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

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

**NOTICE OF JOINT FILING OF THE REPORT OF THE INDEPENDENT REVIEWER**

Plaintiff United States 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, 151 & 171]. The Independent Reviewer's report (with its referenced attachments) is included as Attachment A hereto.

Respectfully submitted,

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**Local Rule 7.1D Certification**

By signature below, counsel certifies that the foregoing document was prepared in Century Schoolbook, 13-point font in compliance with Local Rule 5.1B.

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Special Litigation Section

**IN THE UNITED STATES DISTRICT COURT**
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| | ) | |

**CERTIFICATE OF SERVICE**

I hereby certify 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 19th day of September, 2013.

/s/ *Robert A. Koch*
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Civil Rights Division
Special Litigation Section

# 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 19, 2013

## INTRODUCTORY COMMENTS

This is the third Report issued on the status of compliance with the provisions of the Settlement Agreement in United States v. Georgia. The Report documents and discusses the State's efforts to meet obligations to be completed by July 1, 2013.

Based on the many sources of information available to the Independent Reviewer and her expert consultants in supported housing, supported employment and Assertive Community Treatment (ACT), it is clear that the majority of obligations in this third year related to the support of individuals with a mental illness have been met or exceeded. The flexibility granted by the Court, in its Order of August 29, 2012, for the restructuring of the eight ACT teams and the Quality Management system has led to very productive results.

Despite multiple demands and economic constraints, the Governor and the Georgia General Assembly approved the funding required for the full implementation of the Settlement Agreement in the third year.

Although there are serious systemic issues still to be resolved regarding the transition of individuals with a developmental disability from state hospitals to community settings, there has continued to be a strong focus on the necessary reforms. The Commissioner's decision, in May 2013, to suspend such community placements until health, safety and habilitation could be assured was a critical moment in the transformation of this component of the Department. It is important to emphasize that the Department of Community Health and the Attorney General's Office provided important support to the Department's efforts to remove vulnerable individuals from community provider agencies that failed to meet expected standards of care and habilitation.

The Commissioner of the Department of Behavioral Health and Developmental Disabilities (DBHDD), Frank Berry, has publicly affirmed his commitment to the principles of recovery and meaningful community integration that are the bedrock of this Agreement. He and his staff have worked conscientiously to implement the provisions scheduled for this year of the Agreement. The Department's leadership and staff have been accessible, forthright and responsive to the Independent Reviewer's many requests. The generous help of the Settlement Agreement Coordinator, Pamela Schuble, is greatly appreciated, especially since she undertook additional responsibilities related to the reform of the supports for individuals with a developmental disability transitioning from the state hospitals.

The Parties have maintained a collaborative working relationship that has been of considerable value in identifying and implementing strategies for problem resolution. As requested by the Court, periodic meetings have been scheduled with the amici in order to ensure that information is shared and discussed. The Department of Justice attorneys have assisted the Independent Reviewer throughout the year and have provided expert consultation on the requirements for the Quality Management system.

The implementation of the Settlement Agreement has been expedited by the State's good faith efforts and by the willingness of the Parties to reach reasonable solutions to the issues or concerns often inherent in the reform of complex systems.

The State of Georgia has the undisputed advantage of a strong, well-established network of peer supports as well as an active and engaged advocacy community. The contributions of these stakeholders cannot be overstated. They are absolutely critical to the sustainability of the services and supports implemented under the terms of the Settlement Agreement. Fortunately, there is evidence of stakeholder inclusion in the reform of Georgia's system of supports; the system is becoming stronger and more responsive because of this involvement.

In summary, the mental health programs and supports required by the Settlement Agreement are proceeding as anticipated. The building blocks of a system oriented towards recovery are now visible and largely operational. The fourth year of the Settlement Agreement will be a very critical year to evaluate the continuing strength of these programs and to determine whether all individuals included in the target population, especially those involved with the criminal justice system, are benefitting from these new or redesigned resources. It is also a year where the work of the mental health system as a whole, rather than as a series of its discrete parts, must be measured.

In its Order of July 26, 2013, the Court granted additional time for the review of the transition of individuals with a developmental disability from state hospitals to integrated community settings. There are critical issues to be resolved in order to reach compliance with the Settlement Agreement obligations related to these transitions, including the implementation of Individual Support Plans and the provision of support coordination. As noted above, the Parties are working with great diligence and cooperation to ensure that these terms of the Settlement Agreement are met and that the community placements are individualized, afford meaningful integration in community life, and are characterized by dignity, respect and protection from harm.

The Independent Reviewer's report on the provisions referenced above (Section III.A.2.b.iii. (A)-(C)) will be submitted to the Parties and the Court in late Winter 2014.

## MODIFICATIONS TO THE SETTLEMENT AGREEMENT LANGUAGE

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

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

On two occasions, upon receipt of joint motions by the Parties, the Court has approved modifications to the language of the Settlement Agreement. These modifications have resulted in revised timeframes for certain aspects of the Independent Reviewer's work, including the information to be considered in evaluating compliance with specific provisions of the Settlement Agreement.

The First Modification

On August 29, 2012, the Court approved the first modification requested by the Parties. This modification concerned the requirements for the review of the Assertive Community Treatment (ACT) teams to be established under the Settlement Agreement by July 1, 2012 and the timeframe for submission of reports regarding the Department's Quality Management system.

The Court's Order gave the Department the flexibility it needed to correct any perceived deficiencies in the ACT teams required to be created under this Agreement. It also deferred, until July 1, 2013, a determination of whether the teams operated with fidelity to the Dartmouth model. In addition, the Department was to conduct a root cause analysis and then develop a corrective action plan regarding any perceived deficiencies in the ACT teams, with quarterly reporting on corrective actions until July 1, 2013.

The Department fulfilled its obligations with regard to the ACT teams. The progress in the restructuring of the ACT teams and the implementation of the remedial actions were discussed with the Department of Justice, the amici, and the Independent Reviewer. In addition, the Department increased the budget for the Independent Reviewer in order to permit ongoing consultation by her expert consultant, Angela Rollins. Dr. Rollins conducted five site visits, for a total of thirteen days, to review the operations of the ACT teams, evaluate consistency with the Dartmouth Fidelity Scale, and discuss policy and procedural tasks with key staff in the Department.

The report prepared by Dr. Rollins is attached. Based on her observations, interviews and document review, it is the professional opinion of Dr. Rollins and the Independent Reviewer that the State is in compliance with the Settlement Agreement's requirements regarding the composition, function and model fidelity of the twenty-two ACT teams now established in the State of Georgia. The Department's efforts are to be commended. Although continuing effort will be essential to the sustainability of these teams, it is clear that the Department's decision to rebid eight of the original teams was the correct one.

In addition to the work described above, the Department complied with the Court's directives regarding the Quality Management system. A Quality Management system was instituted by July 1, 2012, although there was agreement that additional work was needed to ensure the comprehensiveness and rigor required for the effective quality assurance mandated by the Settlement Agreement. The Department issued an initial Quality Management Plan on July 1, 2012. A revised Plan was issued in April 2013, following a series of discussions with stakeholders and the Department of Justice's expert consultant, Linda Redman. Ms. Redman provided extensive comments to the Department on both the initial and revised Plans. She has continued to comment on the semi-annual reports issued by the Department, according to the schedule ordered by the Court. As required, the Department issued a provisional

Quality Management report on October 1, 2012; this report was not to be reviewed by the Independent Reviewer. Subsequent reports were issued on February 1, 2013 and August 1, 2013.

The Settlement Agreement requires that the Quality Management system implemented by the State 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, injury/incident data and key performance data. It also requires that the system's review include: 1) the implementation of the plan regarding cessation of admissions for persons with developmental disabilities to the State hospitals; 2) the service requirements of the Settlement Agreement; 3) the contractual compliance of community service boards and/or community providers; and 4) a network analysis.

As documented in its reports and the underlying data requested by the Independent Reviewer, the Department has substantially complied with these obligations. However, in the professional judgment of the Independent Reviewer, it is critical that there be a more concentrated focus on the analysis and reporting of the effects from the above-referenced cessation of admissions to the state hospitals. For example, the Department could track the admission of individuals with both an intellectual disability and a mental illness to its psychiatric hospitals in order to evaluate the effectiveness of its crisis system.

Finally, as discussed below, the extensive work now underway to evaluate the quality of community services for people with a developmental disability who were placed from an institutional setting under the terms of the Settlement Agreement will most probably raise areas requiring further investigation, analysis, and remedial action. The Quality Management system will need to be revisited after these additional facts are known to the State, the Department of Justice and the Independent Reviewer in order to ensure that the necessary comprehensiveness and rigor is indeed present.

The Second Modification

Each year, the Settlement Agreement requires the transition of 150 individuals with a developmental disability from the state hospitals to more integrated and individualized community settings. In the first two years of the Agreement, the Department exceeded its numerical targets but was found to be in non-compliance with more qualitative aspects of these placements, including the implementation of the Individual Support Plan and support coordination. These concerns have persisted about certain community placements, including those implemented during Fiscal Year 2013.

The inadequate residential and day programs experienced by some individuals placed under the Settlement Agreement were documented by the Independent Reviewer and her consultants, the Settlement Agreement Coordinator, and leadership staff from the Department and certain regional offices. These unacceptable services were discussed at Parties' meetings and were the subject of very candid conversations with the Commissioner, the Deputy Commissioner and the Department of Justice.

In May 2013, Commissioner Berry stopped all impending transitions of individuals with a developmental disability from the state hospitals as well as those individuals to be placed from the Craig Center, a skilled nursing facility, at Central State Hospital. The Commissioner directed his staff to conduct a thorough review of the seventy-nine placements completed since the beginning of Fiscal Year 2013 (July

1, 2012) and to determine whether discharge planning was adequate to ensure health, safety and habilitation in all future transitions of individuals with a developmental disability from the state hospitals.

The Commissioner's directives resulted in a number of important decisions and actions, including the removal of individuals placed under the Settlement Agreement from three unsatisfactory community provider agencies. The Department was assisted in its remedial actions by the Department of Community Health, who issues licenses and approves Medicaid reimbursement, and by the Attorney General's office, whose attorneys successfully upheld the State's right to intervene in situations of jeopardy for vulnerable individuals.

The Independent Reviewer and the Department have worked together to develop a joint monitoring questionnaire and to train reviewers to meet reliability standards. The Department has completed individual reviews of all seventy-nine individuals placed during Fiscal Year 2013. Currently, nurse consultants who work under the supervision of the Independent Reviewer are evaluating the supports provided to at least one individual in every house where a placement was made in Fiscal Year 2013.

The evaluation of community placements is linked to the development and implementation of an individualized transition plan/process from the state hospitals. The Department is in the midst of reviewing its protocols and will not effectuate new community placements until there is assurance of a reliable and sustainable transition process. It is intended that there be a careful case by case review of each planned transition, beginning with individuals to be placed in Region 4.

As a result of the substantial work still to be done in order to ensure compliance with the Settlement Agreement, the Parties filed a motion with the Court to extend the Independent Reviewer's report on the placements required for FY13 and, while placements from the state hospitals are under review, to permit the State to use the available approved Waiver-funding to prevent the institutionalization of individuals who are currently in the community.

The Court approved this Joint Motion on July 26, 2013.

As ordered by the Court and with the continuing cooperation of the Parties, the Independent Reviewer intends to complete the reviews of placements required under the terms of the Settlement Agreement and to file a timely report of her findings.

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

| Settlement Agreement Reference | Provision | Rating | Comments |
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| III.A.2.b.i(C) | Between July 1, 2012, and July 1, 2013, the State shall create at least 250 waivers to serve individuals with developmental disabilities in community settings. The State shall move up to 150 individuals with developmental disabilities from the State Hospitals to the community using those waivers. The remaining waivers shall be used to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. The State shall provide family supports to an additional 500 families of people with developmental disabilities. | Compliance | The Court's Order, dated July 26, 2013, modified the language of this provision. The Department has issued 597 waivers to serve individuals with developmental disabilities in community settings. These waivers have been used to prevent institutionalization and to sustain individuals with a developmental disability with their families. The number of individuals with a disability who have moved from state hospitals using these waivers will be reviewed in the Independent Reviewer's report to be issued in late Winter 2014. As of this date, seventy-nine individuals with a developmental disability have been transitioned from state hospitals to community residential settings. |
| III.A.2.b.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 | Although the timeframe for the review of individuals with a developmental disability transitioned from state hospitals to the community has been extended to January 1, 2014, there is no evidence at this time to refute the Department's past compliance with this provision. All host homes reviewed to date have no more than two individuals and the number of individuals served in any congregate community living setting has not exceeded four. |
| III.A.2.b.iii(A) | Assembling professionals and non-professionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Service Plans, as required by the State's HCBS Waiver Program, that are individualized and person centered. | Deferred | The rating of this provision has been deferred by Court Order until January 2014. In the FY11 and 12 reports, the Department was found to be in compliance with this provision. |
| 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. | Deferred | The rating of this provision has been deferred by Court Order until January 2014. In the FY11 and 12 reports, the Department was determined to be in non-compliance with this provision. |
| III.A.2.b.iii(C) | Monitoring the Individual Service Plan to make additional referrals, service changes, and amendments to the plans as identified as needed. | Deferred | The rating of this provision has been deferred by Court Order until January 2014. In the FY 11 and 12 reports, the Department was found to be in non-compliance with this provision. |

| Settlement Agreement Reference | Provision | Rating | Comments |
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| III.A.2.b.iii(D) | The Independent Reviewer will not assess the provisions of this section, III.A.2.b.iii.(A)-(C), in her report for the period ending July 1, 2013. Instead, the review period for this section will be extended six months until January 1, 2014, after which the Independent Reviewer will report on this section pursuant to the draft, review, and comment deadlines enumerated in VI.A. | Deferred | The Independent Reviewer will comply with this requirement. |
| 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 8 mobile crisis teams. According to the Department's data, there were 648 individuals served by the mobile crisis teams across all Regions. The average response time for the mobile crisis teams is 82 minutes; the goal is less than 90 minutes. |
| III.A.2.c.ii(B)(1) | By July 1, 2012, the State will have five Crisis Respite Homes for individuals with developmental disabilities. | Compliance | There are 11 Crisis Respite Homes, including one for children. One individual in the sample of 48 was reviewed in his crisis home; supports were adequate and individualized. |
| III.A.2.c.ii(B)(2) | By July 1, 2013, the State will establish an additional four Crisis Respite Homes for individuals with developmental disabilities. | Compliance | There are 11 Crisis Respite Homes across the State. There are 2 homes in each Region, except for Region 3 which has one Home. There were 270 individuals served in FY 13. |
| III.A.3.a | By July 1, 2013, the State shall create a program to educate judges and law enforcement officials about community supports and services for individuals with developmental disabilities and forensic status. | Compliance | The Department has initiated a program to provide education to judges and law enforcement individuals. In FY13, training was provided to 1121 individuals, including 45 Judges, 1030 law enforcement officials and 46 attorneys. To date, officials from 84 counties have participated in this program. |
| III.A.3.b | Individuals with developmental disabilities and forensic status shall be included in the target population and the waivers described in this Section, if the relevant court finds that community placement is appropriate. This paragraph shall not be interpreted as expanding the State's obligations under paragraph III.A.2.b. | Compliance | There is evidence that individuals with a developmental disability and forensic status are included in the target population. However, the expansion of appropriately individualized resources is in its initial stages. For example, 4 new group residences are being developed but are not yet opened. This group of individuals needs to be prioritized for attention in FY14. |
| III.A.4.a | By July 1, 2013, the State will conduct an audit of community providers of waiver services. | Compliance | The Georgia Quality Management System (GQMS) contract with the Delmarva Foundation mandates that each provider rendering services through the Medicaid waivers to individuals with developmental disabilities has one annual review over the course of five years. Therefore, 40 providers are reviewed each year (39 service providers and one support coordinator agency). The providers are selected randomly. Findings from these reviews are summarized in the Quality Management reports issued by the Department. |

| Settlement Agreement Reference | Provision | Rating | Comments |
|---|---|---|---|
| **III.A.4.b** | **By the Effective Date of this Agreement, the State shall use a CMS approved Quality Improvement Organization ("QIO") or QIO-like organization to assess the quality of services by community providers.** | **Compliance** | **In FY13, the Department again 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 and has worked closely with Department staff to track issues related to specific individuals and providers.** |
| **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 for Quarter Three has been completed and was issued to the Independent Reviewer and the Department of Justice on August 1, 2013. Annual reports are posted on the Delmarva website. The State will need to continue its review of the quality of services to ensure that any remedial actions have occured in a timely manner.** |
| **III.B.1.c** | Pursuant to the Voluntary Compliance Agreement with Health and Human Services, the State established a Mental Health Olmstead List. The State shall ensure that all individuals on the Mental Health Olmstead List as of the Effective Date of this Agreement will, if eligible for services, receive services in the community in accordance with this Settlement Agreement by July 1, 2011. The Parties acknowledge that some individuals on the Mental Health Olmstead List are required to register as sex offenders pursuant to O.C.G.A. § 42-1-12 et seq. The Parties further acknowledge that such registration makes placement in the community more difficult. The Parties may by written consent extend the application of the date set forth in this paragraph as it applies to such individuals. The written consent described in this paragraph will not require Court approval. | **Compliance** | At the time the Settlement Agreement was signed, there were 27 individuals on the Olmstead List. All of these individuals were discharged from the State Hospitals and were provided community services. |
| **III.B.2.a.i(G)** | **All ACT teams will operate with fidelity to the Dartmouth Assertive Community Treatment model.** | **Compliance** | **In FY12, The Parties, with concurrence by the Independent Reviewer, requested that the Court defer evaluation of this provision. The Court approved this request on August 29, 2012 with explicit instructions regarding reporting, root cause analysis and corrective action plans. These instructions were complied with by the Department with close involvement of the Independent Reviewer and her expert consultants. Based on the extensive review conducted by the Independent Reviewer's expert consultant throughout FY13, this provision is in full compliance. All teams funded under this Agreement operate with fidelity to the Dartmouth model. (See attached report by Angela Rollins.)** |

| Settlement Agreement Reference | Provision | Rating | Comments |
|---|---|---|---|
| **III.B.2.a.i(H)(1)** | By July 1, 2011, the State shall have 18 Assertive Community Treatment teams. | **Compliance** | The Department has funded 18 Assertive Community Treatment teams. |
| **III.B.2.a.i(H)(2)** | By July 1, 2012, the State shall have 20 Assertive Community Treatment teams. | **Compliance** | The State has funded 20 Assertive Community Treatment teams. However, change in the composition of the teams is underway. The Department is proceeding with remedial action as required by the Court's Order and with consultation by the Independent Reviewer, the Department of Justice and other interested stakeholders. |
| **III.B.2.a.i(H)(3)** | **By July 1, 2013, the State shall have 22 Assertive Community Treatment teams.** | **Compliance** | **The Department has funded 22 Assertive Community Treatment teams. They are distributed through all six Regions of the state. As of June 30, 2013, there were 1,264 individuals participating in services with the ACT teams. Based on the extensive reviews conducted by the Independent Reviewer's expert consultant, the requirements for this provision have been met fully and with fidelity to the Dartmouth model. (See attached report by Angela Rollins.)** |
| **III.B.2.a.ii(C)(1)** | By July 1, 2012, the State will have two Community Support Teams. | **Compliance** | The State has established two Community Support Teams. Although one team was transferred to another provider beginning in FY13, both teams functioned and provided services from the time of their contract. The two teams supported a total of 71 individuals in FY12. |
| **III.B.2.a.ii(C)(2)** | **By July 1, 2013, the State will have four Community Support Teams.** | **Compliance** | **The Department has established four Community Support Teams (CSTs). They are located in four rural areas of the State. A total of 145 individuals received services from the CSTs in FY13. Under the terms of the Agreement, the Independent Reviewer must assess whether the Community Support Team model provides services that are sufficient to meet the needs of the members of the target population who receive these services. The Independent Reviewer's assessment and recommendations are due by October 30, 2013.** |
| **III.B.2.a.iii(D)(1)** | By July 1, 2011, the State will have one Intensive Case Management team. | **Compliance** | The Department has established two Intensive Case Management teams. |
| **III.B.2.a.iii(D)(2)** | By July 1, 2012, the State will have two Intensive Case Management teams. | **Compliance** | The Department has established two Intensive Case Management teams. The two teams supported a total of 387 individuals in FY12. |
| **III.B.2.a.iii(D)(3)** | **By July 1, 2013, the State will have three Intensive Case Management teams.** | **Compliance** | **The Department has established three Intensive Case Management teams in Regions 1, 3 and 5. These three teams served a total of 235 individuals in FY13. The Independent Reviewer has requested additional information about the caseload in Region 3.** |
| **III.B.2.a.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. |

| Settlement Agreement Reference | Provision | Rating | Comments |
|---|---|---|---|
| III.B.2.b.i(B)(1) | **By July 1, 2013, the State will establish one Crisis Service Center.** | Compliance | **The Department opened a 24-hour, walk-in Crisis Service Center on March 1, 2013. From March 1, 2013 through June 30, 2013, 177 individuals received services in this Center. This is not an unduplicated count and some individuals may have received more than one episode of care during this time period.** |
| III.B.2.b.ii(B)(1) | The State will establish one Crisis Stabilization Program by July 1, 2012. | Compliance | The Department has established two Crisis Stabilization Programs. |
| III.B.2.b.ii(B)(2) | **The State will establish an additional Crisis Stabilization Programs by July 1, 2013.** | Compliance | **The Department's two Crisis Stabilization Programs have remained operational. They each have 16 beds.** |
| III.B.2.b.iii(A) | Beginning on July 1, 2011, the State shall retain funding for 35 beds in non-State community hospitals without regard as to whether such hospitals are freestanding psychiatric hospitals or general, acute care hospitals. | Compliance | **The Department has funded hospital bed days in five community hospitals. These beds remained available in FY13.** |
| III.B.2.b.iv(A) | The State shall operate a toll-free statewide telephone system for persons to access information about resources in the community to assist with a crisis ("Crisis Call Center"). Such assistance includes providing advice and facilitating the delivery of mental health services. | Compliance | **The Georgia Crisis and Access Line operated by Behavioral Health Link continued to provide these services in FY13.** |
| III.B.2.b.iv(B) | The Crisis Call Center shall be staffed by skilled professionals 24 hours per day, 7 days per week, to assess, make referrals, and dispatch available mobile services. The Crisis Call Center shall promptly answer and respond to all crisis calls. | Compliance | **The Georgia Crisis and Access Line complied with these requirements.** |
| III.B.2.b.v(A) | **Mobile crisis services shall respond to crises anywhere in the community (e.g., homes or hospital emergency rooms) 24 hours per day, 7 days per week. The services shall be provided by clinical staff members trained to provide emergency services and shall include clinical staff members with substance abuse expertise and, when available, a peer specialist.** | Compliance | **The mobile crisis services provided by the Department comply with these requirements. The Department responded to requests that training for certified peer specialists be held outside of Atlanta in order to benefit more rural areas of the state.** |
| III.B.2.b.v(B) | **By July 1, 2013, the State shall have mobile crisis services within 91 of 159 counties, with an average annual response time of 1 hour and 10 minutes or less.** | Compliance | **Mobile crisis services have been established in 100 counties, exceeding the requirements of this provision. Statewide, there were 840 individuals served by these teams. The average response time ranged from 49 to 56 minutes, again exceeding the requirements of this provision. The disposition for the majority of individuals (230) served was involuntary inpatient hospitalization. The Independent Reviewer will work with the Department's staff to better understand the range of options investigated by the teams and whether the least restrictive measure was consistently employed by the teams.** |

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| **III.B.2.b.vi(A)** | **Crisis apartments, located in community settings off the grounds of the State Hospitals and staffed by paraprofessionals and, when available, peer specialists, shall serve as an alternative to crisis stabilization programs and to psychiatric hospitalization.** | **Compliance** | **The Department has complied with the staffing and location requirements of this provision.** |
| **III.B.2.b.vi(B)** | **Each crisis apartment will have capacity to serve two individuals with SPMI.** | **Non-compliance** | **The Department has not complied with this provision. One set of crisis apartments established in FY13 was designed for up to four individuals and was located in close proximity to two other residential programs operated by the same provider agency. In addition, one bedroom and bathroom was designated for staff; two individuals in crisis would be expected to share one bedroom. The Independent Reviewer and the Settlement Agreement Coordinator conducted a site visit to this program in July 2013 to confirm these facts.** |
| **III.B.2.b.vi(C)(1)** | **By July 1, 2013, the State will provide six crisis apartments.** | **Non-compliance** | **The Department has not complied with this provision. There were three apartments operational, for a total of six beds, at the end of FY13. A contract was executed on June 27, 2013 for an additional 4 apartments but they were not yet operational.** |
| **III.B.2.c.ii(B)(1)** | By July 1, 2011, the State will provide a total of 100 supported housing beds. | **Compliance** | Although the Department provided the requisite housing vouchers, concern was noted about the review of eligibility and access for hospitalized individuals. |
| **III.B.2.c.ii(B)(2)** | By July 1, 2012, the State will provide a total of 500 supported housing beds. | **Compliance** | The State has exceeded this obligation. (See Consultant's report.) The Department awarded 648 housing vouchers and reassessed its prioritization for these awards. Further collaboration is planned between the Independent Reviewer and the Department to further analyze referrals for the housing vouchers. |
| **III.B.2.c.ii(B)(3)** | **By July 1, 2013, the State will provide a total of 800 supported housing beds.** | **Compliance** | **The State has exceeded this obligation. In FY13, it awarded a total of 1,002 housing vouchers. The Department made adjustments to its review policies and worked closely with its regional offices, service providers, DCA and other organizations to increase program effectiveness and expand housing resources. (See attached report of Martha Knisley.)** |
| **III.B.2.c.ii(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. |

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| **III.B.2.c.ii(C)(3)** | **By July 1, 2013, the State will provide Bridge Funding for 270 individuals with SPMI.** | **Compliance** | **The State has exceeded this obligation. In FY13, the Department provided Bridge Funding for 383 individuals with SPMI. (See attached report of Martha Knisley.)** |
| **III.B.2.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.d.iii(C)** | **By July 1, 2013, the State shall provide Supported Employment services to 440 individuals with SPMI.** | **Compliance** | **The State has exceeded this obligation. According to a report issued by the Department and reviewed by the Independent Reviewer's expert consultant, Supported Employment services, with strong adherence to the Dartmouth fidelity scale, were provided to 682 individuals during FY13. The monthly rate of employment was 42.1%. (See attached report of David Lynde.)** |
| **III.B.2.e.ii(A)** | By July 1, 2012, the State shall provide Peer Support services to up to 235 individuals with SPMI. | **Compliance** | There are 3000 consumers enrolled; there are 72 Peer Support sites in Georgia. |
| **III.B.2.e.ii(B)** | **By July 1, 2013, the State shall provide Peer Support services to up to 535 individuals with SPMI.** | **Compliance** | **The Department has made a substantial commitment to the meaningful involvement of peer support services. The Department's commitment was confirmed by the leadership of the Georgia Mental Health Consumer Network during a July 2013 site visit by the Independent Reviewer. Reportedly, and verified by the submission of names, 571 individuals received peer support services provided by the Georgia Mental Health Consumer Network's three Peer Wellness and Respite Centers and through its Peer Mentoring program.** |
| **III.C.1** | **Individuals under the age of 18 shall not be admitted to, or otherwise served, in the State Hospitals or on State Hospital grounds, unless the individual meets the criteria for emancipated minor, as set forth in Article 6 of Title 15, Chapter 11 of the Georgia Code, O.C.G.A. §§ 15-11-200 et seq.** | **Compliance** | **The Department has complied with this obligation. Two of the three individuals now live in either a host home or a group home supported by very attentive family or staff. The Independent Reviewer and her expert consultant, Karen Green McGowan, have confirmed the status of these two individuals during site visits. Unfortunately, the third individual is now deceased due to irreversible medical conditions experienced at a very young age. This individual received very competent and compassionate care from her physician and nursing staff at Southwestern Regional Hospital, where she was visited by the Independent Reviewer and the Settlement Agreement Coordinator on several occasions.** |

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| **III.C.2** | **Individuals in the target population with developmental disabilities and/or serious and persistent mental illness shall not be transferred from one institutional setting to another or from a State Hospital to a skilled nursing facility, intermediate care facility, or assisted living facility unless consistent with the individual's informed choice or is warranted by the individual's medical condition. Provided, however, if the State is in the process of closing all units of a certain clinical service category at a State Hospital, the State may transfer an individual from one institutional setting to another if appropriate to that individual's needs. Further provided that the State may transfer individuals in State Hospitals with developmental disabilities who are on forensic status to another State Hospital if appropriate to that individual's needs. The State may not transfer an individual from one institutional setting to another more than once.** | **Compliance** | In FY12, 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. **In FY13, the primary focus of institutional closure has been at the skilled nursing facility, the Craig Center, at Central State Hospital. Documentation was provided for thirteen individuals transferred from the Craig Center to nursing homes. Evidence of family preferences for nursing home placement was documented in each case but in only six cases was there clear documentation of the discussion of alternatives to nursing home placement. Currently, placements from the Craig Center are pending further review and approval. Therefore, this issue warrants further attention in the Independent Reviewer's report due in late Winter 2014.** |
| **III.C.3.a.i** | By January 1, 2012, the State shall establish the responsibilities of community service boards and/or community providers through contract, letter of agreement, or other agreement, including but not limited to the community service boards' and/or community providers' responsibilities in developing and implementing transition plans. | **Compliance** | Contract language delineates responsibility for developing and implementing transition planning. |
| **III.C.3.a.ii** | By January 1, 2012, the State shall identify qualified providers through a certified vendor or request for proposal process or other manner consistent with DBHDD policy or State law, including providers in geographically diverse areas of the State consistent with the needs of the individuals covered by this Agreement. | **Compliance** | This provision has been implemented. |
| **III.C.3.a.iii** | By January 1, 2012, the State shall perform a cost rate study of provider reimbursement rates. | **Compliance** | The cost rate study has been completed and is 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. |

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| **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.** | **Compliance** | **This obligation has been met. (See IV.A.4. below.)** |
| **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. |
| **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. At this time, the entire transition process is under careful review by the leadership of the Department. The Independent Reviewer has been apprised of these discussions. Additional discussion of this topic will be included in her report to be issued in late Winter 2014.** |
| **III.D.3.b** | **The regional office shall maintain and provide to the State Hospital a detailed list of all community providers, including all services offered by each provider, to be utilized to identify providers capable of meeting the needs of the individual in the community, and to provide each individual with a choice of providers when possible.** | **Compliance** | **The Regional Offices provided a list to the State Hospitals of all community providers. The Independent Reviewer has copies of this information.** |

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| III.D.3.c | The regional office shall assure that, once identified and selected by the individual, community service boards and/other community providers shall actively participate in the transition plan (to include the implementation of the plan for transition to the community). | Compliance | In the sample reviewed in FY12, there was evidence of participation by community providers. Although it is evident that community providers continue to participate actively in the transition process, this matter continues to be under review by the Department and the Independent Reviewer. |
| III.D.3.d | The community service boards and/or community providers shall be held accountable for the implementation of that portion of the transition plan for which they are responsible to support transition of the individual to the community. | Compliance | Once problems were identified, community service boards and/or community providers were held accountable. There is continuing evidence of this accountability measure in FY13. |
| IV | Quality Management | | |
| IV.A | By January 1, 2012, the State shall institute a quality management system regarding community services for the target populations specified in this Agreement. The quality management system shall perform annual quality service reviews of samples of community providers, including face-to-face meetings with individuals, residents, and staff and reviews of treatment records, incident/injury data, and key-indicator performance data. | Compliance | The Quality Management system has been initiated by the Department. The Quality Management system plan and the reports issued on February 1 and August 1, 2013 document the focus on the community services implemented for the target population specified in this Agreement. The reports substantiate that annual quality service reviews are conducted by the Delmarva Foundation and APS, the External Review Organizations. In addition, the Georgia Mental Health Consumer Network interviewed recipients of mental health services. Incident/injury data was maintained and reviewed for the community system and key-indicator performance data was referenced in the Quality Management system reports. Recommendations made by the Department of Justice's expert consultant have been considered and implemented by the Department in order to further strengthen the Quality Management system, its Plan, and its semi-annual reports. |
| IV.A.1 | The system's review shall include the implementation of the plan regarding cessation of admissions for persons with developmental disabilities to the State Hospitals. | Compliance | The Department tracks data related to the provision of alternatives to state hospital admissions for individuals with a developmental disability. These data focus on various forms of crisis services, including mobile crisis teams and crisis respite care. In addition, the Independent Reviewer has been given the information requested regarding the names of individuals with a developmental disability admitted to state psychiatric units, including forensic units. Since the Department routinely tracks these sets of information and reviews them on a regular basis in preparation of the Quality Management reports, this provision is rated in substantial compliance. However, it is recommended that the Quality Management system initiate more concentrated focus on the analysis and reporting of the effects from the cessation of admissions and include that detailed analysis in its reports on an ongoing basis. |

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| IV.A.2 | The system's review shall include the service requirements of this Agreement. | Compliance | The Quality Management reports issued by the Department document the review of the services provided under the terms of this Agreement. In addition, data regarding services/supports are maintained by the respective Divisions of the Department. The Independent Reviewer was provided with the data from these sources for the preparation of this report. |
| IV.A.3 | The system's review shall include the contractual compliance of community service boards and/or community providers. | Compliance | The Quality Management revised plan and subsequent reports describe the oversight structure for key performance indicators and outcomes as well as the requirements for service providers. External Review Organizations (APS and Delmarva) conduct on-site reviews of provider agencies on an established periodic basis. The Department of Community Health audits community service boards every three years. |
| IV.A.4 | The system's review shall include the network analysis. | Compliance | A comprehensive network analysis was submitted to the Independent Reviewer and the Department of Justice on July 1, 2013. In this report, detailed information was provided about available services/supports in each of the six regions as well as the currently existing gaps in services. Detailed information was also provided about the demographics of each region and the target populations to be served. |
| IV.B | The State's quality management system regarding community services shall analyze key indicator data relevant to the target population and services specified in this Agreement to measure compliance with the State's policies and procedures. | Compliance | The Quality Management reports submitted to date contain analyses of key performance indicators related to specific services required under this Settlement Agreement. For example, there are key performance indicators related to ACT, supported employment, case management, housing and community support teams. |
| IV.C | Beginning on February 1, 2013 and ending on February 1, 2015, the State's quality management system shall create a report at least once every six months summarizing quality assurance activities, findings, and recommendations. The State shall also provide an updated quality management plan by July 1, 2012, and a provisional quality management system report by October 1, 2012. The provisional quality management system report shall not be subject to review by the Independent Reviewer under Section VI.B of the Settlement Agreement. The State shall make all quality management reports publicly available on the DBHDD website. | Compliance | Under the Court's August 29, 2012 Order, the language for this provision was modified. The Department's provisional Quality Management system report was not scheduled to be submitted until October 1, 2012. The Department issued this report in a timely manner, although it was not to be reviewed by the Independent Reviewer. Subsequent reports have been filed in a timely manner on February 1 and August 1, 2013. The Quality Management plan was submitted on July 1, 2012 and revised in April 2013. |

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| 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 are notified of deaths and the results of investigations. Any questions about deaths are discussed with the Department. Under the direction of the DBHDD Medical Director, in October 2012, a community-based mortality review committee was created. The committee meets every other month to review unexpected deaths. There is representation by clinicians who are not employed by the Department. In addition, in FY13, there was evidence that patterns of deaths were reviewed by the Department's leadership. |

**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 housing, Assertive Community Treatment team sites, crisis services, crisis apartments, a county jail, and a Peer Wellness and Respite Center.

Although the compliance ratings regarding the transition of individuals with a developmental disability to community-based programs have been deferred, the Independent Reviewer retained two nurse consultants, Natalie Russo and Vicki Crowder, to assist with the review of at least one individual placed in each residence. These reviews are underway and will be completed no later than January 1, 2014. The findings from the reviews will be discussed in a report to be submitted by the Independent Reviewer in late Winter 2014.

Any reports issued to date from the reviews of the transitioned individuals 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.

It is important to note that the monitoring tool used by the Independent Reviewer and by the Department, in its own reviews of transitioned individuals, is identical. The Independent Reviewer and her two nurse consultants provided training on the monitoring tool to Department staff.

In December 2012, a nurse consultant to the Independent Reviewer, Karen Green McGowan, reviewed the community placements of two of the three institutionalized minors. (The third young woman was too medically unstable to be placed in another setting. She remained in the state hospital and received compassionate and appropriate care from her physician and nursing staff until her death.)

Two expert consultants, David Lynde and Martha Knisley, 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 and are attached to this Report.

A third expert consultant, Angela Rollins, was retained to document the Department's progress in establishing Assertive Community Treatment (ACT) teams. Her report, including her findings from the State Health Authority Yardstick, has been shared with the Parties and is attached to this Report. As agreed to by the Parties, Dr. Rollins spent thirteen days on site in Georgia, working with Department staff and assessing their efforts to establish the requisite complement of ACT teams. The Department increased the Independent Reviewer's budget to allow this additional evaluation.

Finally, as stipulated in the Settlement Agreement, this report has been 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 28, 2013.

**Review of Obligations for Year Three**

A. Serving People with Developmental Disabilities in the Community

As referenced earlier, the Court has ordered that the Independent Reviewer's rating of the quality of the placements of individuals with a developmental disability transitioned from state hospitals to the community be deferred for six months. Consequently, although work is now underway, the findings from the evaluation process will not be discussed in this Report.

However, it is important to acknowledge the very deliberate and important efforts now being implemented by the Department to assess the quality of its own work. To date, the Department has conducted reviews of seventy-nine individuals with a developmental disability placed from state hospitals during FY13. (Three reviews were determined to be inadequate and are being redone.) The Department has initiated a contract with Georgia State University to assist with the compilation and analysis of all of the data elements of the seventy-nine completed monitoring tools. As a result of these reviews, the Department has instituted corrective action plans, as appropriate, and has removed a subset of individuals from the responsibility of poorly performing providers. The Department has kept the Department of Justice and the Independent Reviewer fully informed throughout this process.

The Department has used this challenging period to re-engineer its transition process and to develop a statewide transition protocol. Projected placements are under review in order to ensure that appropriate community supports have been identified and will be available at the time of discharge from the state hospital. The Individual Support Plan process and the function and structure of support coordination are under review with technical assistance from expert consultants in this field.

The planned placements from the Craig Center at Central State Hospital, a skilled nursing facility scheduled to close, are included in the review of transitions from the state hospitals. Individuals in this facility may have a developmental disability or a history of mental illness. The Independent Reviewer has been given information regarding the transfers of thirteen individuals transferred from the Craig Center to nursing homes, prior to the Commissioner's cessation of such transfers. In each of the thirteen cases, there was evidence of family preference for nursing home placement, either because of the person's age, prior or current medical issues, proximity to the family, or past experiences in less restrictive settings. The Department's forthright examination of the degree to which the family or individual had been educated about community-based options documented that such information was clearly provided in six instances (46%). As part of its review of transitions, it is recommended that the Department continue to examine the depth and scope of its educational process about community alternatives to nursing home care in order to ensure that a truly informed choice is made by the individual and/or family member involved in that decision. Additionally, it is to be noted that the individuals with a developmental disability now residing in the Craig Center are to be provided community supports through Waiver funding. It is not clear, at this point, how many of the individuals

with a mental illness will qualify for similar types of funding. In a meeting with the Commissioners of the Department of Behavioral Health and Developmental Disabilities and the Department of Community Health, the Independent Reviewer was assured that the State would explore all options, including the use of available state funds, if necessary, to permit community, rather than nursing home, placements for this group of individuals.

This period of intensive review also permits the Department an opportunity to examine whether the information it has secured through its own Quality Management system is utilized effectively at the Regional level. The Independent Reviewer and the Settlement Agreement Coordinator plan to analyze further the evaluations conducted through the Delmarva Foundation process and the responses from the Regional offices.

Although this has been a very difficult set of issues to address in the third year of the Settlement Agreement, the Department has been very open with its findings and its plans to address them. In order to build a proper foundation for the system, it has welcomed guidance and the identification of relevant resources. Existing community provider agencies that have demonstrated expected practices are provided positive examples for replication. In the end, it is anticipated that a stronger, more individualized and integrated system of supports will be available for Georgians with a developmental disability, especially those who have been institutionalized in state hospitals.

The State has continued to support, and the General Assembly to fund, Home and Community-Based Waiver Services and family supports. The State more than doubled the total waiver requirement specified in the Settlement Agreement, creating 597 new waivers in this review period. It was reported to the Independent Reviewer that the Department has been very encouraging about the use of family support resources and has been very responsive to requests for assistance.

By the end of October 2013, the Independent Reviewer must assess whether the crisis and respite services, including mobile crisis teams, required under this Agreement for individuals with a developmental disability are adequate to address the needs of the target population. At this time, therefore, it was confirmed that the Department has implemented the number of mobile crisis teams and respite homes required by this review period but an evaluation of their function and performance will be deferred until the October report.

B. Serving Persons with Mental Illness in the Community

At the completion of the third year of the Settlement Agreement, it is evident that the building blocks for a community-based system of mental health care are largely in place. The Department has made impressive strides in implementing peer supports, supported housing, supported employment, crisis services and in building Assertive Community Treatment teams. Each of these services is essential to preventing unnecessary hospitalization and to promoting recovery from a mental illness.

The attached reports from the expert consultants retained by the Independent Reviewer document that the Department complied with the development of twenty-two Assertive Community Treatment (ACT) teams and met the expectation of strong fidelity to the Dartmouth model. The Department exceeded the obligations related to the provision of supported housing and bridge funding. The Department exceeded the number of individuals expected to receive supported employment and, in doing so, demonstrated fidelity to the Dartmouth model. These accomplishments are to be commended. They afford a strong foundation for future growth.

The Department has implemented the majority of crisis services required for this period of the Settlement Agreement. It has developed one Crisis Service Center in Region 4; four Community Support Teams in rural areas; two Crisis Stabilization Programs with sixteen beds each; and Mobile Crisis Teams that respond to calls from 100 counties. The Independent Reviewer conducted a site visit to the Crisis Service Center. Additional site visits will occur as the Independent Reviewer's assessment of the Community Support Teams is completed in preparation for her report due on October 30, 2013.

After a site visit to the crisis apartments funded in Region 6 under the terms of the Agreement, a finding of non-compliance has been made for that provision (See B.2.b.vi.). The apartments were designed for four individuals in crisis, not two, and one bedroom/bath was restricted for staff use. The apartments were in close proximity to two other residential programs operated by the same agency. Although the Department contracted, on June 27, 2013, for four apartments (eight beds total) to be established in Region 3, those apartments were not operational at the close of this review period. Therefore, the Department did not comply with the requirement that six crisis apartments be established by July 1, 2013. Currently, there are three crisis apartments, located in Region 1 (one apartment) and Region 2 (two apartments). These three apartments provided support in ninety-one admissions (not an unduplicated count of individuals).

The Department's array of crisis services appears to be effective in that the state hospital census has declined. During the next review period, the Independent Reviewer intends to study more closely the linkages between these programs and how well they are integrated as a system of interventions.

Case management services have been implemented according to the obligations of this review period. There are three intensive case management teams and fifteen case management positions. Although the Independent Reviewer was provided information as to the number of individuals served by each case manager, she has requested additional information regarding the caseload size and the staff to individual ratio.

Intensive Services for Individuals with Severe and Persistent Mental Illness

1. Assertive Community Treatment (ACT):

For this review period, the Settlement Agreement requires that there be twenty-two ACT teams and that they operate with fidelity to the Dartmouth Assertive Community Treatment model. The Independent Reviewer's expert consultant has verified that the Department is in compliance with this obligation. Compliance was determined through an intensive review of data, interviews with

Department staff, interviews with the clients and staff of the ACT teams, and observation of the teams in action. Thirteen days were spent on site in Georgia.

As described in the attached report by Dr. Rollins, the use of the State Health Authority Yardstick (SHAY) confirmed that the Department has strong leadership from the Commissioner's office and those most directly overseeing ACT implementation. There is a state plan of very high quality. The system for monitoring fidelity to the Dartmouth model is solid. There have been multiple improvements in funding for ACT, including an extension of the initial authorization period and expedited authorization processes. ACT training was noted to be more responsive to the articulated needs of the ACT teams.

The opportunities or challenges that remain for the Department include the broad dissemination of the state plan; improving technical assistance to the teams; ensuring prompt follow-up to any necessary corrective actions discovered during the fidelity reviews; and rethinking the qualifications of the substance abuse specialist on the team to permit easier hiring and retention.

Two other significant challenges cited in this report were also referenced in the expert consultants' reports on supported housing and supported employment:

- For sustainability, it is important that the Department analyze whether all members of the target population have appropriate access to these intensive community programs. In particular, there was concern that individuals being discharged from correctional settings or from state forensic units were not referred by their treatment teams at the desired rate. In addition, access to housing continued to be a struggle for some ACT teams, despite the Georgia Housing Voucher Program. Barriers seemed to be related to provider preferences for continuum of care options, client criminal history challenges, and lack of affordable housing options in general.
- The Department has made substantial progress in establishing the building blocks for its mental health system. Attention now needs to be directed towards assessing and strengthening the system as a whole. Attention is warranted now in order to ensure that the discrete components of the mental health system--the building blocks represented by these programs--work consistently and in unison towards the same goals and outcome measures. For example, it was noted that some ACT teams did not understand the principles of supported employment and did not refer their clients to these programs, even though there was an employment specialist on the team.

2. Housing Supports

The attached report on the Georgia Housing Voucher Program, Bridge Funding and other related housing developments verified that the Department, with valuable assistance from its sister agencies, met the obligations for this review period. The Department exceeded both the requirements for the number of housing vouchers and for the amount of Bridge Funding made available to individuals with a mental illness.

The Department's success in meeting these targets appeared to be the result of a combination of factors: the Department's Supported Housing Director's diligence and understanding of rental housing

operations and supported housing requirements; clear direction to and strong support from the Regional Directors and their staff; and the interest and support of referral sources, especially outreach staff from services for people who are homeless and have a mental illness. The Department methodically tracks their required targets and collects additional data in a timely manner, which enables them to self-monitor their performance and better grasp their challenges. The Department and their local service agency partners are becoming informed about the local affordable rental markets, fair housing requirements, consumer choice and accessibility features, which is typically related to success in meeting leasing targets.

This foundation is critically important since the Settlement Agreement requires that the housing voucher program be expanded by 1200 supported housing beds by July 1, 2015. Therefore, over the next two years of the Settlement Agreement, the program must grow by 160% of its current capacity.

It is clear that attention must be given to infrastructure capacity and continued collaboration with housing agency partners and community agencies, if future housing targets are to be achieved. The development of a work plan for the next two years would help “size” the planning process and set clear expectations for these activities.

It is recommended that the Department take additional concrete steps to expand referrals from jails and prisons as well as from hospitals and intensive residential programs. The number of individuals referred to date may reflect the true need but it may also be a reflection of problems with referral processes; lack of agreement on who should be referred; challenges to individuals becoming eligible for a housing program or being approved as a renter.

As noted in Ms. Knisley’s report, many individuals with a developmental disability, and those with co-occurring mental illness and developmental disability, are good candidates for supported housing. Despite the Department’s willingness to include them, they are under-represented in the Department’s housing program; therefore, mapping out a plan to expand outreach and inclusion will be essential.

The Department, the Independent Reviewer and the Independent Reviewer’s consultant, Martha Knisley, have agreed to continue to evaluate these and other challenges to be resolved by the State in the next two years. Periodic reports will be provided at the Parties’ meetings.

3. Supported Employment

The review of Supported Employment services, conducted by the Independent Reviewer’s consultant, David Lynde, confirmed that the Department not only exceeded the numerical target for FY13 (440 individuals with serious and persistent mental illness) but made significant strides in securing the foundation for future statewide growth in this program model. Mr. Lynde reached his conclusions through careful review of data, policies and procedures; interviews with Departmental leadership; interviews with staff from the Georgia Vocational Rehabilitation Agency and the Institute on Human Development and Disability at the University of Georgia; interviews with staff and clients of agencies providing supported employment services; discussions with mental health advocates, including peer and

family advocacy organizations; and observations from site visits to programs in January, April, May and July 2013.

As part of his review, Mr. Lynde again administered the State Health Authority Yardstick (SHAY) to measure the extent and quality of Supported Employment services as an Evidence-Based Practice. The Department's overall score (4.0) in 2013 is considerably higher than its score (2.9) on the same measures in 2012. For example, the Department's Plan for Supported Employment received the highest score possible since it describes a solid framework for the implementation of supported employment services throughout the state. Training modules have been revised in response to ideas and requests made by the provider agencies. There is evidence of a commitment to sustain training resources for the foreseeable future, and a method for continued funding has been identified.

These initiatives, and the leadership that has supported them, are to be commended. They have strengthened the availability and fidelity of the Supported Employment services provided under the terms of the Settlement Agreement. The importance of employment to recovery from mental illness is well researched and well documented. At the time of this report, the monthly rate of employment for individuals receiving Supported Employment services was 42.1%.

There are a number of areas for further action outlined in the attached report on Supported Employment services, including broad dissemination of the Department's Plan; implementing the proposed pilot sites to gauge implementation of the Memorandum of Understanding; and responding to the requests for a rate study. Given the strong performance evidenced in this past Fiscal Year, these actions do not appear to be insurmountable or unrealistic to accomplish. As the report concludes:

> While recognizing the substantial amount of work that DBHDD (the Department) has invested in these improvements, it is likewise important to note that sustaining the gains that have been made will be equally challenging and will require an ongoing focused investment of time, energy and resources on the part of DBHDD. In the next twelve months, it will be vitally important for DBHDD to make the most efficient and effective use of the tools they have now put in place to actively and comprehensively monitor the effectiveness, quality and accountability of Supported Employment Services within their state. It is critical that DBHDD ensures that Supported Employment is being provided in a way that is faithful to the evidence and, most importantly, ensures that Supported Employment is being provided in a recovery-oriented fashion to help as many Georgians with mental illness as possible to be successful with employment in their recovery process.

Finally, although not required by the Settlement Agreement, it is important to reference one of the Department's initiatives to " promote hope, autonomy, and engagement in constructive activity for individuals served by the agencies in the DBHDD network" and to strengthen the ability of clinicians, from both the Department and provider agencies, to implement recovery-oriented treatment. The Beck Initiative, now in its second year of funding, is a collaborative partnership between the Department and the Aaron T. Beck Psychopathology Research Center of the University of Pennsylvania. Intensive training in recovery-oriented cognitive therapy has been provided to 110 staff in Region 4 and is now being

offered to staff in Region 6. Training will be implemented in Regions 1 and 3, beginning in February 2014. This model of therapy is a collaborative treatment approach that prioritizes attainment of individual-directed goals, removal of obstacles to those goals, and engagement of withdrawn individuals in their own recovery. As such, this initiative is an excellent example of using other known evidence-based practices to complement the systemic reform supported by the Settlement Agreement.

## CONCLUSIONS

The State, through its Department of Behavioral Health and Developmental Disabilities, has made very significant progress in implementing the building blocks of a responsive, recovery-oriented mental health system. With a single exception, the requirements for new mental health services have been met or have been exceeded by the Department, often in concert with its sister agencies, and with full support by the Governor and the General Assembly.

The State's good faith effort is again recognized with appreciation, as are the many contributions of its very strong advocacy community.

In the next two years, before the Settlement Agreement ends, it is critical that the State refine and strengthen the mental health system as a **whole** to ensure that the discrete programs, such as Assertive Community Treatment, Supported Employment and Supported Housing, work consistently and uniformly to implement individualized services and supports for the members of the target population, including those with a forensic history or criminal justice involvement. Although many of the key building blocks are in place, and those Settlement Agreement provisions are largely in compliance, at this stage of the Agreement, there is evidence that fragmentation, lack of professional knowledge and lack of action still remain as challenging obstacles, with the result that individuals are not always offered or provided the supports essential to their recovery.

As the system of crisis services matures, it is important that there be a very careful analysis of the impact of those services on the rate of hospitalization and involvement with the criminal justice system, both for individuals with a developmental disability and for those with a mental illness. The Independent Reviewer's report due on October 30, 2013 will evaluate whether certain crisis services are sufficient to address the overall need of people with developmental disabilities, especially in the rural communities.

Although it has been extremely difficult at times, it is fortunate that the Department is taking deliberate action to restructure its system of supports for individuals with a developmental disability. It is premature to evaluate the results of the Department's efforts. However, there is no question that there are very serious efforts underway to examine and to ensure the expected quality of community services and supports, including protection from harm, habilitation and integration. The intent and the work of the Commissioner, the Deputy Commissioner, the Settlement Agreement Coordinator and the Division

leadership are recognized and commended. As required by the most recent Court Order, the Independent Reviewer's report on these reform measures will be issued in late Winter 2014.

In closing this Report, it again seems appropriate to repeat the conclusion from the Reports for Year One and Year Two:

> 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 third 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 19, 2013

**SUMMARY OF FY13 RECOMMENDATIONS**

Previous sections of this report, as well as the attached reports, refer to a number of issues with recommendations for future action by the Department. A brief listing of those recommendations includes:

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

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

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

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

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

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

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

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

**STATUS OF FY12 RECOMMENDATIONS**

The FY12 Report offered the following recommendations for consideration by the State. The Department's leadership and staff addressed the details of the recommendations both in Parties' meetings and in meetings with the Independent Reviewer. On June 1, 2013, a formal response to the recommendations was provided. This response summarized the State's actions to date as well as its future plans.

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.

The Department contracted with the highly regarded "Social Role Valorization Implementation Project" to provide a series of introductory sessions to the principles of social role valorization. These seven training sessions were held in various locations across the State; over two hundred and sixty individuals attended the training. Additional training is scheduled in November 2013. The Department has planned to continue this training at least until June 2015.

The provision of this training was responsive to this recommendation and also to the findings of the Delmarva report on the need to increase community integration and membership.

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.

The enhanced value of host home placements was underscored in the most recent Delmarva report (Quarter 3, 2013) issued by the Department. During FY13, site visits by the Independent Reviewer and the Settlement Coordinator to three individuals placed in three host homes again demonstrated the increased social interaction and individualization inherent in this residential setting. The Department supports the use of host homes and has pointed out that 13% of the individuals transitioned from hospitals in the last three years live in homes of their own/family homes or host homes. The Department's focus on the design of individualized supports is appropriate. However, it continues to be recommended that the Department conduct a more systemic analysis to identify any barriers to the expansion of this residential model by community-based providers.

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

In response to this recommendation, the Department stated that it would continue its documentation of Family Support and its capacity to assist families to meet support needs at less than Waiver costs. Such documentation would be provided to the legislature as it considers future funding. Additionally, the Department will continue to work with Family Support providers and the Family Support workgroup to strengthen and sustain its efforts.

It is recommended that the Department continue to explore and document additional strategies to sustain the structural and programmatic accomplishments resulting from the Settlement Agreement. For example, such strategies might build on the Department's "White Paper: Housing for People with Developmental Disabilities and Behavioral Health Needs," issued in July 2013. This document clearly articulates the Department's vision for the development of integrated housing opportunities and its commitment to the principles and mandates of the Olmstead decision and the Americans with Disabilities Act. The document also outlines the challenges and barriers (stigma, resources and paradigm shift) that must be addressed.

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.

As noted in this and previous reports, the Department has exceeded its obligations under the Settlement Agreement in terms of the number of housing vouchers awarded.

The Department has emphasized that it constantly monitors the referral source of each person entering the Georgia Housing Voucher Program (GHVP). Each year, priority is given to those individuals being discharged from state hospitals. The Department also conducted cross training for hospital personnel on community-based resources, transition planning and the GVHP. The Department is partnering with the Georgia Tech College of Public Policy to review GHVP tenants' service history and sub populations to better understand the initial benefits of the program and referral access.

The Department and the Independent Reviewer's expert consultant on housing continue to work together to analyze referrals to the supported housing vouchers and Bridge Funding. There is agreement between the Department and the Independent Reviewer that work on this issue will continue in the year ahead.

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.

The Department and the Independent Reviewer's housing expert continue to work together on the details related to this recommendation. Additional recommendations will be suggested and discussed in the coming year.

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.

The Department has revised its intake form to ensure that providers with other housing resources (e.g. Shelter Plus Care) are utilized before requesting resources from the Georgia Housing Voucher Program (GHVP). The Department has entered into a partnership with the Veterans Administration to assist their efforts at fully utilizing the Veterans Administration's supported housing program so that GHVP rental assistance would not be required for a similar settlement population (chronic homelessness.)

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

Since this recommendation was made, the Department has organized a workgroup consisting of leadership from forensic services, the regions, mental health, community transition planning and others to identify the barriers related to transition. As a result, on June 14, 2013, training was provided to all forensic hospital staff responsible for discharge planning on the purpose, availability and location of such community services as ACT, intensive case management housing, and Community Support Teams. Criteria for access/eligibility were discussed. Case studies were utilized to problem solve specific relevant examples. The workgroup intends to continue to meet to ensure ongoing coordination. In addition, the Behavioral Health Coordinating Council created a workgroup to address the joint concerns of partner agencies regarding individuals with behavioral issues transitioning from correctional institutions into the community. The Department chairs this workgroup. There is an interagency committee charged with identifying barriers and coming up with proposed solutions. This collaborative work is ongoing.

This recommendation continues to be a priority for the Independent Reviewer and further examination of the Department's efforts and outcomes will continue in FY14.

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

The Department is in agreement with this recommendation. In conjunction with the Department's Director of Housing, increased opportunities have been identified for the utilization of housing vouchers for individuals with a developmental disability placed under the Settlement Agreement. These opportunities now are available for individuals transitioning from the state hospitals, from congregate community settings (group homes), or from Waiver-funded residential settings. Individuals with more challenging placement issues, such as individuals with a developmental disability who have a forensic history, may also benefit from the use of housing vouchers. Additional specialized voucher programs available through the Department of Community Affairs are currently planned for the transition of several individuals with a developmental disability from the state hospitals to a community setting.

This recommendation remains a priority for the Independent Reviewer and her expert consultant in housing and will be reviewed throughout FY14.

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

This recommendation has been implemented. The Supported Employment State Plan has been finalized and was reviewed by the Independent Reviewer's expert consultant. Continued dissemination and implementation of the Plan is anticipated.

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.

The Department and the Independent Reviewer will continue to discuss this recommendation. The cost rate study for Supported Employment Services has not been completed and continues to be a recommendation from the Independent Reviewer's expert consultant in his FY13 report.

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.

This recommendation has been implemented. The training is discussed and evaluated in the FY13 report from the Independent Reviewer's expert consultant on Supported Employment.

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.

This recommendation has been implemented. The coalition meetings are now held in Macon, a location considered more central to the six regions.

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.

The review of critical incidents continues to be a priority for the State, the Department of Justice and the Independent Reviewer. Information requested regarding specific incidents has been transmitted in a timely manner to the Independent Reviewer. The Settlement Agreement Coordinator and the Independent Reviewer are continuing to work together to analyze incidents and any remedial actions that are to be implemented. These efforts will continue in FY14.

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

The Department concurs with the importance of this issue. Although the Department has planned reasonable steps to address this concern, the actual degree to which this issue has been resolved requires the consideration of additional information. This information is being obtained from the monitoring of community placements currently underway by both the Department and the Independent Reviewer. Therefore, comment on this recommendation will be deferred.

# State Health Authority Yardstick (SHAY) Report for Georgia ACT Services

Angela L. Rollins, PhD

September 19, 2013

## Introduction

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

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

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

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

The author also reviewed relevant documentation provided, including:

- State Plan for ACT
- ACT service definition and the operations manual which is now designated as a guideline rather than a regulatory document
- ACT fidelity reports and fidelity score tracking tables, ACT team plans of correction for low fidelity, ACT consumer census tables
- Log of all ACT-related trainings and some ACT training materials
- ACT client outcomes reporting templates and reports
- APS audit tool items and sample report
- Minutes for each ACT Coalition meeting held during the last fiscal year
- Memos documenting ACT policy changes during the last fiscal year
- Georgia Housing Voucher data reports

The author also spent two days visiting two ACT programs in the field and meeting consumers served by one of those teams. The author also made four

additional visits to Georgia from November 2012 to May 2013, a total of eight days, visiting several ACT teams in various regions of Georgia and meeting DBHDD regional staff, as well as meeting with DBHDD staff in Atlanta on each visit to stay on top of developments and discuss Georgia's progress on ACT implementation.

The interviews throughout the year and during this July 2013 visit were rich and open about progress in ACT implementation. As noted in brief summaries from the earlier site visits, when barriers were noted in ACT implementation, DBHDD's response was generally one of thoughtful reflection on the issues, followed promptly by clear and specific actions to reduce or eliminate the barrier. The author appreciates the candor and constructive comments and actions by all stakeholders during this visit and throughout the year.

***The State of Georgia is in compliance with the Settlement Agreement requirement to establish twenty-two ACT teams by July 1, 2013.*** As of the end of June 2013, the twenty-two teams collectively were serving 1,263 consumers. The State is also in compliance with regards to additional requirements related to the composition of ACT teams with multidisciplinary staff, including a dedicated team leader, and the range of services to be provided by the team, including the availability of 24/7 crisis services. However, some teams continue to struggle with obtaining (or retaining) substance abuse specialists with the proper credentials to serve on their teams.

## Summary

Strengths and improvements in ACT implementation:

- Leadership from Commissioner's office and those most directly overseeing ACT implementation, including a high quality state plan.
- Clearer standards for ACT, with streamlined regulatory documents and clearer accountability standards for compliance with those standards.
- Solid fidelity monitoring system.
- Multiple improvements in funding for ACT: increased to state contract funding amounts beyond Year 2; increasing ACT initial authorization length to a year to better fit the model; improving APS processes for authorization to decrease unnecessary burden on ACT providers; allowing dual authorizations to encourage gradual, coordinated transitions from ACT to less intensive services; and allowing Medicaid billing for collateral contacts for ACT consumers.
- Improvements in ACT trainings offered, including attention to provider feedback on what trainings they need for their ACT staff and a focus on follow-up webinars to improve the likelihood that concepts will be retained.

Challenges and recommendations for further improvements in ACT implementation:

- Disseminate the state plan widely.
- For sustainability, a thorough examination of whether ACT is reaching populations of interest to the State is needed. For instance, ACT teams are serving consumers being discharged from state hospitals and correctional settings, but are they being served at the rate desired by the State? Do some ACT teams need more encouragement and/or direction to serve these populations?
- Access to housing continues to be a struggle for some teams, even with the Georgia Housing Voucher program. Barriers seem to be related to provider preferences for continuum of care options, client criminal history challenges, and lack of affordable housing options in general. Some ACT teams may need more encouragement from DBHDD in the form of policies, fidelity review feedback, or other methods to consider independent living options for their consumers.
- Improve recovery potential for ACT consumers by providing technical assistance (some onsite) to help teams use specialist positions to maximum advantage, such as helping supported employment specialists, substance abuse specialists, peer specialists, and nurses focus on their unique roles on an ACT team.
- Ensure that follow-up and corrective action planning with teams scoring below 4.0 on DACTS happens promptly after the fidelity review.
- Consider alternatives that would allow staff with one year or more of substance abuse treatment experience to serve in the role of substance abuse specialist on an ACT team. Substance abuse treatment experience that follows a stagewise approach, as opposed to an abstinence-only approach, could be beneficial to the ACT consumers with dual disorders and address a significant workforce challenge for providers in Georgia.

## Findings

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

### 1. EBP Plan

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

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

**Score**

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

**Comments:**

The State Plan for ACT was included in my packet of materials and covers all areas described above. The plan is a clear description of how the State plans to support ACT services and is a model for how to write an EBP plan. The only

recommendation is to make sure it is now widely disseminated throughout DBHDD, providers, and other stakeholder groups.

**2. Financing: Adequacy**

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

**Score**:

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

**Comments:**

ACT funding primarily includes state contract and Medicaid rehabilitation option billing. Georgia DBHDD used a competitive RFP process to award contracts for high fidelity ACT teams with a maximum of $871,000 in Year 1 state funding, billing actual allowable expenses each month (no more than 1/12 of the total contract amount). Year 2 billing can reach up to $780,000. Teams are permitted a great deal of flexibility in how they use these state funds. On top of the state contract money, teams also bill Medicaid ACT rates ($32.46 per 15 minute unit). DBHDD officials made a significant change recently to allow teams to continue state contracts of up to $780,000 in future years, a significant increase of $130,000 per year that was made as a thoughtful response to providers who were reporting lower rates of Medicaid for ACT consumers, a critical element of budgeting for ACT sustainability.

A significant improvement from 2011 was the increase in ACT authorization length from 90 days to 6 months and then a further lengthening of the initial ACT authorization to a full year, bringing ACT authorization length much closer to the ACT intent of providing services with no arbitrary time limits. Providers and other stakeholders across the State openly expressed gratitude for this important policy change. It was also noted that APS and DBHDD worked to address barriers related to communication and transmission of ACT authorization documentation between APS and providers. APS now is initiating secure email exchanges with providers, has conducted several trainings to assist providers with understanding the documentation requirements (often this resulted in more focused documentation of need for ACT rather than huge transmissions of paperwork), and attends each ACT coalition meeting to stay in contact with ACT providers.

The State modified policies to allow for ACT Medicaid billing for collateral contacts since this is encouraged by the model. A few providers have continued to express a desire to bill for phone contact with consumers, similar to what is allowable for other services in the state Medicaid plan. Some acknowledged that it would “settle” for billing after-hours crisis phone contacts only, since after hours crisis response is a model requirement. That last suggestion might be a reasonable compromise, although it could be difficult to monitor in a practical way.

The State has also made sure to allow for dual authorizations for ACT and other services during transitions to less intensive services to avoid abrupt graduations for ACT. The transitions are very short-term (45 days), so I would like to see the State check in with ACT providers and/or consumers at some point in the next fiscal year to make sure this process works smoothly for consumers transferring to less intensive services.

Georgia ACT programs also have had access to community transition planning authorizations to allow for billing the State while conducting discharge planning from hospitals or other institutions when MRO billing is not an option. The rate is roughly $10/unit less than ACT but still a decent rate. Two teams I spoke with were very familiar with this billing option, use it when appropriate, and find it a helpful option for enrolling consumers who need ACT. I have heard from other stakeholders that some providers are either not familiar with or comfortable billing this source. DBHDD and APS have covered this option in ACT coalition meetings, even recently, including formal presentation slides that were reviewed. As the State considers whether enough of their institutionalized consumers are being served by ACT, encouraging this could be an important point to re-emphasize with providers who are not enrolling formerly institutionalized consumers at the rate one would expect for an ACT team.

Also, to address lower rates of Medicaid in ACT clients, DBHDD is hiring a Medicaid Eligibility Specialist in each region to help with increasing the portion of

consumers with Medicaid. A staff person from DBHDD also performs SOAR training for staff around the state to increase rapid application for social security benefits for eligible persons.

### 3. Financing: Start-Up & Conversion Costs

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

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

**Comments:**

No ACT providers I spoke with expressed concerns about compensation for conversion to ACT. In the early months of 2013, a few providers did express concerns about their ability to draw down enough Medicaid revenue in future years when their state contracts would drop to a maximum of $650,000; however, the State responded by changing policy to maintain state funding maximums at $780,000 at Year 2 and beyond.

The State contracts offer substantial flexibility in terms of the types of items the provider can bill for as well.

Of fundamental importance, the State is currently developing a budget spreadsheet tool to help providers monitor their own bottom line related to ACT services. Providers would be able to insert their own unique staffing and other expenses, productivity levels for staff, rates of consumer caseload with Medicaid, and other variables to help monitor how fiscally sound the team is for planning and sustainability. Given that mental health staff vary widely in their expertise with budget forecasting, this tool could be important in helping less financially sophisticated teams think about staffing patterns and productivity standards that make sense for their team's long-term sustainability.

**4. Training: Ongoing consultation and technical support**

<table>
<tr><td colspan="2">Is there ongoing training, supervision and consultation for the program leader and clinical staff to support implementation of the EBP and clinical skills:<br>(Use boxes to indicate criteria met.)<br>Note: If there is variability among sites, then calculate/estimate the average visits per site.</td></tr>
<tr><td>X</td><td>1) Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training)</td></tr>
<tr><td>X</td><td>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)</td></tr>
<tr><td>X</td><td>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)</td></tr>
<tr><td></td><td>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)</td></tr>
<tr><td>X (ACT Coalition)</td><td>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)</td></tr>
</table>

| | **Score** |
|---|---|
| | 1. 0-1 components |
| | 2. 2 components |
| | 3. 3 components |
| X | 4. 4 components |
| | 5. 5 components |

**Comments:**

ACT 101 training was offered during the Fall 2012 to all new teams. Fidelity assessors perform an initial meet and greet with each team to introduce themselves to the team and to provide basic program consultation around start-up and operations. Teams also receive a lot of technical assistance during the course of fidelity reviews, which most providers reported as helpful and constructive. Teams receive a conference call with fidelity assessors prior to and after the visit. Several providers felt it was important to tell me how they appreciated the responsiveness of the fidelity team, the Director of Adult Mental Health, the Assistant Commissioner for Behavioral Health and other DBHDD staff when they had questions or concerns about ACT services. In many cases, these providers said that DBHDD would seek out answers even if they could not

immediately address the concern, giving the general impression that they were willing to really partner with providers in supporting good clinical practice.

For ACT, the one critical piece of technical assistance that is missing is more onsite technical assistance for staff who need help understanding their role on the team. Several sites expressed a need for help for specific positions, including team leaders, nurses, vocational specialists, and substance abuse specialists. As an example, a number of sites expressed the need for concrete help regarding good team leader functions (e.g., how to help staff organize assessments, treatment planning, and daily provision of services). A couple of teams reported needing help for nurses in how to organize and track medication management. In my own observation of teams, it seems that vocational specialists may need more help in focusing on competitive employment-related goals for consumers. As in the 2011 report, DBHDD has encouraged sites to shadow some of the stronger ACT teams, but this is not part of a systematic "package" of TA that all teams receive. Particularly for new teams, some systematic method for shadowing experienced providers is desirable. Shadowing is usually done after basic skills training is completed and staff have had a chance to work on the ACT team and have questions about how teams are supposed to function or how the daily team meeting is supposed to work. Shadowing can become burdensome to the team being shadowed, particularly if it is repeated often. Staff hosting shadowers usually spend a lot of time talking with their shadows and are not as productive as usual. Spreading out shadow experiences across multiple teams or even offering payment for shadowing are important possible enticements.

On their own, one region's team leaders asked their transition coordinator to organize a quarterly retreat (rotating location around the region) so that team leaders could get together and share ideas about team functions. They also are pondering whether they should rotate a team role to bring along to some of these meetings – i.e., bring along a nurse for one meeting and a vocational specialist for the next. This is a good idea and might minimize the amount of onsite technical assistance that is needed. It also appears that DBHDD is having the ACT 101 trainer return to conduct a team leader retreat.

**5. Training: Quality**

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

| | |
|---|---|
| X | 1) credible and expert trainer |
| X | 2) active learning strategies (e.g. role play, group work, feedback |
| X | 3) good quality manual, e.g. SAMHSA Toolkit |

| | |
|---|---|
| X | 4) comprehensively addresses all elements of the EBP |
| On demand only | 5) modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered |
| X | 6) high quality teaching aides/materials including workbooks/work sheets, slides, videos, handouts, etc., e.g. SAMHSA Toolkit/ West Institute |

**Score**

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

**Comments:**

Trainings were endorsed by providers as much improved. One manager specifically mentioned how glad she was that DBHDD heard their requests about the type of training needed and gave them a good motivational interviewing training. Trainers and materials were of high quality and involved lots of active learning strategies. Follow-up webinars were eagerly anticipated by many providers.

As noted above, shadowing is not systematically offered. Some providers were ambivalent about shadowing, and others indicated they thought some staff could really benefit from a good shadowing experience.

**6. Training: Infrastructure / Sustainability**

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

| | |
|---|---|
| X | 1) offers skills training in the EBP |
| X | 2) offers ongoing supervision and consultation to clinicians to support implementation in new sites |
| X | 3) offer ongoing consultation and training for program EBP leaders to support their role as clinical supervisors and leaders of the EBP |
| Variable | 4) build site capacity to train and supervise their own staff in the EBP |
| X | 5) offers technical assistance and booster trainings in existing EBP sites as needed |

| | |
|---|---|
| X | 6) expansion plan beyond currently identified EBP sites |
| Not systematic | 7) one or more identified model programs with documented high fidelity that offer shadowing opportunities for new programs |
| Some | 8) SMHA commitment to sustain mechanism (e.g. center of excellence, university contracts) for foreseeable future, and a method for funding has been identified |

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

**Comments:**

The State has invested in three fidelity assessors to provide some consultation onsite before, during, and after fidelity assessments, but without a lot of ability to come back and spend time onsite with staff. As mentioned earlier, the State is informally referring sites to some better teams. I would urge the State to systematically select teams based on fidelity scores and which roles are strong/high fidelity on a particular team. Also as mentioned earlier, making this a systematic piece of the overall technical assistance will be important.

Teams across the state are variable in their ability to train their own staff (item 4), although I am less concerned about addressing this item right away.

Some of the ACT trainings are supported by Settlement Agreement funds to pay for high quality external trainers. Funding for this type of infrastructure is always difficult, but certainly a plan for how to sustain quality training and technical assistance should be on the future agenda. If internal, affordable options within the state are not available, can these capacities be built now or can you use usual DBHDD workforce development funds to continue providing some of this technical assistance after the Settlement Agreement period is over?

**7. Training: Penetration**

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

1) *credible and expert trainer,*
2) *active learning strategies (e.g. role play, group work, feedback),*

3) *good quality manual (e.g. SAMHSA toolkit),*
4) *comprehensively addresses all elements of the EBP,*
5) *modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered,*
6) *high quality teaching aids/ materials including workbooks/ work sheets, slides, videos, handouts, etc. e.g. SAMHSA toolkit/ West Institute.*

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

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

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

**Comments:**

Training was high quality on 4 of 5 characteristics and all staff were required to attend. The State has made an effort to offer many trainings in more central locations or multiple locations around the state so that they are more accessible to providers.

**8. SMHA Leadership: Commissioner Level**

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

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

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

**Comments**:

I was able to meet with both the Deputy Commissioner for Programs and the Commissioner himself for this SHAY assessment. Both expressed strong support for ACT and for accountable care in general. On the DBHDD webpage, there are clear references to the need to implement ACT and other evidence-based practices and to constantly find ways to improve on those efforts. DBHDD has devoted substantial personnel and other resources to ACT. I am overwhelmed by evidence of a willingness to identify and address barriers to ACT implementation. This has been a recurring theme in my visit since November 2012. Commissioner-level support for ACT also was noted by providers and other stakeholders as well who are clearly aware of the state's support of ACT. Occasionally, I have heard comments to the effect of – of course they are focused on ACT right now because of the DOJ Settlement Agreement. Time will tell if ACT and other services can be sustained in Georgia. It seems to me, though, that most staff at DBHDD involved with ACT are personally invested in continuing ACT services and would only be limited in the future if legislative or leadership changes force their efforts to move in a different direction. To that end, my main recommendation in this area is to clearly document the value of ACT services so that implementation efforts have a chance to withstand challenges in the future. In a few places, you will see me comment on assessing

whether ACT is serving enough of the desired populations it was intended to serve. Tracking the ability of ACT teams to address tough populations will be useful for more longer-term sustainability efforts.

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

| There is an identified EBP leader (or coordinating team) that is characterized by the following:<br>(Use boxes to indicate which components in place.)<br>*Note: Rate current EBP leader, even if new to post.* | |
|---|---|
| X | 1) EBP leader has adequate dedicated time for EBP implementation (min 10%), and time is protected from distractions, conflicting priorities, and crises, |
| X | 2) There is evidence that the EBP leader has necessary authority to run the implementation, |
| X | 3) There is evidence that the EBP leader has good relationships with community programs, |
| Strong | 4) Is viewed as an effective leader (influence, authority, persistence, knows how to get things done) for the EBP, and can site examples of overcoming implementation barriers or establishing new EBP supports. |

| | **Score** |
|---|---|
| | 1. No EBP leader |
| | 2. 1 components |
| | 3. 2 components |
| | 4. 3 components |
| X | 5. All 4 components |

**Comments:**

DBHDD hired the current Director of Adult Mental Health in October 2011. She devotes more than 10% of her time to ACT and also has much support from her supervisor and the Assistant Commissioner. All are reported by providers and stakeholders alike as being accessible, responsive, and willing to listen to concerns and take action. Several providers noted that it feels like a collaborative partnership rather than “us vs. them.” DBHDD listens but also invites input and is constantly working on communication, though in some instances, I know providers have missed an important message at the ACT coalition meetings. Some teams also reported positively on the responsiveness of their regional staff, including some extensive work by transition coordinators during the transition of ACT consumers to newly contracted ACT teams. Again, on several occasions, I have noted barriers in my field visits to good ACT implementation, only to return in eight weeks to see that a policy change has

already been made to address the concern. DBHDD ACT leadership clearly has the authority to make changes for ACT.

**10. Policy and Regulations: Non SMHA State Agencies**

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

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

*Examples of supporting policies:*

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

*Examples of policies that create barriers:*

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

**Score**

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

5. Virtually all policies and regulations impacting the EBP support/promote the EBP.

**Comments:**

DBHDD has good relationships with the Medicaid office and the housing authority. Medicaid policies are very supportive of ACT, particularly with the new ACT authorization periods and processes and some refinements in the APS audit tool. Although relationships with the housing authority are good and even with the considerable resources provided in the Georgia Housing Voucher program, I am still hearing ACT teams voice concerns related to obtaining proper housing for their consumers. In one provider's words: "there is more homelessness than ever before…[housing] is a constant focus." Some concerns are from providers (and echoed by some criminal justice representatives I spoke with) who seem to adhere to more of continuum of care housing options philosophy: hesitant to place consumers coming out of hospitals or correctional settings directly into independent living using the vouchers. These providers may feel like some consumers need more onsite staff support for some transition period – some providers endorse longer periods of transition than others. Other barriers cited are related to client characteristics like having felony convictions or even sex offense histories that are formidable barriers to any type of decent housing. For instance, even with vouchers, some landlords screen out these consumers. Other barriers are general problems with finding affordable housing for consumers with no or limited incomes. Related to criminal histories and lack of income, one provider said, even if they do find housing, they end up having to place consumers in "bad neighborhoods" that will take them. Another site discussed the impact of gentrification in one geographic area that was formerly rural and had rentable apartments, but now has very little housing for rent of any kind – affordable or otherwise. These are not necessarily barriers to ACT services, but constitute formidable challenges in achieving the goals of the settlement agreement. Certainly, the confusion regarding the housing vouchers that was voiced in 2011 has been addressed because I heard most providers state that they use the vouchers as much as possible and are very thankful for the resource. But the vouchers are not enough to address the overarching societal issues related to finding affordable housing for poor and disabled individuals.

There are still some lingering barriers in that teams struggle to find persons licensed/ certified for substance abuse counseling, per ACT service definition for the substance abuse specialist. In general, teams have been able to eventually find an appropriately credentialed SA specialist, but often are struggling to find a second one, which would be needed to keep them from scoring below a 5 on the SA specialist item. Many teams are taking a reduced DACTS rating of 4 on this item by going a little above 50 consumers with a single substance abuse specialist, but might be hesitant to take many more than about 70 consumers

because this would reduce their DACTS score on this item to a 3. Another potential barrier is lack of vocational rehabilitation funding but the state contract funding and Medicaid rates negate any negative impact on ACT. Overall, the supportive policies outweigh any negatives.

**11. Policies and Regulations: SMHA**

The SMHA has reviewed its own regulations, policies and procedures to identify and remove or mitigate any barriers to EBP implementation, and has introduced new key regulations as necessary to support and promote the EBP.
*Ask SMHA staff and site leadership: What regulations or policies support the EBP implementation? What regulations or policies get in the way?*
*Examples of supporting policies:*

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

*Examples of policies that create barriers:*

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

Score:

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

**Comments:**

DBHDD has made drastic changes in ACT policies and regulations over the last two years, including:

- establishing systematic fidelity monitoring system and tying contracts to ACT standards.
- changing the ACT authorization periods to six months and later extending the initial authorization to one year to more closely fit with longer-term nature of ACT services.

- streamlining all regulatory documents to avoid confusion (e.g., making operations manual align with service definitions and designating the operations manual as a guide rather than a regulatory document).
- modifying ACT admission criteria.
- modifying APS authorization and audit processes and tools to eliminate conflicts with the model (there are still a few audit tool items best. assessed at the program level rather than the record level).
- allowing dual authorizations for ACT and other services to allow for a coordinated graduation from ACT to less intensive services.
- allowing collateral contact billing.
- eliminating an overly strict policy that demanded ACT psychiatrists deliver services in the field (i.e., allowing the metrics of the fidelity item for this standard to determine if services are too office-based).

It is not hyperbole to call this a complete turnaround of SMHA policies in two years. As I mentioned earlier, there is a distinct willingness to examine policies to see how they support or hinder good services for consumers and take action when necessary.

**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:<br>(Use boxes to identify which criteria have been met) | |
|---|---|
| X | 1) Explicit EBP program standards and expectations, consonant with all EBP principles and fidelity components, for delivery of EBP services. *(Note: fidelity scale may be considered EBP program standards, e.g. contract requires fidelity assessment with performance expectation)* |
| X | 2) SMHA has incorporated EBP standards into contracts, criteria for grant awards, licensing, certification, accreditation processes and/or other mechanisms |
| X | 3) Monitors whether EBP standards have been met, |
| X | 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.) |

| | **Score** |
|---|---|
| | 1. No components (e.g., no standards and not using available mechanisms at this time). |
| | 2. 1 components |
| | 3. 2 components |

| | |
|---|---|
| | 4. 3 components |
| X | 5. 4 components |

**Comments:**

DBHDD expects each team to score a 4 or higher on their annual DACTS visit. Additionally, APS audits for some ACT standards as well. Consequences for low DACTS fidelity are clear – teams must write a corrective action plan for challenging items where they score a 1 or a 2. Six teams (of 21 reviewed) scored below a 4.0 on the DACTS during this calendar year (3.61, 3.65, 3.71, 3.71, 3.93, 3.96). From review of the technical assistance follow-up call summaries for these teams, a number of the fidelity item issues experienced were being addressed. Those follow-up calls began June 13, 2013 for some teams whose fidelity review had taken place the previous summer of 2012. For teams that score below a 4.0, I recommend that these reviews take place closer to the original fidelity review and completion of the corrective action plan to increase the level of accountability and urgency for correcting items out of compliance with DACTS standards. For teams that show signs of struggle, a corrective action plan might include a re-assessment of the DACTS on specific items or on the scale in its entirety, even prior to the next annual review. Now that fidelity review team is in place, trained, and caught up on fidelity reviews (the 22nd team was just recently contracted), this should be feasible to accomplish.

The most notable evidence that the state's standards for ACT contracting had consequences occurred in 2012. DBHDD found that ten teams failed to adhere to ACT deliverables, including poor APS audit scores in October 2011 and a repeated assessment in February/March 2012 and some with poor fidelity scores. DBHDD made the difficult decision to avoid renewing those contracts. After the transition to new ACT providers (including transitioning consumers from Three state hospital-operated teams), I was able to speak to transition coordinators, the new ACT providers, and several consumers who transitioned to new teams. The transition went well for most consumers – some had been happy with previous services providers and struggled with the abruptness of the transition (one provider ceased operating a month or so earlier than planned). Two others were not as happy with their former ACT providers and were glad to transition to other providers. Both mentioned feeling like the older teams did not follow through on promises for services and seemed to be more rushed during visits, as if staff had somewhere else to go and were looking at their watch. Service providers and transition coordinators noted problems with lack of basic documentation in the previous ACT providers, including missing MCIPs and ACT authorizations and one provider without a Medicaid number which would eventually yield their team unsustainable.

**13. Quality Improvement: Fidelity Assessment**

| There is a system in place for conducting ongoing fidelity reviews by trained |
|---|

reviewers characterized by the following components:
(Use boxes to indicate criteria met.)
*Note: If fidelity is measured in some but not all sites, answer for the typical site.*

| | |
|---|---|
| X | 1) EBP fidelity (*or functional equivalent designed to assess adherence to all critical components of the EBP model) is measured at defined intervals,* |
| | 2) GOI fidelity (*or functional equivalent designed to assess adherence to all critical components required to implement and sustain delivery of EBP) is measured at defined intervals,* |
| X | 3) Fidelity assessment is measured independently – i.e. not assessed by program itself, *but by SMHA or contracted agency,* |
| X | 4) Fidelity is measured a minimum of annually, |
| X | 5) Fidelity performance data is given to programs and used for purposes of quality improvement, |
| X | 6) Fidelity performance data is reviewed by the SMHA +/- local MHA, |
| X | 7) The SMHA routinely uses fidelity performance data for purposes of quality improvement, to identify and respond to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.), |
| | 8) The fidelity performance data is made public (e.g. website, published in newspaper, etc.). |

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

**Comments:**

The State has implemented its original plan around measuring ACT fidelity at least annually using three trained raters (one supervisor and two other fidelity assessors). The fidelity team was trained by an experienced ACT fidelity assessor from Ohio and includes two assessors who have experience as ACT team leaders, which adds legitimacy to their new state roles. Fidelity reports are provided to the team and fidelity total and item level scores are tracked routinely on spreadsheets and used to identify technical assistance and other needs. Low performers who score below a 4.0 on the DACTS are required to write and execute a corrective action plan. DBHDD reports that fidelity data will soon be available on the DBHDD website, though not at the time of this assessment.

**14. Quality Improvement: Client Outcomes**

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

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

**Score**

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

**Comments:**

DBHDD collects, aggregates, and reports back key ACT outcomes to providers. Currently, teams report team-level rates of outcomes (e.g., % hospitalized, independently housed, employed) each month, resulting in a monthly cross-sectional aggregation by actual calendar month. DBHDD has also begun tracking some ACT consumers prospectively over time so that they can report on ACT consumer progress in relation to tenure on ACT. The first method tabulates the rate of hospitalization in any given month by combining all current ACT consumers on that team, including consumers very new to ACT with consumers who have been on ACT longer. Tracking outcomes by length of time in ACT services tells a different story about how ACT impacts consumer outcomes over time and might be a bit more useful in the long-term. The State consistently talks about the outcomes at ACT coalition meetings and has started using the reports to think about program development.

DBHDD is currently working on a new method of outcomes data collection that would require teams to enter consumer-level outcomes, rather than team aggregates, on a website. They are planning to build in functions that could allow teams to examine their own data in graphs and tables. Currently, consumer-level information that might inform clinical decision-making on a specific case is not available. This is rarely ever observed at the state level but would be a real advancement if the state were able to create a clinically friendly system.

Some ACT Key Performance Indicators will soon be available on a public website, though not at the time of this assessment.

**15. Stakeholders**

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

Scores:

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

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

**Comments:**

Most providers clearly and explicitly expressed feeling like they have a strong partnership with DBHDD staff in providing high quality ACT services following the Dartmouth Assertive Community Treatment Scale. In some cases, managers wanted to start off meetings with me stating how positive and responsive state leaders and fidelity assessors in ACT have been. The exception to the typical provider response during the last year came when one provider expressed some trepidation about voicing complaints for fear of reprisal. Because that was mentioned earlier in the year and not during the July visit, I cannot tell whether this is an ongoing concern. As noted above, this view was not typical.

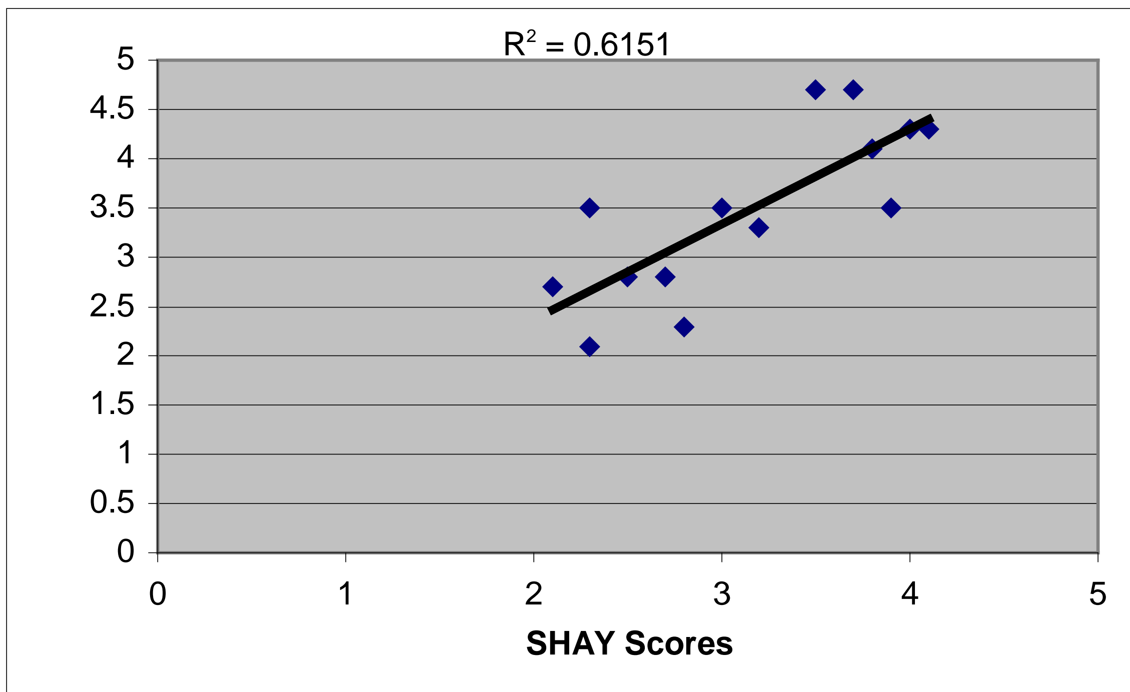
Consumer and family advocate groups also continue to be supportive of ACT, though their role is less of an active partnership. These stakeholders do echo providers' statements about the state's responsiveness to concerns. For instance, stakeholders have made requests of state officials and obtained "four of the five" items that they requested.

Even though scores are technically the same as 2011, I did note a qualitative difference in the relationships between stakeholders and DBHDD. One provider said that he/she appreciated state staff who are willing to say they do not have an answer to a request but will work on it or that they just did not think of something – the lack of defensiveness about barriers or potential weaknesses in the system was viewed as helpful and constructive.

**National Implementing Evidence Based Practices Project Perspective**

The overall mean SHAY score for states participating in the National EBP Project was 3.14. In these states, the overall mean item fidelity score for all EBPs was 3.47. States that successfully implemented EBPs with mean item fidelity score of 4.0 or greater had a mean SHAY of 3.82. It is clear from the graph below that states with higher SHAY scores also had better EBP implementation. In other words, the actions of state leadership described in the contents of the SHAY make a difference.

The following chart plots the mean item fidelity scores and SHAY scores across all states in the National EBP Project.




Note: The scores on the left axis are EBP fidelity scores from the National EBP Project

**Summary of SHAY Scores**

| | 2011 | 2013 |
|---|---|---|
| 1. EBP Plan | 3 | 5 |
| 2. Financing: Adequacy | 5 | 5 |
| 3. Financing: Start-up and Conversion Costs | 3 | 5 |
| 4. Training: Ongoing Consultation & Technical Support | 2 | 4 |
| 5. Training: Quality | 3 | 4 |
| 6. Training: Infrastructure / Sustainability | 1 | 4 |
| 7. Training: Penetration | 4 | 5 |
| 8. SMHA Leadership: Commissioner Level | 5 | 5 |
| 9. SMHA Leadership: EBP Leader | 3 | 5 |
| 10. Policy and Regulations: Non-SMHA | 3 | 4 |
| 11. Policy and Regulations: SMHA | 2 | 5 |
| 12. Policy and Regulations: SMHA EBP Program Standards | 3 | 5 |
| 13. Quality Improvement: Fidelity Assessment | 1 | 4 |
| 14. Quality Improvement: Client Outcome | 1 | 4 |
| 15. Stakeholders: Aver. Score (Consumer, Family, Provider) | 4 | 4 |
| SHAY average = average over all 15 items | 3.58 | 4.53 |

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

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 19, 2013

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## Department of Justice Settlement Agreement

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

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

> "Supported Employment
> i. Supported Employment will be operated according to an evidence-based supported employment model, and it will be assessed by an established fidelity scale such as the scale included in the Substance Abuse and Mental Health Administration ("SAMHSA") supported employment tool kit.
> ii. Enrollment in congregate programs shall not constitute Supported Employment.
> iii. Pursuant to the following schedule…
> (C) By July 1, 2013, the State shall provide Supported Employment services to 440 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 provisions of the Settlement Agreement. According to the "FY 13 Programmatic Report Data: Supported Employment Services," as of the end of May 2013, there were 682 individuals receiving Supported Employment services under the Settlement Agreement. The monthly rate of employment was 42.1 percent. The SHAY, which was focused on the supported employment "slots" under the Settlement Agreement, may be viewed as an instrument to measure the extent and quality of that compliance.

## SHAY Executive Summary

This document provides a summary of the status of the work that has been done by the DBHDD regarding the implementation and dissemination of evidence based Supported Employment (SE) services for adults with severe mental illness (SMI) in the State of Georgia. This is the third SHAY report that has been completed at the request of Elizabeth Jones, Independent Reviewer. The previous SHAY report was completed in September 2012.

## SHAY Introduction

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

The reviewer spent four days in July 2013, specifically; July 14, 15, 16 and 17, meeting with and interviewing a variety of stakeholders in the State of Georgia as well as reading and reviewing relevant documentation provided by DBHDD. In addition to that visit, the reviewer made several interim visits to Georgia in 2013, specifically one in January, two in April and one in May. The July interviews and meetings 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 participating in Supported Employment services, staff from the Georgia Vocational Rehabilitation Agency (GVRA), staff from the Institute on Human Development and Disability at the University of Georgia as well as representatives from consumer and family advocacy organizations and other mental health advocates. Of particular note, the reviewer was also able to meet with Commissioner Frank Berry and Deputy Commissioner Judith Fitzgerald in person during the July 2013 visit.

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

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

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

**SHAY Findings**

**1. EBP Plan**

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

**Narrative**

The leadership at DBHDD has developed a well-written document, "2013 Georgia Department of Health and Developmental Disabilities Supported Employment Strategic Plan" that provides a well-described framework for the implementation of Supported Employment services in the State of Georgia.

The plan provides a working definition of Supported Employment services and describes the ongoing development of two vital partnerships for SE services. First, the partnership between DBHDD and the Georgia Vocational Rehabilitation Agency, and second, the partnership between DBHDD and their SE training and consultation provider, the University of Georgia Institute on Human Development and Disability Center of Excellence Facilitation. More information regarding the

status of these partnerships is discussed in later sections of this report. The plan also briefly describes ongoing SE Coalition Meetings that have been occurring for the past two years between DBHDD staff and community SE providers.

While DBHDD is to be commended for the development of a well-prepared SE Strategic Plan, the next important step will be to assure a broad understanding of this plan across the provider, consumer, family member, and other State agency stakeholder groups in the immediate future. Copies of the plan should be widely circulated combined with the use of existing forums to present and review the plan.

**2. Financing: Adequacy**

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

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

**Narrative**

For the purposes of the Settlement Agreement, funding for the designated SE slots (sometimes referred to as “ADA (Americans with Disabilities Act) slots”) remains fixed at $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, as was recommended last year, this rate structure warrants a careful cost-based examination in collaboration with SE providers to evaluate if the rate is adequate for provider. 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 SE providers and other stakeholders in Georgia.

Several providers continue to voice their perception that the current funding structure for SE services is not sufficient. For example, one provider stated, "We love working with the DOJ slots folks we are serving. We understand the reimbursement rates are not sufficient given all the time we need to spend in meetings and the reviews." While the perception of providers may or may not be accurate, until the results of a thorough cost analysis are completed and published, the perception will continue to be very strong.

A second ongoing complication that warrants further exploration is the process of paying for SE services by 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 remains aware of this complication however, at this point, there has been no changes to the SE data that are collected in order to gather more information about the use of slots and its potential negative impact on consumers in SE services.

**3. Financing: Start-Up & Conversion Costs**

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

| | |
|---|---|
| | 1. No costs of start-up are covered |
| Present | 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 added some new providers of SE slots in the past year. To its credit, DBHDD leadership has worked with new providers by creating access to some training and consultation activities. Typically, DBHDD does not currently reimburse start up costs for a new provider to deliver SE services. Some typical start up costs might 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. However, given that new providers have been

able to start SE services, it does appear that these start up costs for SE services in Georgia are not prohibitive.

**4. Training: Ongoing consultation and technical support**

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

**Narrative**

As described earlier, DBHDD has continued and enhanced their formal training agreement with the Institute on Human Development and Disability at the University of Georgia. The training has provided specific modules for SE staff who have experience with the practice and for staff who are new to SE services and have had little to no previous training. The training providers, working with DBHDD, have established feedback loops about the training effectiveness and have solicited specific ideas for ongoing training needs from SE providers.

Previous concerns regarding specific training content that was not consistent with the evidence-based Supported Employment model were raised and presented to DBHDD. To its credit, DBHDD leadership worked immediately with the training providers to promptly correct this in a satisfactory way. Provider feedback on the training that is being provided is positive and grateful. For example, one provider stated, “Doug (Doug Crandell, UGA/IHDD SE consultant/trainer) has been very supportive to us. Some of our staff have gone the training and learned more about the SE principles, it has been very helpful.”

The amount of time that is available vis-à-vis the training contract for on-site agency consultations (technical assistance) regarding SE services has been increased in the current contract. “Provide on-site technical assistance to the 21 MH SE programs…. Each site can use up to two days (16 hours) of on-site technical assistance.” While DBHDD has developed a foundational training method for employment specialist and SE supervisor skills, it is still vitally important to provide agency-based technical assistance to help providers put those skills and the principles of Supported Employment into their daily workflow. The increased technical assistance time will play an important role in improving SE fidelity scores as well as the quality of SE services evidence by increased employment outcomes. It is strongly recommended that DBHDD leadership work closely with the training and consultation providers to assure that on-site technical assistance is used to address provider deficits identified by the SE fidelity reviews, the SE outcome reporting and feedback from consumers in SE services at each provider in a systematic way.

**5. Training: Quality**

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

**Narrative**

As noted previously, DBHDD has worked to establish an ongoing training mechanism with the Institute on Human Development and Disability at the University of Georgia. They have worked to develop and enhance the credibility of the training and technical assistance being provided through this arrangement and have developed feedback loops about the training. The training is focused on Supported Employment skills and strategies and includes the use of different multi-media activities to support learning. One remaining gap in providing high quality training is the formal designation and use of high fidelity mentor sites to supplement the training that is currently being provided. It is recommended that DBHDD develop a specific method to designate high fidelity (very good SE practice sites) provider sites where staff and leadership from other providers can visit to observe and shadow good SE services being provided in their natural environment. This has been shown to be an important training tool both for new SE providers and for SE providers who need to learn more effective ways to provide employment services at their agencies.

**6. Training: Infrastructure / Sustainability**

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

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

**Narrative**

As previously recognized, DBHDD has made some important improvements and modifications in the provision of SE trainings and consultation services for SE providers in the state. They have set up a model that incorporates feedback from providers both about their training experiences as well as their self-identified training needs for the future. There continues to be a lack of DBHDD designated SE demonstration sites where staff from other programs can make formal visits to observe the modeling of good SE services. These sites should have good SE fidelity scores and should work with the staff from the Institute on Human Development and Disability at the University of Georgia to set up shadowing and observation experiences in a structured and purposeful way. At this point, it is understandable that DBHDD has not developed any formal plans yet to help SE

providers to develop their own internal capacity to train new SE staff; however, this will be an important consideration in the near future.

**7. Training: Penetration**

What percent of sites have been provided high quality training

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

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

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

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

**Narrative**

Over the past year, DBHDD has worked to ensure that all SE providers have access to the SE training and technical assistance services provided in cooperation with the Institute on Human Development and Disability at the University of Georgia. Schedules for training opportunities are well publicized, documented and reviewed at SE coalition meetings. SE providers have found the trainings to be helpful, relevant and engaging. New SE providers have also been provided with access to the training and technical assistance opportunities.

**8. SMHA Leadership: Commissioner Level**

| Commissioner is perceived as a effective leader (influence, authority, persistence, knows how to get things done) concerning EBP implementation who has established EBPs among the top priorities of the SMHA as manifested by: | |
|---|---|
| Present | 1) EBP initiative is incorporated in the state plan, and or other state documents that establish SMHA priorities |
| Present | 2) Allocating one or more staff to EBP, including identifying and delegating necessary authority to an EBP leader for the SMHA |
| Present | 3) Allocation of non-personnel resources to EBP (e.g. money, IT resources, etc.) |
| Present | 4) Uses internal and external meetings, including meetings with stakeholders, to express support for, focus attention on, and move EBP agenda |
| Present | 5) Can cite successful examples of removing policy barriers or establishing new policy supports for EBP |

**Narrative**

The Commissioner of the Georgia Department of Behavioral Health and Developmental Disabilities is Frank Berry. It is noteworthy that Commissioner Berry and Deputy Commissioner Judith Fitzgerald both made themselves available to meet with the reviewer during the July 2013 visit. The feedback provided regarding the Commissioner as an effective leader in relation to Supported Employment services in the state was overwhelmingly positive and

hopeful across all stakeholder groups. Some samples of quotes about the Commissioner and his leadership regarding Supported Employment services include:

> "The Commissioner is phenomenal, he is into mainstream services such as supported employment. He is good at the daily reality of things."

> "The Commissioner has done a lot to improve the state office and provider partnerships, he sees the value of all of that in the state. He definitely understands recovery."

> "I have been a mental health advocate for 24 years in this state, this is the best Commissioner-led opportunity that we have had with this Commissioner right now. It is important that he knows how important that his role is. We know it. It is important that he takes the same message to our state legislature too."

Nearly everyone interviewed stated that they have seen or heard statements from the Commissioner, in public and private meetings, about the value of employment and Supported Employment services to the residents of the State of Georgia. The profound change of tone and demeanor from the Commissioner's office, as well as the elevation of Supported Employment services, along with the value of employment in relationship to recovery, appears to be resonating well across many different levels of the Georgia DBHDD system.

**9. SMHA Leadership: Central Office EBP Leader**

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

**Narrative**

Georgia DBHDD has produced some significant changes and improvements in their relationships with other stakeholders, especially SE providers. Numerous people commented on the difference in communication, responsiveness and openness within the DBHDD leadership regarding SE services. While there remains some confusion among stakeholders as to who the specific SE point person is at DBHDD, this concern pales in comparison to the value of comments that providers and other stakeholders made about the SE team within DBHDD. For example, many people chimed in with agreement when one person stated, "They (DBHDD SE Leadership) get the big picture and they work with us to get solutions to things immediately. They are becoming a good partner." Many people stated that they have asked questions about SE services or asked for assistance from DBHDD; all indicated that they found the SE team at DBHDD to be responsive in a timely and collaborative way.

**10. Policy and Regulations: Non SMHA State Agencies**

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

Examples of supporting policies:

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

Examples of policies that create barriers:

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

| | |
|---|---|
| | Virtually all policies and regulations impacting the EBP serve as barriers |
| | On balance, policies that create barriers outweigh policies that support/promote the EBP |
| Present | 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. The DBHDD leadership has been able to develop and has signed a "Memorandum of Understanding Between Georgia Vocational Rehabilitation Agency and Georgia Department of Behavioral Health and Developmental Disabilities Regarding Supported Employment" in February 2013.

While the official signing of this MOU is an important step in aligning the resources and policies of the Georgia Vocational Rehabilitation Agency (GVRA) and DBHDD, it clearly does not address all of the ongoing concerns in the relationship between GVRA services and DBHDD Supported Employment services on the ground level. It is important for DBHDD and GVRA to move ahead in a very public and timely way with their plans to designate specific regions for pilot sites to implement the concepts in the MOU in the daily interactions between the two agencies. Lessons learned from these pilot sites should be used to inform the larger system about improvements in the working relationship between GVRA services and DBHDD SE services.

One person summed it up this way, "We have been told the MOU is a beginning, like we will play nice together, but it has no specifics, it is just the 2 Peachtree

folks and the VR leadership developing an agreement. We need meetings to hash out the details of this on the ground."

As another person stated, "It is good that the MOU is signed, now we need to blend the two agencies' policies and procedures, we need to figure out how to mesh the SE and VR models and identify opportunities for a more seamless process. We need to be looking at what GVRA can do with SE to help people." This important vision is in stark contrast to the ongoing weighty challenges that continue to exist with the DBHDD and GVRA relationship across the state.

Some of those multiple concerns include: how providers will be able to potentially use Medicaid funds for SE services and still access GVRA funds; how services will be seamless to customers of both systems, even when funding changes; how GVRA will resume providing services to SE clients; and how GVRA and SE can work together to better serve young adults with mental illness who desire employment.

Some specific comments about the relationship between GVRA and DBHDD SE services included:

> "It seems like there is lots of good stuff going on here in the relationship, but VR is still into just providing training for our (SE) clients. VR seems to want to stay away from our clients (with mental illness) because they can not work in their eyes."
>
> "The funding at VR is too limited to be helpful with SE clients. They (GVRA) take the client's application for services but they do not open the client into the job search process, they either open our clients (with mental illness) into assessment but not into job placement services."
>
> "We have been told that there will be no new VR cases opened up for our clients (with mental illness) until sometime between October and January."
>
> "Several GVRA counselors are not allowing Supported Employment clients to apply for or to attempt to enroll in Vocational Rehabilitation services."

> And one provider shared a very profound and personal perspective, "Without the Vocational Rehabilitation services that I received in the past, there is no way that I would be where I am right now. VR helped me several years ago to get a job. I would not have my job right now if it were not for them. I am sad that this type of VR service is not available to many people like me in Georgia right now."

A second equally important state agency relationship is between Georgia DBHDD SE services and Medicaid. The leadership at DBHDD has been working for over a year on establishing a mechanism to use Medicaid funding to pay for some Supported Employment services. This process has been used successfully in many different states. The use of Medicaid funds represents a potentially very strong sustainable funding mechanism for SE services in the state and the leadership should be commended for working on addressing this issue. DBHDD has received approval from the Centers for Medicare & Medicaid Services (CMS) for Medicaid State Plan Language regarding Task Oriented Rehabilitation Services (TORS) to promote recovery and wellness.

There is a significant amount of fear, apprehension and perhaps strong misunderstanding in the SE provider community about how the use of Medicaid funds to reimburse for SE services will affect SE providers. There were numerous concerns raised about this both as it relates to fears of "double-dipping" related to other SE funding mechanisms and as it relates to a perceived fundamental change in the conceptualization and provision of SE services.

Several providers stated their perception that the use of Medicaid funds will force SE service into focusing more on the client's mental illness diagnosis and will require SE providers to be working with deficits and symptoms rather than strengths and skills. Nearly all providers present voiced concerns with the implications and fears they have about using Medicaid to support SE services. It is strongly recommended that GA DBHDD continue to use existing communication methods to gather more information about these perceptions and to provide good accurate billing and funding information to providers to address their concerns.

**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.<br><br>Examples of supporting policies:<br>• SMHA ties EBP delivery to contracts<br>• SMHA ties EBP to licensing/ certification/ regulation<br>• SMHA develops EBP standards consistent with the EBP model<br>• SMHA develops clinical guidelines or fiscal model designed to support model EBP implementation<br>Examples of policies that create barriers:<br>• 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.

An important area for DBHDD to address is a relatively new concern that seems to be emerging and has been reportedly experienced by a number of SE providers who have approached Assertive Community Treatment (ACT) Teams

for potential referrals of ACT clients to SE services. Several providers indicated that the ACT teams' vocational counselors told them that they did not have anyone (ACT clients) on their team that would be a good referral for SE services. As one provider stated, and many agreed strongly, "The vocational counselors on ACT teams are telling us they are assessing who is ready to work and then they say that there is no one who is a client of their ACT services who has reached readiness for employment." This type of employment readiness approach is in direct contrast to the zero exclusion principle of SE services and should be addressed aggressively within the ACT teams across the state.

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

**Narrative**

As stated previously, DBHDD has included language in provider contracts that specifies that SE services will be consistent with the principles of evidence-based Supported Employment services as described in the SAMHSA toolkit and as described by the work of the Dartmouth Psychiatric Research Center regarding updated principles and SE fidelity.

The 2013 DBHDD Supported Employment Strategic Plan includes the following:

"Fidelity reviews are conducted on-site and in a collaborative manner, with focus on quality improvement. SE providers are expected to maintain a minimum fidelity score of 74 (out of a possible 125)."

Additionally, the document, "FY2014-AMH SE Provider Annex-A: Expectations, Outcomes and Payment Method Mental Health and Addictive Disease Adult Specialty Services, " under section "D. Consumer Outcomes" contains the following, "5. Increase in Competitive Employment: At least 35% of adults actively enrolled in Supported Employment services will be competitively employed in integrated settings that pay minimum wage or better."

While both of these represent the establishment of desired benchmarks for SE services from a quality perspective, there does not appear to be any common knowledge about the written description or formal process regarding the explicit consequences for providers who do not achieve these benchmarks. This has not been lost on the providers. During one interim visit to a provider, when asked what DBHDD leadership could do to improve SE services, a CEO stated, "We need to be held more accountable for our employment outcomes."

However, the following language is included in #11 of Annex A in all SE contracts; "Contractor performance for individuals served and outcome measures will be evaluated on an ongoing basis. If Contractor fails to deliver the Consumer Outcomes in Section D. or meet the Contractor Expectations, listed above, Contractor will be notified and may be required or permitted to develop a plan of correction. Continued underperformance may result in contract modification or other contract action, including termination of the contract."

During the July visit, a different provider summed it up this way, "It would be good for DBHDD leadership to incentivize employment outcomes with more money. Right now, we get money just on enrollment of clients to the SE slots so we can

get lots of money without worrying about outcomes. We still get paid the same even if no one gets a job."

It is strongly recommended that the DBHDD leadership develop and implement a formal and documented method to actively hold SE providers accountable for employment outcomes through policy and funding mechanisms on a systemic basis. This accountability might incorporate additional funding or recognition for high performing providers and sanctions or other required quality improvement actions for low performing providers.

**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 |
| Present | 2) GOI fidelity (or functional equivalent designed to assess adherence to all critical components required to implement and sustain delivery of EBP) is measured at defined intervals. |
| Present | 3) Fidelity assessment is measured independent – i.e. not assessed by program itself, but by SMHA or contracted agency |
| Present | 4) Fidelity is measured a minimum of annually |
| Present | 5) Fidelity performance data is given to programs and used for purposes of quality improvement |
| Present | 6) Fidelity performance data is reviewed by the SMHA +/- local MHA |
| | 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**

The DBHDD leadership invested a significant amount of work and resources into the Supported Employment fidelity review process that enabled them to recently complete a full round of SE fidelity reviews at all SE providers in the State of Georgia. In addition to investing in the personnel and travel expenses, the DBHDD leadership also invested in skills training, shadowing and observing fidelity reviews and other learning opportunities for the personnel that conducted the full round of reviews. This investment appears to have paid dividends not only in the completion of a full round of reviews and subsequent fidelity reports but also in a notably improved fidelity monitoring relationship that is growing with providers that was described during interim visits as well as the July visit. This significant improvement is well described by several SE providers when asked about their fidelity reviews, including:

> "The fidelity reviewers were over-the-top with pleasantries and helpfulness. They worked carefully and professionally with us."
>
> "The reviewers sat in on meetings and making observations for hours, they went out into the community with us doing job development. They were sensitive to our culture and our employer relationships."
>
> "The reviewers were more supportive than auditing, it was not a threatening process. They went out to the community with us, they lived with us for two days."
>
> "We were very disappointed in our fidelity score. Our fidelity review showed us we were doing things the old way and some things that we were doing the old way were punitive to our score. People in our agency have been very responsive to the changes we need to make."

Many providers said the most important use of their fidelity review, the findings, and the subsequent report was within their own organizations. Several SE supervisors stated that they took their SE fidelity report to their own administration to highlight what the SE model looks like and what the agency needed to do to improve SE services.

It appears that DBHDD has invested significant and meaningful work into the fidelity review process in order to complete a full round of reviews with numerous providers across the state in a collaborative, quality-improvement focused manner. The next step for the DBHDD leadership is to use the substantial amount of information that is now available from the fidelity review process and feed it all into a carefully constructed comprehensive quality improvement process. DBHDD has shared some information about the fidelity findings with other SE providers but that should be just the beginning of the process.

The leadership at DBHDD has shared some information regarding the fidelity reviews with the SE provider group. Providers have been informed that the information will also be available on the DBHDD website in the near future which will allow public access to this information at that point.

It is strongly recommended that DBHDD in collaboration with providers, consumers and other stakeholders, review the fidelity data for important quality improvement themes including, but not limited to: providers who are outliers for high fidelity scores—and how to publically recognize and support their effectiveness; providers who are outliers for low fidelity scores—and how to best assist them to improve; areas where there are significant strengths in the system (e.g. caseload size) and how to keep those in place; areas where there are significant challenges in the system (e.g. work incentive counseling services) and how to improve that systemically.

While reviewing the SE fidelity data, it is also important to review the lessons learned from the data gathered at all the reviews that may not show up in the fidelity reports. For example, fidelity reviewers gather a list of jobs that have been obtained by clients in the program, combining these lists together would present a systemic picture of what types of jobs SE programs are helping people to obtain. This list should be reviewed to assure that people are obtaining a diverse set up of competitive jobs (not just entry level food service and retail

positions) that match with people's own individual employment goals. It is possible that programs are focusing too much on easier to get positions and not on making good matches with people's hopes and specific recovery goals. As one client stated,

> "I wish that our mental health Supported Employment staff would set higher expectations for us. They seem to put us (clients) into categories or placements where they feel that we (clients) will not have too much stress. We need job opportunities that are much more broad and diverse, not just food services and retail."

Two other recovery-oriented Supported Employment concerns to address with information from fidelity reviews include access to work incentive counseling and helping clients with coping skills to be successful in the work place through integrated services. All clients that were interviewed during interim visits and during the July visit stated that their work incentive counseling consisted primarily of being told that they just can not earn income above the substantial and gainful activity (Social Security SGA). This means that clients are being told they can not earn an annual income over $12,000.00 which virtually eliminates client goals and dreams of home ownership, developing careers, becoming full time employees, and becoming economically self-sufficient. As one client astutely observed, "They tell me that I can not make more than a thousand dollars a month. That means I can only work part-time and I can never work my way up to a career or advancement."

The second important area to examine and address is what types of integrated services are clients in SE getting to help them with developing coping skills and other strategies to manage symptoms and illness-related challenges to help them develop work skills and attributes. When asked what things they were learning to help in this area, every client in the July meeting (including clients from different agencies) stated they have been told, "If you want to work you need to take your medications." This is clearly not a recovery-oriented, strength-based, individualized method of helping clients to learn important skills for employment and their own recovery process.

**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**

DBHDD has established a client outcome reporting mechanism that has been in place for over a year with SE providers. Providers are required to submit monthly reports about SE outcomes including reports on the percentage of clients who are in the SE DOJ slots and their employment rate. Concerns from the SE providers about the time consuming and cumbersome nature of the SE outcome system that is still in place were previously documented. Many providers continue to have the same concerns, as the system has not yet been changed. However, DBHDD reports that they are working on developing and installing a user-friendlier outcome reporting system.

The leadership at DBHDD has shared some information regarding the SE outcomes with the members of the SE provider group. Supported Employment providers have been informed that the information will also be noted on the DBHDD website in the near future which will allow public access to this information at that point.

In the outcome system redesign, it is recommended that DBHDD incorporate measures to address the challenges inherent in the DOJ SE slots mechanism. Currently, providers report only the percentage of people in those slots who were working in competitive employment during the month. While this is an important data component it is not sufficient for assuring that SE services are being effective. For example, a program may be helping clients to get jobs but not helping them to keep jobs, so clients may be quickly losing jobs and are not able to benefit from employment. This non-recovery-oriented approach to SE would not be detected with the current outcome process. As another example, a program may be helping the clients who are working to keep their jobs but not helping any of the unemployed clients to obtain jobs. Once again, this non-recovery-oriented approach to SE would not be detected in the current SE outcome process.

It is recommended that DBHDD move quickly to add data elements to the SE outcome reporting that helps develop a more accurate picture of how well SE services in Georgia are truly helping clients to advance their own recovery process through sustained and successful employment.

**15. Stakeholders**

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

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

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

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

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

**Narrative**

The support for SE services in Georgia has grown even stronger among some of the stakeholder 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. It will be important for the leadership at DBHDD to work on developing formal positions or affiliations with the Georgia Consumer Advocacy Network and family advocacy organizations in the near future, thereby officially sanctioning their place at the table in assuring the overall quality of SE services in the state. The network of providers who have the Settlement Agreement slots remain enthusiastic and committed to the delivery of SE services, especially with the emergence of several new promising actions and activities that have been propagated by DBHDD. 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 process. One consumer summed it all up this way:

> "When I am at my job, I don't feel like I have a mental health issue. When I am at my job, people treat me like a person who does his job. I look forward to getting up and going to work everyday."

**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 Table of Georgia SHAY Scores 2013**

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

## Georgia SHAY Scores 2012 and 2013

The SHAY score earned by the Georgia Department of Behavioral Health and Developmental Disabilities in 2013 is considerably higher than the score earned in 2012. In comparing the SHAY item scores between 2012 and 2013, DBHDD managed to increase the score they earned on thirteen of the items and maintained their progress on the two remaining items. The DBHDD SHAY score did not decrease on any item. The increase in SHAY item scores and in the SHAY total score measures a change in actions, behaviors, policies and procedures on the part of DBHDD regarding evidence-based Supported Employment services for Georgia adults with mental illness.

While recognizing the substantial amount of work that DBHDD has invested in these improvements, it is likewise important to note that sustaining the gains that have been made will be equally challenging and will require an ongoing focused investment of time, energy and resources on the part of DBHDD. In the next twelve months, it will be vitally important for DBHDD to make the most efficient and effective use of the tools they have now put in place to actively and comprehensively monitor the effectiveness, quality and accountability of Supported Employment services within their state. It is critical that DBHDD ensures that SE is being provided in way that is faithful to the evidence and, most importantly, ensures that SE is being provided in a recovery-oriented fashion to help as many Georgians with mental illness as possible to be successful with employment in their recovery process.

**Summary Table of Georgia SHAY Scores 2012 – 2013**

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

2013 Review

Georgia Supported Housing and Bridge Funding

United States of America v the State of Georgia
(Civil Action No. 1:10-CV-249-CAP)

Martha Knisley
Technical Assistance Collaborative, Inc.

September 19, 2013

Introduction

This report to the Independent Reviewer summarizes the progress of the Supported Housing and Bridge Funding programs required by the Settlement Agreement in United States of America v the State of Georgia (Civil Action No. 1:10-CV-249-CAP) for the period of July 1, 2012 through June 30, 2013.

Information analyzed for this report was obtained from written documents provided by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD); information obtained in a Parties/Experts/DBHDD meeting in June 2013; key informant interviews with DBHDD staff, including interviews with Doug Scott, the Director of Housing, and Assistant Commissioner Chris Gault; Region 5 staff, including a meeting with Charles Ringling, Regional Coordinator; an interview with Julia Collins, an ICM Supervisor with Gateway Behavioral Health Services (Gateway is one of Georgia's contract agencies participating in the Georgia Housing Voucher Program (GHVP)); and three site visits with Ms. Collins to visit GHVP participants in their homes in the Savannah area.

This report focuses on the State's progress in three areas: 1.) meeting the Georgia Housing Voucher Program and Bridge Funding targets by type of housing, number of subsidies funded, target population requirements and bridge funding requirements for the year ending June 30, 2013; 2.) supported housing program implementation for priority target populations, including the DBHDD's ability to implement the proposed program for the target population as contemplated in the Settlement Agreement; and 3.) expansion of supported housing resources.

Observations and Findings

1. Housing (GHVP) and Bridge Funding

Georgia Housing Voucher Program

The DBHDD continues to exceed GHVP numerical targets. DBHDD was required to serve 800 individuals by July 1, 2013 and served 1,002 or 127% of the goal. As of July 1, 2013, 762 participants were housed and another seventy-nine were in housing search. This is the third year the DBHDD has reached at least 120% of goal. Over 350 properties were under contract and forty-five service providers were actively serving participants. Participants are living in GHVP arrangements in seventy-four different counties.

The DBHDD keeps records on referrals from point of "notice to proceed," which is basically the DBHDD Supported Housing Director verifying an individual is eligible for the program and the individual can proceed with housing search. In FY 2013, 71% of individuals with a "notice to proceed" had signed leases before the end of the fiscal year[1]. Data is not reported on time from referral to "notice to proceed" but the pace of "notice to proceed" to leases being signed

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

seems within normal range. There were approximately 12% of the leases cancelled, which merits further review to determine if there are any negative trends that can be reversed. Likewise, not all referrals resulted in individuals getting housing. Assessing the referrals that don't result in leases and reporting on these reasons is warranted for quality review purposes.

In FY 13, 47% of participants had zero income and the monthly average rental payment was $509.54. Bridge funding was provided to 383 participants in the third year of this Settlement Agreement, which is 147% of the goal (113 above the goal of 270). The average cost per participant is $2,347[2]. Furnishings and first and second month rent account for 50% of this cost and provider fees account for 20%. The remaining funds (30%) are allocated for household items, food, transportation, medications, moving expenses, utility and security deposits and other expenses.

This program's success in meeting targets appears to be the result of a combination of factors, including the DBHDD Supported Housing Director's diligence and understanding of rental housing operations and supported housing requirements; clear direction to and strong staff support from the DBHDD Regional Directors and their staff; and the interest and support of referral sources, especially homeless services system outreach staff. Meeting this target is also related to the well-documented need for affordable rental housing for individuals who have severe and persistent mental illness and are the target population for this Settlement Agreement.

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

In looking forward, the Settlement Agreement requires that the program be expanded by 1,200 slots by July 1, 2015. This means that, over the next two years, the program is required to grow by 160% of current capacity.

Bridge Funding

Making Bridge Funding available to participants is crucial to the success of this program. Over $1.2 million was spent on furnishings, first and second month's rent, deposits and household items. Furnishings and rent accounted for 49% of these costs. In addition, over $275,000 was spent on provider fees for managing these funds at the participant level. Three hundred and eighty seven (387) individuals or 147% of the goal received bridge funding assistance. This is $3,140 on average for the number of people who signed leases in FY 13. One challenge reported by DBHDD staff is the ability to maintain this level of support as housing resources are developed beyond what is available for individuals in the GHVP.

[2] This number may go higher when all the requests are reported

2. Program Implementation

Program implementation refers to the State's ability to assist people in the priority target populations to get services they need to live in their own homes and become fully integrated into the community. This task is very challenging. Historically, individuals in this target population haven't often gotten opportunities to move into their own home which means staff may not be fully knowledgeable or familiar with supported housing tasks. Likewise, individuals with a severe mental illness are often labeled "not ready" or incapable of living on their own. Or, if given the opportunity, may get housing but may not be successful in retaining their housing and/or remain very isolated in their community. DBHDD staff appear fully cognizant of these obstacles. They have taken some steps and have more plans for overcoming these obstacles, which are described in more detail in this section of this report. How well they do this is diametrically linked to the State's ability to meet its targets.

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

Referrals

Referral patterns for the GHVP have remained consistent with patterns from the two earlier years. Individuals who were homeless at the time of referral comprise 50% of all referrals. Numbers of referrals of individuals increased from 357 to 589 between FY 12 and FY 13. Referrals from hospitals were increased numerically (from 70 in FY 2012 to 196 in FY 13) and as a percentage of the total (from 9% in FY 12 to 17% in 2013); referrals from more intensive settings were down slightly as a percentage (21% to 16% from FY 12 to FY 13) and decreased from 187 to 156 referrals from FY 2012 to FY 2013. Nearly 45% of referrals from more intensive settings in FY 2013 were from group homes or individual care homes. Referrals from families also increased slightly but referrals from jails/prisons remain flat (2 in FY 2013). Most referrals are from Region 3 (205 or 18%) and most homeless referrals are from Region 3 (67%). Region 3 had the highest number of referrals from group homes and individual care homes (29 or 37% of all GH and PH referrals) and hospitals (29 or 37%). Regions 1,2 and 4 have a much higher percentage of referrals from family and friends, 78% of all referrals in this category, and 66% of all referrals in the rent burdened category.

DBHDD is employing a "housing first" approach for many individuals being referred, meaning that referrals come directly from homeless outreach, from hospitals, CSUs or intensive residential programs without first being "transitioned" through group living arrangements. Referrals also come from group homes. DBHDD has not made a policy decision that people need to live there first before moving into supported housing arrangements rather that many group homes were in operation at the time this Agreement was made.

Two referral groups merit attention because of their low numbers; one is the number of referrals from jails and prisons, which is expectantly low at this juncture. Getting referrals from

jails requires a very local hands-on approach, probably most successfully led by Regional Coordinators, although senior DBHDD leadership will also need to be involved. This is already happening from the Commissioner's level on down. Mr. Ringling, the Region 5 Coordinator who has a strong pulse on his community's resources, spoke quite cogently about his commitments and steps he is taking with local officials to increase these referrals in southeastern Georgia. Likewise, a related but separate effort will need to be mounted to increase referrals from state correctional institutions, parole and probation. The Behavioral Health Coordinating Council is in the process of forming a Criminal Justice Transitions into the Community working committee to tackle the problem with this lack of referrals.

The second group of referrals are individuals residing in group or personal care homes, CSUs/CAs, hospitals and intensive residential settings. Combined, these groups only represent 16% of the referrals to the program. Unless these referrals increase substantially and/or there are substantial increases of referrals from jails and prisons, the program will need to increase homeless referrals to meet targets in FY 14 and FY 15. DBHDD is aware of this issue and has made a strong commitment, with additional training and work with regional offices, to expand referrals directly from more restrictive settings this past year.

The current patterns may also be indicative of priorities set at the DBHDD regional levels, where staff are directly responsible for managing this program, and their view of their needs, the strength of referral relationships or a combination of the above. It is likely the homeless issues in Fulton County and all of Region 3 are fairly pronounced and it is also clear from discussions with staff in Region 3 that they have strong connections to all of their referral sources. Most importantly, even with these differences, individuals in the target population are being discharged from more restrictive settings or getting opportunities to move on from congregate or unstable situations which is an underlying goal of this Settlement Agreement.

In Section III.B.2.c.ii(B5) of the Settlement Agreement requires the state to "provide housing supports for approximately 2,000 individuals in the target population with SPMI (by July 2015) *that are deemed ineligible for any other benefits..."* This section has been referenced in earlier reports, as it is highly likely some individuals in the program are eligible for other benefits. However, as a practical matter, being deemed eligible and having access to other benefits may not be the same. It behooves the DBHDD to work closely with Continuums of Care (CoCs), PHAs and DCA to assure individuals in the target population, who are eligible, have as great an access to those resources they are eligible to receive. DBHDD is moving toward a more seamless referral process with the CoCs and has already entered into formal partnerships with the Fulton Co CoC (United Way) and with DCA. This has the effect of maximizing housing resources for the target population, especially those who are deemed ineligible for other benefits.

Housing Access and Stability

The third method for measuring program implementation comes from interviews and site visits. Housing stability is measured by DBHDD at the six month mark, which is the same measure HUD uses to measure housing stability (# < 6 mos leaving/ # > 6 mos in housing). HUD's

standard is 77% at that mark and DBH was at 92% or 15% above that mark for new tenants in each of the first three years of implementation. DBHDD also set their own standard for reengagement of "negative leavers" at 10% and has exceeded that standard with 21% of negative leavers being reengaged. HUD uses these standards to measure Public Housing Authority performance and not necessarily to measure stability of renters. For purposes of this Settlement Agreement, it is helpful to measure stability for the short term but to fully assess tenure and measure the performance of the program, it is advisable to measure tenure at the one and two year mark as well. In addition to measuring tenure, it is also essential to maintain a list of reasons people leave, negatively or positively, to measure the success of individuals being re-engaged and to determine if some reasons individuals are leaving can be reversed.

Taking supported housing programs to scale across a state is a very daunting task. It becomes an even greater challenge if the program experiences a great deal of turnover or if referrals are slow which can happen if referring organizations are either not well organized or not convinced the program can work for the target population. Or this may happen because of the paucity of quality affordable housing in many communities and/or many individuals not meeting background requirements for leasing their own apartments.

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

The first individual we visited was a fifty two year old, African American male. This gentleman has had eight incarcerations and has serious medical conditions including diagnoses of COPD, Emphysema and Glaucoma. He started active substance use (alcohol) at age 13 and cocaine at age 18. He has been homeless off and on since 2010. He was in active use without any period of voluntary abstinence until May of 2012 when he entered a substance abuse treatment program (ASAM level II.5). He was abstinent for three months when referred for psychiatric care because of irritability, mood swings, suicidal thoughts and sleeplessness, which was the first time he was given mental health diagnoses as prior symptoms were attributed to substance use. In May of 2012, he tried to get into a men's residential substance abuse program but was denied because of medical conditions. He lived briefly with a sister until able to get into a shelter until the end of May of 2012. He stayed in a shelter until April 2013 when he was referred to ICM and GHVP in March 2013. He was scheduled for eye surgery at the time we met him and was staying very busy with friends and family. His sister called while we were visiting him. His history indicates he will have difficulty maintaining sobriety and his health

| conditions will need to be monitored closely. |
|---|
| The second individual we met at his home is a 41 year old Caucasian male who was diagnosed with diabetes in his twenties. He became homeless and was living in shelters in Georgia and Florida after experiencing frequent hospitalizations and bizarre behavior on work sites when his blood sugar was too low. He was also admitted to acute care psychiatric facilities in his twenties due to depression and anger problems. Two years ago, he was admitted to a crisis unit for four weeks and transferred to a state hospital where he remained for eleven months. He was referred for GHVP and has been in housing receiving ICM services for seven months. He uses public transportation to get around and sporadically attends a day program where he helps fix the program's computers. However, he reports spending most of his time at the local library branch. He has been admitted to a local community college where he will be studying computer technology but is very fearful he will not be successful because of his diabetes. According to both him and staff, his diabetes is still not under control and he does not have access to the level of care he needs to measure and control his diabetes. He appears very driven but will need a great deal of support, reassurance and adequate health care to meet his goals. |
| Our last visit was with a young man, twenty one years old, who left home at age sixteen because of parental abuse. During his childhood, he moved twenty times because of his father fleeing law enforcement when his mother attempted to see their children. After leaving home, he stayed where he could but had problems with depression and mood swings. He was diagnosed with major depression and anxiety after being admitted to acute care for a suicide attempt at age seventeen. He was hospitalized for one week and was hospitalized a second time for one month at age eighteen after a second suicide attempt. He stayed with a friend of the family and was able to finish high school. Then, at age nineteen, he moved to Georgia to find his mother. His mother kicked him out and he began living in a car. After three months of living in his car, in 2012, he was admitted to an acute care psychiatric unit after making suicidal threats. He was referred to ICM/GHVP and has been in housing since November 2012. He is also attending a day program where he is cooking on a regular basis and hoping to get into culinary school. |

All three of the gentlemen have long histories of treatment and challenging life experiences. All have experienced failure and periods of homelessness and institutional care. They clearly fall into the target population and without help and support--both formal and informal-- will experience many more difficulties and life challenges. For different reasons, they are all good candidates for supported housing; they would not likely succeed in more traditional group residential living. However, all three will need expert medical, psychiatric help and personal support. They are all good candidates for peer support. But the peer support would need to be tailored because the first gentleman needs support to maintain sobriety, the second a friend and health care advocate, and the third and younger gentleman support from someone his age who understands and can help him overcome traumatic life events. In each of their situations, housing is a stabilizer but won't be enough for them to succeed.

Julia Collins, from Gateway was quite familiar with all three of these gentlemen. She understood the value of life supports, the need for individuals to become connected to their

communities and how crucial stable housing is and will be in their lives. We did not meet other members of Gateway's staff so cannot gauge their interactions and overall strengths.

As referenced above, the behavioral health care system must have the capacity to provide recovery-oriented services and in-vivo supports that are focused, highly individualized and well organized. If the system has this capacity, moving into supported housing will become a gateway to a more integrated life to help participants meet their life goals. Supported housing provider staff must have skills in a number of interventions, have strong relationships with other community professionals and resources, including health care providers, and be able to help individuals access education, jobs and benefits and other resources. Often supported housing is considered "independent housing" where people graduate to from other programs and staff receive very little training to do this type of work. The three gentlemen we met in Savannah are evidence that the opposite is true.

DBHDD recognizes the need for supportive housing providers to receive ongoing training and support to be successful. During the past year, DBHDD has brought providers together and discussion is underway for expansion of training in FY 2014. This expansion is being discussed as embedded into training planned for ACT and ICM. This is an excellent idea. If supported housing is considered "outside" or an "add on" rather than an integral part of their work, it will be less effectively implemented. There are likely a number of scenarios where DBHDD can connect these initiatives. For example, ACT and ICM provider contracts and service requirements will continue to be informed by supported housing requirements. Likewise, ACT and ICM will need to consider what "practice changes" they need to make to successfully assist people to move into housing, get jobs and keep them.

Also, since helping individuals meet their recovery goals is a core principle of supported housing, additional peer support to help someone achieve their goals would also be helpful. Peers are indispensible to successful supported housing programs. Likewise, ensuring everyone living in supportive housing has access to crisis services or respite opportunities in lieu of eviction or another type of "negative" loss of their home is critical.

One area where attention is also warranted is in ensuring that the Regional staff and service providers are open to taking more referrals from intensive residential, hospitals, jails and prisons. This would require individuals being served to have access to respite and crisis services that are often needed even after they have moved into their own home. Provider staff will likely need more clinical and care management support to be successful serving individuals with more complex needs.

3. Program Expansion

Perhaps the greatest challenges for DBHDD in meeting its housing targets lies ahead as it expands housing and services opportunities. As shown in the first two sections of this report, the DBHDD has built a solid infrastructure for the GHVP and Bridge Funding program. Forty-five contract providers are delivering services to people moving into newly developed housing arrangements. However, taking these programs to scale and sustaining them requires

expanded infrastructure, increased provider capacity and performance, the ability to expand referrals from several key referral sources and ability to expand housing availability. The infrastructure issues and overall scalability of the program is heightened exponentially when the state begins adding additional housing resources such as the DCA HCV and 811 PRA.

DBHDD staff recognize that their current Supported Housing program needs to evolve and expand to meet the demands of the program and the Settlement Agreement. Doug Scott is carrying out duties ranging from filing, assuring monthly rent obligations are paid, working with staff in each region--both Regional staff and providers on routine matters -- plus trying to make and manage new housing connections to enable the program to grow. In short, he has been a one-man office. For example, the DCA Housing Choice Voucher Program expansion begun last year and discussed in more detail below is more complex, the GHVP is required to more than double in size over the next two fiscal years, cultivating target population referrals requires added attention and other resources must be tapped. In addition, DBHDD and providers are required to do housing eligibility re-determinations annually which adds to the ever expanding workload. To DBHDD's credit, these issues are acknowledged and Doug Scott will be getting assistance.

Last year, the Independent Reviewer raised a question regarding the potential for expanding the rental program to individuals with developmental disabilities. While this issue was not a focus of this review, it is a question that should be considered. DBHDD is building one infrastructure and is making strides in expanding resources that could be beneficial for individuals with developmental disabilities, assuming service resources could be made available. Below is a brief discussion of three examples of program expansion that are underway or on the planning stages for expansion in the next two fiscal years.

Housing Choice Voucher Program
In 2012, the Georgia Department of Community Affairs (DCA) received approval from the US Department of Housing and Urban Development (HUD) to provide preferences in its Housing Choice Voucher Program (DCA HCV) for individuals with "specific disabilities" identified in this Agreement. This approval is in force until July 1, 2015 and DCA has agreed to allow this preference for up to 50% of their turnover units during this period of time. This is a significant opportunity but comes with several challenges. One, the DCA HCV program operates in mostly rural counties. Rural counties have both fewer staff resources to undertake such a program and will have fewer referrals. Two, at the end of FY 2013, only 55 individuals had been transitioned to this new program and, at this rate, less than 250 people would be able to take advantage of this program. The number will likely rise as the DBHDD, DCA and providers move from this start-up period into full implementation. However, there will be potentially up to an additional 1945 vouchers available through this approach before July 1, 2015. Three, the program is more complex to operate. As a federally funded rental program, it has more requirements than the GHVP and is more cumbersome to navigate, regardless of current attempts to simplify for this settlement agreement. For these reasons, the DBHDD will have to carefully plan and give additional attention to implementation to take full advantage of units that may become available.

DBHDD is fully committed to this program as is DCA and steps are being taken both to intensify the referral process and to ensure that Regional DBHDD and service provider staff are fully cognizant of the HCV requirements and able to make timely successful referrals. DBHDD has indicated it will be meeting quarterly with DCA to review and report on effectiveness of reaching goals set forth in this Settlement Agreement and adjust resources accordingly. A second step being planned are "boot camps" which are intensive one to two day work sessions with providers, regional staff and DCA staff to map out responsibilities and action steps and set targets for leasing within a specific time frame. This activity will be monitored closely to ensure results are achieved. Following this intensive period, goals for each region, which are reported as part of the monthly GHVP and Bridge Funding Program Summary, can be set and carefully monitored over the full life of this Agreement.

Additionally it is important to recognize that Georgia, like most states, is experiencing challenges in the availability of decent, affordable, accessible multi-family rental housing. While home ownership is increasing again after the recession, the market is lagging on rental housing development and continuous Federal actions to reduce PHAs budgets put further strain on the budget. Rental housing prices are again rising. The monthly cost for a one bedroom market rate rental unit in Georgia is equal to 94% of an individual's SSI monthly check. (*Priced Out* , The Technical Assistance Collaborative, 2012).

Working agreements with CoCs, PHAs, the DCA and the VA
Four groups, Continuums of Care (CoCs), which are homeless services planning consortiums, Public Housing Authorities (PHAs), the Veterans Administration (VA) and the DCA, have access to plan, plan for and/or fund affordable housing. DBHDD has begun building these partnerships. To date the expanded partnership with the VA has resulted in nineteen individuals in the GHVP being moved to a Veterans Administration Supportive Housing Voucher (VASH) and through an alliance with the City of Atlanta's "Unsheltered No More" program moved forty-seven high risk chronic homeless individuals into a GHVP supportive housing voucher.

These are small steps but can be expanded with DBHDD, including its Regional Offices, committing staff to building relationships with each of these groups to ensure the priority target populations named in this Settlement Agreement have access to affordable housing resources being planned for and made available by these groups/ organizations. Likewise, DBHDD contract service providers can help identify which individuals are eligible for these resources and can assist to provide services where service gaps exist. For example, the VA funds services, which help defray services costs, but PHAs do not. PHAs can enter into preference agreements, but DBHDD service providers must provide services to make this type of arrangement feasible. There are twelve CSBs and Shelter Plus Care provider organizations, operating across multiple counties, actively working to utilize Shelter Plus and Georgia Housing Voucher programs.

In FY 2013, Georgia was one of the first thirteen states to be awarded an 811 PRA Demo award. This program will be managed by the DCA but DBHDD is a full partner in this new modernized 811 program. DCA will receive funds for 150 permanent project based rental subsidies. Therefore, individuals in the target population will have access to project based rental assistance in selected tax credit properties through a partnership agreement with DCA. The program has not yet started. There may be more opportunities to expand tax credit unit set asides if other project-based subsidies could become available. This is a DCA decision, assuming support from DBHDD.

Organizing and cultivating these relationships appears to be underway but, to achieve consistent success, a well organized, targeted plan will be needed. Each group/ organization has different requirements (statutory, regulatory and local), management staff at the state and local levels, mandates and housing contract arrangements. Tracking and ensuring people get routed to programs that they qualify for and that match their needs will likely require more sophisticated technology and staff support at the state and regional level than is currently in place. DBHDD may want to consider requesting the other systems to take on some of the administrative requirements where possible rather than trying to expand in-house operations.

Jails and Prisons

The two examples for program expansion listed above are related to housing resource expansion. This expansion is related to expanding the program for individuals exiting jails and correctional institutions, as referrals from these facilities are very low. This is an opportune time given the state's focus on reducing overcrowding in prisons. Many states across the country have successfully utilized the Intercept Model (Gains Center) to map and improve the diversion and discharge processes from jails and correctional institutions. Regardless of what approach is used, getting referrals directly from jails and prisons requires several administrative steps, firm agreements and programmatic adjustments at the provider level. Likewise, the referees would likely need GHVP resources rather than the more difficult to qualify for HCV or PRA resource.

Recommendations

The findings section of this report refers to a number of issues that merit recommendations. However, below is a summary of those recommendations:

1. At the conclusion of last year's report, a caution was raised that there must be attention given to infrastructure capacity and collaboration with housing agency partners and community agencies, if future housing targets are to be achieved. This report references a number of specifics for infrastructure capacity and collaboration. While the state met the targets again this year, this reviewer and staff agree that meeting future targets will be more difficult because the expectations are greater. Similarly, maintaining the program at the level required by this Settlement Agreement requires "sustained" capacity at the provider, Regional and state level. As referenced in the first section of this report, giving attention to turnover (beyond the six month performance target) is also important to sustain the program. Attention was not

given in last year's report to provider services capacity. However, as referenced in this report, building and sustaining provider capacity is added to this list of recommendations.

2. In this year's report, focus was also given to the need to broaden collaboration with the DCA HCV program staff, CoCs, local jails and prisons, the VA and local PHAs. It is strongly recommended that action steps and outcomes for these collaborations, including making formal referral agreements, cross cutting training, the DCA-DBHDD-provider "boot camps" and activities and relationship building events, be incorporated in a supported housing work plan for this year. It should be noted that some of these activities and events are underway. However a work plan would help "size" the planning process and make clear expectations for these activities.

3. Specifically, the DBHDD should take concrete steps to increase referrals from jails and prisons. These steps include building relationships and working agreements between Regional staff, local providers/CSBs and local Sheriffs and other officials for access, screening and referral arrangements as well as work with service providers.

4. The fourth recommendation is to assess the potential for increasing referrals from hospitals and intensive residential programs. The numbers of individuals being referred may reflect the true need. It may also be a reflection of problems with the referral processes, lack of agreement on who should be referred, challenges to individuals becoming eligible for a housing program, or being approved as a renter. Therefore, reviewing these referral processes may yield some areas for improvement.

5. The fifth recommendation is to make provisions for supported housing for individuals with developmental disabilities and those with co-occurring mental illness and developmental disabilities. Arrangements in this context means making referrals and assuring best practice services are available to match the needs of individuals with developmental disabilities living in supported housing environments. Many individuals with a developmental or intellectual disability are good candidates for supported housing and, like so many other recommendations in this report, mapping out a plan for this initiative will be key.

6. Lastly, there will be many opportunities for the DBHDD to further refine, expand and improve Supported Housing, ACT, ICM and Supported Employment as interconnected initiatives. A simple crosswalk of the initiatives would reveal many opportunities for connecting the programs. As stated above, providing opportunities for peers to be a part of these processes adds incredible value. Reflecting back to the three case studies in this report, an argument can be made that individuals with their own recovery plan can find a way to go to work, school and restore relationships and build new ones.