IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. STATE OF GEORGIA, *et al.*, Defendants.	)	CIVIL ACTION NO. 1:10-CV-249-CAP

NOTICE OF JOINT FILING OF THE REPORT OF THE INDEPENDENT REVIEWER

Plaintiff United States of America and Defendants State of Georgia, et al., hereby jointly file the report of the Independent Reviewer pursuant to ¶ VI.B of the Settlement Agreement [Docket Nos. 112 & 115]. The Independent Reviewer's report (with its referenced attachments) is included as Attachment A hereto.

Respectfully submitted, this 20th day of September.

[signatures on next pages]

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that the foregoing ***Notice of Joint Filing of the Report of the Independent Reviewer*** was electronically filed with the Clerk of Court using the CM/ECF system, which automatically serves notification of such filing to all counsel of record.

This 20th day of September, 2012.

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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 20, 2012

INTRODUCTORY COMMENTS

This is the second 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 scheduled for completion by July 1, 2012.

In many respects, this second year has been one of foundation building, as the State continues its shift from a system based largely on institutional structures and resources to one that is consistent with the principles and operations of an integrated community-based system of supports. In the year ahead, it will be critical to continue a strong emphasis on the quality of the implementation decisions and the strategies required for sustainability.

As recognized in last year's Report, the tasks undertaken by the Department of Behavioral Health and Developmental Disabilities require a substantial commitment of leadership, energy and resources.

The Department has demonstrated very good faith in meetings its obligations. The leadership of the former Commissioner, Dr. Frank Shelp, and that of the newly appointed Commissioner, Mr. Frank Berry, is clearly evident and greatly appreciated.

The State Legislature continued to approve the funding required for the full implementation of the Settlement Agreement in the second year.

The Commissioner of the Department of Community Health and his staff have engaged in discussions with the Independent Reviewer regarding Medicaid funding and the licensing of certain residential services. Their accessibility and responsiveness has contributed towards a positive working relationship.

The staff of the Department of Behavioral Health and Developmental Disabilities have worked diligently and carefully to assist the Independent Reviewer with her requests for information and her questions about compliance efforts. The Settlement Coordinator, Pamela Schuble, has been forthright and generous in her responses and support of the Independent Reviewer's role. The initiation of periodic Parties' meetings has been extremely helpful to clarifying information and strengthening the collaboration towards the common interests embodied in the Settlement Agreement.

Once again, it is important to reiterate that Georgia continues to be fortunate to have an articulate and well-informed group of stakeholders who are deeply committed to the principles and goals of the Settlement Agreement and who are energized and eager to participate in its actual implementation. This stakeholder involvement continues to be critical to the reform envisioned by the Parties to the Settlement Agreement. As the next stages of compliance are reached, it is more important than ever that the community stakeholders have presence and voice in decision-making about their emerging community system.

Continuing attention to the partnership between the State's officers and its community citizens will greatly assist in sustaining and building upon the obligations contained in the Settlement Agreement. Commissioner Berry has expressed, to the Independent Reviewer and others, his commitment to that partnership.

Summary of Compliance: Year Two

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 Commissioner of the Department of Behavioral Health and Developmental Disabilities has complied with this provision and has expressed his intent to develop community based alternatives to institutional care. There was no evidence to indicate that individuals with a developmental disability have been transferred between State Hospitals in contradiction of the commitment to cease 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.

Settlement Agreement Reference	Provision	Rating	Comments
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.
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	Of the 48 individuals reviewed in the sample, none were placed in host homes with more than two individuals or in congregate community living settings with more than four individuals. However, in 2 of the 48 cases reviewed, the individuals lived in residences adjacent to other individuals who had transitioned from a State Hospital.It is recommended that the Department review its expectations regarding siting in order to promote integration. The clustering of residences by providers does not foster opportunities for social interaction with non-disabled people.
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.	Compliance	Individual Service Plans were reviewed for the 48 individuals in the sample. The format used by the Department focused on the needs and preferences of each individual. Training in person-centered planning is required by the Department.

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 review of 48 individuals found that critical supports were missing. Individual reviews were referred to the Department due to rights violations, unsanitary environments, inadequate staffing, unsatisfactory day programs, psychotropic drug use and other concerns. The Department has been responsive and is issuing corrective action plans.
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	Although there were Support Coordinators assigned to each individual in the sample, as noted above, needed supports were found to be lacking. Department staff have been working with the Independent Reviewer to address these concerns and appropriate corrective actions are being taken as a result.
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. According to the Department's data, there were 806 mobile crisis team calls responded to across all Regions.
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.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	The Department utilized the services of the Delmarva Foundation to design and implement a quality assurance review process. The work of Delmarva was expanded to conduct person centered reviews (PCR) of individuals leaving State Hospitals. Delmarva also assesses the quality of services by community providers. The Department participates in the National Core Indicator surveys. The Independent Reviewer has reviewed these reports.
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 has been completed and is in the process of being posted on the Department's website.

Settlement Agreement Reference	Provision	Rating	Comments
III.B.1.c	Pursuant to the Volntary 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.
III.B.2.a.i(G)	**All ACT teams will operate with fidelity to the Dartmouth Assertive Community Treatment model.**	**Not scored**	**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 are being complied with by the Department with close involvement of the Independent Reviewer and her expert consultants.**
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.**	**Not scored**	**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.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.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.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.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.**

Settlement Agreement Reference	Provision	Rating	Comments
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.
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 provided these services.
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.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(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.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.
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.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.**

Settlement Agreement Reference	Provision	Rating	Comments
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.	Non-compliance	Compliance is expected in Fall, 2012. One child has been placed in a host family and is doing well; the second placement has been delayed due to the health status of the individual. However, placement plans are proceeding pending her recovery. The third individual is medically unstable and cannot be moved.
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	There was no evidence of inappropriate transfers from one institution to another. Pending the anticipated closure of Central State Hospital, two individuals were transferred to another institution; they remain institutionalized. The first individual was transferred due to her immigration status. The second individual was transferred due to behavioral concerns. On July 2, 2012, he was reviewed by a psychologist consulting to the Independent Reviewer. Community placement plans are dependent on his stabilization and the identification of an appropriate provider.
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.

Settlement Agreement Reference	Provision	Rating	Comments
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 under advisement by the Commissioner.
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	Evidence of compliance is documented by the actions taken to review ACT 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.	Not scored	Pending review of the Quality Management system. Under the Court's August 29, 2012 Order, the Department's provisional Quality Management system report is not scheduled to be submitted until October 1, 2012. The State's semi-annual Quality Management reports begin on February 1, 2013, and the Quality Management system will be reviewed in more detail in next year's monitoring report.
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.	Compliance	Case Managers and Transition Specialists were assigned at each State Hospital. There is evidence that individuals with challenging behaviors and medical conditions are being referred to and placed in community settings. The discharge planning for individuals in forensic units requires further review.

Settlement Agreement Reference	Provision	Rating	Comments
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.**	**Compliance**	**There was evidence of coordination between the Regional Office and State Hospital. Reorganization of this responsibility is under consideration by the new Commissioner of DBHDD. The Independent Reviewer has been apprised of these discussions.**
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.
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, there was evidence of participation by community providers.**
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. The failure to identify problems has been evaluated under Service Coordination.**
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.**	**Partial Compliance**	**The Quality Management system has been initiated by DBHDD. Delmarva performs annual quality service reviews as required for individuals with developmental disabilities. As evidenced by its updated plan of July 1, 2012, the Department is proceeding to refine its Quality Management system for Behavioral Health. Pursuant to the Court's Order of August 29, 2012, reporting on the Quality Management system has been extended until February 1, 2013.**

Settlement Agreement Reference	Provision	Rating	Comments
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.	Not scored	Under the Court's August 29, 2012 Order, the Department's provisional Quality Management system report is not scheduled to be submitted until October 1, 2012. The State's semi-annual Quality Management reports begin on February 1, 2013, and the Quality
IV.A.2	The system's review shall include he service requirements of this Agreement.	Not scored	Under the Court's August 29, 2012 Order, the Department's provisional Quality Management system report is not scheduled to be submitted until October 1, 2012. The State's semi-annual Quality Management reports begin on February 1, 2013, and the Quality Management system will be reviewed in more detail in next year's monitoring report.
IV.A.3	The system's review shall include the contractual compliance of community service boards and/or community providers.	Not scored	Under the Court's August 29, 2012 Order, the Department's provisional Quality Management system report is not scheduled to be submitted until October 1, 2012. The State's semi-annual Quality Management reports begin on February 1, 2013, and the Quality Management system will be reviewed in more detail in next year's monitoring report.
IV.A.4	The system's review shall include the network analysis.	Not scored	Under the Court's August 29, 2012 Order, the Department's provisional Quality Management system report is not scheduled to be submitted until October 1, 2012. The State's semi-annual Quality Management reports begin on February 1, 2013, and the Quality Management system will be reviewed in more detail in next year's monitoring report.
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.	Not scored	Under the Court's August 29, 2012 Order, the Department's provisional Quality Management system report is not scheduled to be submitted until October 1, 2012. The State's semi-annual Quality Management reports begin on February 1, 2013, and the Quality Management system will be reviewed in more detail in next year's monitoring report.
IV.C	Beginning on July 1, 2012 and ending on July 1, 2014, 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 make them publicly available on the DBHDD website.	Not scored	Under the Court's August 29, 2012 Order, the Department's provisional Quality Management system report is not scheduled to be submitted until October 1, 2012. The State's semi-annual Quality Management reports begin on February 1, 2013, and the Quality Management system will be reviewed in more detail in next year's monitoring report.
IV.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	The Independent Reviewer and the United States were notified of deaths. Questions about deaths are being discussed with the Department. Under the direction of the DBHDD Medical Director, a community-based mortality review committee is being created and implemented. The protocol has been developed but not yet authorized.

SUMMARY OF RECOMMENDATIONS

Based on the findings documented in the Summary of Compliance, the following recommendations are offered to the State for consideration as it continues its work into the next year:

1. Consider providing training to Department staff and providers on "social role valorization" and more clearly articulate expectations regarding the standards for community placement. This values-based training focuses on developing and sustaining community membership for individuals who have been denied opportunities for meaningful participation in their communities. As the Department continues to establish new community-based services and supports, such values-based training could be helpful in designing and ensuring maximum opportunity for interaction with non-disabled people.

2. It is recommended that the Department examine the reasons why host homes are not used more frequently for community placements. As demonstrated by current and past site visits, host home placements generally afforded increased individualization and greater likelihood of social integration.

3. Consider strategies to more clearly articulate and document the plan for sustaining the structural and programmatic accomplishments resulting from the Settlement Agreement.

4. In order to ensure equality of access for all individuals in the target groups, work with the Independent Reviewer to analyze referral of supported housing vouchers and Bridge Funding.

5. In conjunction with the Independent Reviewer, review the long-term arrangements for ensuring the availability of housing resources in each of the next three years.

6. In collaboration with the Independent Reviewer, determine if further clarity is needed to ensure that the "ineligibility for any other benefits" is uniformly understood and applied to all applicable benefits.

7. In conjunction with the Independent Reviewer, review any potential barriers to community placement for individuals awaiting discharge from forensic units.

8. Consider the use of housing vouchers for individuals with developmental disabilities placed under the Settlement Agreement.

9. Develop, with stakeholder input, a written plan regarding the implementation of Supported Employment services.

10. Share the findings of the cost rate study, as well as the data and the calculation process used to complete this study, with providers and other stakeholders.

11. Review training curriculum to ensure that all of the defined principles of evidence-based Supported Employment are addressed. Provide access to trainers who can model skills for employment specialists. Specific and explicit fidelity expectations and expectations related to employment outcomes should be revisited with Supported Employment providers.

12. Consider convening Supported Employment coalition meetings in rotating Regions across the State so that providers have the opportunity to attend some meetings in person.

13. Ensure that the outcomes from corrective action plans resulting from critical incidents are transmitted promptly to the Independent Reviewer and the Department of Justice.

14. Ensure that consents for psychotropic and other medications are documented prior to transition from State Hospitals.

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 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.

Expert consultants were retained to assist with the review of a random sample of forty-eight individuals with a developmental disability who were placed from State Hospitals into the community. In April, in preparation for these reviews, the Department and the Independent Reviewer revised and agreed upon the monitoring tool previously utilized in the Report for Year One. A section on behavioral supports was developed and added to the monitoring tool.

The random sample of forty-eight individuals had a confidence level of 90%. A proportional random sampling method was used to ensure representation across all Regions.

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 has instructed its Regional staff to take corrective actions, as appropriate.

A nurse consultant to the Independent Reviewer reviewed the plans for the placement of two of the three institutionalized minors. (The third young woman is medically unstable and cannot be moved at this time.) She worked closely with Department staff to assess the requirements for a successful transition and visited the youngest individual after she moved in with her host family. The second placement was anticipated in September but has been delayed due to the individual's recent illness. However, the plans for this placement continue to move forward in anticipation of her recovery.

Two 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. The State Health Authority Yardstick (SHAY), a tool developed at Dartmouth University, was used for the evaluation of Supported Employment services provided under the Settlement Agreement. The reports from each of these evaluations have been provided to the Parties.

A third expert consultant was retained to document the Department's progress in establishing Assertive Community Treatment (ACT) teams. Her report has been shared with the Parties. Although the Department's efforts are proceeding with due diligence, it became evident that additional time and guidance was needed to ensure adherence to the expected standards by all teams. Consequently, the Parties, with concurrence of the Independent Reviewer, requested that the Court approve an extension of the timelines for the evaluation of this provision. For similar reasons, an extension was requested for the review to be conducted by the Independent Reviewer regarding the implementation of the Quality Management system. A status conference regarding these motions was held before the Honorable Charles A. Pannell, Jr., on August 28, 2012.

The Court's Order was issued on August 29, 2012. In part, it affirms that all ACT teams will operate with fidelity to the Dartmouth Assertive Community Treatment model. In order to provide the State with the flexibility to correct any perceived deficiencies in the ACT teams required to be created under the Settlement Agreement, it mandates that the Independent Reviewer shall examine and review the performance of the ACT teams by July 1, 2012, but that any determination regarding compliance with the fidelity standards be deferred until July 1, 2013. In addition, the State is required to conduct a root cause analysis of any perceived deficiencies in the ACT teams and to develop a corrective action plan, including timelines. Quarterly reporting on the corrective action plan is required until July 1, 2013. In addition to the above directives, the Court ordered that the State provide an updated Quality Management Plan by July 1, 2012 (this was completed as required); issue a provisional quality management system report by October 1, 2012, that is not subject to review by the Independent Reviewer; and, beginning February 1, 2013, and at least once every six months thereafter until February 1, 2015, create a report summarizing quality assurance activities, findings and recommendations. All Quality Management reports are to be made publicly available on the Department's website.

Finally, as stipulated in the Settlement Agreement, this report was provided in draft form to the Parties for review and comment prior to submission to the Court. A meeting to discuss the draft report was held on August 27, 2012. The thoughtful comments provided by the Parties have been seriously considered in the finalization of this report and modifications to the draft report have been made as thought appropriate.

Review of Obligations for Year Two

A. Serving People with Developmental Disabilities in the Community

1. Enhancement of Community Services

The State documented that 164 individuals with a developmental disability were transferred from State Hospitals, primarily Central State Hospital, during the past year. (The ICF/MR unit at Central State was

closed in June 2012.) In addition, documentation was provided to confirm that additional Home and Community-Based Waiver Services were provided to 117 individuals with a developmental disability and that 2248 individuals with a developmental disability were provided family supports in order to avoid institutionalization.

The data and documentation provided confirm that the Department has exceeded the numerical targets of the Settlement Agreement. The Department's leadership and staff are to be commended for their efforts and for their diligence in ensuring that the compliance requirements were a continuing focus of their responsibilities.

However, the Settlement Agreement also requires that the community placements be appropriately supported by services that are individualized according to the person's strengths and needs. In order to evaluate the individualization, community integration and appropriate supports of the community placements accomplished under the terms of the Settlement Agreement, a sample of forty-eight individuals was selected from the Department's list; a proportional random sampling method was used to ensure representation across the six Regions of the Department of Behavioral Health and Developmental Disabilities.

The individuals in the random sample were predominately male (63%); between the ages of 51-60 (31%); and ambulatory without support (42%). Wheelchairs were required by 31% of the individuals in the sample. Very few individuals (4%) could speak without assistance. The plurality of individuals reviewed expressed themselves through vocalizations (29%).

Forty of the individuals in the sample were placed into group home settings. Host homes were identified for only three of the individuals and supported apartments were used for three individuals. One individual was placed in a crisis respite home; one individual was hospitalized and his residence was under review.

It is recommended that the Department examine the reasons why host homes are not used more frequently for community placements. As demonstrated by current and past site visits, host home placements generally afforded increased individualization and greater likelihood of social integration.

The majority of residential settings were located near community resources, in typical neighborhoods (94%). There were no more than four individuals in any of the residences reviewed for this report. (All placements reviewed met this requirement of the Settlement Agreement.) There were few problems noted with access to transportation. The majority of the individuals reviewed (63%) had the opportunity to attend religious activities. Despite these advantages, however, the findings regarding social integration had not improved significantly from last year's reviews. Although most individuals (85%) experienced weekly community outings, most (70%) went out with their housemates as a group. Virtually none (10%) belonged to community organizations or clubs. Nearly half (48%) had not met their neighbors.

The Department is strongly encouraged to intensify its training of community providers to ensure that maximum opportunities to interact with non-disabled people are available to individuals under their

responsibility. Training in social role valorization would be a valuable addition to the Department's training curriculum.

In addition to the above referenced issues about integration into the local community, continuing concerns were noted regarding the lack of consent for psychotropic medications. Twenty-four individuals were prescribed these powerful drugs; documentation of informed consent was lacking for 63% of the individuals.

The Department of Behavioral Health and Developmental Disabilities was informed promptly of the most critical issues documented during the individual reviews. The Department responded promptly and initiated its own reviews and the development of corrective action plans, as appropriate. Furthermore, as a result of last year's findings, the Department commendably expanded its contract with the DelMarva Foundation to conduct Person-Centered reviews of all individuals placed under the Settlement Agreement. The Independent Reviewer was provided copies of these reviews; the findings generally concur with her own assessments.

The Department's continued cooperation and oversight of community placement decisions and implementation at the Regional level is critical to removing the documented barriers to integration and habilitation.

B. Serving Persons with Mental Illness in the Community

In reviewing the actions taken to comply with this Section of the Settlement Agreement, two expert consultants were retained by the Independent Reviewer to assess and evaluate the implementation of supported employment and supported housing. The State's progress in implementing the requirements of Assertive Community Treatment (ACT) was documented by a third expert consultant. However, the provisions regarding ACT fidelity were not evaluated, pending the Court's approval of an extension of this timeline. The reports from the three experts have been provided to the Parties and are attached to this report. Discussions about supported housing, supported employment and Assertive Community Treatment have continued with the Department of Behavioral Health and Developmental Disabilities. Plans have been initiated for the ongoing review, by the expert consultants, of supported employment and Assertive Community treatment. It has been recommended that the Department work with the Independent Reviewer, over the next six months, to conduct a thorough analysis of the referral mechanisms to the supported housing vouchers. The availability of relevant data needs to be determined before such an analysis can be initiated. This recommendation will complete and strengthen work commenced during this past reporting period.

Intensive Services for Individuals with Severe and Persistent Mental Illness

1. Assertive Community Treatment (ACT):

The Settlement Agreement requires that all ACT teams will operate with fidelity to the Dartmouth Assertive Community Treatment model.

During this past fiscal year, repeated discussions were held with Department staff regarding the implementation of ACT services in compliance with the terms of the Settlement Agreement. Due to interventions and corrective action plans implemented by the Department, in order to ensure fidelity to the requisite standards, the Parties requested and the Court approved, with conditions, an extension of the timeline for evaluation of compliance with ACT services. Although evaluation of compliance was not scored, the report of the expert consultant was completed after extensive review of data and discussion with key Departmental staff, providers from four ACT teams, and interested stakeholders. Since the submission of this expert consultant report, the Department has provided comments and has outlined its plans for ensuring adherence to the fidelity standards. The Department and the Independent Reviewer have agreed upon a schedule for ongoing discussion with the expert consultant. In addition, the Department has moved forward with responding to the Court's recent Order. A root cause analysis of any perceived deficiencies in the performance of the ACT teams has been drafted and is being finalized. The Independent Reviewer and her expert consultant have been consulted about the root cause analysis and have been requested to review the corrective action plan. A meeting to discuss both the root cause analysis and the corrective action plan has been scheduled for October 1, 2012. The amici have been invited to participate in this discussion.

2. Housing Supports

As of July 1, 2012, the State was to provide a total of 500 supported housing beds for individuals with serious and persistent mental illness who are in the target population. Bridge Funding was to be provided to 360 individuals. As confirmed by the findings of the expert consultant to the Independent Reviewer, the State has more than exceeded these obligations. There were 648 housing vouchers awarded and Bridge Funding was provided to 568 individuals. Site visits in the Atlanta area and in Macon demonstrated that the apartments were in typical apartment complexes and that appropriate case management and ACT services were being provided to the individuals with housing vouchers. There was evidence of flexibility in order to meet individualized needs; one woman was given funding for a two-bedroom apartment so that her child could be reunited with her. The innovative design of the housing voucher program and its oversight/management is to be commended.

The expert consultant 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.

The attached expert consultant's report was discussed with the Parties on August 27, 2012. In response, in part, the Department stated that it had conducted a thorough review of the supported housing program after the first few months of its operation. One significant change was the establishment of a priority that states: " DBHDD will provide a priority for those that meet the standards under Tenant Eligibility and those that are transitioning from a state supported hospital or Crisis Stabilization Unit, transitioning from a DBHDD supported intensive residential treatment facility (only when that slot will be occupied by an individual transitioning from a state supported hospital or Crisis Stabilization Unit) and meet the clinical criteria for Assertive Community Treatment services." This prioritization is an important issue and requires further analysis. Discussions have begun with the Department staff as to

how data about referrals to supported housing could be collected and analyzed. It is intended that a collaborative effort between the Department and the Independent Reviewer be initiated within the forthcoming year.

3. Supported Employment

As required in this phase of the Settlement Agreement, there were to be 170 individuals provided with supported employment opportunities in Year Two. The State provided such services to 181 individuals.

As documented by the expert consultant to the Independent Reviewer, the Department, and its new staff leadership in adult mental health services, has made substantial strides in implementing this service component in compliance with fidelity standards. The findings of the expert consultant are detailed in his attached report.

The consultant again utilized the State Health Authority Yardstick (SHAY) to measure the State's commitment to supported employment, its training and technical assistance efforts, and its quality assurance efforts. This year's score shows a significant improvement. With sustained efforts as those demonstrated this past year, it is expected that the Department can meet, and even surpass, the national average score for states participating in the Substance Abuse and Mental Health Services National Implementing Evidence-based Practices Project.

The report offers several recommendations for consideration, including the development of a plan for this Evidence-Based Practice; input from stakeholders in the planning process was encouraged. Other recommendations include investing in workforce training and consultation and addressing the lack of outcomes related to supported employment on a system-wide basis.

CONCLUSION

The State, through its Department of Behavioral Health and Developmental Disabilities, has demonstrated good faith and commitment in its implementation of the Year Two obligations under the Settlement Agreement. The State Legislature continued to approve the funding essential to the development of the requisite programs. The Department of Community Health was accessible to and responsive in its engagement with the Independent Reviewer.

As recognized in this Report, a number of very notable achievements have occurred during this second year of the Settlement Agreement. The former and current leadership of the Department of Behavioral Health and Developmental Disabilities was/is cognizant of the successes and mindful of the challenges to be faced in Year Three.

Many of the challenges facing the Department are consistent with those articulated in last year's Report. Individuals with developmental disabilities are entitled to be transferred from state hospitals into integrated community settings where those opportunities are maximized in a meaningful and individualized manner. The implementation of appropriate host home settings will benefit their

integration and acceptance into their neighborhoods and their communities. The failures to provide meaningful and adequate day programming, to fully monitor health care, and to obtain informed consent for psychotropic medications and behavioral support plans again were noted for some of the individuals placed from the State Hospitals into community settings under the terms of this Settlement Agreement. These concerns have been brought to the attention of the Department of Behavioral Health and Developmental Disabilities; corrective actions have been identified and are in the process of being implemented.

Challenges still remain in the development of supported housing and supported employment; these challenges can affect compliance with the Settlement Agreement in the future. It is hoped that the Department will work closely with the Independent Reviewer to analyze whether the referral process to supported housing is working in an equitable manner; whether obstacles to discharge are being removed for individuals who are stable but placed in forensic units at the state hospital; and to determine whether individuals with a developmental disability can access housing vouchers.

In closing this Report, it seems critical to repeat the conclusion from the Report for Year One:

In drafting the language of the Settlement Agreement, the Parties stated their intent that "the principle of self-determination is honored and that the goals of community integration, appropriate planning and services to support individuals at risk of institutionalization are achieved." This statement of intent is entirely consistent with the goal of the Commissioner of the Department of Behavioral Health and Developmental Disabilities that a continuum of services be reasonably accessible to every Georgian with a disability.

In this second year, the State again has demonstrated that it can and will honor its obligation to comply with the substantive provisions of the Settlement Agreement. The Year ahead must be characterized by further attention to qualitative measures and to the strategies and actions required to sustain these systemic changes.

Respectfully Submitted,

/s/_ _

Elizabeth Jones, Independent Reviewer

September 20, 2012

Review of Assertive Community Treatment (ACT) Services
United States v. Georgia Settlement Agreement
Report Date: September 15, 2012
Angela L. Rollins, Ph.D.

Purpose

This site visit and report was requested by Elizabeth Jones, Independent Reviewer, to help document Georgia's implementation of Assertive Community Treatment (ACT) in the second year of the Settlement Agreement period. The visit took place July 16-19, 2012. Because the State has made several major changes to ACT contracts recently, the purpose of my assessment was limited to documenting how the remaining teams are functioning with respect to the Dartmouth Assertive Community Treatment Scale (DACTS), rather than completion of the State Health Authority Yardstick (SHAY). The DACTS is the current standard for measuring fidelity to the ACT model and is used widely by mental health authorities, both domestically and internationally. In a few instances, meetings with State mental health authority officials or providers highlighted some State progress in ACT implementation that I make note of briefly in an effort to reinforce positive progress. I also include some observations from a visit to the Fulton County Jail in Atlanta regarding mental health services.

Methods

Brief DACTS Assessments

I visited two ACT teams inside the metro-Atlanta area and conducted telephone interviews with program leaders from two other ACT programs outside metro-Atlanta. Each assessment was intended to roughly follow the DACTS team leader interview items to collect information related to ACT implementation. During each of the two team site visits, I was also able to review five charts each and any readily available team recordkeeping or reports. I also viewed the team's general work areas. At one agency, the interview took place in the team conference room with the team's whiteboard of caseload information available for viewing (e.g., consumers hospitalized or in jail, consumers scheduled to see the psychiatrist, consumers exhibiting risk behavior and requiring close monitoring). Because I was not able to conduct a thorough DACTS assessment following established protocols, I intentionally avoid scoring DACTS items

and instead detail information on model elements qualitatively. Staff from all four teams were very generous with their time and very open in describing their team's successes and struggles. An individual item-level report for each participating team is included at the end of this report.

Interviews, Meetings, and Observations

The site visit also included: a meeting with the new Director of Adult Services for DBHDD who took over the position in Fall 2011; a visit to the Fulton County Jail in Atlanta and discussion with the Medical Services Director and Mental Health Director; a meeting of mental health stakeholders; and an exit meeting with DBHDD staff regarding our preliminary thoughts and observations during the site visit.

Themes from brief DACTS Assessments

Teams seem to have clear understanding of ACT standards and are working toward improvements in areas of weakness. The downtown Atlanta team reported being inundated with referrals -- sometimes 20-25 per month. When asked if these referrals are all appropriate, the team leader reported that his impression is that, with occasional exceptions, most are consumers who could benefit from ACT. The perplexing issue with this team is that they are still only at 65 total consumers, even though they are staffed for 100 and have this extremely high rate of referrals. The team is enrolling six consumers each month (the maximum recommended by the DACTS standards), but they are also losing many consumers each month, so they are gaining no traction in building their caseload. Program managers have a few ideas about the core problems involved and are thinking about the issues. The program manager suggested that being allowed more intakes each month might help. (In my opinion, this may simply cause more problems with higher dropout rates, as the team will not be capable of engaging more than six consumers each month.) As another example, the team stated that they are making greater efforts to document informal support network contacts at intake so, when consumers "disappear," the team has a social network to contact to try to locate the person. Despite these ideas and strategies, the team may also need some extra help in strategizing how to better engage the consumers already on their caseload. Taking more than six clients each month would probably not help. The urban teams with consumers

exhibiting high rates of hospitalization, homelessness, and incarceration may need some extra help in coordinating care. They even stated that they feel like a "Jail ACT" team, even though they are not this type of team in any official capacity. It might be wise to help them to think more like a Jail ACT team – they already have three substance abuse specialists, which is a smart and needed use of clinical staff positions. **Recommendation:** Some technical assistance at the team level to perform root cause analysis of drop-outs might be helpful. If the issue reveals, for instance, that consumers are eloping out of Atlanta in search of housing, then finding better ways to address housing needs at intake would become a very important strategy. The team also noted that they have closed some consumers after thirty days or six weeks of being out of contact or poorly engaged, only to have them present again a few weeks later after the chart for the person had been closed. Having to re-enroll them seems inefficient since it requires so much documentation. I would recommend a much longer timeframe for attempting contact before closing the chart. Some states require three or even six months of attempts prior to closing. Six months might be a little long and open agencies up to liabilities, but three months seems like a reasonable standard as a strategy for this particular team. An analysis of whether Atlanta needs more ACT "slots" should also be examined, but focusing on existing teams seems a prudent first step.

Teams are all doing well on crisis coverage and most are attempting to be involved in hospital admissions and discharges, from Team Leader self-report. Teams did report very different results with different hospitals. Some hospitals are difficult to contact to coordinate care. One team outside Atlanta had a couple of significant cases where a private hospital refused to coordinate with them, first citing HIPAA and then responding that the client was not there. In one case, the consumer was discharged to the street, re-offended in Atlanta, and transferred back to his home county jail for probation violation, where the team then learned of all this a year later. If the hospital had coordinated care, all these consequences might have been avoidable, in the team leader's opinion. This team also cited another case where the team repeatedly tried to get in touch with the hospital social worker who stated the consumer would be released that day, but the team knew that the consumer's personal care home family (he had lived there for years) was going on an outing, so they asked for the release the next morning. The hospital social worker's response was to release the person to a completely new personal care home in Atlanta (not his home county). The team "begged" the hospital social worker not to do this – that "this was his *home*." That situation resolved, but only because of

persistence on the part of the team. Several other teams noted difficulties in communicating with hospitals. One team clearly noted differences between public and private hospitals, with private hospitals being much less cooperative. **Recommendation:** I recommend getting more information at a monthly ACT coalition meeting regarding these problems and working with hospitals and providers around possible barriers and solutions. Some helpful information regarding exceptions to HIPAA with regard to treatment can be viewed here: http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html

High staff turnover seems to be a consistent theme for many of the teams, which can definitely impact program fidelity and team morale. Specialist positions seem to be the most common source of turnover and vacancy issues. Some teams are using contract workers to address staffing gaps and others are simply struggling with vacancies. **Recommendation**: This issue might require some thinking amongst the ACT coalition and stakeholders who know the issues at play in the Georgia service system workforce. With one team, we talked about possibilities such as hiring someone before all requirements are met and making the continuation of employment contingent on completing those requirements in a timely manner. What is unclear is whether this would be allowed within the current State standards.

General State-level Themes from Visit

Many teams cited the monthly coalition meetings as helpful.

All teams gave positive feedback regarding lengthening the ACT authorization periods from three-month to six-month authorizations. A couple of teams reported that changes to the continuing stay criteria were also helpful for keeping clients who needed ACT on ACT teams. A couple of teams mentioned that the documentation is still onerous for ACT authorizations. After talking with four teams in three regions, I did hear some reports of inconsistencies in interpretations of authorizations between “main office” APS staff who review and approve authorization requests and some APS staff doing audits in the field. One example given was that a consumer was authorized for ACT, but when the team was audited later by APS, the field auditor questioned the authorization. The team did not understand how they could be held responsible when it was a service already approved by APS. In this case, the auditor

questioned whether the consumer needed ACT, based on the fact that the person had received private psychiatric services and had not received other less intensive core services before ACT. The team did not understand that any less intensive service attempts were required. I am not sure how this particular case *should* be resolved, but it might highlight the need for consistency and communication. A couple of the teams indicated they still struggled with documenting that a consumer met continuing stay criteria, while other teams reported having none of these issues. When I related that one team found that their APS staff were authorizing continuation of ACT services based on crisis episodes, another team felt that their auditors were not using the same criteria.

I was able to observe two DBHDD fidelity assessors performing a DACTS team leader interview during my visit. One assessor in particular seemed to be doing a thorough job and was careful to ask deliberate and helpful questions during the interview for clarifying and scoring the DACTS.

The new Director of Adult Mental Health Services advocated for and received some data analyst time to increase DBHDD's attention to important ACT outcomes and other data. This is an important advance in the use of data for the teams. Data reporting required of each team has been expanded and the State provides team and state-level data on outcomes by both calendar time period and the consumer's length of time in ACT.

During the stakeholders meeting, I mentioned the bi-monthly planning and advisory council meeting that the Director of Adult Mental Heath services described. Most in the group were unfamiliar with this council and continued to express a desire to be more involved in this sort of activity. **Recommendation:** Please attempt to engage this group of stakeholders by letting them know about meetings outside of the ACT Coalition meetings. There still seems to be a gap in communication. When I was referring to the bi-monthly meetings, it is possible I was using the wrong terminology. But even if that is the case, I continue to hear that stakeholders would like to be included in more dialogue with the State.

Fulton County Jail visit

Issues noted during the jail visit are common to the intersection of mental health and criminal justice, such as insufficient funding for re-entry planning and coordination (need outpaces staffing), resulting most critically in difficulty completing requirements to have Medicaid benefits turned back as soon as possible after release. The Fulton County jail has two FTE re-entry staff but large caseloads. Jail re-entry staff will start the process but the provider has to finish the Medicaid application process. The Mental Health Director at the jail also cited issues of multiple providers seeking authorization for services, resulting in confusion for everyone, including consumers and their families. Another barrier to re-entry coordination is the undetermined length of stay in jails so that releases cannot be carefully planned and some consumers are released in the middle of the night without notice. Even Mental Heath staff and re-entry staff in the jail have no way of predicting release in some cases. Another issue is that the jail does not have an automated way of crossing jail census and mental health service data. It may be useful to consider the work of Mark Heyrman at the University of Chicago Law School for state-level communications between corrections and the mental health authority. Cook County in Illinois has a similar system so that community mental health providers and jail censuses can be crossed for care coordination. Atlanta seems to be in need of something similar. The benefit would be that you could quickly see who has some mental health history in the jail and possibly look them up to begin re-entry planning right away, contacting the most recent community mental health provider to let them know where the consumer is located and what the situation looks like. During my brief DACTS assessments, I heard several instances where teams struggled to locate consumers, only to later find out they had been jailed. Some system to get all providers on the same page could improve re-entry planning and post-release care and improve recidivism rates. **Recommendation:** Please consider contacting Mark Heyrman to discuss their approach in Illinois and its potential usefulness in Georgia. (I did provide an email introduction to Heyrman for Judge Susan Tate, who expressed interest in the Illinois initiative). Another idea would be to determine if Atlanta has any kind of health information exchange and whether criminal justice systems have ever been linked to such resources. I have consulted my colleagues at the Regenstrief Institute in Indianapolis who are unaware of criminal justice healthcare providers being included in health information exchanges, but they are intrigued by the idea.

Grady Team 1 Assessment

Date: 7/16/12
Location: Region 3, Atlanta
Sources Used: Five Charts reviewed, Team Leader interview

DACTS Item Areas

		Comments/Observations
H1	Small Caseload	Very small caseloads
H2	Team Approach	Team strategically rotates staff seeing consumers. Three of five charts were for consumers hospitalized or in jail during all or part of the sample period, resulting in minimal face to face contacts.
H3	Program Meeting	Team has daily team meeting, each consumer covered each time
H4	Practicing Team Leader	Current team leader (new hire) is spending most time in direct service, getting to know clients and observing staff. Well over 50% of her time is in direct service, per the productivity report. Also noted multiple direct contacts in chart review. New TL wrote good descriptive notes and seems to be very familiar with application of MI and CBT to this population. Program manager served as interim team leader and delayed hiring to find the "right" person. Seems like a wise decision.
H5	Continuity of Staffing	Team has had five staff turnovers (out of fourteen positions, if you do NOT count psychiatry residents; fifteen if we do count them as a single "position") in last two years.
H6	Staff Capacity	#vacancy months was unclear (I missed this part of the TL interview)
H7	Psychiatrist on Staff	Team has a 20 hour/week psychiatrist and uses four psychiatry residents from Emory and Morehouse who rotate in and out (20 hours/week total for the residents). The DACTS is silent about the use of student trainees, so we have struggled with how to count staffing using students and residents in our own work. In general, we tend to count them if the team leader considers them a team member and they devote some block of time to direct service provision (I think five hours a week is not ideal but maybe it could count). In many ways, I appreciate the ability of academic-training institutions to expose early-career physicians to community-based psychiatry programs like ACT. This could be a critical recruiting mechanism for keeping psychiatrists in community settings. But I also warn providers who use students that, when we count them as staff, we also then should logically count them as staff turnovers when they leave. If they are truly serving consumers, then the consumer would experience some level of loss at the transition to a new psychiatric provider.
H8	Nurse on Staff	Team has one nurse (one vacant nurse position) so a little low on nursing time currently – a CNS is helping as backup while trying to fill the vacant nursing position.
H9	Substance Abuse Specialist on Staff	This team has three addiction specialists, which seems called for. They are serving a mostly dually disordered population (56/65) with multiple, complex needs related to mental health, substance abuse, and comorbid medical conditions.
H10	Vocational Specialist on Staff	Team has a vocational specialist
H11	Program Size	Team has more than ten FTE and is ample to provide a range of comprehensive services and coverage for the current caseload and for the caseload to increase to 100.

O1	**Explicit Admission Criteria**	Team does not deviate from the state's criteria for ACT authorization. Referrals typically come from Grady Hospital inpatient (frequent readmissions), other hospitals, jails, public defenders, DeKalb crisis services, Georgia Regional State Hospital, and self-referrals. It is interesting to note that the program manager reports getting 20-25 referrals a month, many of whom meet ACT criteria, but the program is adhering to the 6 intakes/month DACTS element so they are often turning potential ACT consumers away. When the fidelity assessor asked about the barriers to reaching 100 client caseload, program manager cited the 6 intakes/month rule and also the high number of consumer discharges from the team during the past 12 months: ten returned to jail and were terminated from services, one died, five transferred to other ACT teams, 21 graduated (I did not verify proper coding), and 13 others dropped out (again, I did not verify coding). He also described some of the challenges in serving transient homeless populations and consumers in and out of the criminal justice system (clearly, this team is serving the "right" ACT clients who have intensive service needs). For instance, some consumers were enrolled in the program and would disappear before the team could really engage them. The dilemma with this situation is that if the team is already struggling to engage consumers with an intake rate of 6/month, increasing this intake rate would only make the engagement issue even worse. Team is currently focusing on getting more collateral contact information (e.g., family, friends, landlords, other services providers) up-front with new consumers. This is a great idea. It might be a good idea to focus some TA work with this team around strategically looking at these issues and possible solutions.
O2	**Intake Rate**	6/month mostly; one month, they took eight. See notes above.
O3	**Full Responsibility for Treatment Services**	No brokered services.
O4	**Responsibility for Crisis Services**	Team carries 24/7 crisis responsibilities.
O5	**Responsibility for Hospital Admissions**	I could not quantify this one but there seemed to be a significant group of consumers who showed up at hospitals on their own, without involvement of the team
O6	**Responsibility for Hospital Discharge Planning**	Team meets weekly with inpatient staff so coordination for discharge planning is good in most cases.
O7	**Time-Unlimited Services**	Team experiences significant turnover of clients served, even graduations.
S1	**In-Vivo Services**	Team is actively providing services in the community, almost exclusively in the community
S2	**No Drop-Out Policy**	Team has many drop-outs -- this was a weak area acknowledged by the program manager and the team is actively looking for solutions.
S3	**Assertive Engagement Mechanisms**	Team uses rep payee services but is usually not the payee themselves, has "lots" of contact with jail and probation/parole staff for clients involved in the criminal justice system including contact for three clients in jail on this assessment day. Program manager also routinely mentioned contacting consumers at shelters, in homes, and I saw a number of notes where the team was actively in the community trying to locate consumers. The program manager also reported increasing their contacts with family members and other supporters as a way to keep in touch with their client population that seems transient and easily slips in and out of service systems. Team also

		does some processing with consumers who are refusing or resistant to services to see if switching clinicians or even switching ACT teams would help to engage the person. When describing the length of follow-up with a consumer who is refusing/resistant, the length of time was reported as roughly a month or six-weeks, probably a little too short to engage this tough population with propensity to be transient.
S4	**Intensity of Service**	In three charts, service intensity was fairly low. Weekly averages were 0, 12.5 mins, 32.5 mins for three clients who were missing, hospitalized, and jailed during the course of the two-week period. For the other two charts, the weekly average was 38.5 and 95.5 mins. The client with 38.5 mins had multiple medical problems but was also refusing SA counseling services despite ample encouragement. The team seemed to be struggling to engage four of the five people whose charts I reviewed – engagement again showing up in this element of the model.
S5	**Frequency of Contact**	Findings for frequency were similar. Weekly contacts were 0, .5, 1, 1.5, 2. Three charts documented attempts to see the client yielding nothing, so attempts are being made even though these numbers are low.
S6	**Work with Support System**	No quantitative data collected, but saw a number of instances in charts where the team, as well as the program manager, worked with family and landlords, specifically referencing working with families and other collateral contacts to address client disappearances.
S7	**Individualized Substance Abuse Treatment**	With three SA counselors, the team provides much 1:1 substance abuse work, though the content and frequency were unclear without interviewing these staff.
S8	**Dual Disorder Treatment Groups**	Dual group is offered weekly and attended by 3-6 clients out of approximately 56 with co-occurring disorders. Engagement in this group is a work in progress and complicated by the fact that many clients struggle with making it in to clinic appointments so the staff drive around and pick them up. Program manager described many of their dual consumers as in “pre-contemplation” and an active treatment group remains unappealing to them.
S9	**Dual Disorders (DD) Model**	Program manager seems well-versed in IDDT model, stages of change, stagewise treatment approaches, and using a reduction in use approach rather than abstinence only. Team doc also uses Antabuse for one client to help actively resist use.
S10	**Role of Consumers on Treatment Team**	Team has two certified peer specialists who are full time. One is currently on FMLA. Both have full responsibilities as any other staff member.

Viewpoint Assessment

Date: 7/17/12
Location: Region 3, Lawrenceville (metro Atlanta)
Sources Used: Reviewed five charts and team records, team whiteboard for pertinent information, Team Leader interview, QA staff person sat in for some portions of the interview

DACTS Item Areas

		Comments/Observations
H1	**Small Caseload**	Very small caseload ratios. Team does seem to be using a lot of contractors (one year contracts at a minimum) to fill RN and SW positions and expressed frustration with finding the right permanent staff to fill positions. In some cases, they have tried to recruit the contracted staff who seem to fit, but that does not always work out.
H2	**Team Approach**	Charts indicated use of shared caseload concept with consumers seen by multiple staff in a two-week period. Only one consumer exception – a consumer who had only one staff contact and was a no-show when other staff members attempted to serve the person.
H3	**Program Meeting**	Team has daily team meeting, each consumer covered each time
H4	**Practicing Team Leader**	Program manager is covering the team leader position that turned over 2-3 months prior. She spends 90% of her full-time position devoted to the ACT team while serving as interim team leader and reports spending 25-30% of her time in direct services.
H5	**Continuity of Staffing**	Team has had seven staff turnovers (out of 13 positions) in last two years. As noted above, team has struggled to hire some positions and has resorted to contract workers, though they commit to staying a full year and some are very good.
H6	**Staff Capacity**	Even though turnover was high, vacancy months were fairly low because the team quickly covers vacated positions. Only five vacant months for a SW position in the last year and two months for an RN position.
H7	**Psychiatrist on Staff**	Team has a 20 hour/week psychiatrist (Mon, Tues, Thurs) and 52 clients which is just below the full DACTS standard (.5 MD per each 50 consumers). They would need more MD time to increase their caseload.
H8	**Nurse on Staff**	Team has two nurses on staff (one is contracted) for 52 clients. Plenty of RN time for this caseload.
H9	**Substance Abuse Specialist on Staff**	This team has a full-time SA specialist for 52 clients which meets the DACTS standards.
H10	**Vocational Specialist on Staff**	This team has a full-time Vocational specialist for 52 clients which meets the DACTS standards.
H11	**Program Size**	Team has more than 10 FTE and is ample enough in size to provide a range of comprehensive services and coverage for the current caseload and for the caseload to increase to 100, pending increases in specific specialty positions (i.e., psychiatrist).
O1	**Explicit Admission Criteria**	Team does not deviate from the state's criteria for ACT authorization. When I asked if they feel they have the final "say" in who is admitted to their ACT team, they quickly pointed out that APS really has final say. Recent referrals to the team have come from Georgia Regional Hospital (two), jail (one), and eight others from internal, less intensive, core services, self-referrals or other community partners. The team does a utilization review for ACT team consumers to problem-solve consumers who use less services and are capable of graduating. The team clearly noted on their tracking sheets many

		consumers who are not getting many services because they are refusing, but probably still need ACT.
O2	**Intake Rate**	The team averages about four intakes/month and tries to stick with no more than five or six per month to be able to engage new consumers and have time to perform comprehensive assessments.
O3	**Full Responsibility for Treatment Services**	Program manager reported about 10% of caseload live in group homes with 24/7 staff who support meals, social activities, do some skill building, but do not administer medications (ACT team does this). An additional 25-30% live in personal care homes which seem to be common in Georgia and provide wide-ranging levels of housing support (from very little to substantial). The team also serves about 5-6 consumers who also receive services through the agency's PSR program.
O4	**Responsibility for Crisis Services**	Team carries 24/7 crisis responsibilities, using rotating cell phone. On-call shift rotates across team and runs Sun-Sun.
O5	**Responsibility for Hospital Admissions**	Team was involved in the majority of hospital admissions that the program manager could recall off the top of her head. The only exception was a consumer with borderline personality disorder who tends to act out about once monthly. We talked a bit about it being appropriate to acquire DBT counseling for this consumer without considering it brokering (as long as it is 10% of caseload or less). I did see one chart where a consumer was hospitalized in a recent month with no documented team involvement at admission or prior to hospital discharge. (There was a note by the RN after discharge). I discussed this with program manager before I left so that she could bring this up with the team.
O6	**Responsibility for Hospital Discharge Planning**	See notes above. Also, program leader discussed having in-person and conference call discharge planning with some hospital staff regarding their ACT consumers.
O7	**Time-Unlimited Services**	I was not able to carefully examine consumers discharged in the last year because that usually requires some preparation time for the respondent to collect the information. Anecdotally, the program manager reported eight consumers left the team in June 2012 (which is a high number). Several did not meet continuing stay criteria according to APS, so they would technically count them as graduates. The program manager was clearly uncomfortable with this process and felt that at least some of those consumers still needed ACT services, even if they had not been hospitalized recently.
S1	**In-Vivo Services**	Services are provided almost exclusively in the community with the exception of a couple of psychiatrist visits.
S2	**No Drop-Out Policy**	See notes in O7 above.
S3	**Assertive Engagement Mechanisms**	Team uses rep payee services for three consumers and is constantly evaluating the need for money management education. Program gets lots of referrals from the jail system and holds monthly meetings with jail staff regarding both referrals and follow-ups on ACT consumers who are incarcerated. The team leader also spoke of maintaining good relationships in addition to required reporting to probation officers. The team does not use outpatient commitments but did seem to do a lot of 1013's for hospitalization. The team attempts to engage new consumers who are resistant for at least 30 days and works on using motivational strategies and focusing on small steps and rolling with resistance. For consumers already on the team who are disappearing, the team leader reported they would follow them "endlessly" using similar strategies, aggressively looking for them in the community and even mentioned using advance directives to maintain engagement in treatment. Psychiatric Advance Directives (PAD) seem to be underutilized in

		some locations, so this was really nice to hear. A PAD is a good tool that is both recovery-oriented because it stems from the consumers' choices while they are well and is useful for consumers who can be hard to keep engaged at times. If PADs are underutilized elsewhere in Georgia, this might make a good learning community topic for discussion.
S4	**Intensity of Service**	In the five charts reviewed, the median service intensity was 90.5 mins per week (mean was 70.5 mins, highlighting how outliers can impact the mean). Weekly averages were 15 mins and 25 mins, for two clients who were hospitalized and not home for several home visit attempts. I discussed the lack of contact documented during the hospitalization with the team leader (briefly). Other consumers had mean weekly intensity of 90.5, 103, and 119 mins. The team did not have intensity reports to review. A DACTS score of 5 would require two hours or more; a DACTS score of 4 would require 85-119 mins/week.
S5	**Frequency of Contact**	Based on chart review, contacts averaged .5, 1, 2.5, 3 and 3.5 contacts per week (median = 2.5, mean = 2.1). The team also had tracking reports for contacts for entire caseload during the months of April and May 2012. This reports yielded April median of 2.1 contacts per week (mean=1.9) and May median of 1.8 contacts per week (mean = 1.8). All these scores would roughly score in the 2 or 3 range on DACTS, lower than the intensity score. The report included consumers even if they were not enrolled in ACT the entire month, so these reports might underestimate contacts a bit and make me lean more toward the data from chart review.
S6	**Work with Support System**	No quantitative data collected, but the team leader reported encouraging families to obtain guardianship in some cases.
S7	**Individualized Substance Abuse Treatment**	No quantitative data collected on individual SA treatment provided. (I did not interview SA specialist and team leader felt uncomfortable trying to make estimates, which is understandable). I did see a few individual contacts by the SA specialist during chart review -- one visit was helping a consumer to identify structured activity to help them stay away from substances of abuse, which is clear SA counseling for active treatment dual consumers.
S8	**Dual Disorder Treatment Groups**	Team leader reports that the team offers two once-monthly dual groups offered in different locations (so each group targets different consumers). The group is based on "double trouble" curriculum and the team offers transportation to help support attendance at these groups. About eight consumers attend one group each month and about five attend the other, so about thirteen of the team's thirty (43%) consumers with dual disorders attend a dual group each month.
S9	**Dual Disorders (DD) Model**	The team leader referred to stagewise treatment and motivational enhancement in a number of topics throughout the interview, including reference to how the team approaches consumers with comorbid substance use disorders. A more thorough assessment would yield more data on this topic.
S10	**Role of Consumers on Treatment Team**	Team has no certified peer specialist on staff. The team leader and QA manager indicated they had trouble finding candidates who had completed the certification requirements prior to hire. They had a few candidates who were in the process of receiving certification. We wondered whether regulations would allow the peer specialist to be hired conditionally while the person pursued certification.

River Edge Assessment

Date: 7/18/12
Location: Region 2, Macon and Milledgeville
Sources Used: Team Leader phone interview (brief – 1 hour, due to scheduling limitations)

DACTS Item Areas

		Comments/Observations
H1	**Small Caseload**	Very small caseload for team – 10 FTE for 73 consumers (7.3:1). Team FTE does not include psychiatrist but does include the program manager who continues to function as team leader while the newly hired team leader gets acquainted with the job. (Hired just a couple of weeks prior). Program manager has been functioning as team leader for two years but will eventually transition out of this role. At that point, her FTE would not count toward team staffing in scoring the DACTS. The team's SA specialist position is currently vacant.
H2	**Team Approach**	Not able to assess.
H3	**Program Meeting**	Team has daily team meeting, each consumer covered each time. The doctor attends this meeting all four days that she works with the team. All other staff are full time and attend each meeting.
H4	**Practicing Team Leader**	Program manager has been spending 10 hours per week (about 50% of overall productivity required of a full time clinician) in direct clinical care. The newly hired team leader has been spending roughly 5 hours/week in direct service, mostly shadowing other staff members and meeting consumers this way.
H5	**Continuity of Staffing**	Team has had eleven staff leave (out of eleven positions) in last two years. Turnover is a significant problem and seems to be concentrated in the psychiatrist position (three MDs left in past two years) and nursing positions (five nurses have occupied two nursing positions over the past two years), but also occurs in other positions as well (CPS, BA-level and MA-level clinicians). Hiring in the SA specialist position is also a struggle.
H6	**Staff Capacity**	The team has only experienced five staff months of vacancies in the last year since many of the doctors and nurses stayed until their replacements were ready to start.
H7	**Psychiatrist on Staff**	Team has a 32 hour/week psychiatrist (4, 8-hours days of coverage) and 73 clients. This is just exceeding the DACTS standard. Any client caseload above 80 and the MD time would need to be increased.
H8	**Nurse on Staff**	Team has one full-time RN on staff for 73 clients. The team's second nurse is currently an LPN and is finishing her RN requirements, so technically we cannot count her as fulfilling nursing needs beyond 50 consumers until she completes the requirements. Another LPN (second LPN, 3rd nurse) also is full-time to the team. LPNs count toward general clinical staffing but do not count towards RN positions required. In some cases, LPNs can be good resources for ACT teams by traveling around to administer injections and accompanying consumers on routine primary care appointments. By delegating these tasks to LPNs, a team's RN can focus more on training consumers in medication education, managing more complex physical comorbidities in conjunction with psychiatric treatment, and performing good nursing assessments to inform comprehensive assessment and treatment planning.
H9	**Substance Abuse Specialist on**	The team's SA specialist position is currently vacant. The previous staff person in this position left in May 2012. The program has received no qualified applicants in response to the posted position.

	Staff	
H10	**Vocational Specialist on Staff**	This team has a full-time Vocational specialist for 73 clients which is low for the DACTS standard, but in line with DHDD standards (and most states' requirements for that matter).
H11	**Program Size**	Team has 10.8 FTE and is ample enough in size to provide a range of comprehensive services and coverage for the current caseload and for the caseload to increase to 100, pending increases in specific specialty positions (i.e., psychiatrist, nursing, SA specialist).
O1	**Explicit Admission Criteria**	Team does not deviate from the State's criteria for ACT authorization, though they have added an additional criterion related to an absence of recent acts of physical aggression. The team leader said that, even with this criterion, they will still admit someone but will delay the process until they can come up with a plan for serving the consumer without jeopardizing staff safety. The team receives referrals from a few major sources: Baldwin County jail, the Augusta jail, the River-Edge crisis stabilization unit and other outpatient clinics.
O2	**Intake Rate**	The team was averaging about 4-6 intakes/month but were recently designated as a rural team and only serve two counties now instead of four, so they reported only two intakes each in April and May.
O3	**Full Responsibility for Treatment Services**	Not assessed.
O4	**Responsibility for Crisis Services**	Not assessed.
O5	**Responsibility for Hospital Admissions**	I could not assess cases of hospitalizations to quantify the team's actual involvement in hospital admissions and discharges, but the team leader described three vivid examples of her frustrations with Atlanta-area hospitals around the topic of discharge planning. In one case, the hospital staff would not discuss the case with the team by citing HIPAA, then during another attempt to coordinate by an ACT team member, hospital staff denied the consumer was there (team guessed the person had been discharged). The team found out a year later that the consumer had been discharged to the street (rather than coordinating discharge with the community provider), committed a crime of some sort, ended up in Atlanta's jail and then returned to the home county for a probation violation. The team was reconnected with him a year later, but felt that, had they been allowed to coordinate care during the hospitalization, this situation might have been avoidable. In another case, the team got a call from an Atlanta hospital that the consumer was "on their way home" without any prior notice allowing the team to coordinate discharge care. In a third case, a consumer was in a private psychiatric hospital and the team was in contact with the staff but hospital staff were reportedly resistant to the team's input. The hospital informed the team that the consumer would be discharged that evening when the team knew that the personal care home owner had taken consumers out of town on an overnight outing and this consumer would not be able to go there. (The consumer had lived at this particular residence for years -- the team leader indicated "this was his home.") The hospital staff then said they would release the consumer to an entirely new personal care home in another county (close to the hospital) that evening. The ACT team leader had to beg the hospital staff to delay discharge until the next day when he could return to his home.
O6	**Responsibility for Hospital Discharge Planning**	See notes above.

O7	**Time-Unlimited Services**	Not assessed
S1	**In-Vivo Services**	Not assessed.
S2	**No Drop-Out Policy**	Not assessed.
S3	**Assertive Engagement Mechanisms**	Not assessed.
S4	**Intensity of Service**	Not assessed.
S5	**Frequency of Contact**	Not assessed.
S6	**Work with Support System**	Not assessed.
S7	**Individualized Substance Abuse Treatment**	Not assessed.
S8	**Dual Disorder Treatment Groups**	Not assessed.
S9	**Dual Disorders (DD) Model**	Not assessed.
S10	**Role of Consumers on Treatment Team**	Team has a certified peer specialist on staff. The CPS does not handle medications as other team members do, but this is not an agency restriction on the CPS role, but an accommodation for this particular consumer specialist.

American Work Assessment

Date: 7/18/12
Location: Region 5, Savannah
Sources Used: Phone interview with Team Leader and supervisor

DACTS Item Areas

		Comments/Observations
H1	**Small Caseload**	Very small caseload for team – Eight FTE (not including psychiatrist) for 71 consumers (8.9:1).
H2	**Team Approach**	Not able to assess.
H3	**Program Meeting**	Team has daily team meeting, each consumer covered each time.
H4	**Practicing Team Leader**	Team leader spends roughly 22-25 hours per week in direct service though some months are slightly less. He spends much of this time recruiting and assessing possible ACT consumers in hospitals and shelters. He also spends much time filling in for SA specialist role duties while that position remains vacant. This level of direct service is well-above the expected mark for the team leader.
H5	**Continuity of Staffing**	Team has had five staff leave (out of eleven positions) since April 2011 when team started. As with other teams, filling the specialist positions seems to be a struggle (RN, voc, SA), though this team has not had any issues with psychiatry – has the same contracted psychiatrist since team was started.
H6	**Staff Capacity**	The team has experienced thirteen staff months of vacancies, with twelve of those months from the vacant SA specialist position. They are having trouble finding someone who is properly certified.
H7	**Psychiatrist on Staff**	Team has a 20 hour/week psychiatrist (three days) and 71 clients, so psychiatrist time is low for the caseload.
H8	**Nurse on Staff**	Team has two full-time RNs on staff for 71 clients. The team's second nurse position was recently added to the team roster and was filled in June 2012, as the team's census increased. Nurse time is sufficient now.
H9	**Substance Abuse Specialist on Staff**	The team's SA specialist position is currently vacant. As noted above, the team is struggling to find a certified person. However, the team leader has certification and could potentially count towards this position though it is typically difficult to both manage the team and function as one of the specialists. The program continues to search for viable staff candidates.
H10	**Vocational Specialist on Staff**	This team has recently hired a full-time vocational specialist who will start in 2-3 weeks, but would not count in this item until officially on staff.
H11	**Program Size**	Team has 8.5 FTE, so it is of a decent size and would be above 10 FTE with two vacant positions filled and some increase to psychiatrist time.
O1	**Explicit Admission Criteria**	Team does not deviate from the State's criteria for ACT authorization. All consumers meet these criteria and the team has full authority to refuse referrals who do not meet the criteria. They estimated that 93% of referrals come from Georgia Regional Hospital. Others come from shelters, core providers, and jails.
O2	**Intake Rate**	The team usually stays under six intakes per month, with a few exceptions in early start-up phase. May included 3-4 intakes and June included five.
O3	**Full Responsibility for Treatment Services**	The team does have a few consumers who also receive housing support in one of their group homes or in other individual-apartment supported housing. However, even combined, these would not be 10% of the caseload, so it would not count as brokering. The team's goal for consumer housing was articulated as independent living in scattered-site apartments. The team

		leader reported about 10 of 71 consumers do attend American Work PSR programs. This would count as the only instance of brokering, per the DACTS scoring, but is permitted within DBHDD rules for ACT.
O4	**Responsibility for Crisis Services**	Team rotates crisis coverage 24/7 using an office phone number that gets forwarded to the staff member on call.
O5	**Responsibility for Hospital Admissions**	We could not quantify team's involvement in hospital admissions, but the respondents estimated that almost all admissions involve the team. Occasional exceptions would include cases where family took the person to the hospital in the middle of the night.
O6	**Responsibility for Hospital Discharge Planning**	Again, we could not quantify the team's involvement in hospital discharge planning but the team leader's protocol is for staff to visit the hospital in person the day after admission, if possible. The team leader reported he personally participates in treatment planning at hospital in person, as part of his direct service priorities.
O7	**Time-Unlimited Services**	Team had a very high rate of graduations over the last year, with 17 consumers graduating out of 91 total consumers (19%) served in that same period. The respondents did feel that the APS authorization being extended from three months to six months was an important improvement in policy for their consumers. However, they also reported a disconnect between APS staff in the home office who approved continuing stay criteria and APS field auditors who came out to their site and questioned continuing stay criteria for consumers. The providers felt that the two sets of staff were out of sync and it was causing some confusion. They also stated that they felt that a provider should not be held responsible for continuing stay criteria, once it has been approved by APS.
S1	**In-Vivo Services**	Not assessed.
S2	**No Drop-Out Policy**	The team reported only one dropout in the last year. One other consumer died and another moved. This team's low dropout rate is quite a contrast to the Atlanta-area teams who are really struggling to keep transient consumers engaged.
S3	**Assertive Engagement Mechanisms**	The team does become representative payee for many consumers and works often with mental health courts and jails to keep consumers engaged in services. The reported using outpatient commitments "for what they're worth." When asked to clarify, they reported that their particular justice system required a hospitalization to initiate a commitment and the consumer has to have been seen within two days of a request to invoke the commitment. For almost any consumer, this two-day requirement would be extremely difficult to meet, so I see their point very clearly. The team leader also reported working closely with their local, very active NAMI organization and participating in CIT training program for police. They also mentioned working with and educating families in a number of other points in the interview.
S4	**Intensity of Service**	Not assessed.
S5	**Frequency of Contact**	Not assessed.
S6	**Work with Support System**	Not assessed quantitatively, but as noted above, the team leader reports strong ties with NAMI, the CIT program for which NAMI is highly involved, and with individual family members of their consumers.
S7	**Individualized Substance Abuse Treatment**	25 of 71 consumers have a comorbid substance use disorder. The team leader does provide some individual SA counseling focusing on identifying triggers and using CBT to manage triggers. We did not attempt to quantify extent of individual SA treatment provided.

S8	**Dual Disorder Treatment Groups**	No dual group is currently being offered, but when the SA specialist is hired, the team has a curriculum to use, based on some work done at Texas Christian – Wellness Self-Management Plus.
S9	**Dual Disorders (DD) Model**	Difficult to rate without a full fidelity assessment. The team leader is clearly offering some SA treatment services.
S10	**Role of Consumers on Treatment Team**	Team has a full-time certified peer specialist on staff. For this position, there has never been any turnover.

MEMORANDUM

To: Elizabeth Jones
Independent Reviewer
In the Matter of
United States of America v State of Georgia
(Civil Action No. 1:10-CV-249-CAP)

From: Martha Knisley

RE: Site Visit Summary and Report on
Housing Supports for Individuals with SPMI

Date: September 19, 2012

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Below is the requested report summarizing my site visit to Atlanta, Georgia on August 6, 2012 and a brief review of Georgia's compliance to Supported Housing and Bridge Funding requirements in Schedules 2. c. ii. (A.-C.) of the Settlement Agreement between the United States and the State of Georgia in the above referenced matter.

Overview and Scope of Review

This brief report summarizes implementation of Supported Housing and Bridge Funding as required in this matter for July 1, 2011 through June 30, 2012 and to the Independent Reviewer recommendations for your review during the coming year.

As part of this review, I met with stakeholders, toured supported housing units (funded with Bridge Funding in Fulton County) discussed progress with the Fulton County PATH Team and met with Doug Scott, the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) Supported Housing Director.

I also reviewed three documents:

1. The Georgia Housing Voucher and Bridge Funding Program Summary (dated August 6, 2012);
2. The Georgia Department of Behavioral Health and Developmental Disabilities Housing Voucher and Bridge Funding Program: A Year in Review power point presentation (not dated);
3. The Department of Behavioral Health and Developmental Disabilities (DBHDD) Housing Voucher Program (GHVP)/Bridge Funding SFY 2013 Program Description. (effective date 8-15-2012).

Observations

The documents and the discussions reveal the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) conclusively met the major targets of the Settlement Agreement's Schedule for Supported Housing for the year beginning July 1, 2011 and Bridge Funding

for the same year. The DBHDD also met their targets for 2011. The DBHDD was at 129% of goal for Supported Housing and at 145% of goal for Bridge Funding in 2012.

Mr. Scott and DBHDD began their implementation in 2011 developing a clear decision making process and pipeline for both Supported Housing and Bridge Funding, establishing payment mechanisms and aggressively troubleshooting any potential implementation issues as borne out by their meeting their targets. The stakeholders and Mr. Scott were consistent in their descriptions of how the referral processes were developed and successes DBHDD had in meeting these goals. The Fulton County Path Team understands their mission, have processes in place to achieve their targets, have assigned staff who are knowledgeable of the target population, are well trained and prepared to assist tenants to seek housing, move in and retain their housing. They are knowledgeable of community resources and have built good repertoire with housing owners and property managers. While it is often difficult to generalize staff competencies and to determine how prepared staff are to carry out their assigned task across jurisdictions, cross region data reveals that the successes in the first two years were statewide.

Likewise the performance data demonstrate early success in housing stability and re-engagement. It is not clear what the correlation is between declining hospital census and Supported Housing as only 88 Supported Housing referrals appear to have originated from hospitals and the hospital census has dropped by 300 individuals. However, it is likely there is some correlation between the two.

As a result of reviewing the data and in talking with stakeholders and Mr. Scott, three items stand out as needing "future" exploration by the Independent Reviewer in her role assessing the State's compliance and/or implementation efforts with this Settlement Agreement:

1. The Referral Sources and percentage of referrals for the Georgia Housing Voucher Program are as follows: Homeless (48%), Intensive Residential (10%), Personal Care Homes or Group Homes (10%), Hospital (10%), Family or Friends (9%), Rent Burdened (5%) and Unknown (8%). For Region 3, the percentage of referrals of individuals who are homeless is 67%. The Settlement Agreement does not specify required percentages of individuals referred from any of these sources. It does speak to achieving the dual goals of "community integration" and "planning and services to support individuals at risk of institutionalization."

The agreement further addresses the target SPMI population as individuals "currently being served in 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 and prison." Therefore, based on the underlying principles of the Settlement Agreement, are individuals currently hospitalized, frequently seen in Emergency Rooms, being frequently readmitted to the State Hospitals or being released from jail and prison being afforded access to the housing voucher in the same manner as individuals who are currently homeless? There are many reasons why individuals who are homeless are more frequently referred and placed. The pipeline for referrals is well established. Obviously, individuals who are severely and persistently mentally ill and homeless need housing. However, DBHDD is taking steps to assure their policies and referral processes address this potential uneven distribution of resources available for DBHDD to meet the terms of the Settlement Agreement.

In their Housing Voucher Program (GHVP)/Bridge Funding SFY 2013 Program Description, DBHDD has issued the following policies:

a) No provider that is also a Shelter Plus Care Grantee will be allowed to refer an individual who is homeless unless the federal definition of "homeless" restricts the use of available Shelter Plus Care resources. DBHDD will continually update Shelter Plus Care resource utilization capacity from the state's Continuum of Care jurisdictions.

b) DBHDD will provide a priority for those that meet the standards outlined under Tenant Eligibility and those that are transitioning from a state supported hospital or Crisis Stabilization Unit, transitioning from a DBHDD supported intensive residential treatment facility (only when that slot will be occupied by an individual transitioning from a state supported hospital or Crisis Stabilization Unit) and meet the clinical criteria for Assertive Community Treatment services. DBHDD may from time to time change the Tenant Priority at its sole and absolute discretion.

These policies may result in a change in the number of individuals referred who are homeless and have access to other resources. However, it is too early to tell if the numbers of individuals being referred from state supported hospitals, Crisis Stabilization Units or DBHDD supported intensive residential facilities will increase.

Overall, DBHDD faces difficult choices with the distribution of housing resources. There are simply fewer resources than demand. People with disabilities live on very meager incomes or have no income and obviously individuals who are homeless with a mental illness fall into that category. To their credit, DBHDD leadership has been vocal on the need for more federal and state housing resources for individuals who have a serious and persistent mental illness. DBHDD recently worked closely with the Georgia Department of Community Affairs (DCA) to make application to the HUD Section 811 Supportive Housing for Persons with Disabilities Project Rental Assistance Demonstration program (PRA demo) for additional subsidies for the Settlement Agreement's target populations.

2. The DBHDD has met their current Settlement housing targets but this does not assure that DBHDD will meet future targets. Nevertheless, It is not too early to review the steps DBHDD is taking to achieve future targets. Based on discussions with Doug Scott on this question, he does not underestimate this challenge and is splitting his time between meeting current targets and planning for meeting the longer term targets. Developing supported housing opportunities requires attention to creating affordable quality subsidized rental housing and creating the pipeline of new or moderately rehabilitated multi-family properties. Both types of housing require partnerships with state and federal housing agencies, local Public Housing Authorities, developers and owners/property managers. Both require attention to the unique access and sustainability challenges presented by the target population.

3. The third issue is related to the interpretation of the state providing housing supports to approximately *2,000* individuals in the target population with SPMI that are deemed ineligible for any other benefits pursuant to a specific schedule. The interpretation of "deemed ineligible" may be being interpreted several ways. Does "benefits" in this context include Section *8,* Shelter Plus Care, the new Section 811 PRA? If *yes,* then many individuals getting placed now may be eligible for

those other benefits even if the supply of those benefits at any given time does not equal the demand.

On the other hand, this is not totally logical given that the Section 811PRA is targeted to individuals in the Settlement Agreement and Housing Vouchers could also be targeted.

Under the first scenario, "deemed ineligible" would only include individuals who are turned down for benefits not because there is a limited supply of resources but because a housing authority waiting list is closed or because a local jurisdiction or the state does not have the needed units or Section 8, SPC or PRA subsidies available at any given time or in their portfolio. DBHDD has dealt with this issue in part with their change in policy in FY 2013 restricting individuals who are referred by Shelter Plus Care providers and their commitment to update Shelter Plus Care utilization capacity from the state's Continuums of Care.

Recommendations to the Independent Reviewer

The DBHDD has been successful in meeting the 2011 and 2012 Supported Housing and Bridge Funding targets; there are no immediate reasons to recommend any remedial action. DBHDD has given priority to and fully embraced supported housing with 648 individuals served in Supported Housing and 568 individuals receiving Bridge Funding.

Given the challenges for meeting targets in the future and assuring individuals who are exiting hospitals or frequently using hospitals and emergency rooms have access to these resources, it is recommended the Independent Reviewer undertake three activities in the coming year:

1. DBHDD has taken significant steps to deal with the imbalance in distribution of Supported Housing Vouchers and Bridge Funding. It is recommended the Independent Reviewer monitor the impact of these policies in this fiscal year. It is also recommended the Independent Reviewer review the Transition Planning and Quality Management measures as required in this Settlement Agreement to determine if there are issues related to who is getting referred for these resources. This review may best be accomplished by reviewing the impact of these processes and policies on a sample of the individuals who are in the Agreement's target groups.

2. Review the long term arrangements for making housing resources available. This includes a review of state and local housing markets, the quality of available housing in the local markets, the DCA Section 811PRA Demo application and DBHDD plans for meeting targets in each of the next three years. Completing this exercise may help build support now for resources for the out years of this Agreement

3. Determine if further clarity is needed to assure the "target population with SPMI that are deemed ineligible for any other benefits" requirement is uniformly understood and applied to all applicable benefits.

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 16, 2012

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Department of Justice Settlement Agreement

The reviewer was asked to advise whether the 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…
> (B) By July 1, 2012, the State shall provide Supported Employment services to 170 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) that were interviewed do indicate that DBHDD is complying with the Supported Employment section of the Settlement Agreement. 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.

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 (July 16, 17, 18 and 19, 2012) meeting with and interviewing a variety of stakeholders in the State of Georgia as well as reading and reviewing relevant documentation provided by DBHDD. The interviews that were arranged by a number of stakeholders in Georgia included: staff from DBHDD, providers of SE services for adults with mental illness, family members, consumers, and representatives from consumer and family advocacy organizations and other mental health advocates.

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 welcome that he received from the staff of DBHDD and the visits that were set up with SE providers, clients of SE services and other stakeholders throughout the State. The reviewer met with staff from DBHDD and other stakeholders in Atlanta and with providers in Augusta, Tucker and Smyrna, GA.

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. For the purposes of this 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 Health Authority." 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
	6. Identification of policy and regulatory levers to support EBP
Present	7. Role of other state agencies in supporting and/or implementing the EBP
	8. Defines how EBP interfaces with other SMHA priorities and supports SMHA mission
Present	9. Evaluation for implementation and outcomes of the EBP
	10. The plan is a written document, endorsed by the SMHA

Narrative

The staff at DBHDD recognized that there is not a current written plan that describes how SE services fit with the overall mission of DBHDD or how SE services may be used with other services in the system to promote recovery. However, the staff were able to describe several instances where verbal presentations or presentations that included Power Point slides were given that describe the plan for SE services as they relate to the mission of DBHDD and in support of recovery.

DBHDD has started "Supported Employment Coalition" meetings that are convened every other month (recent meetings were held in February, April and June, 2012) and include staff from DBHDD (Terri Timberlake, Monica Parker and Mary Shulman) as well as representatives from SE provider agencies. These meetings are designed to improve communication, collaboration and building supports for SE between DBHDD and provider agencies. While providers are invited to attend these meetings in person, most attend via teleconferencing.

Without the presence of a clear and comprehensive written plan for SE services, it is difficult to impossible for DBHDD to promote a vision for the system that promotes recovery and describes how evidence-based supported employment will help the system to fulfill that vision. Given the presence of numerous stakeholders with knowledge and experiences regarding SE, DBHDD seems to have some of the important ingredients already present in the State to collaboratively develop and disseminate a written comprehensive state plan regarding SE services.

Also, DBHDD has started the process of reviewing their current Medicaid plan in order to develop billing mechanisms for some parts of SE services. This strategy will help to diversify the funding of SE services for current providers as well as future expansion of SE funding, if needed. Additionally, DBHDD has completed a draft of a Memorandum of Understanding between the Georgia Department of Labor, Vocational Rehabilitation Program and DBHDD regarding Supported

Employment. This draft agreement outlines some important areas of cooperation between the two agencies. The draft has been signed by former DBHDD Commissioner Shelp and is awaiting the signature of Georgia Vocational Rehabilitation Services.

DBHDD has entered into a training agreement with the Institute on Human Development and Disability at the University of Georgia, Athens. Doug Crandell at the University manages this training agreement. Currently, one cadre of provider SE program managers and leaders have completed one of the six week training modules. The training module includes an in person meeting and training followed by six-week courses that are provided via videoconferencing. The training also includes a follow up meeting to review the participants' reactions to the training and to identify further training needs. The second module for SE employment specialists will start soon.

Several people commented on recently increased attention to and support of SE services at the leadership level of DBHDD. One person summarized, "There is beginning to be a true emphasis on SE here. Now, maybe it is only because of the DOJ settlement, but it is great that the emphasis is growing recently. There is movement in the right direction." While there is an emerging plan and associated actions on many levels regarding the implementation of SE services, it would be useful and important for the leadership of DBHDD to develop a written version of this plan with input from consumers, family members,

advocates and providers. A written plan will help provide a constant and consistent message as well as provide the basis for developing specific action or work plans associated with each step. Additionally, a written action plan would also allow the DBHDD leadership to be able to concretely track and record actions taken in support of SE services in the State.

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") is fixed at $410.00 per slot for each provider. 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 required as part of the Settlement Agreement, it still warrants attention to see if the rate is adequate for providers, as well as what the potential implications are for service delivery. DBHDD is currently working on a cost rate study that is in process and not yet completed. It will be important to transparently share the findings of that cost rate study as well as the data and calculation process that are used in completing the cost rate study with providers and other stakeholders in Georgia.

A second complication that warrants some further examination is to look at the consequences and lessons learned from funding SE slots rather than funding specific clients or specific outcomes. For example, an SE provider who is given a fixed number of SE slots may feel strong unintended pressures to make sure that clients (that meet the above criteria) in those slots are the best candidates for rapid employment to keep SE slot outcomes up. This may have the unintended consequence of providers re-assigning clients both into and out of their designated SE slots to improve outcomes and reduce the time and subsequent staffing and other costs that they invest in clients in SE slots. The

leadership at DBHDD is aware of this complication and they are tracking data from providers to mitigate these potential consequences.

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.

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

Narrative

DBHDD has not had any new providers of SE services since the beginning of the settlement process. Leadership is aware of the need to address their existing lack of helping new SE providers with start up costs. DBHDD does not currently reimburse start up costs for a new provider to deliver SE services. Some typical start up costs for SE services includes software adaptations for tracking and reporting employment outcomes and services provided. Other start up costs may include the purchase of laptop computers, cell phones and transportation resources for employment specialists to be providing the majority of SE services in the community.

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)
	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)
	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

As described earlier, DBHDD has entered into a training agreement with the Institute on Human Development and Disability at the University of Georgia. The rollout of the SE training has included in-person meetings with the group of SE provider leaders and managers, followed by a six-week introductory course regarding the principles of SE services which is provided via video telecast. Several providers were grateful for this new initial training method and felt that the video telecast provides a way to engage in training without incurring excessive travel and time costs. This group then had a follow up, in person,

meeting with the trainer to gather feedback about the training and to identify further training needs. The trainer stated "one hundred percent of questions and concerns at the follow up meeting were about how to implement the program with fidelity at the agency level."

A second group of SE practitioners (employment specialists) is currently enrolling to start another six week training rotation. Nearly everyone associated with and participating in the training program described it as being a very helpful and useful beginning, while recognizing that it is not sufficient to address the various training and implementation challenges encountered by providers in the State of Georgia. As one person who completed the first round of training stated, "We need the training to get down to the real skills of SE, not just the overview level. The training needs to fit within the context of our agency, not just the overview."

The existing Scope Statement and Project Deliverables document for Evidence-Based Supported Employment Training and Technical Assistance (dated 02/15/2012) describes further training and consultation steps for employment specialists as well as "on-site training and technical assistance" and "on-site fieldwork during webinar break." However, the course outline offers a very minimal amount of time (3 hours) for "On-site training and technical assistance regarding the Integration of Employment with Mental Health Services" for managerial staff and front line staff. This is clearly an insufficient amount of time

for agency-based on-site consultations regarding the faithful implementation of SE services. In addition, no time is allocated for the "on-site fieldwork."

It is also important for the DBHDD leadership staff to assure that all of the defined principles of evidence-based supported employment services are addressed in the training curriculum and that training in other employment models is not provided which will result in both model-drift and agency confusion. The training curriculum includes information not described in the defined SE principles nor in the SE fidelity scales, including references to the "Discovery Process" (usually associated with Customized Employment, not SE). Several course participants stated that they had noted the introduction of other materials in the SE training. One training participant described it as "a blend of SE training and employment training for people with developmental disabilities mixed in with Customized Employment training." Another person commented on the inclusion of non-SE strategies where the training materials "do not line up with the fidelity scale," such as "finding your personal genius," or training people to take pictures of clients working to perspective employers. Again, these are ideas not consistent with SE fidelity or the evidence-based principles of SE.

As an evidence-based practice, SE has specifically identified skills, strategies, and agency-based policies that are required for good fidelity (effective and faithful to the researched model); SE services that help people to obtain and retain competitive employment. Implementation studies have identified access to

several components of SE agency-based on-site consultation and training to be crucial in order for providers to help people with SE services in the most effective manner possible.

5. Training: Quality

Is high quality training delivered to each site? High quality training should include the following:	
Present	1) Credible and expert trainer
	2) Active learning strategies (e.g. role play, group work, feedback
Present	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
Present	6) High quality teaching aides/materials including workbooks/work sheets, slides, videos, handouts, etc., e.g. SAMHSA Toolkit

Narrative

As noted in two previous sections, the current training agreement with the Institute on Human Development and Disability is a good start in terms of helping providers of SE services for the Settlement Agreement slots to be able to have a common language and common understanding of the principles and ideals of SE services.

It is important, as the training continues, that it incorporates critical components such as sufficient time for individual agency-based on-site consultations regarding the implementation and ongoing improvement of evidence-based SE services. Additionally, the agency-based consultations should incorporate

information gathered from fidelity reviews and working with provider agency leadership to develop specific steps and strategies for each agency to improve their fidelity scores.

Another crucial element to helping employment specialists to learn vital skills, such as job development with employers in the community, is to assure that agencies have access to trainers who are able to work with employment specialists and their supervisors in their communities and with real employers. Job development is best learned when employment specialists have the chance to see the skills modeled for them with employers and are then given the chance to practice and demonstrate those skills while being shadowed by a trainer or supervisor.

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
	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
	5) Offers technical assistance and booster trainings in existing EBP sites as needed
	6) Expansion plan beyond currently identified EBP sites
	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

DBHDD has entered into a training agreement with the Institute on Human Development and Disability to provide training to providers of SE services for the existing Settlement Agreement slots. The initial basic overview training on SE services has been well-received in the field, though some questions exist about training information covered that is not included in the principles of SE or in the SE fidelity scale. It will be important for DBHDD to work with their provider partners and their training partner to expand and enhance the scope and the intensity of the initial overview training to address providing on-site technical

assistance and consultation to provider agency leadership and their Community Service Board partners, as well as expanding the scope of the training to include field demonstrations and skill development for employment specialists. This work can be done in a system sustainable way by focusing training on job development and field mentoring on SE supervisors and teaching them to train their existing SE workforce as well as new employees in the future. Providing the opportunity for SE providers to visit high fidelity SE programs is a very effective learning tool that promotes increased collaboration between providers.

Several states (e.g. Oregon, Maryland and Kansas) have been successful in developing comprehensive training and consultation collaborations with their own universities or other resources to assure access to effective training and consultation resources for SE providers.

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*) *<u>Ongoing training</u> 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)*

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

Narrative

In order to receive credit for how many sites have been able to access high quality training, the State must first assure that the training being provided is of high quality, both in terms of the training content focusing on evidence based SE

skills strategies and in terms of addressing agency based consultation and technical assistance needs sufficiently. At this point, the new training that is being provided has not yet achieved the threshold of high quality training. However, DBHDD has arranged for all SE providers who have slots in the Settlement Agreement to be able to participate in the training program.

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:	
	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

Governor Nathan Deal has appointed Frank W. Berry, III as the new Commissioner of DBHDD starting on August 11, 2012. Given the timing of that significant change in Department leadership, this section of the report will focus on the active leadership at the DBHDD level including leadership being provided by Dr. Terri Timberlake in her position as Director, Adult Mental Health Services for DBHDD. Several people noted a significant change in the leadership at

DBHDD regarding supported employment services and the role that employment can play in the recovery of people with severe mental illness in Georgia.

Several people commented on the apparent change of tone and commitment on the part of DBHDD leadership relative to SE services. People cited the recent well-attended Supported Employment Summit (June 2012) at the Carter Center as one example of a change of tone and presence. Other people noticed a difference in SE recently being included in meetings of the State Mental Health Planning and Advisory Council. One provider seemed to sum it up for many others, “Things are different now, for some years we were invisible, we still did our jobs, but now employment is becoming a big focus.” Another person stated, “The State is beginning to realize how high SE is in terms of being important for clients. We are all starting to come together on this instead of just employment services, we are coming together with other services about employment.” Another stakeholder commented, “It is good that we are helping people to get back to work. I am glad the focus on employment is back. I hope it stays this time.”

Staff from DBHDD described several staff meetings where employment and SE services were on the agenda. People also noted the presence of Dr. Timberlake on the bi-monthly SE coalition calls that were recently started. DBHDD has staff positions that are dedicated either in part or in whole to SE services. Most people stated the belief that Mary Shulman is the point person at DBHDD for SE

services. Providers also described the offering of training and the fidelity site reviews as other signs of increased leadership and support for SE services in Georgia.

9. SMHA Leadership: Central Office EBP Leader

<table>
<tr><td colspan="2">There is an identified EBP leader that is characterized by the following:</td></tr>
<tr><td>Present</td><td rowspan="4">1) EBP leader has adequate dedicated time for EBP implementation (min 10%), and time is protected from distractions, conflicting priorities, and crises
2) There is evidence that the EBP leader has necessary authority to run the implementation
3) There is evidence that EBP leader has good relationships with community programs
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</td></tr>
<tr><td></td></tr>
<tr><td></td></tr>
<tr><td>Present</td></tr>
</table>

Narrative

Staff from DBHDD that were interviewed were clear about the designation and presence of a point person for SE services at their agency (Mary Shuman). Staff members were also clear that the point person has a number of different duties, including being a point person for peer support services and psychosocial rehabilitation services. While the scope of this review is to focus on what is in place rather than what is planned, it is important to note that DBHDD is also hiring another person (Tabatha Lewis) to work on the implementation of SE services in the state. The point person for SE does report directly to the Adult Mental Health Director and appears to work closely on SE services.

Several providers stated that the only time they saw people from the State Office at their agencies for SE was during fidelity reviews. (Fidelity reviews are quality improvement strategies used to measure and improve the extent to which SE providers follow the evidence-based principles of the practice.) All providers described the fidelity review process as being conducted as "compliance audits" rather than collaborative efforts to understand and improve the quality of SE services at their agencies.

While providers were also grateful for the first three SE coalition meetings that have started, they also universally noted that these meetings are a new format and they described a lack of comfort and trust in those meetings. One person commented, "We attend those meetings by telephone, we are not really sure yet who is on those meetings from the State and who is listening and for what reasons." It may be useful to convene those meetings in rotating regions around the State so that providers have the opportunity to attend some meetings in person, which may help with developing a working rapport within that group and improve some of the provider trust and confidence concerns while working with DBHDD SE staff.

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
Present	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
	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

The successful implementation and sustaining of effective supported employment services on a statewide basis often relies upon effective policy and funding collaborations with other important agencies in a state, specifically the state's Vocational Rehabilitation agency and the state's Medicaid Authority or

Agency. DBHDD staff has developed a draft of a Memorandum of Understanding to address some of the important policies and actions between Supported Employment services and the State's Vocational Rehabilitation (VR) services. As described earlier, this draft has been signed on the DBHDD side and was awaiting signature from the State's VR services at the time of the SHAY review. This will be a significant step in aligning the important partnership between SE services and VR services. (On August 27, 2012, the Department informed the Independent Reviewer that the Memorandum of Understanding now was fully signed.)

Aligning policies and procedures between VR and SE services is important at the executive level and equally important at the practice level, on the ground, between local VR counselors and SE providers. There appears to be a great deal of concern and variability in terms of local relationships between the State's VR counselors and SE providers. One provider's SE team leader described, "a great working relationship with my local VR counselor, she is a great partner." This provider stated that the local VR counselor is always receptive to opening up shared clients and has worked very well with SE services. The provider attributed this to a longstanding personal working relationship with the VR counselor.

Other providers described a much different relationship with local VR counselors and SE services. One person seemed to speak for many in a meeting when they

stated, “In the State of Georgia it is counter productive to work with VR on our SE clients. VR counselors are constantly pushing our clients for more assessments to see if they can work. We are trying to get people jobs.” Another provider stated that trying to work with VR “is like adding an anchor to the rapid job search process we are trying to accomplish in SE services.” Many providers expressed the concern that VR counselors do not seem to have any information about what SE services are or how they can work well with VR services. One person stated, “It seems that the VR approach in our state is outdated, they have not had the chance to catch up to where we are at with SE services.” And another comment included, “The last time I even tried to work with VR on SE was two years ago. The VR counselor was not a good match for SE services.” None of the clients who were in SE services were able to describe working with state VR services in getting or keeping a job.

The need to further develop an on-the-ground positive working relationship between VR and SE was also identified by other people. The person doing the training on SE stated that they had the chance to have one meeting with some VR counselors and they were struck by how little information the counselors had about SE services and the focus on rapid competitive employment for clients. Several people voiced the idea that state VR Counselors do not see people with mental illness as good candidates for competitive employment closures and, therefore, do not want them on their caseloads. One person from the State’s VR services summed up the opportunity well, “What really prompted us to get to the

table together [to work on the MOU] is that no one has enough resources to get things done without doing them together. This is a chance for us to come together to do the right thing for the people who need our 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*

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
Present	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 with the SE providers linked to the Settlement Agreement. This language specifies that Supported Employment providers provide SE services that are 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.

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:	
	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
	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 SE services as described in the SAMHSA toolkit, some of the principles of evidence-based supported employment and some of the SE fidelity scale. One clear example of an evidence-based SE principle that is not included in the language, due to the structure of the Settlement Agreement, is the Zero Exclusion criteria which is mitigated by the language for the “Target Population” previously discussed in this report.

DBHDD provided fidelity reviews for three of the Settlement Agreement providers between November 30, 2011 and December 15, 2011. (A more detailed discussion of fidelity is included in item #13 of this report.) Agencies were provided with copies of the Fidelity Review findings. Of particular note for this section is the wide variation from providers regarding the explicit expectations of DBHDD regarding their fidelity findings. While some staff at DBHDD stated the expectation that all providers would have an SE fidelity score of 100 (115 – 125 = Exemplary Fidelity; 100 - 114 = Good Fidelity; 74 – 99 = Fair Fidelity; 73 and below = Not Supported Employment) or higher (using the IPS-25 Fidelity Scale), no provider stated that they were aware of that expectation from DBHDD. One provider stated that DBHDD "expects a written corrective action plan for all items that scored a 2 (on a range of 5 to 1) or lower on the fidelity scale." Another provider stated, "We have no idea what the State expectation is." And a third stated, "I can't answer that." While the leadership at DBHDD may have communicated explicit expectations to providers regarding fidelity previously, it may well be worthwhile to revisit specific and explicit fidelity expectations with SE providers again, including a specific document. There is no language in the SE Service Definition document that identifies provider expectations regarding fidelity.

DBHDD has been gathering data from the Settlement Agreement providers regarding client outcomes (a more detailed discussion of this is included in item #14 of this report). When providers were asked about the expectations of

DBHDD regarding client employment outcomes for the Settlement Agreement slots, there was, once again, great variability in their understandings. One provider stated that DBHDD "expects us to have 40% of people in slots competitively employed. Last year they expected 30%, this year it is 40% and next year it will be 50%. There is no sanction for going below 40%." Another provider stated, "We are considered to have good quality SE services if we are at 35% employment for the ADA slots." And still another provider stated that they were not clear at all on what DBHDD is expecting for employment outcomes, if anything at all. It is noteworthy that the DBHDD SE Coalition Meeting Notes of the June 20, 2012 meeting state, "Discussed initial FY13 target of 35% competitive employment rate." Once again, even if DBHDD has already made outcome expectations clear to providers, including discussing expectations verbally in SE Coalition meetings, it may be worthwhile to revisit this communication and furnish providers with specific and clear written expectations related to employment outcomes for those people in the Settlement Agreement slots.

13. 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*
	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*
	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
	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.)
	8) The fidelity performance data is made public (e.g. website, published in newspaper, etc.)
	No components covered

Narrative

As previously noted, staff from DBHDD conducted fidelity reviews for three providers of SE services for people in the Settlement Agreement slots between November 30, 2011 and December 15, 2011. Reports were written based on the reviews and sent to providers sometime in March 2012. The fidelity reviewers used the newest fidelity scale for evidence-based employment (IPS-25) that was developed in 2008. The reports include findings and recommendations on each of the twenty five items in the fidelity scale. This may

be the first time that some of the staff from DBHDD participated in the conducting of fidelity reviews for SE providers.

One of the substantial benefits of implementing evidence-based practices in mental health is that, by their very definition, evidence-based practices must have a fidelity scale that measures the extent to which providers of the service are following the principles of the practice that have been identified through research. Fidelity scales provide process based measurements that are extremely helpful as a quality improvement tool to assess where agencies are in terms of their faithfulness to the practice; to understand what barriers or challenges are common for agencies across a system; and to provide a specific focus and structure to improve the quality of SE services in order to help more people to achieve their competitive employment goals.

The collective experiences of agencies that received fidelity reviews were that the reviews were not conducted in a quality improvement fashion but were instead conducted and written up as compliance audits. Many providers raised questions about the qualifications and the experiences of the staff from DBHDD who conducted the audit and if they had ever been formally trained in conducting SE fidelity reviews or if they had ever had the experience of shadowing well-trained SE fidelity reviewers doing a review. One provider summarized their experience this way, “The most challenging part of the fidelity review was that we were being rated on things that we did not know that we needed to do, for

example having job development logs, until after the review was over." Another provider stated, "We had a fidelity review that felt very punitive to us. The evaluators of fidelity were very black and white in the way they viewed things." Another person commented that, during the fidelity review, reviewers continually stated that things were "out of compliance with fidelity." One provider felt this way, "The fidelity was much more of a compliance audit than a collaborative quality improvement activity. We have had other external fidelity reviews here that were collaborative. This review was nothing like that." The written fidelity report for each agency includes references to a "fidelity audit" as well as language about a "fidelity review."

Many providers raised questions about how the IPS-25 fidelity scale should be used differently when the provider of SE services and the provider of other mental health services are from different agencies. Several providers felt they were being held accountable for things that they cannot change or influence. The most common example was that agencies felt blamed for not having their employment staff attend integrated mental health treatment team meetings when the mental health providers do not have those meetings occurring in their agencies.

Providers stated they were required to submit "corrective action plans" for all items in the fidelity review that received a score of 2 or lower. When asked if they were provided with any types of consultation or technical assistance from

DBHDD on how to improve those items, providers stated they had a phone call on the review but did not receive any consultation services regarding improving fidelity. While the agencies each received reports, they stated they were not given any information about how they did in the review compared with other providers in the state.

As stated earlier, this may be the first use of SE fidelity reviews in the DBHDD system and, as such, there may be an important learning curve across the system. Fidelity reviews work best when agencies being reviewed are prepared for the reviews beforehand by having access to an overview training that provides them with information about what is covered in the review; how information for the review will be obtained; how information will be translated into scoring; who will receive copies of the review, how to use the review to improve employment outcomes; and, then, agency-based consultation services to work with agency leadership on strategies to improve the quality of SE services by using fidelity reviews. It is also important to develop a shared understanding and trust of the fidelity review process between the fidelity reviewers, the agency leadership and the leadership at DBHDD.

Many states have a statewide SE leadership team that has access to all fidelity reviews and findings for the purpose of monitoring and improving the quality of SE services across the state in collaboration with their training and technical assistance centers. Specific trainings and consultations may be designed to

address areas where fidelity scores are low across the state. Additionally, when providers have access to other providers' fidelity scores (or the range) then they are able to identify those other providers who may be doing well in an area where they are weak and then seek consultation in that area from the other provider. It would be useful for DBHDD to seek out some expert consultation and training on providing fidelity reviews at the agency level as well as developing a system based focus on fidelity as a quality improvement tool for SE services.

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
	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
	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

Supported employment services produce clear and easily defined important recovery-oriented fundamental outcomes such as the percentage of people obtaining and retaining competitive employment in their communities. DBHDD is collecting information monthly, including employment outcomes, from providers who have the Settlement Agreement slots. This information includes a number of different “fields” such as “Number of new job starts this month,” “Number

competitively employed at the END of this month," and "Average hours worked per week."

The staff members at DBHDD have been able to use this data to formulate monthly summary reports for the providers of the Settlement Agreement slots, including the trends of the total number of consumers served per month; the competitive employment trends by month; and the percentage of consumers looking for a job who have contact with an employer within 30 days. These are excellent examples of reports that can be used to focus on quality improvement at both the system and the provider level. DBHDD staff stated that the directors of provider agencies receive feedback from DBHDD based on reports developed from the provider data, while providers reported that they did not receive this type of summary data back from DBHDD regarding outcomes.

Many providers expressed confusion and dismay about the gathering and use of outcome data related to SE services. One provider covered two large tables with the spreadsheet that providers are asked to input data into on a monthly basis as a visual way to display how complicated and timely the data input process is for them. All providers stated the data gathering is a very lengthy and costly process in terms of staff time to input the data. Another provider stated, "We are not sure why this data system, or its uses, or the reasons, or any of the benefits of using this data system." Another provider summarized it this way, "I want to understand why we are doing this (SE data system) and why we are spending so much time to enter this data."

Given the two vastly different understandings as to whether DBHDD is sending this data to providers, combined with numerous provider questions and concerns with the SE data and the collection method, it may be useful to have an open dialogue with the providers of SE services about how this data is being used and disseminated. Once again, any written document that outlines how the data is used and where the data can be accessed by providers for quality improvement purposes would also be helpful to address potential provider concerns and questions about SE data collection.

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
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.

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

Narrative

The support for SE services in Georgia is quite strong across numerous stakeholder and advocacy groups. Georgia has a very active chapter of APSE (Association for People in Supported Employment). The Georgia Consumer Advocacy Network has a large annual conference. Numerous people cited that that group has chosen employment and supported employment as their top priority for numerous years. The network of providers who have the Settlement Agreement slots appear to be very enthusiastic and committed to the delivery of SE services. Family members and mental health advocates are clear about their support for supported employment and the importance of employment in helping their loved ones to make progress with their recovery.

National Implementing Evidence Based Practices Project SHAY Data

The overall average SHAY item score for states participating in the Substance Abuse and Mental Health Services (SAMHSA) National Implementing Evidence Based Practices Project was 3.14. In those states, the overall average item fidelity score across all five identified EBPs was 3.47. In those states where provider agencies were able to successfully implement EBPs (average EBP fidelity item score of 4.0 or higher), the State Mental Health Authority had an average SHAY item score of 3.82. States with higher SHAY scores also had better EBP implementation. In other words, the actions of the State Mental Health Authority described in the contents of the SHAY are associated with the fidelity and quality of services provided at the local level.

Summary of Georgia SE SHAY Item Scores 2012

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