	$0	$0	**$379,015**
GAINESVILLE	$417,758	$0	$0	$0	**$417,758**
HINESVILLE	$225,004	$0	$0	$0	**$225,004**
JOHNS CREEK CITY	$270,117	$0	$0	$0	**$270,117**
MACON	$1,533,672	$629,797	$0	$0	**$2,163,469**
MARIETTA	$542,384	$0	$0	$0	**$542,384**
ROME	$406,047	$0	$0	$0	**$406,047**
ROSWELL	$431,921	$0	$0	$0	**$431,921**
SANDY SPRINGS CITY	$545,644	$0	$0	$0	**$545,644**
SAVANNAH	$2,114,251	$640,899	$174,789	$0	**$2,929,939**
SMYRNA CITY	$293,025	$0	$0	$0	**$293,025**

AREA	CDBG	HOME	ESG	HOPWA	TOTAL
VALDOSTA	$550,525	$0	$0	$0	**$550,525**
WARNER ROBINS	$472,827	$0	$0	$0	**$472,827**
CHEROKEE COUNTY	$983,383	$0	$0	$0	**$983,383**
CLAYTON COUNTY	$2,078,435	$693,760	$164,201	$0	**$2,936,396**
COBB COUNTY	$3,060,484	$1,592,730	$249,798	$0	**$4,903,012**
DE KALB COUNTY	$4,625,313	$1,748,808	$382,895	$0	**$6,757,016**
FULTON COUNTY	$1,676,919	$623,396	$136,276	$0	**$2,436,591**
GWINNETT COUNTY	$5,098,532	$1,505,743	$397,141	$0	**$7,001,416**
HENRY COUNTY	$1,002,637	$0	$0	$0	**$1,002,637**
GEORGIA STATE PROGRAM	$36,929,936	$15,146,654	$3,950,646	$2,204,852	**$58,232,088**
TOTAL	**$76,042,176**	**$26,307,744**	**$6,177,815**	**$17,385,692**	**$125,913,427**

The HOME program, as described below, provides the most direct opportunities for housing for persons with disabilities covered by the Settlement Agreement. Information on the other federal programs is included in Appendix B.

Of all of these resources, the HOME Investment Partnerships Program (HOME) funds offer the greatest opportunity to access affordable housing for persons covered by the Settlement Agreement. The HOME program is a formula grant of federal housing funds given to states and localities (referred to as “participating jurisdictions” or PJs).

HOME funds can be used to:

- Build, buy, and renovate rental housing;
- Finance homeownership opportunities;
- Repair homes, including making buildings physically accessible; or
- Provide rental subsidies to eligible households. (TBRA)

Of these eligible activities, HOME TBRA provides the greatest opportunity to create integrated housing. HOME TBRA is similar to HCV by providing rental assistance to eligible participants to rent units from private landlords in the community. The HOME TBRA must be allocated by the participating jurisdiction in two-year funding increments from a specific one-year HOME allocation.

About half of the HOME participating jurisdictions have tried TBRA although the number of households assisted is relatively small.

TABLE 8: HOME FUNDS AND TBRA

AREA	HOME	TBRA Program	Notes
ALBANY	$408,309	x	43 households since 1992
ATHENS-CLARKE	$244,250		
ATLANTA	$1,648,209	x	358 households since 1992
AUGUSTA	$733,800		
COLUMBUS-MUSCOGEE	$691,389		
MACON	$629,797		
SAVANNAH	$640,899		
CLAYTON COUNTY	$693,760	x	11 households since 2000
COBB COUNTY	$1,592,730	x	202 households since 1992
DE KALB COUNTY	$1,748,808	x	41 households since 1992
FULTON COUNTY	$623,396	x	3,346 households since 2000
GWINNETT COUNTY	$1,505,743		
GEORGIA STATE PROGRAM	$15,146,654	x*	65 households since 1992 *See DCA current initiative outlined below
TOTAL	**$26,307,744**		

As part of its Strategic Plan, DCA set aside $1 million to create a HOME Tenant-based Rental Assistance Program for individuals enrolled in the Georgia Money Follows the Person program (MFP) and provides 24 months of rental assistance to eligible applicants. As allowed by HOME regulations, the program gives the TBRA participant the ability to move to an apartment or home in a neighborhood and community of their choosing. The MFP resources provide community-based services. The TBRA funds provide rental assistance to help pay a portion of the cost of the participants monthly rent and utility costs as well as pay security and utility deposits for the assisted rental unit.

Section 811 Supportive Housing for Persons with Disabilities Program (Section 811)

The Section 811 program traditionally had funded the development of supportive housing for people with disabilities between the ages of 16 and 62. Historically, the program had been referred to as the "one-stop shopping" program because it provided both capital funding and a project-based rental assistance contract for non-profit organizations to develop new permanent supportive housing for persons with disabilities. Appendix B includes a table listing the Section 811 awards in Georgia since 2003. In January, 2011, President Obama signed into law the Frank Melville Supportive Housing Investment Act of 2010, legislation to revitalize and reform the Section 811 program. The "one-stop" option remains authorized within the reformed Section 811 program. However, the program includes two new approaches to creating integrated permanent supportive housing: the Modernized Capital Advance/Project Rental Assistance Contract (PRAC) multi-family option, and the Project Rental Assistance (PRA) option. Both

options require that properties receiving Section 811 assistance limit the total number of units with permanent supportive housing use restrictions to 25% or less. Although all three of these options are authorized in the legislation, the FY 2012, 2013 and 2014 appropriations, direct that all funding for new Section 811 units be provided solely through the PRA option. Currently, there are no regulations for this program, but program guidelines are anticipated.

In FY 12, Georgia was successful in being one of 13 states that received an allocation of Section 811 PRA resources and with this award will obtain 350 new Section 811 housing units. Depending on the availability of new annual federal appropriations, the Section 811 program is one mechanism to grow capacity for the target population.

Section 202 Program

The Section 202 Supportive Housing for the Elderly Program is the only federally funded housing program designed specifically for older persons. Since its inception in 1959, the program has supported the creation of approximately 6,200 housing facilities for older persons, accounting for approximately 250,000 residential units. In general, eligibility is restricted to persons who are at least 62 years of age and have incomes below 50 percent of their area's median income.

Continuum of Care (CoC)

In 1987, Congress passed the first federal law specifically addressing homelessness. The Stewart B. McKinney Homeless Assistance Act of 1987, later renamed the McKinney-Vento Homeless Assistance Act, provides federal financial support for a variety of programs to meet the many needs of individuals and families who are homeless. The program was amended and reauthorized as the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH) in May 2009. The housing programs it authorizes are administered by HUD's Office of Special Needs Assistance Programs.

The Continuum of Care planning process was designed to promote the development of comprehensive systems to address homelessness by providing communities with a framework for organizing and delivering housing and services.

There are 9 Continuum of Care planning groups in Georgia - 8 local CoCs and a Balance of State CoC that captures those communities not contained within the jurisdictions of the local CoCs. Table 9 lists the CoCs in Georgia.

TABLE 9: GEORGIA CONTINUUM OF CARE COMMUNITIES

CoC
Atlanta CoC
Athens/Clarke County CoC
Augusta CoC
Columbus-Muscogee/Russell CoC
Fulton County CoC

CoC
Marietta/Cobb County CoC
Savannah/Chatham CoC
Dekalb County CoC
Georgia Balance of State CoC

Within these nine CoCs are an inventory of emergency shelter beds, transitional housing beds, and permanent housing beds created and maintained for homeless individuals and families. Table 10 includes information about the number of emergency shelter (ES), transitional housing (TH) and permanent supportive housing (PSH) beds across the state. This housing inventory is self-reported by the Continuum of Care each year. As Table 10 documents, the number of PSH units for homeless persons in Georgia has greatly increased in recent years.

TABLE 10: BEDS FOR HOMELESS PERSONS

EXCERPT FROM CONTINUUM OF CARE HOUSING INVENTORY CHARTS – 2008 THROUGH 2010

Type	2011		2012		2013		Change 2011-2013	
	Families	Individs.	Families	Individs.	Families	Individs.	Families	Individs.
ES	1,566	3,571	1,677	2,962	1,666	2,652	6%	-26%
TH	3,261	2,769	2,668	2,152	2,531	2,504	-22%	-10%
PSH	2,767	2,745	1,994	2,828	2,832	4,221	2%	54%

As a whole, the CoCs in Georgia have been working to initiate systems change to create additional permanent supportive housing beds and reduce the number of emergency shelter and transitional housing beds. The PSH beds can only be used to house persons who meet the definition of homelessness as found in the HEARTH Defining Homeless Final Rule published December 5, 2011, the CoC Interim Rule, published July 31, 2012 and applicable Notice of Funding Availability (NOFA).

Low Income Housing Tax Credits

The federal government created the Low Income Housing Tax Credit (LIHTC) program to encourage the development of new mixed-income rental housing that would benefit low-income households. At the federal level, the program is not administered by HUD, but rather by the Internal Revenue Service (IRS) within the Department of Treasury. Each year, the LIHTC program produces approximately $6 billion of private investment in affordable housing. In Georgia, the Georgia Housing Finance Authority (GHFA) is the State of Georgia's housing agency. The Georgia Department of Community Affairs (DCA) administers the program for GHFA, including the LIHTC program.

Many types of rental housing can be developed using the LIHTC program including:

- Multifamily rental housing

- Mixed-use projects that include both rental housing and commercial space
- Single Room Occupancy (SRO) housing
- Scattered-sites that can be "bundled together" as one project

The Low Income Housing Tax Credit program requires states to develop a Qualified Allocation Plan (QAP) – describing how the LIHTC program will be utilized to meet the housing needs and housing priorities of the state. The QAP must be submitted to the Department of Treasury/IRS each year in order for the state to receive its LIHTC allocation.

The QAP is prepared by the state through a process that includes a public hearing to solicit the public's comments on high priority housing needs and on the strategies proposed by the state to address these needs. The QAP must also provide information on the competitive process that the state will administer to award tax credits as well as any priorities for funding, set-asides, or threshold requirements adopted by the state. These may include bonus points for projects that serve targeted subpopulations.

- The GA Low Income Housing Tax Credit program has funded over 900 properties and close to 200,000 units of housing that meets LIHTC eligibility criteria. There are certain threshold criteria in the LIHTC competition including the requirement that successful properties be marketed to people with disabilities, that outreach is conducted to people with disabilities and that through this marketing there is contact with local service providers. Each project selected for an award of credits must prepare and submit a Marketing Plan outlining how the project will market units to tenants with special needs. At a minimum, Marketing Plans must:
    - Incorporate outreach efforts to each service provider, homeless shelter or local disability advocacy organization in the county in which the project is located.
    - Affirmatively market persons with disabilities and the homeless.
    - Establish and maintain relationships between the management agent and community service providers.

In recent QAPs, DCA has given points to proposed projects that would set aside 15% of units for persons with disabilities. In addition, specific to the Settlement Agreement, the most recent QAP provided scoring Incentives that award extra points to projects which have an Owner and Developer that agree to accept a rental assistance from a state, federal or other approved organization for up to fifteen percent of the units in their Georgia owned tax credit developments for the purpose of housing tenants covered by the settlement agreement. This last provision aligns with Georgia's interest in obtaining additional Section 811 PRA resources. Another incentive in the QAP are extra points to an application with a commitment of project-based rental assistance from a PHA which has elected to offer a preference in their HCV programs for persons with specific disabilities identified in the settlement agreement.

DCA assumes a 7% vacancy rate or turnover of occupied units to vacant units in its underwriting.

Veteran Housing Options

According to HUD's 2009 Annual Homeless Assessment Report – Veterans Supplement, there were an estimated 2,760 homeless veterans in Georgia on any given night in time. These veterans represented 14% of all homeless people in the state.[1]

VASH is a joint project between the Dept of Veteran Affairs (VA) and the Department of Housing and Urban Development (HUD). The goal of the program is to transition veterans from homelessness to having permanent, secure, safe housing so that they may rebuild their lives. The clientele in VASH vary from families to single vets and from Vietnam era to returning OIF/OEF[1] vets. This program is administered in terms of a housing voucher from HUD for veterans to rent a home or an apartment, and intensive case management services provided by the VA for five years. After the five years, the veteran may turn his or her VASH voucher into a housing choice voucher to maintain their apartment, freeing up the VASH voucher and case management for another veteran. The Case Management services are administered for five years and are highly individualized to support the vet and /or family to reach self sufficiency and success.

As of February 2014, there were a total of 1,820 VASH vouchers in Georgia administered by 8 different PHAs.

TABLE 11: VASH VOUCHERS

PHA	City	VASH Vouchers
Housing Authority of the City of Augusta	Augusta	135
Housing Authority of Savannah	Savannah	80
Housing Authority of the City of Marietta	Marietta	90
Housing Authority Of the City Of College Park	College Park	100
Housing Authority of Dekalb County	Decatur	615
GA Department of Community Affairs	Atlanta	415
Housing Authority of the City of Decatur	Decatur	250
Housing Authority of the City of Atlanta	Atlanta	135
	TOTAL	**1820**

c. Georgia Specific Initiatives

Georgia Housing Voucher Program (GHVP)

DBHDD administers the Georgia Housing Voucher Program which can provide up to 2,000 individuals covered by the Settlement Agreement who are "deemed ineligible for any other benefits" with a rental subsidy. In addition, the resources available to DBHDD can also pay for modifications to units to accommodate the physical needs of tenants and initial bridge funding that can include rent depositions, modifications to apartments for minor accessibility repairs, household furnishings, moving expenses, minor tenant caused repairs, and a $500 onetime fee

for the provider to help transition the tenant into the housing placement. In the most recent report dated September 2013, Martha Knisley of TAC reported to the Independent Reviewer that the GHVP had exceeded its numerical targets by having served 1,002 at the time of the review. By May 2014 almost 1,500 had received the vouchers.

Department of Community Affairs (DCA)

The Georgia Department of Community Affairs operates the second largest HCV program in the State. In February 2012, DCA developed Strategic Recommendations to develop strategies to help the State meet the terms and conditions of the Settlement Agreement. Despite a reduction in the number of overall vouchers DCA could issue and a long waiting list, DCA committed to allocating 100 vouchers in FY 2012 and 500 vouchers in FY 13, 500 in FY14 and 500 in FY 15 for persons covered by the Settlement Agreement. DCA obtained approval from HUD on May 3, 2012 to set these specific preferences.

In addition to creating this preference for those covered by the Settlement Agreement, DCA further encouraged that these HCVs be linked to those persons receiving GHVP rental assistance. This linkage would facilitate the transition of GHVP participants onto a more long term rental subsidy and also free up additional GHVP resources to assist additional individuals. This linkage accepted that certain persons covered by GHVP would not be eligible for DCA HCV assistance due to federal eligibility restrictions (e.g. immigration status, certain criminal offenses, etc.). To date, 107 of the 1,500 GHVP vouchers have been transitioned to the DCA HCVs.

From discussions with DBHDD and DCA staff, the transition to DCA was initially slow due to certain obstacles including:

1. GHVP rent payments exceeded the DCA payment standards;
2. GHVP units did not pass HQS; and
3. Landlords/property owners were reluctant to shift to the HCV program.

These limitations are important to understand in maximizing the HCVs that were set aside for the Settlement Agreement as well as in approaching other PHAs to establish a similar preference.

Housing Quality Standards, as mentioned previously, certify that the unit meets basic health and safety conditions. At initial occupancy units must be inspected to determine if they meet HQS. If a unit does not meet HQS, a landlord is given a period of time to remedy the infraction. After the initial certification, units must be re-inspected annually. At times, a unit that first met HQS will no longer meet it upon recertification due to wear and tear or more extensive abuse by the tenant. PHAs do not have flexibility regarding these HQS requirements. However, community organizations or local government agencies can work with the PHAs to ensure a timely inspection and can work with the landlords to find resources to correction violations.

DBHDD at times approved rents that exceeded DCA's payment standard. Therefore, landlords were reluctant to switch from the GHVP to DCA's HCV because it would require them to lower the unit's rent.

Section Three: Housing Opportunities and Capacity

The housing market throughout Georgia is such that those covered by the Settlement Agreement who need supportive housing will require a rental subsidy to ensure this housing placement. According to the March/April 2014 Journal of Housing and Community Development, Georgia has three of the top ten worst counties (Cobb, Gwinnett and DeKalb Counties) in the country for affordability and availability. But as the data at the beginning of this report indicated, in no community could someone with a very low income afford the Fair Market Rent in any county.

As noted in Section 1, DBHDD has made great progress in housing close to 1,500 individuals with the GHVP subsidies. Of these GHVP holders, over 100 have moved onto DCA HCVs. The success of GHVP presents an argument to find more long term subsidies to which the GHVP can be linked. This bridge to HCVs would continue to allow DBHDD to use its resources to quickly house additional people.

One limitation of the link to DCA's HCVs is that voucher holders must live in DCA's region. If a GHVP recipient is living in a community not covered by DCA but by another PHA, the DCA vouchers cannot be used in that community.

For these reasons the following are recommendations to increase capacity related to HCVs:

1. Continue to work to link GHVP to DCA HCV. As already mentioned, this will free up GHVP resources that can be used to either expedite new individuals into housing or to cover some of the initial move in costs or repair costs that could delay identifying accessible units or perhaps units that do not meet HQS.
2. Work with other PHAs to create a preference for individuals covered by the Settlement Agreement. Since DCA's HCV can only be used in areas not covered by other PHAs, expanding the supply of HCVs by other PHAs could expand options and opportunities for individuals in need of PSH.
3. Encourage DCA and the other PHAs to consider increasing the payment standard on a case by case basis as a reasonable accommodation. This could increase the rate at which the GHVP vouchers transition to the more permanent HCVs.
4. Investigate whether GHVP resources could be used to make repairs on units that do not meet HQS in addition to its ability to make repairs to create accessibility. This may increase the pool of available units and also increase the transition from GHVP to HCVs.
5. Encourage DBHDD vendors to outreach to the LIHTC developments and to track their receptiveness to GHVP or HCV holders. As discussed earlier, these developers are required to outreach and market to people with disabilities.

6. In addition to increasing access to HCVs statewide, encouraging the participating jurisdictions in Georgia to create a HOME TBRA set-aside similar to DCA's would provide an additional rental subsidy. While these TBRAs must be appropriated on a two year basis, the PJ could renew the subsidy. This option could prove useful in communities where the PHA will not or cannot create a preference in its HCV program.
7. The CoCs have demonstrated a willingness to create additional PSH even in the absence of new resources from HUD. While eligibility requirements are strict for access to CoC-funded PSH it would be a wise strategy to target those PJs and those PHAs who have either previously created program for persons with disabilities or who have created HOME TBRA programs.
8. Table 12 highlights those PJs and PHAs that could be a starting point for DBHDD outreach. These communities either receive HOME funds and have created a HOME TBRA program or have a PHA that has received at least one of HUD's special vouchers or are in a community covered by a local CoC.

TABLE 12: POSSIBLE COMMUNITIES TO TARGET

AREA	HOME	HOME TBRA Program	PHA Open HCV Wait List	Special vouchers of some type	CoC Community
ALBANY	$408,309	x		2	
ATHENS-CLARKE	$244,250				x
ATLANTA	$1,648,209	x		283	x
AUGUSTA	$733,800		Yes	116	x
COLUMBUS-MUSCOGEE	$691,389			42	x
MACON	$629,797			120	
SAVANNAH	$640,899			VASH	x
CLAYTON COUNTY	$693,760	x			
COBB COUNTY	$1,592,730	x			
DE KALB COUNTY	$1,748,808	x			x
FULTON COUNTY	$623,396	x		20	x
GWINNETT COUNTY	$1,505,743				
DECATUR PHA	0	Na		121	
ROCKMART HA	0	Na		58	
MARIETTA HA	0	Na		4	x
NW GEORGIA	0	Na		20	

Estimated Available Permanent Supportive Housing

DBHDD is interested in the overall availability or capacity of Permanent Supportive Housing for persons covered by the Settlement Agreement. TAC summarizes this capacity in the following ways:

1) Dedicated resources for those covered by the Settlement Agreement
2) Estimate of Settlement Agreement clients already housed by these programs.
3) Potential resources for those covered by the Settlement Agreement.

TABLE 13: DEDICATED RESOURCES

Housing Program	Current Vouchers/Subsidies Available	New Projected vouchers/subsidies in			Cumulative Total
		Year 1	Year 2	Year 3	
GHVP	1,500	500	0	0	2,000
DCA HCV	100	500	500	500	1,600
DCA HOME	60	40	0	0	100
811 PRA		75	100	100	275
Subtotal					3,975
Annual Turnover (5%) to subsequent year			56	33	89
	1,660	1,115	656	633	4,064

Table 13 lists those resources already dedicated to house those covered by the Settlement Agreement over the next three years. In addition, it assumes a modest five percent turnover in these units and subsidies that would then be available to other persons covered by the Settlement Agreement. As indicated, resources are available that could house over 4,000 persons covered by the Settlement Agreement.

Estimated Settlement Agreement Clients Already in Permanent Supportive Housing

The eligibility requirements for existing permanent supported housing programs in Georgia are aligned with those covered by the Settlement Agreement. For example, HUD's Shelter Plus Care program (now refunded under the CoC Program Interim Rule), restrict eligibility to persons who are homeless and disabled. The existing 811 program eligibility was restricted to low income persons with disabilities up to age 62. The 202 programs serve low income persons age 62 or older with incomes below 50% of area median income. Table 14 identifies these programs.

TABLE 14: RESOURCES CURRENTLY HOUSING SETTLEMENT AGREEMENT TARGET POPULATION

Housing Program	Current PSH Units for Individuals	Estimated Percentage Settlement Agreement (25% SPC/811) (10% 202)	Turnover of Units to Settlement Agreement Clients (5%)		Cumulative Total
		Year 1 (25%)	Year 2	Year 3	
SPC/CoC Rental Assistance	4,221	1,055	53	53	1,161
Existing 811	392	98	5	5	108
Existing 202	977	97	5	5	107
Subtotal		1,250	63	63	1,376

Not all occupants of these resources would meet Settlement Agreement criteria. For purposes of this report, TAC estimates that at least one quarter of the Shelter Plus Care/CoC Program participants meet Settlement Agreement criteria. In years two and three it is estimated that there will be a five percent turnover each year. Similarly, the Existing 811 programs which house low income persons with disabilities under age 62 would also include some persons covered by the Settlement Agreement. TAC estimates that a quarter of this population could be covered by the Settlement Agreement and a similar 5% turnover annually. Finally, for the 202 program it is estimated that only 10 percent of the current units are housing Settlement Agreement population with a similar five percent turnover each year. Based on these projections, close to 1,400 units are available over this three year period to house those covered by the Settlement Agreement.

The State of Georgia, through DCA's HOME TBRA and HCVs has made a significant commitment to housing those covered by the Settlement Agreement. Additional resources may be leveraged by partnering with other PJs and PHAs. However, the current fiscal climate would indicate that this approach may not yield as many units since HOME and HCVs programs are experiencing cuts in funding. TAC identified those PJs and PHAs who might be willing, either through previous special needs vouchers or other HOME TBRA to consider a modest preference, set aside or new program to be developed. Table 15 (Page 26) highlights some of these potential resources. Exploring such arrangements with any of the PJs and PHAs could yield additional capacity than what is estimated here.

TABLE 15: POTENTIAL PSH RESOURCES FOR SETTLEMENT AGREEMENT CLIENTS

Housing Program	Current Vouchers/Subsidies Available	Targeted Request for Set-aside/Preference Year 1	Year 2	Year 3	Cumulative Total
Other PHA HCV	Target three PHAs	480	480	480	1,440
	Augusta PHA	(10)	(10)	(10)	
	Atlanta	(450)	(450)	(450)	
	Decatur	(20)	(20)	(20)	
Local PJ HOME TBRA	See chart 15A below	30	0	0	30
Subtotal		510	480	480	1,470

TABLE 15A: THE HOME TBRA PROJECTIONS ARE BASED ON THE FOLLOWING

COBB COUNTY	$1,592,730	Annual cost of 1 Subsidy (737 FMR – 215 tenant contribution) x 12 = 6,264	Annual cost of 10 Subsidies x 2 years =125,280
DE KALB COUNTY	$1,748,808	$6,264	$125,280
Atlanta	$1,648,209	$6,264	$125,280
Subtotal		30 TBRA	$375,840

Table 16 summarizes the actual and projected number of permanent supportive housing units/resources that either are or could be available to individuals covered by the Settlement Agreement.

TABLE 16A: TOTAL PSH CAPACITY

	Year 1	Year 2	Year 3	Total
Existing resources dedicated to settlement population	1,115	656	633	4,064
Estimated capacity of supported housing currently housing individuals covered by settlement	1,250	63	63	1,376
Potential additional capacity through additional preferences	510	480	480	1,470
Total Capacity	2,845	1,199	1,176	6,910

TABLE 16B: POTENTIAL HCV SET ASIDES

Other PHA HCV	Total vouchers x (5% estimated turnover) x .5 (half to new preference) = annual available for Settlement Agreement	Estimated New vouchers/subsidies per year			
		1	2	3	Cumulative
Augusta PHA	11	10	10	10	30
Atlanta	450	450	450	450	1350
Decatur	0	20	20	20	60
Total		480	480	480	1,440

DBHDD could increase its supported housing capacity further by converting state-only resources in residential services into Medicaid funded services. DBHDD currently spends approximately $24 million in non-matched resources in residential programs. DBHDD has the Medicaid state plan in place to do this, and is beginning to address this. State funds saved as a result of additional federal financial participation could be re-allocated to supported housing capacity in the GHVP, support non-Medicaid eligible individuals, or fund non-eligible housing support services.

Section Three: Determining "In Need of Supported Housing"

As part of its settlement agreement with the Department of Justice (DOJ), Georgia DBHDD is required to provide an array of community based services to support 9,000 individuals to live in the community. DBHDD estimates that the target of 9,000 individuals relates to individuals who meet the criteria for populations and access specific services as described in the settlement agreement. The services to be made available include Assertive Community Treatment (ACT), Community Support Teams (CST), Intensive Case Management (ICM) and Case Services (CM).

Additionally, a mix of crisis support services are to be developed, including Crisis Service Centers, Crisis Stabilization Centers, Mobile Crisis Services and a Crisis Line. DBHDD has been very focused and aggressive in creating these services and most required services are in place and being accessed, or nearly in place. Approximately 4,500 individuals have accessed settlement services to date.

The Settlement agreement also requires DBHDD to determine who among the 9,000 individuals identified as part of the settlement class is in need of Permanent Supported Housing (PSH). TAC's scope of work for DBHDD under this contract was limited to assisting DBHDD in defining "in need of supported housing" and to provide training consultation for DBHDD Regional staff, providers, and other key participants as identified by DBHDD on issues pertaining to maximizing housing permanency and preservation for the settlement population. It was not the purpose to estimate numbers of consumers covered through the settlement who are in need of supported housing.

Supported housing is defined in the settlement agreement as deeply subsidized, affordable housing that provides tenancy rights, and an array of flexible community based services that are available (but not mandatory) to assist the individuals with accessing and maintaining housing. Of the approximate 4,500 individuals who have accessed settlement services to date, DBHDD reports that 84% are housed.

It is expected that not all of the individuals will need supported housing. It is likely that the majority of individuals will live with family or in existing homes of their own. Others may require a supervised level of support and assistance, such as a group home, and some may choose other housing options available in their community, including personal care homes. While DBHDD intends to reduce use of congregate, boarding or personal care homes by increasing access to supported housing opportunities, a portion of these settings may meet criteria for supported housing placement if they are substantially consistent with the definition of supported housing in the settlement agreement.

During this process, TAC worked with DBHDD to clearly articulate criteria for those in the settlement class are "in need of supported housing." The criteria are as follows:

1. Eligibility for Settlement Services:

    a. Core customer eligibility criteria;
    b. LOCUS scores of 1, 2, 3 and many with a score of 4 (with adequate support services) could live in supported housing. LOCUS scores of 5, 6 and some with a 4 would need other settings;
    c. Presence of functional limitations;
    d. Specific indicators of continuous high-service needs (ACT)

2. Preference: Consumer has indicated a preference to live in supported housing.

3. Prioritization

    a. Homeless or At-risk of homelessness (i.e. discharge from an institution such as hospital, nursing facility, ICF/DD, or jail with no placement option), those living in uninhabitable or substandard housing)
    b. Those living in short term or transitional housing with no tenancy rights or other discharge options

4. Exclusionary Criteria

    a. Choosing and able to live with family and/or friends;
    b. LOCUS score of 5 and 6 unless the supports needed as developed in a person-centered planning process can be provided.

Defining Criteria for Supported Housing

DBHDD applies eligibility criteria for determining level of service needs for each of the settlement services. These include meeting Core customer eligibility criteria, use of the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS), presence of functional limitations, and specific indicators of continuous high-service needs in the case of Assertive Community Treatment (ACT). Additionally, DBHDD specifies a LOCUS score range (2-6) and documented financial need as eligibility criteria for Housing Supplement assistance.

Combined, meeting specific level of service needs (as determined through the LOCUS and resulting composite score) and meeting the criteria for Housing Supplement assistance constitute basic eligibility for supported housing using a DBHDD funded rental subsidy (GVHP). Individuals may access other supported housing opportunities which are not funded by DBHDD and are described in Sections One and Two. Each of these state or federal housing programs provide leased based housing with tenant rights and most of these opportunities meet the supported housing setting requirements as described in the Settlement Agreement.

Depending on the availability of affordable housing resources in a given region, DBHDD may need to further prioritize to ensure those most in need gain access to supported housing. Among all of those who are eligible, those most in need of supported housing are individuals who are homeless or at imminent risk of homelessness. At risk of homelessness includes individuals soon to be discharged from an institution (including hospital, nursing facility, ICF/DD facility or jail) with no home or other discharge placement, and those living in uninhabitable or substandard housing. These individuals should be prioritized for available supported housing opportunities. Other individuals in need of supported housing are those living in short term or transitional housing with no tenancy rights and no other options upon discharge.

Through the data reported on the Monthly Programmatic Reports, DBHDD can identify the current housing arrangements of those actively receiving settlement services and note trends to project possible estimates of those in need of supported housing, and those who will not need it. Data on living arrangements for individuals receiving services for 30 days or more are captured through Sections C or D (Living Arrangements) of the Monthly Programmatic Report. As such, data will only capture those individuals who are still receiving one of the settlement services, and not include those who have accessed one of these services in the past and are no longer engaged with the service.

The reports for ICM and CST have similar options under Section C. For the ACT Monthly Programmatic Report, Section D: Living Arrangements has slightly different options.

Not in need of PSH:

It is common for individuals to choose to live with family and/or friends, and these arrangements often do not have full tenancy rights in terms of lease in place. Individuals who choose and are able to live with family or friends are not considered in need of supported housing even though they may be accessing settlement class services. Sections C/D of the Monthly Programmatic Reports include these options:

- ACT: Living with Friends or Family with no tenancy rights.
- ICM or CST: Temporary housing: living with friends or family with no tenancy rights.

Because this data represents approximately one-half of the target population, the percentage of individuals who have accessed settlement services to date who are living with family or friends may also serve as an estimated percentage of the total 9,000 individuals accessing settlement services who will live with family or friends, and as such, not need supported housing.

Currently living in Supported Housing or other living arrangement that meet the terms as described in the Settlement Agreement:

The settlement states that by July 1, 2015, 50% of Supported Housing units shall be provided in scattered-site housing as well as apartments clustered in a single building. Scattered site housing is further described as having no more than 20% of the units in one building, or no more than two units in one building (whichever is greater).

The following options from the Monthly Programmatic Reports appear to meet this definition for scattered or clustered supported housing. For apartments in multi-unit buildings, DBHDD staff will need to confirm that they meet the concentration requirements.

- ICM or CST: Permanent Housing: Apartment, Home with full tenancy rights
- ACT: Living in apartment or home with full tenancy rights
- ACT: Living in supported housing with full tenancy rights

In addition to a permanent housing apartment with tenancy rights (which may or may not be subsidized through the Georgia Housing Voucher Program), certain residential services settings may meet the terms of the settlement covered by the implied allowance of 50% of supported housing units not provided in scattered site or clustered supported housing. The settlement agreement explicitly states that personal care homes shall not qualify as scattered site housing.

Some of these settings may meet the definition of supported housing (integrated permanent housing with tenancy rights linked with a flexible array of community based services). The following living arrangement options as noted on the Monthly Programmatic Reports may meet the definition of supported housing and as such, be eligible for consideration within the 50% of supported housing that is not scattered site or clustered. In addition to the settings listed below, those apartments in multi-unit buildings that exceed the 20% concentration threshold may meet the definition for supported housing for this category of acceptable housing opportunities.

- ICM or CST: Permanent Housing: SRO, Boarding Home, PCH, Group Home with full tenancy rights
- ACT: Living in congregate housing, boarding home, personal care home – **only** if it can be determined that the person has full tenancy rights

However, while the settings listed above may meet the definition for supported housing, DBHDD has articulated values that will guide decision-making for preferred housing options in the future.

These are: the belief that housing is essential to recovery and independence; informed choice must anchor the selection of any housing option; access to a full continuum of housing options is fundamental to informed choice; and successful living arrangements are integrated in local communities. DBHDD will focus on the experience of consumers as tenants and intends to strengthen and increase permanent supported housing opportunities.

Therefore, DBHDD chooses to apply more stringent criteria to existing congregate housing settings to ensure these reflect standards aligned with criteria for integrated permanent supported housing. Criteria include tenancy rights, defined occupancy limits, concentration of units within larger buildings does not exceed 20%, and a documented statement of the individual choice/preference for housing. Prior to this specific project, TAC previously provided a draft checklist to assess housing settings and DBHDD has reviewed and expanded upon this tool. DBHDD has not yet implemented this tool. It will do so as it is finalized and DBHDD conducts a thorough analysis of its' residential services system as it prepares to implement Medicaid reimbursement within these programs to maximize resources and access federal funds.

In Need of PSH:

Of the individuals who are currently receiving, on a wait list for, or have been referred to one of the settlement services, those who are pending discharge from an institution (hospital, nursing home or jail) with no home or discharge placement, those who are homeless, or living in temporary housing with no tenancy rights are most in need of PSH. These individuals should be prioritized for referral to supportive housing opportunities.

Among those currently receiving settlement services DBHDD can identify these individuals through the data captured on the Monthly Programmatic Reports. Living Arrangement indicating homelessness or at risk of homelessness are captured on the Monthly Programmatic Reports under:

- ICM or CST: Emergency Housing
- ICM or CST: Living on the street, homeless shelter, or motel
- ICM or CST: Temporary housing with no tenancy rights (boarding home, group home, temporary housing)
- ACT: Living on the Street, homeless shelter, motel

Some individuals may be assessed to need supervision, increased support and on site staffing provided by supervised residential services settings. Such models of housing do not have tenancy rights and are transitional in nature. While these individuals do not need supportive housing at the time of admission, they will most likely need this housing option upon discharge.

Including this group in the number for in need of supported housing also encourages needed flow through the residential services system. Individuals currently living in one of the settings below could be transitioned into supported housing, creating openings in a supervised setting for those individuals who are homeless or pending discharged and assessed as in need of this level of residential treatment.

These living arrangements are indicated on the Monthly Programmatic Reports as follows:

- ACT: Living in Congregate Housing, Boarding Home, Personal Care Home, or Group Home (unless these settings are considered permanent housing with tenancy rights as is indicated as an option on the ICM/CST report).
- ICM or CST: Temporary Housing: Boarding Home, Group Home, Temp. Housing with no tenancy rights

Section Four: Training areas to strengthen DBHDD's ability to work with providers to maximize access to supported housing opportunities and promote housing permanency and preservation.

Summary of provider focus groups on assessing and accessing supported housing.

DBHDD arranged for participation in a focus group attended by primarily ACT providers and DBHDD Regional Staff for each region. Only ACT providers were present for the focus group so this summary does not include input from Community Support Team, Intensive Case Management or Case Management service providers. Most participated via conference call, one region attended in person. Questions posed focused on referrals for service, assessment of housing needs, and access to housing options.

Referral for ACT services

All participants agreed that referrals for ACT services come from a variety of referral sources including: outpatient treatment providers, state and private hospitals, jails, probation and parole, PATH teams, family and Residential Services programs. Referrals come directly to the provider. All participants described that they determine eligibility for ACT services using standard criteria as outlined by DBHDD. Providers make the decision to enroll or not. If a person is assessed as not eligible for ACT services, a referral to other service providers is made by the ACT providers. Only one region described having a standard referral form use by all providers (Region 1). Providers in the other regions each have unique forms and processes. All participants described a referral and intake process that includes assessment based on information provided on the referral form combined with a face to face meeting with the individual.

Assessing housing needs and accessing housing opportunities

All ACT staff described exploring a person's need for housing as part of the initial intake and assessment process. Most participants described using a housing readiness determination approach based on functioning level in areas such as cooking, ADLs, safety with medication, criminal background, drug or alcohol use, past living experience, and existing of supports. Only one participant offered inquiring into the person's housing preference as a key consideration for housing options.

Referrals to housing opportunities also depend greatly on available resources within a region and community. Many commented on the need for greater supervised or group home options.

Regions with greater resources and a continuum of housing options seem to rely more on supervised living arrangements that include on-site staffing. These include semi-intensive and intensive levels of residential services and personal care homes. Regions without these resources tend to access the GHVP or other scattered sites models of housing. It is probable that more individuals could be referred to supported housing opportunities if 1) opportunities are available and 2) provider staff are encouraged to make greater use of these opportunities.

The focus group did not discuss service activities provided to support individuals in accessing and maintaining housing in the community. It is not clear if the ACT providers participating in the focus group see assisting with housing applications and rehabilitation activities such as developing the array of skills necessary to get and keep housing as part of their role, or if they perceive training in these areas to be provided by Residential Services programs or personal care homes.

ACT teams by their very design emphasize the provision of home based treatment. To encourage increased referrals to supported housing, staff training in conducting housing assessments that emphasizes tenant screening and housing retention barriers (instead of conducting functional assessments that often screen people out of supported housing) may be beneficial. Additionally, training in housing and tenancy support interventions and services would be helpful.

General themes from Focus Group:

1. Role of choice in determining housing needs and options.

   Providers have primary responsibility for receiving referrals, assessing eligibility for services, and assessing and determining need and access to supported housing opportunities as part of the initial intake process. Based on assessed or perceived competence in general skill areas associated with independent living (most mentioned basic ADLs and taking medications) a determination is made as to what type of housing is most appropriate and whether a referral is made to supervised residential services or the GHVP. There appears to be little consideration for individual choice or preference as a primary factor in making housing referrals.

2. Emphasis on determining readiness for independent living based on functional assessment at time of intake instead of conducting housing based assessment based on preferred housing option.

   The assessment process described by most participants in the focus group emphasized staff determining an individual's "housing readiness" to live independently in the community. This type of approach potentially screens out individuals who, with support, could live in supported housing. Individuals assessed as not having the skills necessary to live independently at the time of intake are determined to need more supervised residential services. Yet, the support needed to live successfully in community based supported housing is available through the array of settlement services. This includes the level of assistance needed by individuals with challenging and complex clinical

profiles and functional limitations. Competencies necessary to live independently can be accommodated or taught through various psychosocial and evidence based interventions. The addition of crisis services further enhances the system's capacity to adequately support many individuals in supported housing who may be assessed as lacking housing readiness.

Delivering effective housing support services begins with understanding the individual's preferences and choice in housing and conducting an assessment of strengths and needs as these relate to the desired setting. This approach is consistent with personal care planning as is required by the new Home and Community Based Services Final Rule (January 2014) and best practice. Assessment domains include tenant screening and housing retention barriers as opposed to a generic psychosocial assessment. Functional deficits related to a behavioral health disorder are considered in light of how these may, or may not impact accessing and maintaining housing. Service type, intensity and frequency are adjusted to meet the changing needs of the individual. Reasonable accommodations are negotiated with landlords and property managers as needed. Housing retention is seen as the ultimate goal.

To promote personal choice and preference as a primary factor for considering housing options and referral, create a standardized Housing Choice/Preference form as part of all settlement services intake applications. This form should document: 1) the individual's housing choice, 2) options available and presented to the individuals, and 3) the individual's selection among the available options. If the person's preference in not available, a plan to assist the person to access desired housing when available should become part of the service plan. Provider training on exploring a person's housing history, exploring choice, decision making among housing options and negotiating housing selection.

DBHDD should provide training on a psychiatric rehabilitation approach to establishing housing goals, conducting housing based preferences and needs assessment, developing housing plans and providing tenancy support services. This approach has been referred to as the "Choose, Get and Keep" model and is a recognized by SAMHSA as an evidence-based practice. Most tenancy based service activities are compatible with all available settlement services. A crosswalk of tenancy support services with allowable activities for each of the settlement services can be developed.

Appendix A: PHA Programs in Georgia

TABLE A1: PHA PROGRAMS IN GEORGIA

PHA	City	PH/HCV/Both	PH Units	Vouchers
Abbeville HA	Abbeville	PH	14	0
Acworth HA	Acworth	PH	0	0
Adel HA	Nashville	PH	60	0
Alamo HA	Alamo	PH	38	0
Albany HA	Albany	Both	1,209	61
Alma HA	Alma	PH	325	0
Americus HA	Americus	Both	480	716
Arlington HA	Cuthbert	PH	24	0
Ashburn HA	Ashburn	PH	168	0
Athens HA	Athens	PH	1,259	0
Atkinson County HA	Nashville	PH	23	0
Atlanta HA	Atlanta	Both	8,485	19,804
Augusta HA	Augusta	Both	2,376	4,114
Bainbridge HA	Bainbridge	PH	284	0
Barnesville HA	Barnesville	PH	132	0
Baxley HA	Baxley	PH	159	0
Blackshear HA	Waycross	PH	56	0
Blakely HA	Blakely	PH	159	0
Blue Ridge HA	Blue Ridge	PH	48	0
Boston HA	Thomasville	PH	39	0
Bowdon HA	Bowdon	PH	55	0
Bremen HA	Bremen	PH	80	0
Brunswick HA	Brunswick	Both	589	750
Buchanan HA	Buchanan	PH	46	0
Buena Vista HA	Columbus	PH	79	0
Buford HA	Buford	PH	189	0
Byron HA	Byron	PH	32	0
Cairo HA	Cairo	PH	185	0
Calhoun HA	Calhoun	PH	249	0
Camilla HA	Camilla	PH	442	0
Canton HA	Canton	PH	145	0
Carrollton HA	Carrollton	Both	238	163
Cave Spring HA	Cave Spring	PH	20	0
Cedartown HA	Cedartown	PH	304	0
Chatsworth HA	Chatsworth	PH	68	0
City Of Atlanta DHCD	Atlanta	HCV	0	44
City Of Marietta HA	Marietta	HCV	0	657

PHA	City	PH/HCV/Both	PH Units	Vouchers
Claxton HA	Claxton	PH	204	0
Clayton HA	Clayton	PH	99	0
Cochran HA	Cochran	PH	115	0
College Park HA	College Park	Both	264	408
Colquitt HA	Colquitt	PH	89	0
Columbus HA	Columbus	Both	2,299	2,333
Comer HA	Comer	PH	30	0
Commerce HA	Commerce	PH	50	0
Conyers HA	Conyers	PH	290	0
Cordele HA	Cordele	PH	439	0
Covington HA	Covington	PH	280	0
Crawfordville HA	Warrenton	PH	14	0
Cumming HA	Cumming	PH	50	0
Cuthbert HA	Cuthbert	PH	122	0
Dahlonega HA	Dahlonega	PH	30	0
Dallas HA	Dallas	PH	157	0
Danielsville HA	Danielsville	PH	30	0
Dawson HA	Dawson	PH	116	0
Decatur HA	Decatur	Both	346	868
Dekalb County Ha	Decatur	Both	468	4,383
Doerun HA	Moultrie	PH	44	0
Douglas City HA	Douglas	PH	381	0
Douglas County HA	Douglasville	PH	110	0
Dublin HA	Dublin	PH	545	0
East Point HA	East Point	Both	383	455
Eastman HA	Eastman	PH	219	0
Eatonton HA	Eatonton	PH	114	0
Edison HA	Cuthbert	PH	64	0
Elberton HA	Elberton	PH	185	0
Ellaville HA	Columbus	PH	40	0
Ellijay HA	Ellijay	PH	110	0
Etowah Area Consol HA	Cartersville	PH	357	0
Fairburn HA	Fairburn	PH	24	0
Fitzgerald HA	Fitzgerald	PH	221	0
Flint Area Consol HA	Montezuma	PH	381	0
Fort Gaines HA	Cuthbert	PH	24	0
Fort Valley HA	Fort Valley	PH	100	0
Franklin HA	Franklin	PH	78	0
Ft Oglethorpe HA	Fort Oglethorpe	PH	74	0

PHA	City	PH/HCV/Both	PH Units	Vouchers
Fulton County HA	Atlanta	Both	677	847
Gainesville HA	Gainesville	PH	495	0
Georgia DCA	Atlanta	HCV	0	16,936
Gibson HA	Gibson	PH	24	0
Glennville HA	Glennville	PH	120	0
Glenwood HA	Glenwood	PH	48	0
Grantville HA	Hogansville	PH	20	0
Greensboro HA	Greensboro	PH	111	0
Greenville HA	Greenville	PH	80	0
Griffin HA	Griffin	PH	250	0
Hahira HA	Nashville	PH	16	0
Hampton HA	Hampton	PH	25	0
Harlem HA	Harlem	PH	44	0
Harris County HA	Columbus	PH	43	0
Hartwell HA	Hartwell	PH	180	0
Hawkinsville HA	Hawkinsville	PH	86	0
Hazlehurst HA	Hazlehurst	PH	134	0
Hinesville HA	Hinesville	PH	77	0
Hogansville HA	Hogansville	PH	114	0
Homerville HA	Homerville	PH	80	0
Houston County HA	Warner Robins	PH	40	0
Jackson HA	Jackson	PH	89	0
Jasper HA	Jasper	PH	152	0
Jefferson HA	Jefferson	PH	90	0
Jesup HA	Jesup	PH	214	0
Jonesboro HA	Jonesboro	Both	32	1,840
Lafayette HA	Lafayette	PH	300	0
Lagrange HA	Lagrange	PH	420	0
Lakeland HA	Nashville	PH	20	0
Lavonia HA	Lavonia	PH	180	0
Lawrenceville HA	Lawrenceville	PH	212	0
Lee County HA	Albany,	PH	98	0
Lincolnton HA	Lincolnton	PH	60	0
Lithonia HA	Lithonia	Both	75	96
Loganville HA	Loganville	PH	20	0
Louisville HA	Louisville	PH	78	0
Lumber City HA	Lumber City	PH	23	0
Lyons HA	Lyons	PH	130	0
Macon HA	Macon	Both	2,272	2,954
Madison HA	Madison	PH	66	0

PHA	City	PH/HCV/Both	PH Units	Vouchers
Manchester HA	Manchester	PH	50	0
Marietta HA	Marietta	Both	164	1,992
McCaysville HA	Mc Caysville	PH	88	0
McDonough HA	McDonough	PH	118	0
McRae HA	McRae	PH	66	0
Menlo HA	Menlo	PH	20	0
Metter HA	Metter	PH	122	0
Milledgeville HA	Milledgeville	PH	321	0
Millen HA	Millen	PH	86	0
Monroe HA	Monroe	PH	383	0
Monticello HA	Monticello	PH	58	0
Moultrie HA	Moultrie	PH	328	0
Mt Vernon HA	Mount Vernon	PH	35	0
Nahunta HA	Nahunta	PH	41	0
Nashville HA	Nashville	PH	159	0
NE Georgia HA	Toccoa	PH	705	0
Newnan HA	Newnan	Both	532	85
Newton HA	Camilla	PH	42	0
Nicholls HA	Alma	PH	20	0
Norcross HA	Norcross	PH	45	0
NW Georgia HA	Rome	Both	943	620
Ocilla HA	Ocilla	PH	165	0
Palmetto HA	Fairburn	PH	20	0
Pearson HA	Nashville	PH	21	0
Pelham HA	Pelham	PH	210	0
Perry HA	Perry	PH	50	0
Quitman HA	Quitman	PH	202	0
Reidsville HA	Reidsville	PH	174	0
Ringgold HA	Ringgold	PH	30	0
Roberta HA	Roberta	PH	70	0
Rochelle HA	Rochelle	PH	14	0
Roswell HA	Roswell	PH	103	0
Royston HA	Royston	PH	185	0
Sandersville HA	Sandersville	PH	142	0
Savannah HA	Savannah	Both	1,938	2,992
Screven County HA	Sylvania	PH	14	0
SE Georgia Cons HA	St. Marys	PH	164	0
Senoia HA	Senoia	PH	31	0
Shellman HA	Cuthbert	PH	20	0

PHA	City	PH/HCV/Both	PH Units	Vouchers
Social Circle HA	Social Circle	PH	70	0
Soperton HA	Soperton	PH	120	0
Sparta HA	Sparta	PH	24	0
Statesboro HA	Statesboro	PH	148	0
Stewart County HA	Lumpkin	PH	70	0
Summerville HA	Summerville	PH	224	0
Swainsboro HA	Swainsboro	PH	244	0
Sylvania HA	Sylvania	PH	78	0
Sylvester HA	Sylvester	PH	261	0
Tallapoosa HA	Tallapoosa	PH	211	0
Tennille HA	Tennille	PH	72	0
Thomaston HA	Thomaston	PH	288	0
Thomasville HA	Thomasville	PH	254	0
Thomson HA	Thomson	PH	200	0
Tifton HA	Tifton	PH	383	0
Tri-City Housing Authority	Woodland	PH	67	0
Unadilla HA	Unadilla	PH	154	0
Union City HA	Newnan	PH	16	0
Union Point HA	Union Point	PH	61	0
Valdosta HA	Valdosta	PH	532	0
Vidalia HA	Vidalia	PH	110	0
Vienna HA	Vienna	PH	80	0
Villa Rica HA	Villa Rica	PH	141	0
Warner Robins HA	Warner Robins	PH	427	0
Warrenton HA	Warrenton	PH	100	0
Washington HA	Washington	PH	119	0
Waycross HA	Waycross	PH	359	0
Waynesboro HA	Waynesboro	PH	387	0
West Point HA	West Point	PH	223	0
Winder HA	Winder	PH	325	0
Woodbury HA	Woodbury	PH	12	0
Wrightsville HA	Wrightsville	PH	90	0
TOTAL			**47,929**	**63,118**

Appendix B: Income of renters in HOME-funded rental housing

TABLE B1:

INCOMES OF RENTERS IN HOME-FUNDED RENTAL HOUSING IN GEORGIA AS OF 09/30/2013

Participating Jurisdiction	% of tenants of HOME-funded rental housing whose income is 0-30% of AMI (as compared to other renters)	% of tenants of HOME-funded rental housing whose income is 0-50% of AMI (as compared to other renters)
Albany	44	85
Athens-Clarke	40	88
Atlanta	22	72
Augusta	23	58
Clayton County	Not available	Not available
Cobb County Consortium	59	85
Columbus-Muscogee	48	68
DeKalb County	21	72
Fulton County Consortium	61	94
Gwinnett County	5	45
Macon	88	88
Savannah	31	81
State of GA	31	79
National Average	**46**	**83**

Appendix C: Section 811 Supportive Housing Grants for People with Disabilities

TABLE C1:
SECTION 811 SUPPORTIVE HOUSING GRANTS FOR THE PEOPLE WITH DISABILITIES PROGRAM

Award Year	Sponsor or Project Name	City	Rental Subsidy	Capital Advance	# Units Awarded
2012	Georgia Housing and Finance Authority	Atlanta	$4,160,771	-	150
2010 and 2011	Georgia Rehabilitation Institute, Inc.	Augusta	$111,300	$1,476,200	12
	Right In The Community, Inc.	Austell	$40,500	$422,600	4
	Right In The Community, Inc.	Austell	$40,500	$422,600	4
	Georgia Behavioral Health Services, Inc.	Milledgeville	$121,500	$1,224,100	12
	Camellia Manor, Inc	Oglethorpe	$50,700	$615,100	5
	The Water Oaks, Inc	Reynolds	$50,700	$615,100	5
2009	Right in the Community, Inc.	Austell	$39,300	$428,800	4
	Advocacy Resource Center-Macon, Inc.	Macon	$39,300	$428,800	4
	GA Behavioral Services, Inc.	Macon	$98,100	$1,198,800	10
	Advocacy Resource Center-Macon, Inc.	Macon	$39,300	$428,800	4
	Right in the Community, Inc.	Marietta	$39,300	$428,800	4
2008	Albany Advocacy Resource Center Inc.	Albany	$67,200	$837,300	7
	GA Rehabilitation Institute, Inc.	Augusta	$124,800	$1,572,500	14
	GA Rehabilitation Institute, Inc.	Augusta	$57,600	$595,100	6
	Right in the Community, Inc.	Marietta	$38,400	$412,500	4
2007	ARC Cobb, Inc.	Austell	$37,200	$366,800	4
	Goodwill Industries – Big Bend, Inc.	Cairo	$129,600	$1,507,800	15
	ARC Cobb, Inc.	Mableton	$37,200	$366,800	4
	VOA Southeast Inc.	Trenton	$111,000	$1,207,300	13
2006	Cobb Arc, Inc.	Mableton	$36,000	$341.000	4
	Cobb Arc, Inc.	Marietta	$36,000	$341,000	4
2005	Cobb ARC, Inc.	Austell	$57,500	$325,100	4
	Volunteers of America Southeast Inc.	Lafayette	$129,000	$778,000	10
	Cobb ARC, Inc.	Mableton	$57,500	$325,100	4
2004	Albany Advocacy Resource Center, Inc.	Albany	$111,500	$693,200	8
	Easter Seals of Middle Georgia, Inc.	Dublin	$70,000	$431,100	6
	Cobb ARC, Inc.	Kennesaw	$56,000	$288,400	4

Award Year	Sponsor or Project Name	City	Rental Subsidy	Capital Advance	# Units Awarded
	Cobb ARC, Inc.	Mableton	$56,000	$288,400	4
	Cherokee Day Training Center	Woodstock	$56,000	$288,400	4
2003	Cobb ARC. Inc.	Cartersville	$54,500	$275,100	4
	VOA Southeast, Inc.	Griffin	$163,500	$853,000	13
	VOA Southeast, Inc.	Lafayette	$163,500	$853,000	13
	Cobb ARC, Inc.	Marietta	$54,500	$275,100	4
	Easter Seals of Southern Georgia, Inc.	Waycross	$82,000	$472,800	8
	VOA Southeast, Inc.	Waycross	$163,500	$853,000	13
TOTAL			**$6,781,271**	**$21,896,841**	**392**

Appendix D: Section 202 Supportive Housing for the Elderly Program

The Supportive Housing for the Elderly program (Section 202) helps expand the supply of affordable housing with supportive services for elderly people (age 62 and older). This program provides capital advances to finance the construction and rehabilitation of structures that will serve as supportive housing for very low-income elderly people and provides rent subsidies for the projects to help make them affordable. Section 202 capital advances finance property acquisition, site improvement, conversion, demolition, relocation, and other expenses associated with supportive housing for the elderly. The capital advance does not have to be repaid as long as the project serves very low-income elderly persons for 40 years. Section 202 project rental assistance covers the difference between the HUD-approved operating cost per unit and the tenant's rent. Project rental assistance contract payments can be approved up to five years. However, contracts are renewable based on the availability of funds.

As with the 811 program, each year HUD publishes a NOFA for the Section 202 funding appropriated by Congress. The NOFA specifies the number of Section 202 units allocated to each HUD jurisdiction and only non-profit organizations are eligible to apply. As seen in Table D1, Georgia has been successful in obtaining over 900 new Section 202 housing units.

In January 2011, the Section 202 Supportive Housing for the Elderly Act of 2010 (referred to as S.118) was enacted. Like the Melville Act described above, this act amends and implements reforms to the Section 202 program. S.118 streamlines and simplifies the program to allow for increased participation by non-profit developers, private lenders, investors and state and local funding agencies.

Currently, no funds have been appropriated for FY 2012 or FY 2013 Section 202 Capital Advances.

TABLE D1: SECTION 202 SUPPORTIVE HOUSING FOR THE ELDERLY PROGRAM

Award Year	Sponsor or Project Name	City	Rental Subsidy	Capital Advance	# Units Awarded
2003	Trinity Community Development Corporation	Albany	$681,000	$3,294,300	50
	Retirement Housing Foundation	Macon	$1,196,500	$6,056,200	88
	Valdosta Deliverance Evangelistic Center	Valdosta	$408,500	$1,968,400	30
	VOA Southeast, Inc.	Waycross	$449,500	$2,230,900	34
2004	Retirement Housing Foundation	Columbus	$1,030,000	$5,654,800	75
	SW Georgia Housing Development Corporation	Cuthbert	$250,500	$1,293,400	18
	United Church Homes	Jackson	$459,500	$2,480,900	33
	DASH for LaGrange, Inc.	LaGrange	$417,500	$2,227,500	31
	Housing development Corp. of	Oglethorpe	$445,500	$2,386,100	33

Award Year	Sponsor or Project Name	City	Rental Subsidy	Capital Advance	# Units Awarded
	Macon				
2005	Mercy Housing Southeast, Inc.	Decatur	$931,500	$5,390,100	66
	Broadway Towers Inc.	Lawrenceville	$602,000	$3,418,900	42
	Housing Development Corp. of Macon & Taylor	Reynolds	$387,000	$2,194,500	28
2006	Salem Baptist Church of Atlanta Inc.	Atlanta	$492,000	$4,780,100	56
	Providence Missionary Baptist Church	Atlanta	$402,600	$3,929,800	46
	Valdosta Deliverance Evangelistic Center	Valdosta	$268,500	$2,438,200	30
2007	Innovative Housing Initiatives	Albany	$221,700	$2,228,900	24
	Family Worship Center Church of God	Cairo	$157,200	$1,578,800	17
2008	South Atlantic Conference	Atlanta	$469,800	$5,211,100	50
	GA Rehabilitation Institute, Inc.	Harlem	$144,000	$1,607,300	16
	Retirement Housing Foundation	Lithonia	$508,200	$5,626,200	54
2009	National Church Residences	Atlanta	$343,200	$3,906,300	36
	Family Worship Center Church of God	Cairo	$137,400	$1,443,200	14
	United Church Residence	Savannah	$382,200	$4,337,800	40
2010 and 2011	Mercy Housing Southeast	Atlanta	$434,700	$4,719,100	44
	Georgia Rehabilitation Institute, Inc.	Harlem	$81,000	$816,000	8
	VOA Southeast, Inc.	Waycross	$131,400	$1,428,100	14
	Total		**11,432,900**	**82,646,900**	**977**

Appendix E: Other Federal Resources

A. Housing Opportunities for Persons with AIDS Program (HOPWA)

HOPWA funding provides housing assistance and related supportive services by grantees who are encouraged to develop community-wide strategies and form partnerships with area nonprofit organizations. HOPWA funds may be used for a wide range of housing, social services, program planning, and development costs. These include, but are not limited to, the acquisition, rehabilitation, or new construction of housing units; costs for facility operations; rental assistance; and short-term payments to prevent homelessness. HOPWA funds also may be used for health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living, and other supportive services.[1]

HOPWA funds are awarded through the Consolidated Plan as a block grant to states and larger metropolitan areas based on the incidences of AIDS in these areas and competitively through an annual Notice of Funding Availability (NOFA). In Georgia, the City of Atlanta, the City of Augusta, and the State of Georgia all receive formula allocation funds (see Table 8 Page 16). Table E1 below includes data regarding how these funds are used in Georgia.

TABLE E1: UTILIZATION OF HOPWA FORMULA FUNDING IN 2012-2013

	% of Expenditures			
	Supportive Services	Housing Assistance	Housing Information Services	Admin
City of Atlanta	41.0	48.0	1.0	10.0
City of Augusta	32.0	56.0	-	12.0
City of Savannah*	48.0	42.0	-	10.0
State of Georgia	44.0	48.0	-	8.0

* Indicates a competitive grant

B. Emergency Solutions Grants (ESG)

On May 20, 2009 President Obama enacted the Homeless Emergency and Rapid Transition to Housing (HEARTH) Act of 2009. The HEARTH Act provides communities with new resources and better tools to prevent and end homelessness, including revamping the ESG program. The key changes that reflect this new emphasis are the expansion of the homelessness prevention component of the program and the addition of a new rapid re-housing assistance component.

The current ESG program provides federal grants to states and localities based on a formula. To receive ESG funds, each state/entitlement community must submit a Consolidated Plan to HUD describing how the ESG resources will be used to meet local needs.

Under HEARTH, ESG eligible components include:

- Street Outreach
- Emergency Shelter
- Homelessness Prevention
- Rapid Re-Housing
- Homeless Management Information Systems (HMIS)
- Administration (up to 7.5% of ESG allocation)

Some of these activities, specifically Rapid Re-Housing and HMIS, are new allowable activities under ESG.

In Fiscal Year 2013, Georgia received over $5.2 million in ESG resources.

TABLE E2: ESG FUNDING IN 2013

Location	FY2013 Allocation
Atlanta	$567,371
Augusta	$125,715
Clayton County	$134,113
Cobb County	$198,613
De Kalb County	$349,366
Fulton County	$123,845
Gwinnett County	$315,068
Savannah	$154,069
Georgia State Program	$3,308,761
TOTAL	**$5,276,921.00**

C. Grant and Per Diem Program (GPD)

Veteran Affair's Homeless Providers Grant and Per Diem Program is offered annually (as funding permits) by the Department of Veterans Affairs Health Care for Homeless Veterans (HCHV) Programs to fund community agencies providing services to homeless Veterans. The purpose of the program is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination.[1] The program provides transitional supportive housing for up to 24 months for veterans. Table E3 below includes a list of some GPD programs in Georgia.

Table E3: GPD Programs in Georgia

Atlanta	Transition House Inc.	72 beds
Atlanta	Gateway	46 beds
Atlanta	Salvation Army	64 beds

Homeless liaisons at the VA medical Centers are the main point of contact for all other VA services and housing programs. Table E4 below provides the VA contact information for Georgia.

TABLE E4: VA HOMELESS COORDINATORS[1]

	VA Point of Contact	Telephone Number	Email Address
Atlanta	Sally Eddins, LCSW	404-321-6111 ext: 4673	sally.eddins@va.gov
Augusta	Beverly Knighten	706-733-0188, extension 7426	Beverly.knighten@va.gov
Dublin	Michael Bland	478-272-1210 ext 2189	michael.bland@va.gov

D. Support Services for Low-Income Veterans Families (SSVF)

On July 26, U.S. Department of Veterans Affairs (VA) Secretary Eric Shinseki announced the award of 85 new grants under the VA's new Supportive Services for Veteran Families (SSVF) Program. The SSVF Program is a new VA program that awards grants to private non-profit organizations and consumer cooperatives that will provide supportive services to very low-income Veterans and their families residing in or transitioning to permanent housing. The grantees will provide a range of supportive services designed to promote housing stability.

As seen in Table E5, in Georgia, 2 grantees received over $1.3 million dollars in SSVF funding in 2012, and in 2013, five more grantees received an additional $5.6 million dollars.

TABLE E5: SSVF GRANT AWARDS

Award Year	Sponsor or Project Name	City	Grant Award
2012	Action Ministries, Inc.	Atlanta	1,000,000
2012	Decatur Cooperative Ministry, Inc.	Decatur	320,720
2013	Central Savannah River Area Economic Opportunity Authority, Inc.	Augusta	1,098,918
2013	Action Ministries	Atlanta	1,007,000
2013	Decatur Cooperative Ministry, Inc.	Decatur	549,370
2013	Travelers Aid of Metropolitan Atlanta, Inc.	Atlanta	1,007,000
2013	United Way of Metropolitan Atlanta	Atlanta	2,000,000
TOTAL			**6,983,008**

State of Georgia

Review of Supported Employment Services

Under the United States v. Georgia Settlement Agreement

and the

Findings from the State Health Authority Yardstick

Requested by Elizabeth Jones, Independent Reviewer

David Lynde, MSW

September 15, 2014

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Department of Justice Settlement Agreement

The reviewer was asked to advise again whether the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) has met the requirements of the Settlement Agreement regarding the provision of Supported Employment programs, and then to evaluate the quality of these services by completing a State Health Authority Yardstick (SHAY) review.

The Settlement Agreement section on Supported Employment contains the following language:

> "Supported Employment
> i. Supported Employment will be operated according to an evidence-based supported employment model, and it will be assessed by an established fidelity scale such as the scale included in the Substance Abuse and Mental Health Administration ("SAMHSA") supported employment tool kit.
> ii. Enrollment in congregate programs shall not constitute Supported Employment.
> iii. Pursuant to the following schedule…
> (D) By July 1, 2014, the State shall provide Supported Employment services to 500 individuals with SPMI."

While it is beyond the scope of the work of this reviewer to check the validity and the reliability of the specific data provided by DBHDD, the data presented from DBHDD and the information confirmed by a variety of stakeholders (including providers) who were interviewed do indicate that DBHDD is complying with the Supported Employment provisions of the Settlement Agreement. According to the "FY 14 Programmatic Report Data: Supported Employment Services," as of the end of June 2014, there were 998 individuals receiving Supported Employment services under the Settlement Agreement. The monthly rate of employment was 47.3 percent across Supported Employment programs. It is worth noting that 47.3 percent employment is a reasonable and appropriate employment rate for people in Supported Employment services. The SHAY, which was focused on the supported employment "slots" under the Settlement Agreement, may be viewed as an instrument to measure the extent and quality of that compliance.

SHAY Executive Summary

This document provides a summary of the status of the work that has been done by the DBHDD regarding the implementation and dissemination of evidence based Supported Employment (SE) services for adults with severe mental illness (SMI) in the State of Georgia. This is the fourth SHAY report that has been completed at the request of Elizabeth Jones, Independent Reviewer. The last SHAY report was completed in September 2013.

SHAY Introduction

The State Health Authority Yardstick (SHAY) was designed by a group of mental health researchers and implementers who were interested in assessing the facilitating conditions for the adoption of Evidence-Based Practices (EBPs) created by a state's health or mental health authority.

The reviewer spent four days in July 2014, specifically; July 28, 29, 30 and 31, reviewing documentation including: agency fidelity reports, monthly programmatic data for SE programs, SE coalition meeting notes, training documents, fidelity outcomes summary, technical assistance and consultation reports, as well as report summaries from an independent SE consultant. During the four days in July 2014, the reviewer also attended meetings with and interviewed a variety of stakeholders in the State of Georgia. The July 2014 interviews and meetings in Georgia included: staff from GA DBHDD, providers of SE services for adults with mental illness, family members, consumers participating in Supported Employment services, staff and the Executive Director from the Georgia Vocational Rehabilitation Agency (GVRA), staff from the Institute on Human Development and Disability at the University of Georgia, and an interview with an independent Supported Employment (SE) trainer and consultant, as well as representatives from consumer and family advocacy organizations and other mental health advocates. Of particular note, the reviewer was also able to meet with Commissioner Frank Berry in person and Deputy Commissioner Judith Fitzgerald by telephone during the July 2014 visit. In addition to July 2014 visit, the reviewer made interim visits to Georgia in October 2013 and December of 2013 as well as in May 2014. During the May 2014 visit, the reviewer met with SE providers and clients and also observed an ACT team. Information from the May 2014 and other interim visits was used in the development of the findings for this report.

The reviewer was asked to assess the extent that policies, procedures and practices are present in Georgia regarding SE services. Evidence-based Supported Employment is a Substance Abuse and Mental Health Services (SAMHSA) recognized practice that has been repeatedly demonstrated to be the most effective means to help adults with SMI to obtain and retain competitive employment as part of their recovery process.

The reviewer is grateful for the warm and friendly professional courtesies that were graciously extended by the leadership and staff at DBHDD for all of the visits and communications that have occurred over the past year. The reviewer also appreciates the open and frank discussions that occurred at several levels of the Georgia DBHDD system regarding evidence-based Supported Employment services over the same time frame.

The SHAY is a tool for assessing the state health or mental health authority responsible for mental health policy and Medicaid policies in a state. As with the previous report, the scope (or unit of analysis) for the SHAY is focused on the SE slots defined by the "Settlement Agreement." The SHAY examines the policies, procedures and actions that are currently in place within a state system, or in this case, part of the state system. The SHAY does not incorporate planned activities; rather it focuses exclusively on what has been accomplished and what is currently occurring within a state. For the purposes of this, DBHDD has been identified as the "State Mental Health Authority (SMHA)." This report details the findings from information gathered in each of fifteen separate items contained in the SHAY. For each item, the report includes a brief description of the item and identifies the scoring criteria. Each item is scored on a numerical scale ranging from "five" being fully implemented to a "one" designating substantial deficits in implementation. Recommendations for improvement also are included with each item. A summary table for the scoring of the SHAY items is contained at the end of the report.

SHAY Findings

1. EBP Plan

The SMHA has an Evidence Based Practices (EBP) plan to address the following:

Present	1. A defined scope for initial and future implementation efforts
Present	2. Strategy for outreach, education, and consensus building among providers and other stakeholders
Present	3. Identification of partners and community champions
Present	4. Sources of funding
Present	5. Training resources
Present	6. Identification of policy and regulatory levers to support EBP
Present	7. Role of other state agencies in supporting and/or implementing the EBP
Present	8. Defines how EBP interfaces with other SMHA priorities and supports SMHA mission
Present	9. Evaluation for implementation and outcomes of the EBP
Present	10. The plan is a written document, endorsed by the SMHA

Narrative

As indicated in the 2013 SHAY report, DBHDD has developed a well-written document, “2013 Georgia Department of Health and Developmental Disabilities Supported Employment Strategic Plan” that provides a well-described framework for the implementation of Supported Employment services in the State of Georgia. That plan has been circulated and discussed since its inception.

Given the approaching end of the “Settlement Agreement,” it is strongly recommended that GA DBHDD leadership develop a concise SE plan that focuses exclusively on sustaining the progress that the Department and its partners have made in the development of SE services and the infrastructure to support those services. This plan should describe all efforts and strategies underway to diversify and secure funding for SE providers after the completion of

the "Settlement Agreement" as well as other activities at the state-level to secure and develop strategic partnerships with agencies like the Georgia Vocational Rehabilitation Agency.

2. Financing: Adequacy

Is the funding model for the EBP adequate to cover costs, including direct service, supervision, and reasonable overhead? Are all EBP sites funded at the same level? Do sites have adequate funding so that practice pays for itself?

	1. No components of services are reimbursable
	2. Some costs are covered
Present	3. Most costs are covered
	4. Service pays for itself (e.g. all costs covered adequately, or finding of covered components compensates for non-covered components)
	5. Service pays for itself and reimbursement rates attractive relative to competing non-EBP services.

Narrative

For the purposes of the Settlement Agreement, funding for the designated SE slots (sometimes referred to as "ADA (Americans with Disabilities Act) slots") remains fixed at the same rate of $410.00 per slot for each provider. This rate has remained unchanged since the beginning of the Settlement Agreement.

Unlike most SE systems, this funding is "slot-specific" and not specific to individual clients in SE services or tied to SE landmarks or outcomes. Enrollment in the designated SE slots is defined in the Settlement Agreement:

> The target population for the community services described in this Section (III.B) shall be approximately 9,000 individuals by July 1, 2015, with SPMI who are currently being served in the State Hospitals, who are frequently readmitted to the State Hospitals, who are frequently seen in Emergency Rooms, who are chronically homeless, and/or who are being released from jails or prisons.

b. Individuals with serious and persistent mental illness and forensic status shall be included in the target population, if the relevant court finds that community service is appropriate.

While this slot based funding structure is implemented as part of the Settlement Agreement, as was recommended last year, this rate structure still warrants a careful cost-based examination in collaboration with SE providers to evaluate if the rate is adequate for providers. It will be important to transparently share the findings of that cost rate study as well as the data and calculation processes that are used in completing the cost rate study with SE providers and other stakeholders in Georgia.

The most prominent concern among SE providers is that payments for SE services will be radically reduced at cessation of the Settlement Agreement. As one provider summed it up, "We are all deeply concerned that 2016 will be a replay of 2008 all over again." In 2008, providers stated that rates and reimbursement for SE services were cut substantially resulting in reductions in numerous SE providers and drastic reductions in the availability of SE services across the state.

A second cost consideration raised by the SE providers relates to the nature of clients currently being enrolled in SE slots. Providers are now being asked to enroll clients in the SE slots who meet the "Locus 3" level of need. This has resulted in providers working with clients on SE who have more recent hospital stays and more frequent involvement with the legal system. This results in more SE work to achieve good job matches. As a result, providers feel like the time and work put into the SE slots is more than it was only a few years ago. As one provider stated, "The funding rate has not changed for several years now. It is too low for the increased expectations and the increased accountability we now have for SE services. The current rate just doesn't pay the costs, we have regular financial struggles with our SE services."

Another complication created by the Locus 3 level of need for SE slots is that many people with mental illness who are receiving services are not being provided an opportunity to participate in Supported Employment services. Many providers stated they have had to refuse people with serious mental illnesses who wanted (and most probably would benefit from) SE services because they do not have any capacity to help those people to achieve their employment goals.

Additionally, it is recommended that DBHDD share the existing work they have done on cost modeling with providers as soon as possible so that providers are actively engaged in the new financial modeling process for SE services.

3. Financing: Start-Up & Conversion Costs

Are costs of start up and or conversion covered, including: 1) Lost productivity for staff training, 2) hiring staff before clients enrolled (e.g. ACT), 3) any costs associated with agency planning and meetings, 4) changing medical records if necessary, 5) computer hardware and/or software if necessary, etc.

	1. No costs of start-up are covered
	2. Few costs are covered
Present	3. Some costs are covered
	4. Majority of costs are covered
	5. Programs are fully compensated for costs of conversion

Narrative

DBHDD has added some new SE slots in the past year. To their credit, DBHDD leadership has worked with new SE providers by creating access to some training and consultation activities. DBHDD leadership has verbally expressed a commitment to review any written requests from new SE providers regarding potential financial resources for starting SE services.

4. Training: Ongoing consultation and technical support

Is there ongoing training, supervision and consultation for the program leader and clinical staff to support implementation of the EBP and clinical skills:

Present	1) Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training)
Present	2) Initial agency consultation re: implementation strategies, policies and procedures, etc. (e.g. 1 - 3 meetings with leadership prior to implementation or during initial training)
Present	3) Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (minimum of 3 months, e.g. monthly x 12 months)
	4) On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months)
Present	5) Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (minimum of 3 months, e.g. monthly X 12 months)
	No components covered

Narrative

DBHDD has continued their SE training and consultation agreement with the Institute on Human Development and Disability at the University of Georgia. The training has provided specific modules for SE staff who have experience with the practice and for staff who are new to SE services and have had little to no previous training. The training continues to rely heavily on the use of webinars as the primary source of training. While this is an important ingredient, it is not fully sufficient to help SE provider staff to learn all the skills necessary for high quality SE services.

Numerous providers gave significant and pronounced praise regarding the onsite training and consultation that they received from Ms. Meka McNeal, an independent SE trainer and consultant from Maryland who has been contracted

by GA DBHDD to provide onsite consultation and training to SE sites that had some challenges with their fidelity scores. One provider described the consultation from Ms. McNeal in this way; "You could not have found a better person on this earth to send us." Another provider stated, "It was totally different, I expected another person to show up in a suit. Instead she showed up ready to go out into our community and work with our employers beside us."

It is strongly recommended that GA DBHDD invest the necessary resources to make onsite, community-based skill demonstrations of SE, as were provided by Ms. McNeal during her visit, regularly available to all SE programs. The current training relies too heavily on web-based information and does not support enough time and resources for SE providers with in the field demonstrations. As Ms. McNeal wrote in her Technical Assistance, Consultation and Training Report:

> "The level of training that program leaders shared with the consultant/trainer doesn't seem to match with the level of training needed. Most programs reported an online training of IPS and maybe a visit from a trainer. It is suggested that Georgia leaders consider the idea of having two dedicated trainers who would be available to visit programs to provide on-site technical assistance and training."

5. Training: Quality

Is high quality training delivered to each site? High quality training should include the following:

Present	1) Credible and expert trainer
Present	2) Active learning strategies (e.g. role play, group work, feedback
Present	3) Good quality manual, e.g. SAMHSA Toolkit
Present	4) Comprehensively addresses all elements of the EBP
	5) Modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered
Present	6) High quality teaching aides/materials including workbooks/work sheets, slides, videos, handouts, etc., e.g. SAMHSA Toolkit

Narrative

GA DBHDD has continued their ongoing training relationship with the Institute on Human Development and Disability at the University of Georgia. One additional improvement in the training process that was made by GA DBHDD is the inclusion of the opportunity for SE programs with good fidelity scores to act as shadow or demonstration sites for other SE programs. Many providers stated they have already taken advantage of this additional training resource and providers strongly indicated this process is very beneficial to all parties involved. As one provider described it, “We have done visits with other agencies. It is good to see what they are doing. We are not looking at it as good versus bad, instead we see it as a chance to get good quality improvement ideas instead of just being in our own little world.”

Once again, it is strongly recommended that DBHDD find the resources to provide site based modeling of SE skills and site based observations of providers using SE skills in their communities with clients and potential employers. See the narrative under “4. Training: Ongoing consultation and technical support.”

6. Training: Infrastructure / Sustainability

Has the state established a mechanism to allow for continuation and expansion of training activities related to this EBP, for example relationship with a university training and research center, establishing a center for excellence, establishing a learning network or learning collaborative. This mechanism should include the following components:

Present	1) Offers skills training in the EBP
Present	2) Offers ongoing supervision and consultation to clinicians to support implementation in new sites
Present	3) Offer ongoing consultation and training for program EBP leaders to support their role as clinical supervisors and leaders of the EBP
	4) Build site capacity to train and supervise their own staff in the EBP
Present	5) Offers technical assistance and booster trainings in existing EBP sites as needed
Present	6) Expansion plan beyond currently identified EBP sites
Present	7) One or more identified model programs with documented high fidelity that offer shadowing opportunities for new programs
Present	8) SMHA commitment to sustain mechanism (e.g. center of excellence, university contracts) for foreseeable future, and a method for funding has been identified
	No components covered

Narrative

As previously recognized, DBHDD has made some enhancements regarding the provision of SE trainings and consultation services for SE providers in the state. The previously stated recommended addition of available resources to provide on-site modeling and demonstrations of SE skills in the community by a skilled SE trainer would be a substantial improvement in this area.

7. Training: Penetration

What percent of sites have been provided high quality training

(Defined as having a score of "3 or higher" on item #4. Training: Ongoing consultation and technical support)

Ongoing training should include 3 or more of the following components:

1) Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training)
2) Initial agency consultation re: implementation strategies, policies and procedures, etc. (e.g. 1 - 3 meetings with leadership prior to implementation or during initial training)
3) Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (minimum of 3 months, e.g. monthly x 12 months)
4) On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months).
5) Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (minimum of 3 months, e.g. monthly X 12 months)

	1. 0 – 20 %
	2. 20 – 40%
	3. 40 – 60%
	4. 60 – 80%
Present	5. 80 – 100%

Narrative

DBHDD continues to provide some level of SE training and consultation services to numerous SE providers across the state.

8. SMHA Leadership: Commissioner Level

Commissioner is perceived as a effective leader (influence, authority, persistence, knows how to get things done) concerning EBP implementation who has established EBPs among the top priorities of the SMHA as manifested by:

Present	1) EBP initiative is incorporated in the state plan, and or other state documents that establish SMHA priorities
Present	2) Allocating one or more staff to EBP, including identifying and delegating necessary authority to an EBP leader for the SMHA
Present	3) Allocation of non-personnel resources to EBP (e.g. money, IT resources, etc.)
Present	4) Uses internal and external meetings, including meetings with stakeholders, to express support for, focus attention on, and move EBP agenda
Present	5) Can cite successful examples of removing policy barriers or establishing new policy supports for EBP

Narrative

The Commissioner of the Georgia Department of Behavioral Health and Developmental Disabilities is Frank Berry who was interviewed in person once again during this review. Deputy Commissioner Judith Fitzgerald made herself available by telephone during the same time. Providers as well as all other stakeholders in the Georgia system continue to praise the Commissioner for his leadership regarding SE services. As one provider, who seemed to speak for many stated, “Commissioner Berry speaks about SE publicly wherever he goes. He talks about a recovery vision that includes housing and employment. The Commissioner has been very supportive regarding Supported Employment.”

9. SMHA Leadership: Central Office EBP Leader

There is an identified EBP leader that is characterized by the following:	
Present	1) EBP leader has adequate dedicated time for EBP implementation (min 10%), and time is protected from distractions, conflicting priorities, and crises
Present	2) There is evidence that the EBP leader has necessary authority to run the implementation
Present	3) There is evidence that EBP leader has good relationships with community programs
Present	4) Is viewed as an effective leader (influence, authority, persistence, knows how to get things done) for the EBP, and can site examples of overcoming implementation barriers or establishing new EBP supports

Narrative

The SE staff members at GA DBHDD have established good working relationships with the SE providers in their community using an integrated team approach. When asked which person at GA DBHDD a provider would contact for assistance, providers replied that they have a range of options and resources available to them. Providers stated their communications with the SE team at DBHDD have been respected and DBHDD staff has been very responsive. Providers identified four key people that have been helpful and accessible; Dr. Timberlake, Vernell Jones, Tammatha Kinder and Erica Walker. GA DBHDD has made significant strides in forging and continuing to develop these positive provider relationships.

10. Policy and Regulations: Non SMHA State Agencies

The SMHA has developed effective interagency relations (other state agencies, counties, governors office, state legislature) to support and promote the EBP as necessary/appropriate, identifying and removing or mitigating any barriers to EBP implementation, and has introduced new key facilitating regulations as necessary to support the EBP.

Examples of supporting policies:

- Medicaid agency provides reimbursement for the EBP (If Medicaid not under the SMHA)
- The state's vocational rehabilitation agency pays for supported employment programs

Examples of policies that create barriers:

- Medicaid agency excludes EBP, or critical component, e.g. disallows any services delivered in the community (If Medicaid agency not under the SMHA)
- State vocational rehabilitation agency does not allow all clients looking for work access to services, or prohibits delivery of other aspects of the supported employment model

	Virtually all policies and regulations impacting the EBP serve as barriers
	On balance, policies that create barriers outweigh policies that support/promote the EBP
	Policies that support/promote the EBP are approximately equally balanced by policies that create barriers
Present	On balance, policies that support/promote the EBP outweigh policies that create barriers
	Virtually all policies and regulations impacting the EBP support/promote the EBP

Narrative

GA DBHDD has made some new and significant progress in this area by launching two new pilot sites to demonstrate and further understand how SE services can be provided in a collaborative partnership with the Georgia Vocational Rehabilitation Agency (GVRA). Several states have increased the success of both agencies by developing strong working affiliations between behavioral health and state vocational rehabilitation services. Both clients and staff from both GVRA and an SE provider were interviewed regarding their work together. The universal experience at the pilot site appears to be one of great

receptivity from all parties. Clients described the pilot as being very receptive to their needs as well as their individual employment goals. Staff from GVRA provided insights about their learning, as one Vocational Rehabilitation counselor described it;

> "By sitting in on the integrated team meetings (SE employment specialist and other members of the client's mental health treatment team), I began to learn about all the supports that are in place and working with the client. Previously, I might have thought, do I want to put my reputation on the line for a person with a mental illness? But now I have begun to understand all the services that are wrapped around this person to help them with their challenges."

Conversely, one employment specialist stated,

> "By having the VR Counselor sitting in on our team meetings, I began to understand the concerns that VR has and I have started thinking more about how can we help VR to address those concerns."

The lessons learned in these pilot sites and the successful capturing and sharing of those lessons across the system provide critical ingredients to further develop the GVRA and GA DBHDD collaboration regarding SE services to better benefit clients. The Executive Director of GVRA is clearly supportive of this pilot work and building upon the lessons learned at these pilot sites.

There remains significant work to do across the state to improve relationships between SE providers and GVRA. While some providers describe good working relationships, other providers continue to state they have no working partnerships at all with GVRA staff. As one provider stated, "They (GA DBHDD) keep saying things will improve with Vocational Rehabilitation. It will really happen. Things will get better. But nothing is happening in our area. Nothing is better in our area of the state." Another provider echoed this concern, "We are still not getting any access to state vocational rehabilitation services for the clients we are working with." And a third provider stated their view of attempting to work with the state's vocational rehabilitation services in this way, "Working with VR (vocational rehabilitation) the way they work now is against fidelity for Supported Employment services because the vocational rehabilitation counselors want lots

of pre-employment assessments and lots of pre-vocational testing done before looking at competitive employment for our clients."

Developing a collaborative partnership between GA DBHDD and GVRA will not only help citizens of Georgia with a mental illness to more effectively obtain competitive employment, but it will also serve to strengthen both agencies. Many states have worked with a funding structure that is currently being discussed in Georgia whereby some state dollars from DBHDD might be reallocated to GVRA who might use those funds to draw down more federal matching dollars for state vocational rehabilitation services. (Apparently Georgia has left millions of federal vocational rehabilitation matching dollars on the table over the past three years.) The increased matched federal funds are then used to provide state vocational rehabilitation services to people with serious mental illnesses, and in several places, those funds have also been used to hire or develop specialized vocational rehabilitation counselors who are trained to work effectively with SE programs and job candidates with mental illness.

A second key partner in this area is the State's Medicaid division. GA DBHDD is working with the State's Medicaid division to develop diversified funding for SE services. Continued work on this will benefit SE services over the long run—especially when considering factors that contribute to successful sustaining of SE services.

11. Policies and Regulations: SMHA

The SMHA has reviewed its own regulations, policies and procedures to identify and remove or mitigate any barriers to EBP implementation, and has introduced new key regulations as necessary to support and promote the EBP.

Examples of supporting policies:

- SMHA ties EBP delivery to contracts
- SMHA ties EBP to licensing/ certification/ regulation
- SMHA develops EBP standards consistent with the EBP model
- SMHA develops clinical guidelines or fiscal model designed to support model EBP implementation

Examples of policies that create barriers:

- SMHA licensing/ certification/ regulations directly interfere with programs ability to implement EBP

Present

Score:

1. Virtually all policies and regulations impacting the EBP act as barriers
2. On balance, policies that create barriers outweigh policies that support/promote the EBP
3. Policies that are support/promote the EBP are approximately equally balanced by policies that create barriers
4. On balance, policies that support/promote the EBP outweigh policies that create barriers
5. Virtually all policies and regulations impacting the EBP support/promote the EBP

Narrative

DBHDD has incorporated language into their contracting procedures that Supported Employment providers are required to provide SE services consistent with the description of evidence-based Supported Employment in the SAMHSA toolkits as well as most of the identified principles of evidence-based Supported Employment services.

A concern that was raised in the 2013 SHAY report that continues to exist is the relationship between SE providers and the “vocational specialists” that are on Assertive Community Treatment (ACT) teams. It appears that the vocational

specialists on ACT teams are not helping clients to directly obtain employment in their communities. Instead, employment providers and others universally regard these vocational specialists as "doing nothing about employment." Many providers stated they are contacted by ACT teams to provide SE services despite the presence of designated and funded "vocational specialists" on ACT teams. Several providers feel like the "vocational specialist" acts like a "gatekeeper" to decide who can and who cannot be referred out to SE services. While referring services outside of a team is contrary to established principles of ACT, the idea of a gatekeeper is likewise contrary to the very principles of SE services.

Staff at DBHDD stated they have raised this concern with ACT providers; however, raising the concern has not appeared to change any behaviors. Given the limited availability for employment services and the high interest in the State of Georgia, it seems crucial to actively address the lack of employment services being provided by "vocational specialists" on ACT teams.

11. Policies and Regulations: SMHA EBP Program Standards

The SMHA has developed and implemented EBP standards consistent with the EBP model with the following components:

Present	1) Explicit EBP program standards and expectations, consonant with all EBP principles and fidelity components, for delivery of EBP services
Present	2) SMHA has incorporated EBP standards into contracts, criteria for grant awards, licensing, certification, accreditation processes and/or other mechanisms
Present	3) Monitors whether EBP standards have been met
Present	4) Defines explicit consequences if EBP standards not met (e.g. contracts require delivery of model supported employment services, and contract penalties or non-renewal if standards not met; or licensing/accreditation standards if not met result in consequences for program license.)

Narrative

As stated previously, DBHDD has included language in provider contracts that specifies that SE services will be consistent with the principles of evidence-based

Supported Employment services as described in the SAMHSA Supported Employment toolkit. The leadership at DBHDD appears to actively track and share information regarding how well providers are meeting these expectations.

12. Quality Improvement: Fidelity Assessment

There is a system in place for conducting ongoing fidelity reviews by trained reviewers characterized by the following components:

Present	1) EBP fidelity (or functional equivalent designed to assess adherence to all critical components of the EBP model) is measured at defined intervals
Present	2) GOI fidelity (or functional equivalent designed to assess adherence to all critical components required to implement and sustain delivery of EBP) is measured at defined intervals.
Present	3) Fidelity assessment is measured independent – i.e. not assessed by program itself, but by SMHA or contracted agency
Present	4) Fidelity is measured a minimum of annually
Present	5) Fidelity performance data is given to programs and used for purposes of quality improvement
Present	6) Fidelity performance data is reviewed by the SMHA +/- local MHA
Present	7) The SMHA routinely uses fidelity performance data for purposes of quality improvement, to identify and response to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.)
Present	8) The fidelity performance data is made public (e.g. website, published in newspaper, etc.)
	No components covered

Narrative

The leadership at GA DBHDD has built a credible, experienced and trained staff to provide regular and consistent fidelity reviews for all designated SE providers in the State. To their credit, the leadership has also posted the information regarding provider fidelity reviews for each agency on their website. GA DBHDD

has also taken specific actions with one SE provider who did not achieve a basic level of fidelity by not contracting with that provider for SE slots.

DBHDD also recently hosted a roundtable discussion regarding SE fidelity for providers to raise questions and concerns about the fidelity process. To their credit, DBHDD has providers now interested in and invested in their fidelity findings. As one provider stated, “Fidelity reviews give me the ideas and ways to improve our SE services.” Another commented, “Fidelity helps me to better understand what they (DBHDD) are looking for, like the vocational rehabilitation relationship and employer contacts.”

At the same time, providers voiced numerous concerns about how some specific items regarding fidelity are being monitored and scored. There were plentiful concerns about the fidelity items related to diversity of jobs and diversity of employers. Some providers reported being marked down for a diversity of employers because clients were working for the same chain of restaurants but in completely different towns. Other providers stated they feel they are in a double bind, on one hand they are asked to honor client preferences about where they want to work, while on the other hand they are marked down on their scoring for following those client preferences. As one frustrated provider stated, “What am I supposed to do when a client says that is where they want to work? Should I tell the client, I know you want to work there but I can’t let you because of fidelity?”

Providers also voiced abundant concerns and misgivings regarding the use and scoring of the fidelity scale for core providers versus specialty (employment only) providers. Specialty providers feel they are unable to force core providers to hold integrated team meetings for SE services, yet they are being marked down for not attending those meetings. As on specialty provider stated, “I attend every single meeting they invite me to every month. What else can I do, I can’t make them hold meetings? That is all I can do.”

In order to maintain the successful progress that has been made to integrated fidelity measures into the GA DBHDD system, it is vital for DBHDD leadership to find ways to address and remediate these provider concerns and questions regarding SE fidelity.

14. Quality Improvement: Client Outcomes

A mechanism is in place for collecting and using client outcome data characterized by the following:

Present	1) Outcome measures, or indicators are standardized statewide, AND the outcome measures have documented reliability/validity, or indicators are nationally developed/recognized
Present	2) Client outcomes are measured every 6 months at a minimum
Present	3) Client outcome data is used routinely to develop reports on agency performance
Present	4) Client specific outcome data are given to programs and practitioners to support clinical decision making and treatment planning
	5) Agency performance data are given to programs and used for purposes of quality improvement
Present	6) Agency performance data are reviewed by the SMHA +/- local MHA
Present	7) The SMHA routinely uses agency performance data for purposes of quality improvement; performance data trigger state action. Client outcome data is used as a mechanism for identification and response to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.).
	8) The agency performance data is made public (e.g. website, published in newspaper, etc.)

Narrative

DBHDD has made some progress in this area. Outcome reports are now made available to providers on a regular basis. Providers were aware of the general outcomes for people in SE services across the state. However, the outcomes for SE programs do not appear to be available on the GA DBHDD website where SE fidelity reports are readily accessible.

Tracking specific individual outcomes for SE is an important tool for sustainability and for ongoing quality improvement for SE services. One fidelity reviewer reported interviewing a client who was employed and in Supported Employment services for 18 years. When using a slot-based outcome tool, this person would continue to be on the report as competitively employed; however, when using individual client-level data, a strong case would be made for helping this person to transition their employment supports to other sources and then opening up a new SE position for another unemployed client who would benefit from SE services.

Tracking individual client-level SE outcomes also allows the leadership at DBHDD to build a case for sustaining SE with specific data. For example: Did the person use fewer services after starting employment? Did the person stay out of the hospital longer after starting employment? How long has the person remained in employment? As one stakeholder observed,

> "We have not done enough to describe all the good things that have happened to people in Supported Employment services in the DOJ (Department of Justice) slots as reasons to show that SE works here in Georgia. That should be the case we are making to keep SE after the Settlement Agreement is over."

The following text regarding tracking client level specific outcomes is repeated from the 2013 SHAY report as it continues to be relevant and not addressed:

> "In the outcome system redesign, it is recommended that DBHDD incorporate measures to address the challenges inherent in the DOJ SE slots mechanism. Currently, providers report only the percentage of people in those slots who were working in competitive employment during the month. While this is an important data component, it is not sufficient for assuring that SE services are being effective. For example, a program may be helping clients to get jobs but not helping them to keep jobs, so

> clients may be quickly losing jobs and are not able to benefit from employment. This non-recovery-oriented approach to SE would not be detected with the current outcome process. As another example, a program may be helping the clients who are working to keep their jobs but not helping any of the unemployed clients to obtain jobs. Once again, this non-recovery-oriented approach to SE would not be detected in the current SE outcome process."

A comprehensive outcome system that identifies individual client-level specifics about SE services is crucial to providing the most effective and the most accountable SE services within the state. Some specific information that should be captured in such a system includes:

- Length of time the person has been in SE services
- Length of time between the person entering SE services and obtaining employment
- Length of time the person has been employed
- Length of time the person has had "stable" employment
- Number of SE clients successfully graduated from SE services while employed.

Client level data would allow people to build a data based story, combined with personal narratives regarding Supported Employment in Georgia. As one SE participant reflected:

> "Being in Supported Employment is very encouraging in terms of work. You have a person checking things out with you and sometimes for you. Having an employment specialist in your corner is encouraging and hopeful. You keep looking for a job because of the supports."

And another employed participant stated,

> "I have a job now because of my employment specialist. I was very picky in looking for a job and she listened to me. They found me a job with the City but that was indoors and I wanted to work outdoors. They kept asking me what I wanted to do. We are encouraged to follow what we want to do. My employment specialist wanted me to choose where I wanted to go to work. She has been very supportive."

15. Stakeholders

The degree to which consumers, families, and providers are opposed or supportive of EBP implementation.

Consumer Stakeholders	
	1. Active, ongoing opposition to the EBP
	2. Opposition outweighs support, or opinion is evenly split, but no active campaigning against EBP
	3. Stakeholder is generally indifferent
	4. Generally supportive, but no partnerships, or active proponents.
Present	5. Stakeholder advocacy organization leadership/opinion leaders currently offer active, ongoing support for the EBP. Evidence of partnering on initiatives.

Family Stakeholders	
	1. Active, ongoing opposition to the EBP
	2. Opposition outweighs support, or opinion is evenly split, but no active campaigning against EBP
	3. Stakeholder is generally indifferent
Present	4. Generally supportive, but no partnerships, or active proponents.
	5. Stakeholder advocacy organization leadership/opinion leaders currently offer active, ongoing support for the EBP. Evidence of partnering on initiatives.

Provider Stakeholders	
	1. Active, ongoing opposition to the EBP
	2. Opposition outweighs support, or opinion is evenly split, but no active campaigning against EBP
	3. Stakeholder is generally indifferent
	4. Generally supportive, but no partnerships, or active proponents.
Present	5. Stakeholder advocacy organization leadership/opinion leaders currently offer active, ongoing support for the EBP. Evidence of partnering on initiatives.

5	15. Summary Stakeholder Score: (Average of 3 scores below)
5	15.a Consumers Stakeholders Score
4	15.b Family Stakeholders Score
5	15.c Providers Stakeholders Score

Narrative

The support and engagement among providers and consumers in Georgia for Supported Employment services appears to be quite strong. Given the concerns that have been raised and echoed regarding the potential for significant cuts and reductions in SE services, this seems like a critical time for the leadership at GA DBHDD to actively engage supportive stakeholders in a formal planning and communication process regarding specific strategies and ideas for sustaining the gains the State of Georgia had made under the current "Settlement Agreement" in order to avoid the worst fears of many. As one stakeholder put it, "We have a history here in this State of being in compliance with things until we are no longer forced to remain in compliance."

Summary Table of Georgia SHAY Scores 2014

1. EBP Plan	5
2. Financing: Adequacy	3
3. Financing: Start-up and Conversion Costs	3
4. Training: Ongoing Consultation & Technical Support	4
5. Training: Quality	4
6. Training: Infrastructure / Sustainability	5
7. Training: Penetration	5
8. SMHA Leadership: Commissioner Level	5
9. SMHA Leadership: EBP Leader	5
10. Policy and Regulations: Non-SMHA	4
11. Policy and Regulations: SMHA	4
12. Policy and Regulations: SMHA EBP Program Standards	5
13. Quality Improvement: Fidelity Assessment	5
14. Quality Improvement: Client Outcome	4
15. Stakeholders: Average Score (Consumer, Family, Provider)	5
Total SHAY Score	66
Average SHAY Item Score	4.4

Summary Table of Georgia SHAY Scores 2012 – 2014

SHAY Item	2012 score	2013 score	2014 score
1. EBP Plan	4	5	5
2. Financing: Adequacy	3	3	3
3. Financing: Start-up and Conversion Costs	1	2	3
4. Training: Ongoing Consultation & Technical Support	2	4	4
5. Training: Quality	3	4	4
6. Training: Infrastructure / Sustainability	3	4	5
7. Training: Penetration	1	5	5
8. SMHA Leadership: Commissioner Level	4	5	5
9. SMHA Leadership: EBP Leader	3	5	5
10. Policy and Regulations: Non-SMHA	2	3	4
11. Policy and Regulations: SMHA	4	4	4
12. Policy and Regulations: SMHA EBP Program Standards	3	5	5
13. Quality Improvement: Fidelity Assessment	3	4	5
14. Quality Improvement: Client Outcome	3	3	4
15. Stakeholders: Average Score (Consumer, Family, Provider)	4	5	5
Total SHAY Score	43	61	66
Average SHAY Item Score	2.9	4.0	4.4