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

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., 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 is included as Attachment A (its referenced attachments are included as Attachment B).

Pursuant to ¶ VII.A.3 of the Settlement Agreement, the parties jointly request a non-evidentiary status conference.

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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CERTIFICATE OF SERVICE

I hereby certify that on this 18th day of September, 2015, I electronically filed the **JOINT FILING OF THE REPORT OF THE INDEPENDENT REVIEWER** with the Clerk of Court using the CM/ECF system which will automatically send email notification of such filing to all of the attorneys of record.

/s/ Katherine Houston
KATHERINE HOUSTON

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 17, 2015

INTRODUCTORY COMMENTS

This is the fifth Annual 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, 2015.

As in each year of this Agreement, it is clear that the State of Georgia has undertaken its Settlement Agreement obligations with a commitment to systemic reform. The Governor and the State Legislature have continued to approve the funding requested for the implementation of the Settlement Agreement. Although there are findings of non-compliance with certain provisions, the State, through its leadership at the Department of Behavioral Health and Developmental Disabilities (DBHDD), has demonstrated a consistent good faith effort to work to address acknowledged concerns and to implement its overall obligations. As will be discussed in this Report, discrete aspects of the Settlement Agreement will require additional time and resources in order to reach substantial compliance.

This Report describes the findings of the independent Reviewer and her subject matter consultants. As required, the Parties were provided a copy of the draft Report and the consultants' reports on August 17, 2015. The Independent Reviewer and her consultants carefully considered all comments and recommendations.

OVERALL FINDINGS

Provisions Related to Individuals with a Developmental Disability

On March 20, 2015, the Independent Reviewer's Supplemental Report was filed with this Court. The Supplemental Report focused on the remediation of implementation concerns referenced in both her previous Annual Report, filed by the Parties in September 2014, and her first Supplemental Report, filed in March 2014.

The March 2015 Supplemental Report again documented the failure to resolve non-compliance with key provisions of the Settlement Agreement. Those provisions included the obligations to:

- Move 150 individuals with developmental disabilities from the State Hospitals to the community [III.A.2.b.i (D)];
- Assemble 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 Individualized Service Plans, as required by the State's HCBS Waiver Program, that are individualized and person centered [III.A.2.b.iii (A)];

- Assist the individual to gain access to needed medical, social, education, transportation, housing, nutritional and other services identified in the Individual Service Plan [III.A.2.b.iii (B)]; and
- Monitor the Individual Service Plan to make additional referrals, service changes, and amendments to the plans as identified as needed [III.A.2.b.iii. (C)].

This Settlement Agreement is focused on community integration. In order to meaningfully experience the opportunities and relationships offered in community settings, adults with a developmental disability must receive appropriately individualized supports that help them to develop their skills and to minimize any adverse risks, including injury or death. Essential safeguards must be present at the individual, programmatic and systemic levels. These multiple safeguards must be continually assessed for their adequacy and effectiveness.

As discussed in this Report, as of this date, those areas of non-compliance have not been remedied. Although the State has proposed, and begun to implement, some reasonable plans to rectify these recurrent gaps in the community system, there has been inadequate progress statewide and a failure to establish and meet meaningful timelines. Thus, substantial compliance with these provisions will require additional time, resources and strategies for reform.

As past Reports have documented, on June 30, 2014, the State issued a Priority Plan in response to seven of the nine recommendations made by the Independent Reviewer. Those seven recommendations were:

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

6. Develop and implement sustainable strategies for the ongoing monitoring and evaluation of community placements to remedy issues such as lack of communication, information sharing, and feedback.
7. Recruit and retain provider agencies with requisite experience with individuals with medical and behavioral complexities.[1]

The State has proposed, and has begun to implement to varying degrees, its plans to address these recommendations. Consultants, with the expertise necessary for this major reform, have been retained and qualified DBHDD staff has been assigned to the work involved in transition planning; the oversight of health care; the development of clinical interventions and the realignment of the Regional offices (now called Field Offices).

At this time, however, these new resources and assignments continue to be in the formative stages and to have limited availability.

For example, community-based clinical teams are absolutely essential if the health and therapy needs of medically fragile and behaviorally challenged individuals are to be supported and safeguarded in each Region of the State. As of April 2015, the State has established one Integrated Clinical Support Team (ICST) through Benchmark Human Services, a well-regarded provider agency in Georgia. Reports from the Benchmark ICST indicate that their professional staff's technical assistance and training have been well received but, as of June 2015, they have provided technical assistance to only eight agencies in Region 2 and, for a number of reasons, including scheduling demands and the need for more information, they have not been able to complete all requests for assessments. (There have been ninety referrals from community agencies since April 2015.) Notwithstanding the demand in Region 2 alone, at this time, there are plans only to develop one ICST. Given the size of the State and the highly varied availability of clinical professionals, especially in the rural areas, more than one ICST is required for successful oversight and the delivery of individualized clinical supports.

Given the relative scarcity of clinical professionals, other approaches may need to be considered. In Region 4, the model developed for the Community Clinical Team, established in FY14, utilizes clinical professionals from the now-closed Southwestern State Hospital to provide consultation to community providers, including Primary Care Physicians and medical facilities, serving medically complex individuals. Recently, a physician and psychiatrist have joined the neurologist already assigned to this function. In order to meet statewide demand, there should be consideration of the retraining and reassignment of other clinical professionals currently working within the system.

[1] The other two recommendations focused on conducting independent mortality reviews and identifying exit criteria to enable the State to reach identifiable goals necessary for compliance.

Following the receipt of the draft version of this Report, DBHDD's leadership met with the Independent Reviewer to discuss her recommendation about the expansion for the community-based Integrated Clinical Support Team (ICST). There is agreement that this discussion will continue. A meeting for this purpose has been scheduled for September 29, 2015.

The consultant and leadership resources invested in the systemic reforms, clearly outlined in the Priority Plan and in the Pioneer Project, have placed only four individuals in community residential settings, the last two placements occurring on June 22, 2015. While these placements have been examined by the Independent Reviewer and found to be very positive in both the planning and implementation aspects, they are limited in number. This is especially troubling because 266 individuals are still confined to state hospitals[2] and the completion of a comprehensive transition plan/process has been pushed forward to July 1, 2016. (The Independent Reviewer has been given a copy of the draft Transition Manual, dated August 6, 2015, but it is not yet in effect.) Although the clinical resources are not sufficiently available yet to warrant additional placements of the adults with the most complex behavioral and medical needs, there are other institutionalized individuals who could be placed in a responsible manner with appropriately individualized supports.

In fact, during this Fiscal Year, there were ten individuals with forensic histories who were discharged from State hospitals as a result of Court orders for their release or whose families/guardians requested their discharge. These individuals were reviewed through the Transition Fidelity Committee, a Committee comprised of key DBHDD staff mandated to review each discharge plan for its sufficiency prior to any approval of the community placement. For individuals without medical or behavioral complexity, review by the Transition Fidelity Committee may be sufficient, as long as the engagement of Support Coordination is provided well before discharge.

[2] As of August 12, 2015, it was reported that there were 223 individuals at Gracewood and 43 individuals at Atlanta Regional. Of these, 179 adults are in the ICF units of Gracewood, 44 individuals are in the SNF at Gracewood and 43 individuals are in the SNF at Atlanta Regional. There were 20 people transferred from Southwestern State Hospital when it closed in December 2013. Two individuals are included in the Gracewood census. Fourteen individuals were sent to Atlanta Regional. Of these, 3 have died, 1 was transferred to Easter Seals in Region 4 (she was visited by the Independent Reviewer and the Director of Settlement Services and was doing well), and 10 remain at Atlanta Regional today. When the Craig Center closed in June 2015, there had been 60 individuals transferred to State Hospitals: 2 individuals went to an adult mental health unit; 32 were transferred to Gracewood. Twenty-nine individuals remain at Gracewood, 3 have died; 26 individuals were transferred to Atlanta Regional. Five have died and 21 remain there. Of the 8 deaths, 5 were expected and 3 were unexpected.

Current information from DBHDD reported that there are twenty-three institutionalized individuals on the transition list for community placements. However, major barriers have been identified for seventeen of these individuals; two individuals are having their barriers to placement addressed; and four individuals are well into the discharge process.

Support Coordination is the linchpin to the implementation of the Individual Support Plan. It is also an essential safeguard for minimizing adverse risk. There are plans in the initial stages to strengthen Support Coordination. The four individuals placed under the Pioneer Project in Region 2 had extended engagement prior to their discharges. Intensive Support Coordination resources still are available to a limited number of individuals in Region 4 only. Pending the changes to the State's Home and Community-Based Waiver, there has not yet been an extension of these plans to other areas of the State or to other individuals who are currently institutionalized. The roles and expectations for Support Coordination have not yet been standardized statewide. DBHDD has reported that this change will occur in the second phase of the current cost rate study.

DBHDD is currently revising the Individual Support Plan format to strengthen its person-centeredness. This desired goal is to be implemented in conjunction with the new Administrative Services Organization; the timeline, as reported in the "Interim Quality Management Report," is January 2016.

The "Interim Quality Management Report" issued by DBHDD on August 1, 2015, described in very unsettling detail the lack of trained staff currently responsible for individuals with a developmental disability in twenty-seven provider agencies.[3] The findings point to the urgency to recruit and retain competent providers:

- 41% of the professional staff attached to the organization was not properly trained, licensed, credentialed, experienced and competent.
- 15% of all other staff was not properly trained, licensed, credentialed, experienced and competent.
- Job descriptions were not in place for 64% of the personnel.
- 52% of all staff having direct contact with consumers did not have all required annual training within the first sixty days and annually thereafter.

[3] The findings in this most recent report are comparable to findings described in the Annual Quality Management Report dated February 2015. This report showed a decline in provider compliance with training requirements essential to the safeguarding of individuals under their responsibility.

- 42% of the organizations with oversight for medication or that administer medication did not follow federal and state laws, rules, regulations and best practices.[4]

The "Interim Report" did not describe the specific actions taken to address these failures to meet fundamental expectations. As a result, it is not clear as to whether corrective actions have been implemented. The "Interim Report" did, however, conclude this Section by stating: "The Division of DD must continue to hold providers accountable regarding responsibilities to train staff and conduct background screening, to ensure that there is a greater chance individuals will be treated with respect and maintain health and safety. If staff has the knowledge regarding health issues, medications, rights, safety, and person centered practices, the more likely they are to share this information with individuals served, to help them become more independent and knowledgeable. Technical assistance and accountability will be increased with the implementation of the Georgia Collaborative ASO."[5]

In its recently released "2013/2014 Annual Mortality Report," dated August 15, 2015, DBHDD stated that it would "utilize a database that is being developed to track the identification of deficient practices and the corresponding recommendations and corrective actions that are described in quality review, audit reports, and reports concerning providers' performance including compliance with contractual, regulatory, and programmatic requirements; CMRC (Community Mortality Review Committee) and external mortality review recommendations will be included in his database."[6] DBHDD has reported that this database will be operational in September 2015.

Training for provider agencies on critical aspects for the prevention of aspiration, bowel obstruction, GERD, seizures and dehydration (the "Fatal Five") was led by Karen Green McGowan Consultants, another well-regarded professional team, on June 24 and 25, 2015. (The training was designed originally for agencies in Region 2 but other agencies then were invited to attend.) This training was held over a two-day period; additional training is scheduled. Clearly, this instruction is of very high importance and it is critical that there be much more training of this nature statewide. (During the reviews conducted this summer, at least two provider agencies asked the Independent Reviewer's nurse consultants for additional guidance on preventing aspiration pneumonia. Descriptive material on the importance of oral hygiene was forwarded to them after the visits.)

[4] See page 50. The reviews documented Qualifications and Training as part of the QEPR Administrative Review conducted by Delmarva between July 1, 2014 and March 21, 2015.
[5] See page 55 of the "interim Quality Management Report."
[6] See page 41 of the "2013/2014 Annual Mortality Report," dated August 15, 2015.

The Independent Reviewer's 2014 recommendations were substantially addressed in the Priority Plan issued by DBHDD. The conceptual framework outlined in that Plan is reasonable and reflects expected practices in the field. However, as noted in the March 2015 Supplemental Report,[7] the timeframes and resources available for implementation of the Plan have been of concern. As a result, there has been only incremental progress to date in the implementation of these reforms. A greater sense of urgency is needed, if the critically required changes in Georgia's system are to be accomplished, as intended by the leadership of DBHDD. Explicit timelines need to be established, disseminated throughout the system and met. Given the difficulties described by leadership staff in their attempts to restructure the system, there may need to be additional resources assigned to the Pioneer Project in Region 2 in order to expand its goals and effect its implementation in other parts of the State.

Provisions Related to Individuals with a Serious and Persistent Mental Illness

At this time, based on the information derived from myriad sources over the course of the year, it is the Independent Reviewer's professional judgment that the State has reached substantial compliance with the majority of its obligations under the Settlement Agreement related to the development of a comprehensive community-based system of support for adults with a serious and persistent mental illness. Although there is non-compliance with one specific provision related to supported housing [III.B.2.c.ii(A)] and there are important issues to be addressed regarding discharge planning, significant strides have been made in the availability of Assertive Community Treatment, crisis services, supported employment and supported housing. As documented in the attached supplemental reports:

- The requirement for the provision of supported employment has been exceeded. It has been confirmed that six hundred and fifteen adults are being assisted in their search for competitive employment. Over fifty percent of these individuals have been employed.
- There are twenty-two Assertive Community Treatment teams throughout the State. These teams continue to substantially meet the fidelity scale measures mandated by the Settlement Agreement. There is evidence of an increased, although still evolving, focus on the recovery model. The gains in the implementation of the recovery model are not yet uniform but promising practices have been demonstrated, as a result of

[7] The Independent Reviewer's Supplemental Report stated: "On June 30, 2014, the State's Priority Plan was submitted in a timely manner. Upon review, it was considered to be responsive to the overall obligations of the Settlement Agreement. However, the Department of Justice, the Amici and the Independent Reviewer expressed concern regarding both the availability of resources required for implementation and the time that would be needed to implement the expected reforms." (See page 3)

technical assistance and guidance from the Department's leadership and its Office of Recovery Transformation.

- The components of the crisis service system for adults with a serious mental illness interact appropriately. The work of GCAL, the crisis line and epicenter of referrals for assistance, is especially effective. The use of Crisis Stabilization Programs has reduced the use of state hospital beds. For example, in Region 1, the use of state hospital beds for adults in crisis has declined from 25% (in 2010) to less than 2% (in 2015). In Region 2, there has been a 48% decrease in hospital admissions from a high of 1730 in FY11 to 824 in FY14. Thus far, in FY15, crisis services have diverted 53.6% of the individuals seen in Region 2 from inpatient hospitalization.
- Supported housing vouchers have been made available to 2428 adults who were hospitalized, homeless, or under-housed. Bridge funding was provided to 871 adults. For the fifth consecutive year, the requirements of the Settlement Agreement were exceeded. The collaboration between the Department of Behavioral Health and Developmental Disabilities, its sister agency, the Department of Community Affairs, and Local Housing Authorities is exemplary. The implementation of the Georgia Housing Voucher Program can be considered a national model.

The impact of these successful initiatives on the daily lives of individuals with serious mental illness cannot be overstated. For example:

- A twenty-eight year old woman, who resides in the Augusta area (Region 2), spent most of the last fifteen years in a state hospital with only brief periods in community-based residential programs. She has both a serious mental illness and a developmental disability. For over two years, the Assertive Community Treatment team in that Region worked strenuously with hospital and regional staff to accomplish her discharge. Since November 2014, she has lived in her own (spotlessly maintained) apartment funded with a Home and Community-Based Services waiver. Her ACT team visits her frequently and serves as her representative payee, as she cannot read. She has had one Emergency Room visit for a medical issue. She has learned to manage her own medications. She is demonstrably proud of her success and would like to graduate from ACT services but "not yet."

As the Department refines its information management systems, it is expected that more data about the effect of its reforms can be shared with key stakeholders and with the general public. The Administrative Services Organization (ASO) contract has been awarded and implementation is underway for its work with the mental health and developmental disability services under the Department's responsibility.

Notwithstanding the major strides described above, there are two very critical obligations related to the provision of mental health services that were not found to be in compliance. It is highly recommended that both of these obligations continue to receive independent oversight.

First, as is recognized by the State, compliance has not been achieved with the provision that requires that: "By July 1, 2015, the State will have the capacity to provide Supported Housing to any of the 9,000 persons in the target population who need such support. The Supported Housing required by this provision may be in the form of assistance from the Georgia Department of Community Affairs, the federal Department of Housing and Urban Development, and from any other governmental or private source." [III.B.2.c.ii.(A.)].

There has been extensive discussion about this provision. The State will require additional time to complete its plans for determining need and choice and for ensuring that adults with serious and persistent mental illness confined to correctional facilities are fully included.

The Independent Reviewer and her consultant on housing, Ms. Knisley, are hopeful that the Parties and the Court will agree to the additional time required to achieve full compliance with the terms of this provision.

Second, the Settlement Agreement states: "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." (See III.B.1.b.) In order to review the access to community services for individuals included in this definition, the Independent Reviewer began to review discharge planning. This work was performed under provision III.D.3.a. and, in part, under the aegis of the "Notice of Termination of Settlement Agreement and Joint Request to Close Case," filed by the Parties, on February 5, 2014, regarding the CRIPA action. This document states that "The parties agree that effective implementation of the discharge and planning terms are essential to compliance with the 2010 Settlement Agreement and will be subject to the Court's jurisdiction and enforcement, if necessary, in Civil Action No. 1:10-CV-249." After review, it was concluded that the weaknesses and fragmentation noted in the forensic discharge planning process may create barriers to community placement. This finding is in contrast to the very commendable progress recently seen in discharge planning for ten adults with both a developmental disability and forensic status. Their discharges illustrate that, with proper planning, forensic clients can make successful transitions to community-based services.

In addition to the problems with discharge planning, members of the Judiciary interviewed by the Independent Reviewer for this Annual Report cited a lack of confidence in risk assessments; the failure to provide sufficient detail about the plans for community placement, including the levels of supervision and oversight; and the absence of consistent and reliable clinical presence

in the discussion of discharge plans during the Court hearings. Furthermore, Judges (and a District Attorney) expressed an interest in learning more about the fidelity standards for Assertive Community Treatment and other community-based interventions and indicated an interest in actually visiting community-based mental health programs. These are all opportunities for enhanced attention by the State.

The Settlement Agreement requires that the State maintain substantial compliance with all provisions for a period of one year. (See VII. 2). As referenced in last year's Annual Report, there are certain aspects of the mental health system that must not lose focused attention:

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

Given the significant accomplishments in the mental health system, it would be timely and appropriate for the State to discuss its plans for the forthcoming year and to inform its stakeholders of its strategies for ensuring sustainability. It would also be very important to celebrate these achievements and to recognize the efforts that have been underway by so many people for the last five years.

Summary of Compliance: Year Five			
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.
III.A.1.b	The State will make any necessary changes to administrative regulations and take best efforts to amend any statutes that may require such admissions.	**Compliance**	In House Bill 324, the State Legislature amended Chapter 4 of Title 37 of the Official Code of Georgia Annotated.
III.A.2.b.i(A)	By July 1, 2011, the State shall move 150 individuals with developmental disabilities from the State Hospitals to the community and the State shall create 150 waivers to accomplish this transition. In addition, the State shall move from the State Hospitals to the community all individuals with an existing and active waiver as of the Effective Date of this Agreement, provided such placement is consistent with the individual's informed choice. The State shall provide family supports to a minimum of 400 families of people with developmental disabilities.	**Compliance**	By July 1, 2011, the Department placed more than 150 individuals with a developmental disability into community residential settings supported by the Home and Community-Based Waiver. A sample of 48 individuals was reviewed. Identified concerns were referred to the Department and corrective actions were initiated. Nine of the 11 individuals hospitalized with an existing Waiver were discharged to community settings. Two individuals remained hospitalized. Delays in placement were attributed to family objections or to provider-related issues. The Department continued to pursue appropriate community placements for these two individuals. More than 400 individuals were provided with family supports. Because there was substantial compliance with this provision, a positive rating was given.
III.A.2.b.i(B)	Between July 1, 2011, and July 1, 2012, the State shall move 150 individuals with developmental disabilities from the State Hospitals to the community. The State shall create 150 waivers to accomplish this transition. The State shall also create 100 additional waivers to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. The State shall provide family supports to an additional 450 families of people with developmental disabilities.	**Compliance**	The Department placed 164 individuals with a developmental disability into community residential settings supported by the Home and Community-Based Waiver. A statistically relevant sample of 48 individuals was reviewed. Identified concerns have been referred to the Department and corrective actions are being initiated. Although in compliance, it is recommended that the Department review its policies and guidance regarding expectations for community placement and to provide greater oversight of service coordination at the Regional level. The two hospitalized individuals referenced in the provision above have either been placed or have a placement in process. Two other individuals with existing and active Waivers at the time of the Settlement Agreement were rehospitalized. Those individuals were reviewed by a psychologist consulting with the Independent Reviewer. Community placements are being actively pursued; an experienced provider has been recruited. The Department issued 117 Waivers to avoid institutionalization of individuals with a developmental disability residing in the community. Family supports were provided for 2248 individuals through 38 provider agencies.

Settlement Agreement Reference	Provision	Rating	Comments
III.A.2.b.i(C)	Between July 1, 2012, and July 1, 2013, the State shall create at least 250 waivers to serve individuals with developmental disabilities in community settings. The State shall move up to 150 individuals with developmental disabilities from the State Hospitals to the community using those waivers. The remaining waivers shall be used to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. The State shall provide family supports to an additional 500 families of people with developmental disabilities.	**Compliance**	The Court's Order, dated July 26, 2013, modified the language of this provision. The Department has issued 597 waivers to serve individuals with developmental disabilities in community settings. These waivers have been used to prevent institutionalization and to sustain individuals with a developmental disability with their families. The number of individuals with a disability who have moved from state hospitals using these waivers will be reviewed in the Independent Reviewer's report to be issued in late Winter 2014. As of this date, seventy-nine individuals with a developmental disability have been transitioned from state hospitals to community residential settings.
III.A.2.b.i(D)	Between July 1, 2013, and July 1, 2014, the State shall move 150 individuals with developmental disabilities from the State Hospitals to the community. The State shall create 150 waivers to accomplish this transition. The State shall also create 100 additional waivers to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. The State shall provide family supports to an additional 500 families of people with developmental disabilities.	**Non-compliance**	With few exceptions (three), placements from State Hospitals have been suspended. The Department is planning and developing remedial actions to permit the resumption of individualized community placements. A "pioneer" project is being initiated in Region 2 to demonstrate improved transition, support coordination and habilitation practices. In total, 46 individuals were transitioned from State Hospitals during this Fiscal Year. The State issued 100 additional waivers to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. In FY14, the State provided family supports to a total of 1155 families of people with developmental disabilities.
III.A.2.b.i(E)	**Between July 1, 2014, and July 1, 2015, the State shall attempt to move any remaining individuals with developmental disabilities from the State Hospitals to the community. The State shall create up to 150 waivers to accomplish this transition. The State shall also create 100 additional waivers to prevent the hospitalization of individuals with developmental disabilities who are currently in the community. The State shall provide family supports to an additional 500 families of people with developmental disabilities.**	**Non-compliance**	**With few exceptions (fourteen), placements from State Hospitals have been suspended. The Department continues to plan and develop remedial actions to permit the resumption of individualized community placements. However, the pace of reform has been slower than anticipated. A "Pioneer Project" has been initiated in Region 2 to demonstrate improved transition, support coordination and habilitation practices. In FY15, the State reported that it provided family supports to an additional 1,136 families of people with developmental disabilities.**
III.A.2.b.i(F)	**Any persons with developmental disabilities remaining in State Hospitals on July 2, 2015, shall be served in the most integrated setting appropriate to their needs.**	**Deferred**	**It is premature to rate this provision.**
III.A.2.b.ii(B)	Individuals in the target population shall not be served in a host home or a congregate community living setting unless such placement is consistent with the individual's informed choice. For individuals in the target population not served in their own home or their family's home, the number of individuals served in a host home as defined by Georgia law shall not exceed two, and the number of individuals served in any congregate community living setting shall not exceed four.	**Compliance**	The Department remains in substantial compliance with this provision. All host homes reviewed to date have no more than two individuals. With one recently identified exception, the number of individuals served in any congregate community living setting has not exceeded four.

Settlement Agreement Reference	Provision	Rating	Comments
III.A.2.b.iii(A)	Assembling professionals and non-professionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Service Plans, as required by the State's HCBS Waiver Program, that are individualized and person centered.	Non-compliance	**The rating of this provision was deferred initially by Court Order until January 2014. As of July 1, 2015, the Department has not achieved compliance with this provision. There are plans underway to achieve compliance but additional time is needed.**
III.A.2.b.iii(B)	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, and other services identified in the Individual Service Plan.	Non-compliance	**The rating of this provision was deferred initially by Court Order until January 2014. As of July 1, 2015, the Department has not achieved compliance with this provision. There are plans underway to achieve compliance but additional time is needed.**
III.A.2.b.iii(C)	Monitoring the Individual Service Plan to make additional referrals, service changes, and amendments to the plans as identified as needed.	Non-compliance	**The rating of this provision was deferred initially by Court Order until January 2014. As of July 1, 2015, the Department has not achieved compliance with this provision. There are plans underway to achieve compliance but additional time is needed.**
III.A.2.b.iii(D)	The Independent Reviewer will not assess the provisions of this section, III.A.2.b.iii.(A)-(C), in her report for the period ending July 1, 2013. Instead, the review period for this section will be extended six months until January 1, 2014, after which the Independent Reviewer will report on this section pursuant to the draft, review, and comment deadlines enumerated in VI.A.	Completed	**The Independent Reviewer has complied with this requirement. Her first Supplemental Report was filed with the Court on March 24, 2014. Her second Supplemental Report was filed with the Court on March 20, 2015.**
III.A.2.c.i(A)	By July 1, 2012, the State will have six mobile crisis teams for persons with developmental disabilities.	Compliance	**There are 12 mobile crisis teams for individuals with developmental disabilities. They are located in every Region.**
III.A.2.c.ii(B)(1)	By July 1, 2012, the State will have five Crisis Respite Homes for individuals with developmental disabilities.	Compliance	There are 11 Crisis Respite Homes, including one for children. One individual in the sample of 48 was reviewed in his crisis home; supports were adequate and individualized.
III.A.2.c.ii(B)(2)	By July 1, 2013, the State will establish an additional four Crisis Respite Homes for individuals with developmental disabilities.	Compliance	There are 11 Crisis Respite Homes across the State. There are 2 homes in each Region, except for Region 3 which has one Home. There were 270 individuals served in FY13.
III.A.2.c.ii(B)(3)	By July 1, 2014, the State will establish an additional three Crisis Respite Homes for individuals with developmental disabilities.	Non-compliance	**There are 11 Crisis Respite Homes across the State. A contract for the twelfth Home was issued but as of July 1, 2015 the Home has not been opened. Furthermore, there are serious concerns about the use of these homes for long lengths of stay.**
III.A.3.a	By July 1, 2013, the State shall create a program to educate judges and law enforcement officials about community supports and services for individuals with developmental disabilities and forensic status.	Compliance	**The Department has initiated a program to provide education to judges and law enforcement individuals. In FY14, training was provided to 1433 individuals, including 130 Judges, 1279 law enforcement officials and 24 attorneys. In FY15, training was provided to 889 individuals, including 11 Judges, 827 law enforcement officials and 51 attorneys.**

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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. In FY15, 10 individuals were transferred from State hospitals to community placements. The placements reviewed to date have been appropriately designed and implemented.**
III.A.4.a	By July 1, 2013, the State will conduct an audit of community providers of waiver services.	**Compliance**	The Georgia Quality Management System (GQMS) contract with the Delmarva Foundation mandates that each provider rendering services through the Medicaid waivers to individuals with developmental disabilities has one annual review over the course of five years. Therefore, 40 providers are reviewed each year (39 service providers and one support coordinator agency). The providers are selected randomly. Findings from these reviews are summarized in the Quality Management reports issued by the Department.
III.A.4.b	By the Effective Date of this Agreement, the State shall use a CMS approved Quality Improvement Organization ("QIO") or QIO-like organization to assess the quality of services by community providers.	**Compliance**	**In FY15, the Department again utilized the services of the Delmarva Foundation to design and implement a quality assurance review process. Delmarva also assessed the quality of services by community providers. The Department participated in the National Core Indicator surveys.**
III.A.4.d	The State shall assess compliance on an annual basis and shall take appropriate action based on each assessment.	**Non-compliance**	**The Delmarva Foundation issues annual reports assessing the quality of services by community providers for individuals with a developmental disability. The most recent report was issued to the Independent Reviewer and the Department of Justice on August 1, 2015. Annual reports are posted on the Delmarva website. The State will need to continue its review of the quality of services to ensure that any remedial actions have occured in a timely manner. The Regions receive the information from Delmarva and are expected to take timely remedial action. As cited in this Report, no evidence was provided that remedial action was taken to address serious deficits in provider compliance with training requirements.**
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.

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III.B.2.a.i(G)	All ACT teams will operate with fidelity to the Dartmouth Assertive Community Treatment model.	Compliance	**In FY12, The Parties, with concurrence by the Independent Reviewer, requested that the Court defer evaluation of this provision. The Court approved this request on August 29, 2012 with explicit instructions regarding reporting, root cause analysis and corrective action plans. These instructions were complied with by the Department with close involvement of the Independent Reviewer and her expert consultants. In FY15, this provision continues to be in compliance. All teams funded under this Agreement are expected to operate with fidelity to the Dartmouth model. Certain lower performing teams received additional oversight and review; scores improved after technical assistance was provided by DBHDD. Additional information is included in the attached report by Angela Rollins.**
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, 2015, there were 1,477 individuals participating in services with the ACT teams. For a discussion of the ACT teams, see attached report by Angela Rollins.**
III.B.2.a.ii(C)(1)	By July 1, 2012, the State will have two Community Support Teams.	Compliance	The State has established two Community Support Teams. Although one team was transferred to another provider beginning in FY13, both teams functioned and provided services from the time of their contract. The two teams supported a total of 71 individuals in FY12.
III.B.2.a.ii(C)(2)	By July 1, 2013, the State will have four Community Support Teams.	Compliance	The Department has established four Community Support Teams (CSTs). They are located in four rural areas of the State. A total of 145 individuals received services from the CSTs in FY13. Under the terms of the Agreement, the Independent Reviewer must assess whether the Community Support Team model provides services that are sufficient to meet the needs of the members of the target population who receive these services. The Independent Reviewer's assessment and recommendations are due by October 30, 2013.
III.B.2.a.ii(C)(3)	**By July 1, 2014, the State will have eight Community Support Teams.**	Compliance	**There are 8 Community Support Teams operating within 5 of the 6 Regions. On June 30, 2015, the number of people participating in CST services was 289.**

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III.B.2.a.iii(D)(1)	By July 1, 2011, the State will have one Intensive Case Management team.	**Compliance**	The Department has established two Intensive Case Management teams.
III.B.2.a.iii(D)(2)	By July 1, 2012, the State will have two Intensive Case Management teams.	**Compliance**	The Department has established two Intensive Case Management teams. The two teams supported a total of 387 individuals in FY12.
III.B.2.a.iii(D)(3)	By July 1, 2013, the State will have three Intensive Case Management teams.	**Compliance**	The Department has established three Intensive Case Management teams in Regions 1, 3 and 5. These three teams served a total of 235 individuals in FY13. The Independent Reviewer has requested additional information about the caseload in Region 3.
III.B.2.a.iii(D)(4)	By July 1, 2014, the State will have eight Intensive Case Management teams.	**Compliance**	There are 8 Intensive Case Management teams throughout the 6 Regions. On June 30, 2014, the number of people participating in ICM services was 885.
III.B.2.a.iii(D)(5)	By July 1, 2015, the State will have 14 Intensive Case Management teams.	**Compliance**	**There are 14 Intensive Case Management teams throughout the 6 Regions. On June 30, 2015, the number of people participating in ICM services was 1450.**
III.B.2.a.iv(C)(1)	By July 1, 2012, the State will have five Case Management service providers.	**Compliance**	The Department has established five Case Management service providers. Case Management services were provided to 257 individuals in FY12.
III.B.2.a.iv(C)(2)	By July 1, 2013, the State will have 15 Case Management service providers.	**Compliance**	The 15 case management positions funded by the Department supported 1,893 individuals throughout the six Regions. The Independent Reviewer has requested additional information regarding caseload expectations.
III.B.2.a.iv(C)(3)	By July 1, 2014, the State will have 25 Case Management service providers.	**Compliance**	There are 25 Case Management service providers throughout the six Regions. On June 30, 2014, the number of people partipating in CM services was 761.
III.B.2.a.iv(C)(4)	**By July 1, 2015, the State will have 45 Case Management service providers.**	**Compliance**	**There are 52 Case Management positions and 19 provider agencies throughout the six Regions. On June 30, 2015, the number of people partipating in CM services was 1364.**
III.B.2.b.i(B)(1)	By July 1, 2013, the State will establish one Crisis Service Center.	**Compliance**	The Department opened a 24-hour, walk-in Crisis Service Center on March 1, 2013. From March 1, 2013 through June 30, 2013, 177 individuals received services in this Center. This is not an unduplicated count and some individuals may have received more than one episode of care during this time period.
III.B.2.b.i(B)(2)	By July 1, 2014, the State will establish an additional two Crisis Service Centers.	**Compliance**	There are four 24-hour Crisis Service Centers. Three are in Region 4; and one is in Region 6. During FY14, 3,309 people received CSC services.
III.B.2.b.i(B)(3)	**By July 1, 2015, the State will establish an additional three Crisis Service Centers.**	**Compliance**	**There are six 24-hour Crisis Service Centers in operation. A seventh center opened on June 30, 2015. Three are in Region 4; three are in Region 6; and one is in Region 2. During FY15, 7139 people (duplicated count) received CSC services.**
III.B.2.b.ii(B)(1)	The State will establish one Crisis Stabilization Program by July 1, 2012.	**Compliance**	The Department has established two Crisis Stabilization Programs.
III.B.2.b.ii(B)(2)	The State will establish an additional Crisis Stabilization Program by July 1, 2013.	**Compliance**	The Department's two Crisis Stabilization Programs have remained operational. They each have 16 beds.
III.B.2.b.ii(B)(3)	The State will establish an additional Crisis Stabilization Program by July 1, 2014.	**Compliance**	A third 16-bed Crisis Stabilization Program was opened in Savannah on June 30, 2014.
III.B.2.b.iii(A)	Beginning on July 1, 2011, the State shall retain funding for 35 beds in non-State community hospitals without regard as to whether such hospitals are freestanding psychiatric hospitals or general, acute care hospitals.	**Compliance**	**The Department has continued to fund hospital bed days in community hospitals in FY15. The contract beds are used primarily in Regions 1 and 4.**

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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 FY15.**
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.**
III.B.2.b.v(B)(1)	By July 1, 2013, the State shall have mobile crisis services within 91 of 159 counties, with an average annual response time of 1 hour and 10 minutes or less.	**Compliance**	Mobile crisis services have been established in 100 counties, exceeding the requirements of this provision. Statewide, there were 840 individuals served by these teams. The average response time ranged from 49 to 56 minutes, again exceeding the requirements of this provision. The disposition for the majority of individuals (230) served was involuntary inpatient hospitalization. The Independent Reviewer will work with the Department's staff to better understand the range of options investigated by the teams and whether the least restrictive measure was consistently employed by the teams.
III.B.2.b.v(B)(2)	By July 1, 2014, the State shall have mobile crisis services within 126 of 159 counties, with an average annual response time of 1 hour and 5 minutes or less.	**Compliance**	There are two mobile crisis providers covering all 159 counties in the State. The average response time was 49 minutes in FY14. As of June 30, 2014, 14,981 people had received mobile crisis services.
III.B.2.b.v(B)(3)	**By July 1, 2015, the State shall have mobile crisis services within all 159 of 159 counties, with an average annual response time of 1 hour or less.**	**Compliance**	**There are two mobile crisis providers covering all 159 counties in the State. The average response time was 55 minutes in FY15. As of June 30, 2015, 18,052 people had received mobile crisis services.**
III.B.2.b.vi(A)	Crisis apartments, located in community settings off the grounds of the State Hospitals and staffed by paraprofessionals and, when available, peer specialists, shall serve as an alternative to crisis stabilization programs and to psychiatric hospitalization.	**Compliance**	The Department has complied with the staffing and location requirements of this provision.
III.B.2.b.vi(B)	Each crisis apartment will have capacity to serve two individuals with SPMI.	**Compliance**	The Department has now complied with this provision. Crisis apartments have the capacity to serve two individuals with SPMI.

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III.B.2.b.vi(C)(1)	By July 1, 2013, the State will provide six crisis apartments.	Non-compliance	The Department has not complied with this provision. There were three apartments operational, for a total of six beds, at the end of FY13. A contract was executed on June 27, 2013 for an additional 4 apartments but they were not yet operational.
III.B.2.b.vi(C)(2)	By July 1, 2014, the State will provide 12 crisis apartments.	Compliance	There are 13 crisis apartments with a total of 25 beds throughout four Regions. 159 individuals were served in FY14.
III.B.2.b.vi(C)(3)	**By July 1, 2015, the State will provide 18 crisis apartments.**	Compliance	**There are 19 crisis apartments with a total of 37 beds throughout all Regions in the State. 313 individuals were served in FY15.**
III.B.2.c.i(A)	**Supported Housing includes scattered-site housing as well as apartments clustered in a single building. By July 1, 2015, 50% of Supported Housing units shall be provided in scattered-site housing, which requires that no more than 20% of the units in one building, or no more than two units in one building (whichever is greater), may be used to provide Supported Housing under this agreement. Personal care homes shall not qualify as scattered-site housing.**	Compliance	**The State has complied with this provision. For detailed information, see the attached report by Martha Knisley.**
III.B.2.c.i(B)	**It is the intent of the parties that approximately 60% of persons in the target population receiving scattered-site Supported Housing will reside in a two- bedroom apartment, and that approximately 40% of persons in the target population receiving scattered-site Supported Housing will reside in a one-bedroom apartment. Provided, however, nothing in Section III.B.2.c shall require the State to forego federal funding or federal programs to provide housing for persons in the target population with SPMI.**	Compliance	**The State has complied with this provision. For detailed information, see the attached report by Martha Knisley.**
III.B.2.c.i(C)	**Bridge Funding includes the provision of deposits, household necessities, living expenses, and other supports during the time needed for a person to become eligible and a recipient of federal disability or other supplemental income.**	Compliance	**The State has complied with this provision. For detailed information, see the attached report by Martha Knisley.**
III.B.2.c.ii(A)	**By July 1, 2015, the State will have capacity to provide Supported Housing to any of the 9,000 persons in the target population who need such support. The Supported Housing required by this provision may be in the form of assistance from the Georgia Department of Community Affairs, the federal Department of Housing and Urban Development, and from any other governmental or private source.**	Non-compliance	**As discussed in the attached report by Martha Knisley, the State does not yet have this capacity. Additional work is required; this work is underway. Compliance with this provision will require additional time.**

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III.B.2.c.ii(B)(1)	By July 1, 2011, the State will provide a total of 100 supported housing beds.	**Compliance**	Although the Department provided the requisite housing vouchers, concern was noted about the review of eligibility and access for hospitalized individuals.
III.B.2.c.ii(B)(2)	By July 1, 2012, the State will provide a total of 500 supported housing beds.	**Compliance**	The State has exceeded this obligation. (See Consultant's report.) The Department awarded 648 housing vouchers and reassessed its prioritization for these awards. Further collaboration is planned between the Independent Reviewer and the Department to further analyze referrals for the housing vouchers.
III.B.2.c.ii(B)(3)	By July 1, 2013, the State will provide a total of 800 supported housing beds.	**Compliance**	The State has exceeded this obligation. In FY13, it awarded a total of 1,002 housing vouchers. The Department made adjustments to its review policies and worked closely with its regional offices, service providers, DCA and other organizations to increase program effectiveness and expand housing resources. (See attached report of Martha Knisley.)
III.B.2.c.ii(B)(4)	By July 1, 2014, the State will provide a total of 1,400 supported housing beds.	**Compliance**	By July 1, 2014, there were 1,649 individuals served in supported housing beds. (See attached report of Martha Knisley.)
III.B.2.c.ii(B)(5)	**By July 1, 2015, the State will provide a total of 2,000 supported housing beds.**	**Compliance**	**By July 1, 2015, there were 2428 individuals served in supported housing beds. See attached report of Martha Knisley.**
III.B.2.c.ii(C)(1)	By July 1, 2011, the State will provide Bridge Funding for 90 individuals with SPMI. The State will also commence taking reasonable efforts to assist persons with SPMI to qualify in a timely manner for eligible supplemental income.	**Compliance**	The Department provided Bridge Funding as required.
III.B.2.c.ii(C)(2)	By July 1, 2012, the State will provide Bridge Funding for 360 individuals with SPMI.	**Compliance**	The State has exceeded this obligation. (See Consultant's report.) The Department provided Bridge Funding for 568 individuals.
III.B.2.c.ii(C)(3)	By July 1, 2013, the State will provide Bridge Funding for 270 individuals with SPMI.	**Compliance**	The State has exceeded this obligation. In FY13, the Department provided Bridge Funding for 383 individuals with SPMI. (See attached report of Martha Knisley.)
III.B.2.c.ii(C)(4)	By July 1, 2014, the State will provide Bridge Funding for 540 individuals with SPMI.	**Compliance**	Bridge Funding was provided for 709 participants in FY14. (See attached report of Martha Knisley.)
III.B.2.c.ii(C)(5)	**By July 1, 2015, the State will provide Bridge Funding for 540 individuals with SPMI.**	**Compliance**	**Bridge Funding was provided for 871 participants in FY15. (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.

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III.B.2.d.iii(C)	By July 1, 2013, the State shall provide Supported Employment services to 440 individuals with SPMI.	**Compliance**	The State has exceeded this obligation. According to a report issued by the Department and reviewed by the Independent Reviewer's expert consultant, Supported Employment services, with strong adherence to the Dartmouth fidelity scale, were provided to 682 individuals during FY13. The monthly rate of employment was 42.1%. (See attached report of David Lynde.)
III.B.2.d.iii(D)	By July 1, 2014, the State shall provide Supported Employment services to 500 individuals with SPMI.	**Compliance**	The State has exceeded this obligation. Supported Employment services were provided to 988 individuals during FY14. The monthly rate of employment was 47.3%. (See attached report of David Lynde.)
III.B.2.d.iii(E)	**By July 1, 2015, the State shall provide Supported Employment services to 550 individuals with SPMI.**	**Compliance**	**The State has exceeded this obligation. Supported Employment services were provided to 615 individuals during FY15. The monthly rate of employment was 51.5% across all programs. (See attached report of David Lynde.)**
III.B.2.e.ii(A)	By July 1, 2012, the State shall provide Peer Support services to up to 235 individuals with SPMI.	**Compliance**	There are 3000 consumers enrolled; there are 72 Peer Support sites in Georgia.
III.B.2.e.ii(B)	By July 1, 2013, the State shall provide Peer Support services to up to 535 individuals with SPMI.	**Compliance**	The Department has made a substantial commitment to the meaningful involvement of peer support services. The Department's commitment was confirmed by the leadership of the Georgia Mental Health Consumer Network during a July 2013 site visit by the Independent Reviewer. Reportedly, and verified by the submission of names, 571 individuals received peer support services provided by the Georgia Mental Health Consumer Network's three Peer Wellness and Respite Centers and through its Peer Mentoring program.
III.B.2.e.ii(C)	By July 1, 2014, the State shall provide Peer Support services to up to 835 individuals with SPMI.	**Compliance**	Since January 1, 2011, a total of 1,583 individuals have received Peer Support services provided by Georgia Mental Health Consumer Network's three Peer Wellness and Respite Centers and through its Peer Mentoring program. In FY14, there was documentation of 767 discrete units of support.
III.C.1	Individuals under the age of 18 shall not be admitted to, or otherwise served, in the State Hospitals or on State Hospital grounds, unless the individual meets the criteria for emancipated minor, as set forth in Article 6 of Title 15, Chapter 11 of the Georgia Code, O.C.G.A. §§ 15-11-200 et seq.	**Compliance**	The Department has complied with this obligation.

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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 FY14, the primary focus of institutional closures has been at Southwestern State Hospital and the Craig Center at Central State Hospital. Southwestern State Hospital closed on December 30, 2013. Currently, placements from the Craig Center are pending further review and approval. Individuals have been transferred to Gracewood and Georgia Regional Hospital in Atlanta. The Independent Reviewer has been closely tracking these transfers and has been conducting site visits to both of these institutions. **In FY15, the Craig Center closed. Individuals were transferred to Gracewood and Georgia Regional Hospital in Atlanta. The Independent Reviewer continues to track these transfers and conduct site visits to both of these institutions.**
III.C.3.a.i	By January 1, 2012, the State shall establish the responsibilities of community service boards and/or community providers through contract, letter of agreement, or other agreement, including but not limited to the community service boards' and/or community providers' responsibilities in developing and implementing transition plans.	Compliance	Contract language delineates responsibility for developing and implementing transition planning.
III.C.3.a.ii	By January 1, 2012, the State shall identify qualified providers through a certified vendor or request for proposal process or other manner consistent with DBHDD policy or State law, including providers in geographically diverse areas of the State consistent with the needs of the individuals covered by this Agreement.	Compliance	This provision has been implemented.
III.C.3.a.iii	By January 1, 2012, the State shall perform a cost rate study of provider reimbursement rates.	Compliance	**A new cost rate study is underway. It is focused on services for individuals with a developmental disability.**
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.	**Non-compliance**	**Based on DBHDD's latest Quality Management report, compliance with training requirements was not maintained by a significant number of provider agencies responsible for individuals with a developmental disability.**
III.C.3.a.vi	By January 1, 2012, the State shall utilize contract management and corrective action plans to achieve the goals of this Agreement and of State agencies.	**Compliance**	The Independent Reviewer has been informed of actions taken to achieve the goals of this Agreement and of State agencies. Such actions include the termination of provider contracts. In FY14, nine provider contracts were terminated. Seven were providers of developmental disabilities services and two were providers for behavioral health services. **In FY15, six provider contracts were terminated.**
III.C.3.b	Beginning on January 1, 2012 and on at least an annual basis, the State shall perform a network analysis to assess the availability of supports and services in the community.	**Compliance**	**This obligation continues to be met. The Independent Reviewer was provided a copy of the Regional Network Analysis completed this year. The Independent Reviewer appreciated the work that went into the preparation of these reports. It is her understanding that the Regional Network Analysis will be discontinued in its current form.**
III.D.1	By July 1, 2011, the State shall have at least one case manager and by July 1, 2012, at least one transition specialist per State Hospital to review transition planning for individuals who have challenging behaviors or medical conditions that impede their transition to the community, including individuals whose transition planning team cannot agree on a transition plan or does not recommend that the individual be discharged. The transition specialists will also review all transition plans for individuals who have been in a State Hospital for more than 45 days.	**Non-compliance**	**Case Managers and Transition Specialists were assigned at each State Hospital. However, at this time, with limited exceptions, community placements have been suspended.**
III.D.3.a	For persons identified in the developmental disability and mental illness target populations of this Settlement Agreement, planning for transition to the community shall be the responsibility of the appropriate regional office and shall be carried out through collaborative engagement with the discharge planning process of the State Hospitals and provider(s) chosen by the individual or the individual's guardian where required.	**Non-compliance**	**At this time, the entire transition process continues to be under review and placements have been limited. Furthermore, as discussed in the Report narrative, preliminary concerns have been identified about the effectiveness of discharge planning and require further examination by the Independent Reviewer and consultation with the Parties.**
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.

Settlement Agreement Reference	Provision	Rating	Comments
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. **In FY15, community providers were actively involved in the transitions that did occur.**
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 FY15.**
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.	Non-compliance	**The Quality Management system plan and the report issued most recently on August 1, 2015 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. Incident/injury data was maintained and reviewed for the community system and key-indicator performance data was referenced in the Quality Management system reports. However, there was no evidence that the negative findings from the annual quality service reviews were addressed in a timely and complete manner. The Quality Management report issued in February 2015 documented similar negative findings.**
IV.A.1	The system's review shall include the implementation of the plan regarding cessation of admissions for persons with developmental disabilities to the State Hospitals.	Compliance	The Department tracks data related to the provision of alternatives to state hospital admissions for individuals with a developmental disability. These data focus on various forms of crisis services, including mobile crisis teams and crisis respite care. Since the Department routinely tracks these sets of information and reviews them on a regular basis in preparation of the Quality Management reports, this provision is rated in substantial compliance.
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.

Settlement Agreement Reference	Provision	Rating	Comments
IV.A.4	The system's review shall include the network analysis.	Compliance	**A comprehensive network analysis was submitted to the Independent Reviewer on June 30, 2015. 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	**Although this provision ended on February 1, 2015, the Department continues to be in compliance with this provision. Reports continue to be submitted in a timely manner to the Independent Reviewer and the Department of Justice.**
V	**Implementation of the Agreement**		
V.E	The State shall notify the Independent Reviewer(s) promptly upon the death of any individual actively receiving services pursuant to this Agreement. The State shall, via email, forward to the United States and the Independent Reviewer(s) electronic copies of all completed incident reports and final reports of investigations related to such incidents as well as any autopsies and death summaries in the State's possession.	Compliance	**Although there have been some issues with timeliness, the Department remains in substantial compliance with this provision. The Independent Reviewer and the United States are notified of deaths and the results of investigations. At this time, the Department's mortality review process continues to undergo scrutiny and revision. The Independent Reviewer is working closely with the Department on this matter. The Department has retained a qualified independent entity, the Columbus Organization, to review the deaths of individuals transitioned from State Hospitals to community placements. In addition, the Department has contracted with two consultants who review all deaths by suicide. Furthermore, on August 15, 2015, the Department issued its first Annual Mortality Review Report. The independent Reviewer has continued to track the numbers and causes of death of individuals in the target population. In FY15, she followed up on the implementation of recommendations made by the Columbus Organization. She continues to bring concerns to the attention of DBHDD.**

ADDITIONAL DISCUSSION OF SPECIFIC COMPLIANCE FINDINGS

The following narrative provides further discussion on selected findings related to the provisions summarized in the above Compliance Chart. Extensive examination of the major requirements related to the mental health system is found in the attached reports by the Independent Reviewer's subject matter consultants in supported housing, supported employment, crisis services and Assertive Community Treatment (ACT). Recommendations are summarized at the end of this Report.

METHODOLOGY

The leadership and staff of the Department of Behavioral Health and Developmental Disabilities (DBHDD) have been accessible in a timely and forthright manner to the Independent Reviewer and all of her expert consultants. All requests for documents, interviews and site visits were respectfully and graciously complied with through the assistance of the Director of Settlement Services, Pamela Schuble. The Independent Reviewer and all of her consultants want to express their genuine appreciation for her work.

The Independent Reviewer and her seven expert consultants in supported housing, supported employment, crisis services, Assertive Community Treatment (ACT), behavioral interventions and health care drew from a variety of sources to form their professional judgments regarding compliance with the Settlement Agreement obligations for Georgia's individuals with mental illness and/or a developmental disability. These sources included multiple site visits, throughout the year, in every Region of the State. The on-site work involved attendance at team meetings; observations of staff performing their duties; interviews with staff and the individuals receiving support; and visits, some as long as five hours, to residential and day program locations. In addition, the information and data contained in numerous documents were reviewed. There were many thoughtful discussions with the leadership and staff of the Department of Behavioral Health and Developmental Disabilities (DBHDD) as well as fruitful conversations with provider agency staff, individuals receiving services/supports, their families and their advocates, including members of the Judiciary. Parties' meetings were held until March 2015, the beginning of the Parties' negotiations on a possible extension to certain provisions of the Agreement. When convened, these discussions were collaborative, informative and focused on important issues of concern to both Parties.

The attached reports from the Independent Reviewer's subject matter consultants describe the methods each used to obtain and confirm data and other forms of information.

The Independent Reviewer organized the work performed to review individuals with a developmental disability. Access to individuals, sites and documents was coordinated with and assisted by the Director of Settlement Services. There were several discrete components to these efforts.

First, the list of forty-eight individuals reviewed by the Independent Reviewer and her nurse consultants in 2011, the first year of the Settlement Agreement, was retrieved. The statistician consulting to the Independent Reviewer drew a random sample of twenty-one individuals from the list after the names of three deceased individuals were removed as well as the name of one individual who has asked to be excluded from further review. (After a difficult transition, this young woman is now very successfully living in a group home in Region 2. She is an active member of the Pioneer Project Advisory Group.) Each of the selected individuals was assigned for review to either a nurse consultant or a behavioral psychologist, depending on the major issues identified in their 2011 review. (Both nurses, Marisa Brown and Shirley Roth, have Masters degrees in nursing and both have over thirty years of experience in the field of developmental disabilities. The psychologist, Patrick Heick, is a Board certified Doctoral level Behavior Analyst. He worked with DBHDD's behavior analyst at the time to develop the criteria to be monitored in the Behavioral Interventions section of the Monitoring Tool. The Monitoring Tool and its Interpretive Guidelines have been agreed to by DBHDD and, in fact, have been used with Regional staff.) Twelve individuals were assigned to the "Health Group"; nine individuals were assigned to the "Behavioral Group." Site visits were conducted to each of the selected individuals; the individual was seen at either the residential or day program and the Monitoring Tool was completed based on observation, interview and document review.

In addition, two individuals who were not institutionalized previously and are now receiving residential supports under the Home and Community-Based Services Waiver were randomly selected for review by a nurse consultant. Each received the same level of examination as the individuals described above. Another two women, previously institutionalized in Region 4 and identified in DBHDD monitoring records as at-risk for weight loss, also were selected for review by the nurse consultant.

Second, after it was learned that certain individuals had been placed in Crisis Respite Homes for lengthy periods of time, the Independent Reviewer selected four individuals for review by Dr. Heick. The selection was based on the length of time in the Crisis Respite Home. Both the Independent Reviewer and Dr. Heick made site visits to the two Crisis Respite Homes. In addition, two other individuals, who were seen by a Mobile Crisis Team in Region 1, were selected for Dr. Heick's review after a site visit made by the Independent Reviewer and her consultant on crisis services, Stephen Baron.

Third, the Independent Reviewer asked Dr. Heick to review the two men who were recently placed through the Pioneer Project. Dr. Heick interviewed the men and visited their home.

Finally, the Independent Reviewer asked that three individuals be reviewed to determine the current status of each and whether, if applicable, their community residences appeared to be supporting their needs. The Independent Reviewer and the Director of Settlement Services have followed the two men quite closely over the five years of this Agreement. The third individual is a young woman who was one of the three minors referenced in the Settlement Agreement.

In total, there were 36 individuals with a developmental disability reviewed for this Report.

Copies of all completed Monitoring Tools have been shared with the Parties.

OBSERVATIONS AND FINDINGS

Selected Issues Related to the Support of Individuals with a Developmental Disability

A. Crisis Services:

The Settlement Agreement requires that by July 1, 2014, the State develop and implement an array of community-based crisis services. These interventions include six mobile crisis teams and twelve Crisis Respite Homes. As documented in last year's Annual Report, the provision for mobile crisis teams has been in compliance since July 1, 2012 but the State operationalized only eleven Crisis Respite Homes. It was found in non-compliance with that provision [III.A.2.c.ii.(B)(2)]. As of July 1, 2015, the State remains in non-compliance. There are eleven Crisis Respite Homes and one new contract for a site in Warner-Robbins (Peach County), GA. That Crisis Respite Home is projected to be in use by the latter part of 2015.

However, the review of crisis services conducted in preparation for this Report has identified even deeper concerns. The Independent Reviewer and her consulting psychologist have confirmed that Crisis Respite Homes have been used for long-term residential placements instead of their intended purpose of seven to ten days of respite care. Confirmation of this fact was reached after site visits by the Independent Reviewer and the Director of Settlement Services to eight of the eleven Homes. Further, an intensive review was completed of four individuals who are now placed in Crisis Respite Homes in Region 2. Site visits to and interviews with both the individuals and their staff documented that:

- S.G.'s stay in the Crisis Respite Home has exceeded 2.5 years. There are no plans for an alternative placement.

- T.F. has been living in the Crisis Respite Home for over six months. A placement plan has been discussed but was not approved at the time of the site visit.
- F.D. has been placed in the Crisis Respite Home for fourteen months. There is no alternative placement plan in place. (He was not in crisis at the time of his admission; he had asked to leave his current provider and this option was used as the alternative.)
- T.H. has been in the Crisis Respite Home for more than three years, since June 12, 2012. There are no plans for his discharge; in fact, during the site visits, it was stated that T.H. should remain there since he has formed trusting relationships with the staff.

The Independent Reviewer met another individual, B.B., who has been in the Crisis Respite Home for eight months. This was her third admission. The previous admission lasted nine months. B.B. was not reviewed in depth; staff at the Crisis Respite Home reported that another placement was being explored but was not finalized.

The review of the first four individuals referenced above documented that none of the individuals had a current Behavior Support Plan. There was no guardian/individual involved in any planning for a Behavior Support Plan. There were no descriptions found of the staff training required for work with these four individuals, except in emergency situations, and, therefore, no evidence of training in positive behavioral supports. In fact, the lack of involvement by trained Behavioral Specialists was notably disturbing.

Although reasonable measures certainly must be taken to minimize risk that may be present during a crisis situation, it is important to emphasize the restrictions and the sterile environments experienced in these Crisis Respite Homes, originally designed for short-term placements. There is plexiglass over the televisions and there are no mirrors. Furniture, with the exception of dining room chairs, is bolted to the floor. In two of the three houses referenced above, there is no cooking or preparation of meals. Food for all meals is prepared at either a nearby hospital or day program and delivered to the houses. (The very thoughtful manager of one Crisis Respite Home has planted a garden so that there may be some fresh vegetables.) Space for personal belongings is very limited and there is a notable absence of any personalization. For example, despite the fact that B.B. has had two admissions of at least eight months each, her belongings were crammed onto a small shelf in an alcove of her bedroom wall. She had no dresser and no chair.

The Independent Reviewer has provided DBHDD with examples of less restrictive and more amenable crisis program environments. This provision has been found to be in non-compliance because the twelfth Crisis Respite Home was not operational by July 1, 2015 and because there is clear evidence that these residences are being used for lengthy placement periods, far exceeding the seven to ten days established by policy.

Again, it is strongly recommended that DBHDD complete an intensive review of the use of these houses and prioritize the development of appropriate community-based alternatives for individuals presenting with the need for other places to live.

It is also recommended that DBHDD perform a comprehensive review of its entire array of crisis resources for individuals with a developmental disability. After this thorough analysis, it may be valuable to convert some of the Crisis Respite beds (developed under the terms of the Settlement Agreement) into more specialized residential placement options.

Since the issuance of her draft Report, the Independent Reviewer has been informed that DBHDD intends to begin this comprehensive review in October 2015.

B. Supports for Health Care:

The twelve individuals randomly selected for the reviews by the nurse consultants lived in group homes (8), host homes (3) and with their family (1). (Two of the women lived in the same house as the young woman who was placed from the State Hospital as a minor.)

Four of these individuals (33%) had moved at least once since their discharge from the State Hospital. This is important information given the risks of transfer trauma.[8] In addition, these changes in placement raise questions about the adequacy of transition planning or the sufficiency of the placements themselves. For example, one individual was brought back to his family home due to serious concerns about care in his original placement.

All reports have been forwarded to the Parties. As documented in the nurse consultant reports:

- Two of the twelve individuals received nursing care that did not meet professional standards of care. One individual (C.P.) was referred to DBHDD for further attention. He was experiencing weight loss and blackened stools. There was insufficient attention to these concerns by the nursing staff at this individual's residence. Regional staff investigated the situation and found that, following the nurse consultant's visit and expressed concerns, C.P. had been taken to his physician for further examination and tests. (The results of those tests are not known at this time.) In the other situation, the family of B.M. voiced concern that their brother's physical changes (toe drop) had not been addressed.

[8] Transfer Trauma is a well-researched and documented risk. Avoidance of transfer trauma requires careful planning and support by trained staff. According to information provided by DBHDD, of the 430 individuals with a developmental disability transferred from State Hospitals and now living in community settings, 76 (18%) have changed providers since discharge and 66 (15%) have moved within residential settings under the responsibility of the same provider.

- The three Host Home families for E.L., W.C., and R.T. were observed to provide conscientious care. In addition, it was noted that the individuals had become part of an extended family and were treated with consideration and affection.
- The two women (Cy.P. and M.A.S.) who lived in the same house, along with the young woman placed as a minor, were noted to have a very competent team of nurses providing support. There was evidence of strong coordination in addressing health issues. It was noted, however, that no active treatment was observed in the five hours of the site visit.
- The man (J.M.) living with his sister was noted to require more support than his sister was currently receiving. She raised concerns about the ISP process, the turnover of direct support staff helping her to care for her brother, and the lack of reliable transportation. This individual needed adaptive equipment and environmental modifications, including a communication device and a ramp. (DBHDD has informed the Independent Reviewer that the concerns about adaptive equipment and environmental modification now have been addressed.)
- Nursing staff working with medically complex individuals in two sites asked the nurse consultants for more guidance about minimizing the risk of aspiration pneumonia. It was highly recommended by the Independent Reviewer's nurse consultants that training on this subject be expedited and resource materials be widely distributed. Although aspiration pneumonia is not wholly preventable, there are specific steps, including increased oral hygiene, which can help to reduce its occurrence in vulnerable individuals.
- There were concerns, including a risk for pica and the failure to use her communication book, cited about the day program for Z.C.

C. Behavioral Supports:

The nine individuals reviewed in this cluster lived in group homes (3), Host Homes (3), with family (1), in a crisis respite home, until removed by DBHDD (1), and in the State Hospital (1).

Three of the individuals (33%) had been relocated from their original placements.

The reports from these nine reviews have been forwarded to the Parties. Notable findings included:

- The individual (J.R.) residing in the State Hospital has been confined there since May 31, 2014—more than fourteen months. He has Behavioral Guidelines rather than a more robustly developed Behavior Support Plan. He has been in the community only twice since his admission. On both occasions, his behavior was appropriate. However, he

shows a reluctance for social interaction, perhaps because has difficulty with expressive language. He has limited opportunity for skill development. There is no current plan for his discharge from the State Hospital.

- The Host Home provider for one individual (M.F.) has supported him since his 2010 discharge from the State Hospital. He has made numerous repairs to his home due to the individual's undesired behaviors (urinating, sometimes volitionally, on the bed, floor and his clothing.) There was a strong smell of urine in the bedroom. The Behavior Support Plan was current but there were significant gaps noted, including the identification of positive reinforcement.
- It was observed that staff was vigilant and cautious in observing one individual (M.G.) for pica. As a result of their high level of management, there has been an absence of pica. In addition, the individual's elopement and property destruction behaviors have not been an issue.
- An individual (D.B.) who lives with his family and receives in-home supports is waiting for Medicaid authorization for a swallow study. His Behavior Support Plan does not address his hoarding or self-injurious behavior. As a result, this individual's mother has installed a monitoring device so she can be alerted if her son gets up during the night.
- Finally, one individual (C.B.) in the sample reviewed by the Independent Reviewer's behavioral consultant was reported to DBHDD due to the perceived risks in her host home respite setting. The risks were related to her behavior, the lack of trained staff and the absence of appropriate behavioral programming. After the Independent Reviewer's telephone call, DBHDD took immediate action and removed C.B. to a Crisis Respite House.

D. Additional Reviews:

At the Independent Reviewer's request, there were fifteen targeted reviews completed in addition to the twenty-one randomly selected reviews discussed above. Four of these reviews were referenced in the section regarding crisis services. The other reviews included:

- Two individuals with a developmental disability received crisis intervention from a Mobile Crisis Team and Crisis Respite Home in Region 1. One individual (O.B.) was in jail and, during his interview, described his personal goals for an apartment, a job, and a girlfriend. He will need considerable support to accomplish these goals, which staff think are unrealistic. There was no plan in place for the supports he will require after he leaves jail. It was assumed that he would be placed in a crisis home. The second individual (S.G.) is dually diagnosed and had been admitted to a State Hospital. She declined an attempt to interview her shortly after the interview began.

- One of the individuals placed in 2011 (M.S.) experienced very short community tenure. His provider at the time stated that his discharge was not adequately planned. The Independent Reviewer has followed his treatment trajectory for five years now. He remains confined to the State Hospital and, although his name is on the Region 2 transition list, it is reported that there are major barriers to his release from the Hospital. Although M.S. is not a forensic client, he was placed on a forensic unit based on his treating professionals' opinion that he required more structure than available on the non-forensic units. The Independent Reviewer has noted several times that this is a rights restriction. The decision should be reviewed, especially if M.S. is to move towards discharge in a reasonable period of time.
- A nurse consultant reviewed two women (B.Y. and J.G.) in Region 4 who were reported to have weight loss concerns. Although the provider had been cited for numerous deficiencies at one point, there were no deficiencies in care noted during the site visit.
- A nurse consultant reviewed the young woman (A.C.) included in the group of three minors. She is thriving in her community placement and was described as receiving excellent nursing care. She has gained weight and grown in height. Although the nursing care was very attentive, she has been hospitalized three times for aspiration pneumonia and needs to be watched carefully during meals to minimize risk, as described in her mealtime protocol.
- Both the Independent Reviewer and the Director of Settlement Services have monitored the several precarious community placements of an individual (R.B.) who requires careful attention by trained staff. His last placement, in a crisis host home, raised serious concerns. He was noted to be at risk of falls and choking. As a result, he was transitioned to another provider agency. He was recently observed to have adjusted well to his new surroundings, housemates and staff. The Independent Reviewer had hoped to document his entire history of community placements but his records have not been safeguarded during his changes in placement and there is scant evidence now of his past experiences. It has been recommended that DBHDD take definitive actions to secure records.
- A nurse consultant reviewed two men (R.G. and K.T.) who receive Waiver-funded services and entered services from the community. Both men live in Host Homes. K.T. was placed into his new residence in May 2015. It appeared to be a supportive setting with a number of community experiences, including plans for line dancing. R.G. has lived with his host family since he was six years old. He is now twenty-seven years old and is clearly an integral part of the family. There were no issues or concerns noted at either site.
- The Independent Reviewer's consulting Behavioral Analyst reviewed the two men (G.J. and A.S.) who have most recently been transitioned from State Hospitals to community

placements under the guidelines of the Pioneer Project. Both men expressed satisfaction with their new home and activities. The preparations for their transitions were well thought out and there now appears to be many positive experiences in their daily lives.

These reviews reflect a cross-section of the issues discussed in this Report. The findings range from situations that could or do present risk to the individual to residential settings that offer a nurturing environment with trusting relationships. It is hoped that these examples will provoke thoughtful discussion and be the catalyst for concrete actions to enhance the quality of community supports.

Finally, it will be noted that the Compliance Chart has a rating of Non-compliance for two provisions regarding Quality Management (III.A.4.d and IV.A.) because of the lack of information available to the Independent Reviewer regarding the corrective actions taken to address the negative findings from the QEPR. In addition, the "interim Quality Management Report" stated that the "crisis data shows that the system is operating as it should, with the individual receiving crisis supports in the least restrictive environment as possible…" [9] This is inaccurate. The review of long lengths of stay in residences designed for short-term stays undercuts this assumption.

Selected Issues Related to the Support of Individuals with a Serious Mental Illness

Many of the findings from this year's review of community mental health programs have been discussed or highlighted throughout this Report. Although specific details and examples will vary across the various components of the mental health system, there are several overarching themes that can be identified:

- Continuing education is required throughout the mental health system to move away from the concept of a "readiness model" that arbitrarily establishes prerequisites for greater independence and self-determination. This barrier to a recovery-oriented system of care has been highlighted repeatedly throughout the last five years. In addition to training that is value-based, there needs to be pragmatic examples of successful programmatic strategies for supporting an individual who wishes to have his/her own apartment, for example. The work done by the Beck Institute, funded by DBHDD, is an excellent example of teaching and mentoring new approaches that will have a substantial impact on an individual's recovery from mental illness. The transformation of this work from out-of-state consultants to a locus within Georgia is also illustrative of how practices can be encouraged to change.

[9] See page 14 of the "Interim Quality Management Report."

- Interagency collaboration has been a definite strength in the work to increase supported housing and supported employment. The collaboration between advocates, community providers, DBHDD staff and local jails, such as the Nick Project and the Gwinnett County initiative, are examples that could be expanded statewide, if resources were available.
- Continuity of care across the discrete components of the mental health system will require continuing attention, if reforms are to be sustained. Now that the building blocks of the mental health system are largely in place, it would be useful to take a step back to look at whether the system works as a whole.
- The impact of the systemic reform still needs to be captured through outcome data and data that demonstrate cost-effectiveness. The measures should stretch beyond what is presently done. For example, a reduction in jail days and Emergency Room visits may be as important to quantify as a reduction in the use of state hospital beds.
- The examination of State Hospital discharge practices must be continued, even after the end of the Settlement Agreement. In particular, the lengthy hospital stays of individuals with a dual diagnosis of mental illness and a developmental disability require careful scrutiny, preferably by practitioners who are independent of the system. An additional area of focus should be discharges from hospitals to shelters. This year, the Independent Reviewer interviewed two operators of shelters for homeless adults in Regions 1 and 3 and confirmed that this practice continues to occur, sometimes with very damaging results.
- The State's plans for sustainability should be discussed with key stakeholders. As noted in at least two consultant reports, there are concerns about the cessation or reduction of funding. These concerns should be addressed.
- There should be known consequences for repeated failures to perform to expected standards. This was referenced in the consultant report on Assertive Community Treatment but it applies to other components of the mental health system as well. (DBHDD has informed the Independent Reviewer that the continuing development of both the Office of Accountability and Compliance and the Office of Quality Improvement and Provider Management is the proposed solution.)
- Now that the foundation of the mental health system has gone beyond the initial stages of construction, it would be valuable to investigate other models for discrete program elements. For example, the Crisis Stabilization Units have a distinctly institutional quality with nursing stations and other characteristics of State Hospital admission wards. Effective treatment and safety can be maintained in more welcoming environments, especially with the presence of peer mentors. The recent redesign of the crisis apartments to include some one-bedroom units is an example of a positive action taken by DBHDD.

These themes are meant to help strengthen the system, even as the numerical and programmatic requirements included in the Settlement Agreement are sustained. There is an opportunity now to think into the years ahead and to envision what additional actions can be taken to refine the system's design and to increase its responsiveness to its constituents.

CONCLUDING COMMENTS

As discussed in earlier sections of this Report and as described in detail by the Independent Reviewer's subject matter consultants, this fifth year marks a turning point in the evolution of Georgia's mental health system. The building blocks for a comprehensive system have been put into place and have set the stage for the next set of reforms.

These reforms must focus on ensuring equality of access for all individuals with a serious and persistent mental illness. In addition, members of the advocacy community have suggested that there be enhanced efforts to expand cultural and linguistic access by engaging bilingual or trilingual licensed clinicians. These professional resources are not widely available and will require creative recruitment and retention strategies. At this time, for example, it was reported that Assertive Community Treatment Teams have limited ability to work with the Latino community members who are experiencing mental health challenges. Advocates have also recommended that there be an effort to inquire whether consumer members of Assertive Community Treatment Teams feel supported in their roles and that actions be taken to address any expressed concerns.

The reports prepared by the Independent Reviewer's consultants have stressed the need to continue to incorporate a recovery orientation into every aspect of the mental health system. While there have been significant efforts noted, especially in the past year, ongoing instruction and direction are still essential at this stage in the system's evolution. It will be important to provide further education about the principles of and strategies for recovery to the Courts, housing providers, the staff of community agencies and other key stakeholders.

The initiation of the Administrative Services Organization now permits DBHDD to collect and analyze data to an extent not previously possible. Throughout the last five years, despite valiant efforts by Departmental staff, it has been difficult to capture sufficient data about outcomes. As the focus on sustainability sharpens in the next year, it will be critical to present evidence of the mental health system's reforms and the resulting impact on individuals, communities and the State as a whole. An inter-agency initiative to collaborate on outcome data would be very beneficial to advocates and other stakeholders interested in seeing cost-effective results.

Finally, while it has been challenging to retrieve certain outcome data, the use of the State Health Authority Yardstick (SHAY) has demonstrated, over this five-year period, that the State has facilitated the evolution and implementation of two Evidence-Based Practices. The overall scores for Supported Employment and Assertive Community Treatment have increased from 2.9 and 3.58 respectively in the earliest years to 4.6 and 4.4 in this fifth year. The requisite changes for these two Evidence-Based Practices have been incorporated into critical dimensions of the system's foundation. They now will need to be sustained.

This fifth year of the Settlement Agreement finds the system for individuals with a developmental disability to be striving to ameliorate substantial structural and programmatic weaknesses. Although there was evidence of harm in the early transitions from the State Hospitals, the gravity of the problems was not clearly recognized until the placements were suspended and a deeper investigation was initiated. It was important to suspend the placements; the Commissioner is to be commended for that decision.

Now, the reforms that are beginning to occur require additional time and resources, if adverse risks are to be minimized to the greatest extent possible. The Independent Reviewer strongly urges that additional time be granted for non-compliance to be cured. At this stage in the history of services and supports for individuals with intellectual/developmental disabilities, there are lessons that have been learned that can help shape the new direction and help avoid costly mistakes. The Priority Plan developed by the State outlines many of those lessons. The Pioneer Project includes those lessons in its strategies. However, there also must be a series of stringent timelines, specific outcome measures and a frank assessment of available resources, if the systemic reform is to move forward in a reasonable manner without unnecessary delay and risk.

Georgia is incredibly fortunate to have such a seasoned and committed advocacy and peer support community. The meaningful involvement of such respected and experienced people is especially valuable at this critical time. In the end, the strongest safeguards of quality will come from the knowledgeable and caring members of Georgia's own communities.

I would like to express my deep appreciation for all of the generous assistance, guidance and honest discussion that I have experienced from so many people over the last five years. It has been a privilege to be part of the reform efforts in Georgia and, in my role as Independent Reviewer, to participate in the building of community alternatives to institutions.

2015 RECOMMENDATIONS

There are recommendations included throughout this Report. They include the following:

- In order to ensure the implementation of Individual Support Plans, as required under this Agreement, DBHDD should consider expanding the number of Integrated Clinical Support Teams (ICSTs) throughout the State.

STATUS: the Department's leadership has agreed to consider this recommendation and has held an initial discussion with the Independent Reviewer about it. The discussion wil be continued at a meeting scheduled for September 29, 2015.

- In order to meet statewide demand, there should be consideration of the retraining and reassignment of other clinical professionals currently working within the system.

- In order to ensure timely community placement for currently institutionalized individuals with a developmental disability who are not medically or behaviorally complex, DBHDD should consider appropriate strategies, including comprehensive review by the Transition Fidelity Committee, to expedite the discharge process from State Hospitals. Individuals with previously identified community placements should be prioritized to prevent erosion of skills and to fulfill the individual's expectations for discharge.

- The roles and expectations for Support Coordination should be standardized statewide.

STATUS: DBHDD has reported that this change will occur in the second phase of the current cost rate study.

- DBHDD should continue to take definitive actions to promote continuity of care by cross-training providers responsible for the programs supporting adults with a mental illness.

- DBHDD should complete an intensive review of the use of Crisis Respite Homes and prioritize the development of appropriate community-based alternatives for individuals presenting with the need for a place to live. DBHDD should perform a comprehensive review of its entire array of crisis resources for individuals with a developmental disability.

STATUS: DBHDD has informed the Independent Reviewer that this review is scheduled to begin on October 1, 2015.

- The Independent Reviewer's nurse consultants have strongly recommended that statewide training on aspiration pneumonia be expedited and that the most recent resource materials be widely distributed to the provider community.

- DBHDD should take definitive actions to secure records.

- DBHDD is encouraged to continue to deliver competency-based training related to the implementation of a recovery-oriented system of treatment.

- Interagency collaboration should continue to be a priority and successful initiatives, such as the collaboration between advocates, community providers, DBHDD staff and local jails, as evidenced in the Nick Project and in Gwinnett County, should be expanded statewide.

- Now that the building blocks of the mental health system are largely in place, DBHDD and its stakeholders should take a step back to look at whether the system works as a whole.

- The impact of the systemic reform still needs to be captured through outcome data and data that demonstrate cost-effectiveness. The measures should stretch beyond what is presently done. For example, a reduction in jail days and Emergency Room visits may be as important to quantify as a reduction in the use of state hospital beds.

- The examination of State Hospital discharge practices must be continued, even after the end of the Settlement Agreement. In particular, the lengthy hospital stays of individuals with a dual diagnosis of mental illness and a developmental disability require careful scrutiny, preferably by practitioners who are independent of the system. An additional area of focus should be discharges from hospitals to shelters.

- The State's plans for sustainability should be discussed with key stakeholders. As noted in at least two consultant reports, there are concerns about the cessation or reduction of funding. These concerns should be addressed.

- There should be known consequences for repeated failures to perform to expected standards. This was referenced in the consultant report on Assertive Community Treatment but it applies to other components of the mental health system as well.

STATUS: DBHDD has informed the Independent Reviewer that the continuing development of both the Office of Accountability and Compliance and the Office of Quality Improvement and Provider Management is the proposed solution.

- Members of the advocacy community have suggested that there be enhanced efforts to expand cultural and linguistic access by engaging bilingual or trilingual licensed

clinicians. These professional resources are not widely available and will require creative recruitment and retention strategies.

- Now that the foundation of the mental health system has gone beyond the initial stages of construction, it would be valuable for DBHDD to investigate other models for discrete program elements. For example, the Crisis Stabilization Units have a distinctly institutional quality with nursing stations and other characteristics of State Hospital admission wards. Effective treatment and safety can be maintained in more welcoming environments, especially with the presence of peer mentors.

SUPPORTED HOUSING:

Below is a list of the earlier recommendations and actions. Explanations are provided if the recommendations were modified, developed further, still in progress and/or under review:

1. **Further develop and sustain Supported Housing capacity through the DCA-DBHDD Partnership:** In February's report, the State's progress to develop capacity through this joint arrangement was noted along with recommendations for steps to create capacity for up to 9,000 individuals in the target population who are in need of Supported Housing.

   - **DBHDD and DCA should establish a broad written Memorandum of Agreement (MOA) to meet current commitments and set "actionable" goals to expand Supported Housing resources.** As stated above, a comprehensive actionable MOA was completed in April 2015. Over time, this joint effort will do more than any other feasible activity for the State to reach its maximum supported housing capacity. As stated in the discussion section of this Report, the DCA commitment to "furthering fair housing" is both laudable and unique. Likewise the agencies' approaches to maximize resources are both sound and laudable. Completed

   - **DCA should request an extension of the HUD approved Remedial Tenant Selection Preference Agreement to enable the State to meet its future *Olmstead* obligations, including meeting capacity of up to 9,000 individuals with SPMI as defined in the current Settlement Agreement.** DCA and DBHDD made this request to HUD to extend the Preference Agreement beyond the June 30, 2015 expiration date. This request was granted on April 23, 2015 for the time period necessary for the State to meet its housing obligation under this Agreement. Completed

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

their 2015 QAP as part of their overall QAP strategy for meeting their *Olmstead* obligations and as furthered referenced below. In Progress

- **DBHDD was asked to examine their current working agreements (across each initiative) and to refine them to assure adequate resources are in place to maximize the HUD approved Selection Preference Agreement, to meet the 2013 and the 2014 811 PRA requirements and to meet any additional arrangements to implement the 2014 LIHTC program Integrated Supported Housing and Target Population Preference.** Completed

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

- **DCA and DBHDD should continuously evaluate the need for expanding housing resources.** As referenced in this report, DCA has added incentives in the QAP; they and DBHDD are working with PHAs to add Project Based Subsidies to LIHTC funded projects (with a disability preference). DBHDD has asked the two "moving to work" PHAs, Macon and Atlanta, to offer HCVs to individuals in the GHVP. As these initiatives are further developed, DCA and DBHDD will have more precise projection of their potential expanded capacity for the next 24-48 months depending on award and production schedules. In Progress

- **DCA should assume responsibility for GHVP inspections which consolidates this function in one place. There may be other functions that need to be consolidated across agencies to maximize sustainability as the program continues to grow. For example, 811 PRA referral processes should be the same or as similar as possible with HCV referrals. DCA and DBHDD should work out how housing search will work simultaneously across these two programs**. DCA and DBHDD are jointly developing a uniform referral process and DBHDD has suggested the Georgia Mental Health Consumer Network take on responsibility for managing GHVP-HCV transition administrative tasks and reauthorization tasks in concert with service providers. In Progress

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

3. **DBHDD should assess the potential for increasing referrals from hospitals, intensive residential settings, group homes and personal care homes.** The number of referrals

from hospitals and intensive residential settings has increased but DBHDD depends on referrals from discharge planners and may be unaware of the potential for more referrals. As referenced in February 2015, DBHDD should be constantly targeting these settings for referrals. The same is true for personal care and group homes where low numbers of individuals being referred may or may not reflect the true need or that consumers are given a choice to move. It may be more a reflection of perceived "readiness" or concern on the part of providers that they may lose revenue. Through the newly developed Needs and Choice Evaluation, DBHDD is positioned to track these referrals more closely and provide training and technical assistance where necessary to increase referrals. In Progress

4. **Assessing Need**

   - **Implement process to determine need now and in the future:** DBHDD is well underway with its Supported Housing Needs and Choice Evaluation but this process is complex and will require at least two to three more months to complete. One issue DBHDD is just now adding to their protocol is a baseline assessment of individuals exiting jails and prisons. In Progress

   - **Establish objective criteria for determining need:** Based on the June 1, 2015 Policy and in recent discussions and observation, DBHDD is following through on this recommendation and implementation will occur in the Post Baseline Phase of the Needs and Choice Evaluation. In Progress

   - **Project Capacity and Need for the future.** Based on progress to date and the need for more time to evaluate capacity and need, a finding of Capacity and Need is not being made at this time. However, there are positive signs that this finding can be made during this fiscal year. DBHDD should continue to implement its planned actions. In Progress

5. **Quality and Performance Improvements.** It is recommended that DBHDD and DCA establish performance benchmarks in FY 2016.

6. **The State should make certain that GHVP is resource of last resort.** The State has made good faith efforts to include this provision in their MOA and in their work with PHAs and Regional Transition Coordinators and providers. Making progress.

7. **DBHDD should develop stronger ties across its own programs**. In the 2014 report, a recommendation was made to link the ACT, Supported Employment and Supported Housing strategies, operations, requirements, care management, fidelity or other reviews, expectations and/or training to build stronger ties among these initiatives to improve overall performance and outcomes. The 2015 site visits amplify the urgent need for stronger ties across these initiatives.

DBHDD is taking the opportunity of the Supported Housing Needs and Choice Evaluation to offer more training and create a curriculum for building provider capacity and doing it in a manner to develop stronger ties. Embedding the DBHDD Supported Housing Unit more deeply in the DBHDD Office of Adult Mental Health is a positive move. It is recommended that DBHDD focus on strengthening ties across the forensic initiatives and add technical assistance to the Housing Needs and Choice Evaluation initiative, as training is important but not likely sufficient to improve overall performance to the level needed for this initiative to succeed.

DBHDD and DCA are exploring an additional contract with the Georgia Mental Health Consumer Network for critical administrative tasks. This is also an ideal time to further embed supported housing services interventions into the Certified Peer Specialist certification curriculum and to explore additional options for Certified Peer Specialists to be direct service providers, in addition to managing administrative and evaluator functions.

8. **DBHDD should continue to include individuals with intellectual disabilities as a priority population for its new initiatives**. Making Progress.

DISCHARGE PLANNING:

1. There should be training of all clinical staff, both in the Hospital and for the Regional staff responsible for transition planning, on the DBHDD policies related to transition planning so they know and understand their role and the role of others as recommended.

2. DBHDD should create a database that tracks all Court, treatment meetings and assessments so that important forensic deadlines are stated, evaluations are completed timely and clinical decisions can be thoughtfully prepared.

3. Risk Assessments must be reviewed for clinical sufficiency. Specificity about the current risk factors, and what supports, environment, and skills can be used to mitigate their likelihood, should be standard across all risk assessments.

4. DBHDD must address the serious vacancy issue among most of the clinical disciplines necessary to appropriately plan and effectuate discharge for forensic clients. While forensic status individuals require the expertise of each discipline, the existing clinical staff is called upon to opine on individuals who they may not know well and to sometimes testify on important legal/psychiatric issues without the benefit of time necessary to know the individual.

5. DBHDD should immediately state that all individuals who are ready for discharge should be in the most integrated setting. The Department must, through policy and practice,

demonstrate that housing choices are individualized, taking into consideration all the important domains that reduce risk and increase the likelihood of success.

DBHDD should determine the amount and type of housing options needed for those in forensic status.

6. DBHDD should regularly offer to train the Court, the defense bar, prosecutors and providers regarding behavioral health issues and forensic status. Familiarity and ongoing conversation is needed among all parties.

CRISIS SERVICES:

1. DBHDD leadership should ensure that there is a robust comprehensive crisis system in place that produces regular data reports that are widely shared; that the reports measure the critical components of the system including, but not limited to, timely access to care and the utilization of community based crisis services; that problems are identified in a timely manner and addressed; and that roles and responsibilities for problem solving are well known throughout the Department, with other State agencies, as well as with family members, advocates, law enforcement and other key stakeholders.

2. Addressing the crisis service needs for individuals with a developmental disability must be a priority.

    - Based on the relatively small number of individuals seen more than once by the mobile crisis teams (556) as well as the number of individuals staying far more than the initial seven day limit of the Crisis Respite Homes, a process needs to be put place for formal planning and problem solving for individuals with developmental disabilities who have complex needs and challenges that must be addressed in order for them to have a positive quality of life in the community.
    - While recognizing the geographic challenges of a large state such as Georgia, the State should evaluate if it is offering the right range of services to meet the crisis and immediate needs demands of individuals with developmental disabilities. The State should re-evaluate the way it offers services to see what services are missing and what should be retained. For example, is it cost effective to offer forty-eight beds through the Crisis Respite Homes that have such low utilization rates or are there more efficient ways to utilize these resources that could better address the needs of individuals with developmental disabilities.

STATUS: DBHDD has informed the Independent Reviewer that its review of the crisis service system will begin on October 1, 2015.

3. The Department should continue to support the CSBs to provide open access. The State should determine if it should strengthen its current policy of strongly encouraging same day access to services and, if it does, the State needs to understand the fiscal impact to CSBs as well as the possible return on this investment to the State on using less costly ambulatory services that have some potential to reduce more expensive services offered by BHCCs, CSPs, or other acute inpatient service.

4. The State should determine the number of CSP beds needed statewide and also review if there is any potential revenue from third-party payers that may be available to CSPs.

5. It would be very beneficial for DBHDD to address stakeholder concerns about access and information and to develop viable ways of sharing data about the use of crisis services and their effectiveness with the larger community.

ASSERTIVE COMMUNITY TREATMENT

Areas for improvement remain, including:

1. Sustainability concerns with regard to outcomes monitoring and Medicaid.

    - Although the State did a small evaluation of the impact of ACT on hospitalization over time, this work needs to continue, with an examination of other outcomes, wider sampling methods, and answering other key questions from stakeholders. In addition, the Independent Reviewer's consultant met several consumers with success stories that exemplify the personal impact on consumers underlying the quantitative outcomes in graphs. Both methods should be highlighted for various stakeholder groups in a way that depicts what ACT services can do in Georgia.

    - Some sites reported improvements in Medicaid penetration across ACT caseloads, while others still struggle. The State should continue to work with providers using tools developed for fiscal planning and offering Medicaid enrollment support via regional office staff.

2. Recovery orientation of ACT should continue to be a focus, although much effort was exerted in training and onsite technical assistance and found useful this past year by several teams. Future work could include engaging teams or individual staff that exemplify recovery-oriented ACT to work with other teams, such as offering peers the opportunity to network and shadow strong peers in the field (e.g., one peer observed on a site visit was particularly good at engaging a new consumer).

- Emphasize independent living options for ACT consumers – some teams still seem resistant to this idea while others appear to be doing a good job of helping consumers live independently or semi-independently after periods of long hospitalization.

- Emphasize supported employment and good job development skills for ACT employment specialists. Although the role of the ACT employment specialist was properly clarified this year, most ACT employment specialists continue to struggle with how to do this work (e.g., how to perform proper job development for this population) and maintain productivity standards.

- Re-emphasize the goal of ACT services as person-centered, relationship-centered, intensive mental health services as opposed to getting consumers to take medications. These sentiments vary widely across teams and across staff within a single team.

3. Although progress in the specification and follow-up with corrective action plans was noted this year, continued progress should be to define consequences for repeated non-compliance with DACTS standards in the event this becomes necessary.

SUPPORTED EMPLOYMENT

1. Given the approaching end of the "Settlement Agreement," it is strongly recommended that DBHDD leadership develop a concise SE plan that focuses exclusively on sustaining the progress that the Department and its partners have made in the development of SE services and the infrastructure to support those services. This plan should describe all efforts and strategies underway to diversify and secure funding for SE providers after the completion of the "Settlement Agreement" as well as other activities at the state-level to secure and develop strategic partnerships with agencies like the Georgia Vocational Rehabilitation Agency.
2. It is recommended that DBHDD consider developing a written post-settlement SE document that describes the planned funding integration methods. It is also recommended that DBHDD continue its existing outreach efforts to engage SE providers in a hearty dialogue about TORS funding and SE services.
3. In order to maintain the successful progress that has been made to integrate fidelity measures into the DBHDD system, it is vital for DBHDD leadership to find ways to address and remediate these provider concerns and questions regarding SE fidelity.

RECOMMENDATION SUMMARIES

NOTE: Each year, since 2012, the subject matter experts working with the Independent Reviewer have included recommendations in their respective reports. All of those recommendations will not be repeated here. However, the recommendations described below draw from the findings of the expert consultants as well as from the Independent Reviewer's own observations and experiences.

SUMMARY OF YEAR FOUR RECOMMENDATIONS (September 2014 Report)

The following recommendations were included in the Independent Reviewer's FY 2014 Report. A brief update of the current status of each recommendation is noted below in bold type:

Recommendation One:

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

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

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

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

Current Status: The Independent Reviewer's Supplemental Report, dated March 17, 2015, was filed with the Court, as recommended above. The report contained a review of the actions taken by the State to begin to address acknowledged deficiencies in the community-based systems of support for individuals with a developmental disability. The report also included documentation of the progress made by the Department of Behavioral Health and Developmental Disabilities (DBHDD) in improving the performance of certain Assertive Community Treatment (ACT) teams and in continuing its efforts to achieve full compliance with the Settlement Agreement's provisions regarding supported housing. The Supplemental Report's findings were discussed multiple times in the Independent Reviewer's meetings with the State as well as in the meetings held with the State by her consultants in supported

housing, Martha Knisley from the Technical Assistance Collaborative, and in Assertive Community Treatment, Dr. Angela Rollins, Research Director for the ACT Center of Indiana.

Recommendation Two:

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

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

Current Status: The Independent Reviewer retained the expertise of Dr. Patrick Canavan, then Director of St. Elizabeths Hospital in Washington, D.C., to advise her on the accessibility and availability of community-based services and supports for individuals with forensic histories, as defined in the Settlement Agreement's target population. He was greatly assisted by DBHDD staff and legal advocates in obtaining the information he needed. His work is under discussion with the Parties.

Recommendation Three:

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

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

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

The Independent Reviewer is in the process of retaining an expert consultant to assist her in the review of crisis services for individuals included in the target population for the Settlement

Agreement. She requests that the Department (DBHDD) identify the appropriate staff to work with her as she plans and implements her work related to crisis services.

Current Status: The Independent Reviewer retained consultation from Stephen Baron, former Director of the Department of Behavioral Health in the District of Columbia and former President/Chief Executive Officer of Baltimore Mental Health Services, a public mental health system. Mr. Baron reviewed crisis services for both individuals with a mental illness and those with a developmental disability. His report is attached. Mr. Baron's recommendations were discussed with the State on September 4, 2015. Mr. Baron was provided with timely and responsive assistance from the leadership of DBHDD.

Recommendation Four:

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

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

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

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

Current Status: As discussed in the attached report by the Independent Reviewer's consultant for supported housing, Martha Knisley, extensive work is underway to reach compliance with this Provision. Numerous discussions have been held with the leadership of DBHDD in order to design a strategic process for achieving the requisite capacity. The work regarding Needs Assessment and Choice has begun but is not yet completed. The State has acknowledged that additional time will be required to reach compliance. Ms. Knisley continues to review the work of DBHDD and its sister agency, the Department of Community Affairs (DCA).

Recommendation Five:

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

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

Current Status: As referenced in the attached reports on Assertive Community Treatment, Supported Employment and Supported Housing by Dr. Rollins, Mr. Lynde and Ms. Knisley, respectively, there is evidence of an increased focus on moving the community mental health system towards a recovery-orientation. The efforts of the Office of Recovery Transformation and those of the Georgia Consumer Network have been instrumental to these efforts. It is recognized that these efforts must be sustained.

The Independent Reviewer and her consultants worked together and often conducted joint site-visits to ensure accuracy in their fact-finding and to obtain a deeper understanding of the complexities of the mental health system.

SUMMARY OF RECOMMENDATIONS (MARCH 2014 SUPPLEMENTAL REPORT)

Recommendation One:

As referenced earlier, there is an urgent need to develop and implement sufficient health practitioner oversight of the medically fragile individuals transferred from State Hospitals to community settings. Other state jurisdictions have had to confront similar challenges. As a result, there is a solid base of knowledge to draw from in designing appropriately individualized supports for this group of high-risk individuals. It has been recommended that the Department explore the development of a Medical Safeguards Project, such as those implemented in Pennsylvania and Massachusetts, to assist in the building of its oversight capacity. In addition, there needs to be further examination of the availability of clinical expertise in the community, including occupational and physical therapists, in order to ensure the availability of appropriate supports.

Current Status: This recommendation continues to require decisive and urgent attention if adverse risks are to be minimized/avoided. The development of the Integrated Clinical Support Team and the Pioneer Project are responsive to this recommendation but are currently operational only in Region 2.

Recommendation Two:

The Department took decisive action in removing individuals from poorly performing or negligent provider agencies. However, the options for new placements were limited and, thus, constrained the smooth and timely transition to other residential settings. The need for additional resources should be explored in order to ensure sufficient capacity for emergency situations involving an entire provider agency. In addition, the experiences with these three provider agencies should be the catalyst for additional review of provider agency qualifications once problems/concerns are initially discovered.

Current Status: This recommendation continues to require decisive and urgent attention.

Recommendation Three:

The Department's efforts to strengthen the transition process have identified the clear need to obtain a more complete understanding of those individuals still placed in State Hospitals. An updated assessment would permit more accurate planning for the development of community

resources. It is recommended that these assessments be conducted on a regional basis and that the findings be compared against the current availability of requisite resources, including clinical expertise.

Current Status: Although there has been the beginning of such assessments, this recommendation continues to require substantial attention.

Recommendation Four:

The Department should retain an independent consultant/consultant group to conduct mortality reviews for individuals placed under the Settlement Agreement. Independent review of any such deaths would strengthen the Department's knowledge about provider agencies and the availability/provision of critical supports.

Current Status: DBHDD implemented this recommendation, but only for individuals who have been placed from state hospitals under the aegis of the Settlement Agreement, when it retained the Columbus Organization. DBHDD has reported that it intends to learn from these reviews in order to improve its own investigations and to implement system improvements. It has begun this work and will continue to review it with the Independent Reviewer.

Recommendation Five:

The Department and the Independent Reviewer have agreed to develop a joint review process under the supervision of the Independent Reviewer. Details of team composition are still in the discussion stage but the process is anticipated to begin by early Summer 2014, in time for the preparation of the next Annual Report by the Independent Reviewer. The Department has increased the Independent Reviewer's budget to permit this work to commence.

Current Status: There was initial work implemented to address this recommendation. The Independent Reviewer and staff from Region 2 and 3 completed some joint reviews. However, the initiative was not sustained, primarily because of the other work assigned to the Regional staff.

SUMMARY OF YEAR THREE RECOMMENDATIONS (September 2013 Report)

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

Recommendation One:

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.

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

Current Status: The Independent Reviewer continues to recommend that the state hospital admissions of individuals with both an intellectual disability and a mental illness be tracked and analyzed, especially as it relates to length of stay and the efficacy of treatment modalities.

Recommendation Two:

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.

Prior Status: The Independent Reviewer and the Department discussed this recommendation. The Department had recognized that "crisis services are often the first point of encounter with the behavioral health delivery system for an individual or family, and can, therefore, set the future course of the individual's or family's attitude toward, and relationship with, the system." Stakeholder meetings held in October and December 2012 were followed by the formation of a Steering Committee that met from February to June 2013. Over the period of August 2013 through April 2014, a "Community Behavioral Health Crisis Continuum Strategic Plan" was developed by a Departmental workgroup that included staff from adult mental health, child and adolescent mental health, addictive diseases, suicide prevention and the Office of Recovery.

The Strategic Plan was based on the findings and recommendations of the Steering Committee. The Departmental workgroup has continued to meet quarterly to move forward the work required for the implementation of the Strategic Plan. The Independent Reviewer was provided a copy of the Strategic Plan. It outlines goals and timelines that extend until June 30, 2016. The Independent Reviewer and Departmental staff intend to meet periodically to ascertain progress towards these goals.

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

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

Current Status: The report of the Independent Reviewer's consultant has been completed and has been shared with the Parties. It was strongly recommended that the DBHDD prioritize a review of the crisis services for individuals with a developmental disability. This review is scheduled to begin on October 1, 2015.

Recommendation Three:

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.

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

Current Status: DBHDD and its sister agency the Department of Community Affairs (DCA) have forged an extremely effective working relationship. There also is evidence of strong

partnerships at the Regional level as the respective agencies collaborate to increase the availability of supported housing for individuals with a serious mental illness.

Recommendation Four:

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.

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

Current Status: As discussed in the most recent report by Ms. Knisley, these initiatives have continued to be implemented and there is evidence of strengthened collaboration as a result.

Recommendations Five and Six:

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

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.

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

Current Status: Both of these recommendations continue to require attention and concerted action in order to ensure maximum access to supported housing for individuals who are currently living in intensive residential treatment programs or who are currently confined to state hospitals, especially the forensic units, jails and prisons.

Recommendation Seven:

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.

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

Current Status: At this time, it is reported that more than twenty-seven individuals with a developmental disability have been provided Georgia Housing Vouchers through DBHDD. Region 5 has the greatest concentration with fourteen individuals so placed. This is very encouraging and these examples should be used as illustrations of this possibility.

Recommendation Eight:

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.

Prior Status: There is documentation that confirms the Department's efforts to increase collaboration between the programmatic components of its behavioral health system. For example, the agendas for monthly meetings/teleconferences with providers responsible for Supported Employment, Assertive Community Treatment, and Community Support consistently reflect discussion about understanding and using resources, including housing vouchers, available throughout the State's system. On January 15, 2014, providers responsible for these services as well as those responsible for crisis services and Intensive Case Management held a combined meeting/retreat to strengthen their collaboration. On February 20, 2014, providers of Assertive Community Treatment and Community Support met for joint training. On February

25, 2014, a training session on “Recovery-Oriented Engagement and Service Delivery” was held in Macon, Georgia. Further, the Quality Councils for Behavioral Health review the data, discuss the findings and issue recommendations. These efforts are positive and are commended. Nonetheless, continuing and expanded efforts are strongly recommended, especially in the area of recovery-oriented training. As discussed in the attached reports by Ms. Knisley, Mr. Lynde and Dr. Rollins, the understanding of recovery-oriented principles and practices appears to be uneven and some providers are in need of more intense support and supervision.

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

Current Status: Progress has been noted in this recommendation for increased collaboration towards a recovery-orientation in the various components of the mental health system. These actions are applauded; it is encouraged that they be continued and expanded.

SUMMARY OF RECOMMENDATIONS (September 2012 Report)

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.

Recommendation One:

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.

Prior Status: 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.

Current Status: This training was not continued as planned. Values-based training continues to be recommended by the Independent Reviewer as well as training in "practical' programmatic strategies to ensure meaningful community integration and participation for members of the target population.

Recommendation Two:

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.

Prior Status: 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.

Current Status: The use of host homes as an alternative to group settings continues to be recommended by the Independent Reviewer. The most recent reviews completed by her health and behavioral consultants have confirmed the very positive outcomes achieved in this setting with well-trained and well-supported host home providers.

Recommendation Three:

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

Prior Status: 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.

Current Status: As this fifth year comes to an end, the State has acknowledged its obligation to demonstrate sustainability. The Independent Reviewer encourages the State to continue

to reach out to stakeholders and to discuss its intentions and plans to continue to evolve and strengthen its array of services and supports for people in the target population. As noted in the most recent reports on supported housing and Assertive Community Treatment, there is evidence of concern and a need for reassurance with specific plans.

Recommendation Four:

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.

Prior Status: 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.

Current Status: This work continued as planned.

Recommendation Five:

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.

Prior Status: 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.

Current Status: This work continued as planned.

Recommendation Six:

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.

Prior Status: 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.)

Current Status: As discussed in the most recent report on supported housing by Ms. Knisley, the State either has addressed these issues and recommendations or is making progress in doing so.

Recommendation Seven:

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

Prior Status: 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.

Current Status: The access to integrated community opportunities for individuals in the forensic system continues to require attention and the implementation of remedial actions. The Independent Reviewer continues to discuss this recommendation with the Parties.

Recommendation Eight:

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

Prior Status: 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.

Current Status: As referenced above, to date, more than twenty-seven adults with a developmental disability have received supported housing through the provision of Georgia's housing vouchers. This opportunity continues to be important for heightened attention by DBHDD at the regional and State Office levels.

Recommendation Nine:

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

Prior Status: 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.

Current Status: This recommendation has been satisfied.

Recommendation Ten:

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.

Prior Status: 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.

Current Status: DBHDD continues to review rates and this matter continues to be under advisement.

Recommendation Eleven:

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.

Prior Status: 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.

Current Status: This recommendation has been addressed. DBHDD is encouraged to continue its training initiatives; they are well received.

Recommendation Twelve:

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

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

Current Status: This recommendation has been implemented.

Recommendation Thirteen:

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

Prior Status: 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.

Current Status: Although the Independent Reviewer has been provided with whatever information she has requested, it is recommended that the State continue to explore and implement effective actions for the prompt review and remediation of critical incidents. DBHDD is strongly encouraged to include independent oversight.

Recommendation Fourteen:

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

Prior Status: 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.

Current Status: This serious issue is not resolved. Recent reviews conducted by the Independent Reviewer document that individuals diagnosed with a profound intellectual disability or with impaired cognitive ability are still being asked to sign consent for medication and other treatment interventions.

Attachment B

ATTACHMENTS: CONSULTANT REPORTS

Supported Housing: Martha Knisley

Supported Employment: David Lynde

Crisis Services: Stephen Baron

Assertive Community Treatment: Angela Rollins

2015 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 14, 2015

Introduction

This report to the Independent Reviewer summarizes the progress of the Supported Housing and Bridge Funding programs required by the Settlement Agreement in United States of America v the State of Georgia (Civil Action No. 1:10-CV-249-CAP), referred to hereafter as the Settlement Agreement, for the period of February 1, 2015 through June 30, 2015.

An earlier Supplemental Supported Housing and Bridge Funding Report was submitted to the Independent Reviewer on February 16, 2015 describing the state's potential compliance with the Settlement Agreement requirements. This current report covers actions taken and reports generated by the State from February 1, 2015 to June 30, 2015, to demonstrate progress towards compliance with the recommendations made in February and this report includes seven recommendations for additional actions for the State to take to come into compliance and make improvements for the future.

Information analyzed for this report was obtained from written documents provided by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Georgia Department of Community Affairs (DCA); key informant interviews with the Amici and DBHDD staff, including interviews with Judy Fitzgerald, Chief of Staff, Monica Parker, Director of the DBHDD Division of Community Mental Health, Dr. Terri Timberlake, Director, Office of Adult Mental Health, Letitia Robinson, Office of Adult Mental Health Program Coordinator for Residential Support Services, Pam Schuble, Director of Settlement Services and Doug Scott, Office of Adult Mental Health Director of Housing on two separate dates and observation of one of the regional sessions of the "Housing First Training for Intensive Community Services and State Hospitals" held in Tucker, Georgia on June 24, 2015. This training is part of the DBHDD Housing Need and Choice Evaluation training sessions.

A meeting was held with Department of Community Affairs (DCA) Deputy Commissioner Carmen Chubb and key DCA staff, Judy Fitzgerald and key DBHDD staff. This review also included site visits to Thomasville and Columbus on July 23 and 24 that included meetings with Jennifer Dunn, Regional Services Administrator for Region 4, Sharon Pyles, Region 4 Transitional (housing) Coordinator and Sam Page, Region 6 Transitional (housing) Coordinator plus a home visit and drive by visits in Region 4 (Thomasville) and a meeting with community housing leaders in Region 6 (Columbus).

This report focuses on the State's progress in three areas: 1.) meeting the Georgia Housing Voucher Program (GHVP sometimes referred to as GHVs or GHV) and Bridge Funding targets by type of housing, number of subsidies funded, target population, scattered site and bridge funding requirements for the year ending June 30, 2015 and projected GHVP allocations for FY 2016; 2.) program implementation and expansion; and 3.) the State's progress to meet the July 1, 2015 requirement to "have capacity to provide Supported Housing to any of the 9,000 individuals in the target population who need such support."

Observations and Findings

1. Housing (GHVP) and Bridge Funding

Georgia Housing Voucher Program
The DBHDD continues to exceed GHVP numerical targets. DBHDD was required to "provide 2,000 supported housing beds by July 1, 2015." There were 2,428 individuals housed by the end of FY 2015[1]. This is the fifth year DBHDD has surpassed 110% of its annual leasing target. There were 1,623 signed leases in the GHVP on June 30, 2015. On July 1, 2015, 236 were "active" meaning they were in housing search status; other slots are still available but individuals not yet in "active" housing search.

The number of slots approved for funding and total number of individuals who were housed during the year is used to measure compliance. The metric reported annually is the number of housing referrals given; referred to as the "notice to proceed." The DBHDD Supported Housing Director verifies an individual is eligible for the program and the individual can proceed with the housing search. In FY 2015, 66% of individuals with a "notice to proceed" had signed leases before the end of the fiscal year[2]. Data is not reported on time from referral to "notice to proceed" but the pace of "notice to proceed" to leases being signed seems reasonably timely.

The number of people with signed leases on the last day of the fiscal year may be lower than the total number of individuals who were housed during the year because individuals are constantly looking for housing, moving in and leaving their homes. This "churn" process is predictable for any rental program although there is one cautionary note with the State's GHVP leasing numbers; the program only had an 81% occupancy rate on June 30, 2015. This means that on any given day, 19% of the subsidies are not in use although, as referenced above, 236 individuals were actively looking for housing at the end of the year.

There were approximately 10% of the leases cancelled, which is slightly but not significantly higher than the 8% cancelled in the previous year. Not all referrals resulted in individuals getting housing and some individuals were terminated or chose to leave the program during the year. This is typical but it will be important to continue to assess the "churn" rate[3] to fully assess the number of individuals seeking or leaving housing at any given time, the costs associated with the churn rate over time and the program's capacity to manage and reduce the churn rate.

The number of properties under contract in the past two years increased from 661 to 986, a 42% increase. Participants are living in GHVP arrangements in 88 different counties which is a 16% increase over the past year. The number of providers actively serving participants

[1] Georgia Housing Voucher and Bridge Funding Program Summary (7/02/15); most data in this section comes from this summary
[2] The primary reason that only 66% had signed leases is that "notices to proceed" can be issued until the end of the fiscal year and the individual was then signing a lease the following month or in the new fiscal year
[3] number of units being leased (new and turnover) and vacated during the year

increased substantially from 45 to 77 providers (30%) over the past two years. These figures are significant for two reasons. One, the program must be considered successful by local property managers and landlords for there to be this level of growth. The affordable housing rental community is generally well organized locally and information about this program often travels by word of mouth. If the view of the program was negative, this level of growth could not be achieved or sustained. Secondly, the growth to properties in 88 counties means that access is increased for individuals who choose to live in rural areas. Individuals typically have difficulty finding decent, affordable, safe housing in rural communities. This also means there are 71 counties where vouchers are not being used; these are rural counties. One Regional Transitional Coordinator reported he did not have a wait list. This means housing is available and not having a list is indicative of the Regional staff keeping up with their workload and having reliable housing sources in their communities.

In FY 15, 42% of participants had zero income and the monthly average rental payment was $407.81, down from the previous year; this is a positive step because lower rental payments over time enables the program to increase the number of units that can be leased.

Bridge Funding

Bridge funding was provided to 871 participants in FY 2015, which is 39% above the goal for the year. The state also met its overall target for bridge funding required in the Settlement Agreement. The average "bridge" cost per participant is approximately $3,200.[4]. Furnishings and first and second month rent account for 48% of this cost and provider fees account for 20%. The remaining funds (32%) are allocated for household items, food, transportation, medications, moving expenses, utility and security deposits and other expenses.

FY2015 Allocation

The SFY 2015 allocation for the GHVP and the Bridge subsidy combined was approximately $11 million. For planning purposes, the State has combined the two line items to cover costs associated with additional individuals moving into rental units. This is important going forward especially as the program expands with more individuals getting HCVs, project based subsidies and 811 PRA. By combining line items, the State has the flexibility to allocate more funding for bridge resources for individuals moving into units with other subsidies.

Scattered Site

The Settlement Agreement requires Supported Housing to include scattered-site housing as well as apartments clustered in a single building. "By July 1, 2015, 50% of Supported Housing units shall be provided in scattered-site housing, which requires that no more than 30% of the units in one building, or no more than two units in one building (whichever is greater), may be used to provide Supported Housing under this Agreement. Personal care homes shall not qualify as scattered site housing."[5] A survey conducted by DBHDD in June, 2015 found that 87% of housing was scattered site (1,381/1,581), 37% above the minimum standard. This

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

[5] Georgia Settlement Agreement, Section III.B.2.c.i.(B)

reviewer and the Independent Reviewer drove through multiple properties listed in Cobb County to verify the DBHDD designations of scattered site in January 2015 and Regional Transition Coordinators used the same process for further verification. Further evidence for scattered site is in the DBHDD report on total numbers of locations and property owners involved in the program. The new 811 PRA, HCV (preference) program units are scattered site as well. Personal care homes have never been used for GHVP.

2. Program Implementation and Expansion

Program implementation refers to the State's ability to assist individuals in the target population to get the services and resources they qualify for to be referred to the available housing and to sustain their housing and become more fully integrated into the community. As referenced in previous reports, this task is very challenging. Historically, individuals in the target population haven't had opportunities to move into their own home which means staff may not be fully knowledgeable or familiar with supported housing. Likewise, individuals with a severe and persistent mental illness are often labeled "not ready," "needing structure" or incapable of living on their own. 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. Some referral sources such as PATH teams and some discharge planners have this type of planning included in their job requirements, are more adept and/or cognizant of assisting with transitions; for others such as correctional personnel this may be more difficult. Likewise, there are significant barriers to accessing affordable housing at this scale for this target population.

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

Referrals

There have been 2,809 approved referrals to the GHVP over the past five years. Since 2012, the categories of where people were living at the time of referral as a percentage of approved referrals has been fairly consistent across the five categories (target population) even as the overall number of referrals has increased substantially. Individuals who were homeless at the time of referral comprise 52% of all approved referrals. In Region 3 in FY 2015, the percentage of referrals that were homeless at the time of referral is 73% (560/764) and the percentage in each of the other Regions is less than 50%. Effectively, this means in Region III, the GHVP is a subsidy program for individuals who have a disability and are chronically homeless. But based on previous site visits, a significant number of individuals referred to the GHVP may have qualified for the program from one category in the target population but their recent (2 year) history would indicate they could have qualified in multiple categories.

The number of referrals of persons hospitalized rose slightly, 332 to 370 over the previous year but accounted for a slightly lower percentage of referrals overall (16% in FY 2014 down to 13% in FY 2015). The percentage of referrals of individuals residing in intensive residential settings

at the time of referral increased from 8% in FY 2014 to 14% in FY 2015 (217/280) but this percentage is closer to the 16% recorded for FY 2013. Referrals of individuals living with families also increased from 8% in FY 13 to 13% in FY 14 (251/343). Regions 1, 4 and 5 have a much higher percentage of referrals of individuals living with family and friends; 78% of all referrals in this category. Referrals from individuals residing in CSUs (and CAs) and PCHs and GHs remain low, 1% and 5% respectively (total 132/172). DBHDD added a “rent burdened only” category to their list of "current residential status" but only 2% of referrals were from individuals in this category.

Referrals of individuals in jails and prisons increased from "5" over a three year period to 26 in FY 14 to 67 in FY 2015. But this number is only part of the story. It is difficult for individuals who are incarcerated to get referred, get an ID upon release, make a housing choice, go through an eligibility process(es) and move before release from a correctional facility or jail. For jail releases, the issue is often related to how quickly release decisions are made by the court and often with little or no notice. For prisons, the difficulty is more often related to the reality that individuals are not routinely sent to prisons near their home so it is more difficult to make discharge arrangements if a person will be moving across the state when released. DBHDD broadened the time frame for qualifying as a referral following release to get a clearer picture of the number of individuals exiting jails or prisons and coming into the GHVP or other supported housing programs.

As reported in February 2015, DBHDD has placed a high priority on getting correctional facility and jail referrals. Specifically, Regional Transition Coordinators are forming stronger relationships with Department of Corrections personnel at Valdosta and Zebulon and in the Fulton and DeKalb jails along with Atlanta Legal Aid. But these efforts notwithstanding, according to Regional Transition Coordinators, the process is still arduous and the numbers of referrals remain low.

DBHDD is employing a "housing first" approach for many individuals being referred, meaning referrals come directly from homeless outreach, from hospitals, CSUs or intensive residential programs to providers without first being "transitioned" through group living arrangements. As referenced last year, DBHDD has not made a policy decision that people need to live in "structured" settings first before moving into supported housing arrangements. As the State rolls out its Need and Choice Evaluation system, being clear on assuring individuals have the opportunity to move to the most integrated setting, including not using a “step down” where not necessary, will need clarity in policy and training. There will be individuals who can benefit from a "brief" transition “step down” option and this has shown to be beneficial for jail and prison referrals when there is inadequate time or access to make a supported housing referral. The key though is always making this time brief. Across the country, there are many examples of how this approach went awry when brief became long term.

This year the Independent Reviewer requested a review of Forensic Services and referrals. This review raised questions regarding the referral practices for individuals exiting hospitals who were on a forensic (legal) status at the time of admission and then treated as a forensic patient.

Typically, individuals with this type of status have more challenges getting into a subsidized housing arrangement and often staff (hospital and community) are reluctant to attempt those arrangements or they consider them inappropriate. The Community Integration Home (CIH) program, which was created for individuals who no longer require inpatient care, is often the first option considered even though DBHDD reports the majority of individuals move to other residential options.

The CIH program is expanding this coming year. However, two issues arise from the DBHDD placement approach. One, it is not clear individuals are given a choice based on their request, need and safety concerns (typically an issue raised by the court) to have options, including a GHVP slot, especially if their desire is to move to a county that does not have a CIH program. Secondly, individuals may not have been given the opportunity to move from the CIH to the GHVP as their safety and any remaining clinical issues are satisfied. According to 2014 data[6], 59% of CIH residents remained in the program more than a year and over the 68 individuals in the program on 5/22/14, four had been in CIH for over five years.

This is a broader issue than forensic sub-population access. DBHDD should affirmatively assure that any sub-population or "status" group that is being under-referred consistently, such as individuals with a forensic status at admission to a state psychiatric hospital, is being offered the same opportunity to move into a more integrated setting offered through the GHVP.

Another sub-population is individuals residing in group or personal care homes. Combined, these groups only represent 7% of the referrals to the program. The DBHDD "ADA" service criteria for access supportive housing would appear to exclude most individuals who in the past moved into group homes and personal care homes. While it is true these settings are more community-like than larger institutions, they have often been referred to as “transitional” when in reality people stay there because they or their providers do not believe they are capable of living in their own home. Likewise in an interview with a major provider in one Region in July, 2015, when asked what resources were needed, she replied "more personal care homes.” It was clear from the interview that this provider was of the belief that some individuals could not live in a more integrated setting but more importantly if an individual moves to one of these settings they may not qualify for supported housing later on.

DBHDD also reports that many people living in these settings are referred to more independent living options operated by residential providers. According to DBHDD, a significant number of provider-based options could also be considered supported housing because they meet the definitional requirements of supported housing. DBHDD has raised the potential for these options to be included in the State's overall supported housing capacity and DBHDD has agreed to identify these options using the Settlement Agreement definition of supported housing to propose a number that then can be verified before adding these options to the State's supported housing capacity numbers.

[6] Current Forensic CIH resident data (5/22/14).

The DBHDD Office of Adult Mental Health is responsible for the Housing Needs and Choice Evaluation and as part of that implementation is taking the opportunity to broaden the DBHDD referral strategies and combining current programs into one supported housing portfolio. This is a very important step and one that can certainly expand choices. However, this reviewer had not been apprised that these options exist until recently and will take additional steps to verify that these options meet the definitional requirements and to ensure the target population has access to these options. A recommendation on target population access is included in this report.

The February 2015 report included a reference to DBHDD entering into a working relationship with the VA Homeless Veterans programs to assist individuals in the Settlement target population who qualify for VASH vouchers to get a VASH voucher rather than having to use limited GHVP resources. Some homeless veterans may be able to also qualify for Support Services for Low-income Families (SSVF), gaining access to resources including security deposits and back rent. If this resource is available, it should be used first. So, overall, both the VA and DBHDD benefit from this arrangement. In FY 15, 26 individuals got $36,410 in Bridge funding for an average of $461 per individual funded. Likewise 37 individuals exiting hospitals got $41,962 for an average of $1,134 per individual in Bridge funding only. These options are an excellent use of a small amount of funds as long as they are considered last dollar spent and leverage other resources.

The DBHDD has consistently maintained good working relationships with CoCs. CoCs and local homeless programs have benefitted from the GHVP because otherwise they would have had to tap their scarce resources for rental assistance. In FY 15, 1,467 individuals who were homeless were referred for a GHV. But as with the Veterans program, Georgia's Shelter Plus Care program has funding capacity for 1,350 individuals and these resources should be used where available as well. Additionally, individuals are screened out if Shelter Plus Care Resources are available and CoCs are encouraged to apply for new funds when possible which helps the State increase capacity.

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

Each of the last three years, Regional housing staff and, more recently, DCA have referenced the difficulties getting individuals transitioned to HCVs because the GHVP was paying rent above the HCV payment standard and even paying above 110% of the standard. While it is important to engage property managers and landlords and give them incentives to lease to individuals in the target population, it also has a downside when new resources (with federal

payment rules) become available.

It is to DBHDD's benefit to build strong reciprocal working relationships across systems, even those with housing resources. The State has affirmed the GHVP is always the last not first option thus assuring GVHP resources are available to those who are going to be deemed ineligible for other benefits.

The DBHDD and DCA should be commended for these new approaches and partnerships as it allows the DBHDD to use GHVP funds selectively and in turn increase capacity.

Housing Access and Stability

Housing stability is measured by DBHDD at the six month mark, which is the same measure HUD uses to measure housing stability (# < 6 mos leaving/ # > 6 mos in housing). HUD's standard is 77% at that mark and the State was at 92% or 15% above that mark for new tenants in each of the first four years of implementation. DBHDD also set their own standard for re-engagement of "negative leavers" at 10% and has exceeded that standard by 10% with 20% of negative leavers being re-engaged in FY 15. HUD uses this standard to measure Public Housing Authority performance; however, this is not the only measure that should be used to measure stability of renters---six months is simply not sufficient for measuring stability. In addition to measuring tenure, it is also essential to monitor “negative leavers” for trends.

As previously referenced for purposes of this Settlement Agreement, it is more useful to measure stability over the long term and measure the performance of the program. In FY 15, DBHDD reported on longer term housing stability as follows:

FY 2011 Program Participants:	82 out of 117	70%
FY 2012 Program Participants:	350 out of 483	72%
FY 2013 Program Participants:	281 out of 363	77%
FY 2014 Program Participants:	533 out of 577	83%
FY 2015 Program Participants:	769 out of 816	94%
Total Placed:	1,993 out of 2412	82%

Even though it is difficult to make comparisons across states, these longer term percentages are within the acceptable range for a state funded "housing first" Supported Housing program. With transitions to the DCA HCV program, the GHVP percentage dips to 85%. Maintaining 85% is a desirable long term goal. It is recommended the DBHDD and DCA use this same stability measuring yardstick across all the rental programs in the future.

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, many individuals not meeting background requirements for leasing their own apartments or some owners not being willing to include

utilities in rent, which would enable more individuals with "zero income" to get into units under the Fair Market Rent (FMR) rent threshold.

Providers are often challenged with shifting their staff's skills to supporting individuals in their own home. This is a result of their not having experience providing this type of support before or because they are much more accustomed to operating group residences, which requires different skills sets, approaches and knowledge. Often, this is described as providers having a different philosophy, believing in a continuum approach, where people move from institutions or homelessness to group residences where they are "supervised" or need "structure" before moving on their own. Regardless of the reasons, skills and knowledge or philosophy, the need for a consistent presence (DBHDD Regional and State staff), training and coaching can close the gap between the desired outcomes of this program and current provider knowledge, skill and philosophical differences with this approach. Building provider capacity is always a challenge. The State though has many providers who are going the extra mile to assist consumers, who have made the shifts described above and are enthusiastic about how getting into housing is opening up new opportunities for individuals in the target populations.

Housing Need

The DBHDD will have the opportunity this fiscal year to complete their comprehensive "Housing Need and Choice Evaluation Process" and demonstrate their capacity to meet the supported housing need of individuals in the target population. The Settlement Agreement states "the State will have the capacity to provide Supported Housing to any of the 9,000 individuals in the target population who need such support". Need can be translated into "projected annual demand." This can be estimated once the needs assessment is completed and verified for completeness. Since demand is fluid and since the DBHDD is not reporting 9,000 individuals in service, the projected demand will likely be less than 9,000.

However DBHDD will also need to demonstrate that individuals in the target population can gain access to supported housing. This means that on ongoing basis individuals in the target population will be provided access to housing based on their expressed choice and need. The above referenced verification process will include verification for access.

The DBHDD began their "Housing Need and Choice Evaluation Process" over six months ago to assess the need of up to 9,000 individuals in the target population. DBHDD has divided this initiative into five action steps: (1) set policy for a Supported Housing Needs and Choice Evaluation tool to be administered to individuals meeting the ADA Settlement criteria who are currently served in ten (10) services or programs (established June 1, 2015); (2) conduct a baseline of the level of need for supported housing during a three month period from date of their Policy; (3) establish ongoing evaluations for individuals admitted to State Hospitals, newly enrolled in community-based adult mental health services, follow-up risk assessments and housing plan follow-up and documentation; (4) implementation of a Quality Assurance and Compliance Monitoring system; and (5) training for all applicable providers on the implementation this policy and its component activities. This will include training on "housing first" and community based service approaches that lead to individuals being able to sustain

their recovery and life in the most integrated setting possible. DBHDD has contracted with the Georgia Mental Health Consumer Network to provide the Housing Need Evaluators (HNEs) to complete the initial evaluation.

The reviewer has reviewed documents, discussed progress of the initiative with staff on multiple occasions and attended one of the provider trainings in June. The Supported Housing Needs and Choice Evaluation policy applies to individuals who qualify for services[7] and who reside in CSUs, CIH and CRR programs but not personal care homes. Housing Choice and Needs evaluations and Risk Assessments will need to be conducted for the entire Settlement target population who qualify for services, specifically referrals from the criminal justice system. DBHDD has indicated it will use a sampling process to add jail and prison populations in the baseline review. It may be more complicated to get referrals from personal care homes but DBHDD should consider how this could be accomplished.

This is a very ambitious proposal and it will be another six months before a valid assessment of the effectiveness of this initiative can be made.

Provider Capacity

Ongoing challenges exist with the behavioral health care system's capacity to provide recovery-oriented services and in-vivo supports that are focused, highly individualized and well organized as they do in any state's disabilities services programs. In the February 2015 report, a concern was raised about the supported housing program being separated organizationally, in operations, provider expectations and in provider performance and quality review approaches.

With the transition to the DBHDD Office of Adult Services having more responsibility for Supported housing implementation, with the Housing First and Residential Services Training and the Choice and Need Evaluation and Implementation underway, the DBHDD has a great opportunity to make progress on the provider capacity issue.

3. Program Expansion

Along with assessing need, the State's biggest challenge in meeting and sustaining Settlement Agreement supported housing targets is taking supported housing to scale so individuals with SPMI who need supported housing will have access to it. The Supported Housing required by this provision may be in the form of assistance from the Georgia Department of Community Affairs, the federal Department of Housing and Urban Development, and from any other governmental or private source.[8]" This section includes a summary of program expansion in FY 15 and a summary of Georgia's progress and plans to meet the above referenced obligation.

[7] The DBHDD has a very specific entrance criterion for ACT, ICM, CST or CM. It includes the individual being: Homeless (one year or 4 times within 3 years, in hospital (last 6 months), in jail or correctional facility (last 6 months) or using ERs (3 times in the last 12 months) in addition to other more detailed level of need and functioning requirements.

[8] Settlement Agreement, Section III.B.2.c.ii.(A)

Additionally, it is important to continue to reference that Georgia, like most states, is experiencing challenges in the availability of decent, affordable, accessible multi-family rental housing. Housing Choice Vouchers, especially in urban areas, are very limited. The monthly cost for a one bedroom market rate rental unit in Georgia is equal to 93% of an individual's SSI monthly check and, in the Atlanta and Savannah Metropolitan Statistical Areas, exceeds 100% of an individual's SSI check.[9] According to the National Low Income Housing Coalition[10], there are only 29 affordable and available housing units per 100 households with incomes 30% or below the Area Median Income (AMI). In many rural Georgia communities, Regional Transitional Coordinators report there is simply not available affordable, decent multi-family rental stock. These issues have to be carefully considered when measuring the state's ability to secure affordable housing for the target population.

4. Housing Resources

Joint DCA-DBHDD MOA and Resource Expansion

In April 2015, the DCA and DBHDD signed a seminal Memorandum of Agreement (MOA) that is remarkable in its breadth and level of commitment, with each agency committing to tangible steps and outcomes not often seen between state housing and human service agencies. Several of the commitments in the MOA codify already developed joint initiatives, including the HCV with the Tenant Selection Preference and 811 PRA applications to HUD. This MOA though goes beyond the existing partnership.

The MOA includes the following items: (1) Develop and implement a Unified Referral Strategy; (2) Develop and implement a Determination of Need for Permanent Supported Housing; (3) Maximize the Use of the GHVP (with the GHVP being considered only for individuals who are not eligible for other resources or not able to access other resources in a timely manner); (4) Maximize the HUD approved HCV Tenant Selection Preference for the Settlement Agreement Population; (5) Maximize Housing Resources; and (6) Provide the most efficient use of State resources and maximize the expertise of each individual state agency. Each of these items is both comprehensive and concrete with responsibilities well delineated and target dates for completion. If the agencies are successful in accomplishing these strategies, they will have made the best use of the "partnership" options available to them.

The 4th strategy, the DCA Housing Choice Voucher Program (DCA HCVP or HCV) expansion, began three years ago and provides needed housing resources in areas of the state where these resources are the primary HCVs available. In 2012, the Georgia Department of Community Affairs (DCA) received approval from the US Department of Housing and Urban Development (HUD) to provide preferences in the HCVP for individuals with "specific disabilities" identified in this Agreement. This approval was in force until July 1, 2015 and DCA agreed to allow this preference for up to 50% of their turnover units (DCA's total HCV capacity is 16,936) during this

[9] *Priced Out* , The Technical Assistance Collaborative, 2014

[10] *Affordable Housing Nowhere to be Found for Millions,* Housing Spotlight, Volume 5, Issue 1, The National Low Income Coalition (March 2015)

period of time. By the end of FY 2015, 168 individuals had been transitioned to this new program. This opportunity came with multiple challenges including the fact that the DCA HCV program operates mostly in rural counties where there are both fewer staff to assist and fewer individuals in the target population who could also qualify for a HCV. The HCV program is a federal program with more regulations that require more time for processing and validation, including a requirement that rental payments cannot exceed 110% of the HUD payment standard.

As reported in February 2015, the DCA and DBHDD requested an extension of the HUD approved Remedial Tenant Selection Preference Agreement to enable the State to meet their future *Olmstead* obligations. On April 23, 2015, HUD granted this extension for the time period necessary for the State to meet its housing obligation under this Agreement. While this time period is unknown, DCA has committed to moving forward to utilize as many HCVs as possible during this extension including taking direct referrals to the HCV.

According to the 2015 GHVP-HCVP Status Update, 168 vouchers have been converted. In the February 2015 report, the challenges with staffing to assist individuals with making an application for Section 8 and also with assisting individuals with GHVP renewals were raised as an impediment to conversions and renewals being completed in a timely manner. The same issue will arise once the 811 PRA program gets underway. The DBHDD is exploring the potential for a contract with the Georgia Mental Health Consumer Network to manage the Renewals and Conversions with individuals and providers. This would have the potential to create expertise in one organization to manage this process, much like a state hires an administrative services organization to manage services. While it is not clear yet that this approach will increase timeliness, choices and potential numbers of referrals, it is an interesting concept worth pursuing. Likewise, DCA has committed to taking referrals directly of individuals who have not yet been in the GHVP to help increase the number of referrals for the HCV program.

The 5th strategy is already in motion with the DCA LIHTC program as described above. The DCA's 2015 Qualified Allocation Plan (QAP) included an Affirmatively Furthering Fair Housing Marketing Plan and Tenant Selection Plan in their Low Income Housing Tax Credit (LIHTC) Qualified Allocation Plan (QAP). This marketing plan is more specific than typically found in LIHTC QAPs and, among a number of requirements, focuses the attention of owners/developers towards affirmatively marketing units to persons with disabilities and persons who are homeless and builds in a requirement for establishing a screening process recognizing the need for reasonable accommodations, making the application process accessible to people with disabilities.

The DCA selects projects to be funded through an elaborate scoring system, giving value to those housing amenities, locations, accessibility, priority populations, etc. consistent with their priorities. DCA added a 2 point incentive for integrated housing opportunities for individuals with disabilities in 2014 and 21 successful LIHTC applications included units for up to 160 individuals. In 2015, the number of applications increased to 65 out of 75 applications for over

400 additional units. The DCA added a 3 point incentive for an application with a commitment of HUD Section 8 project based rental assistance from a Public Housing Authority for persons in the target population and additional persons with disabilities, including individuals in the Money Follows the Person (MFP) program and persons with developmental disabilities. The DCA hosted a meeting with twelve (12) prominent Georgia PHAs (including Atlanta, Columbus, Augusta, Macon, Savannah and DeKalb Housing Authorities) inviting them to join DCA in an effort to provide a tenant preference for individuals covered under the Settlement Agreement. DeKalb has already received the preference and Macon's is in progress. Eight applications (across 3 communities-Macon, Dekalb and Atlanta) claimed points for this section. Another three applications claimed points for innovative integrative housing opportunities for disabled populations.

Working agreements with CoCs, PHAs, the DCA and the VA

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

Section 811 PRA Demonstration

In FY 2013, Georgia was one of the first thirteen states to be awarded an 811 PRA Demo award and one of six states to receive a second award in 2015. This program is managed by the DCA but DBHDD is a full partner in this new modernized 811 program. DCA received funding for 150 permanent project based rental subsidies in 2013 and another 350 in 2015 for a total value of $14,335,178 for the first five years of assistance, renewable up to a total of 30 years.

While the 811 PRA program is a great opportunity, the program is just getting underway, is also somewhat complicated to implement, especially to assure referrals of individuals covered by the Settlement Agreement are made in a timely manner. DCA forecasts this population will get up to 70% of the PRA 811 assistance based on preliminary projections. After a review of the application protocols, this percentage appears doable but not without a great deal of work by DBHDD at all levels. A discussion with staff and review of the Statewide 811 Operations Committee agendas reveals the State is moving forward and hopes to have 50 Rental Assistance Contracts (RACs) signed in the fall of 2015. Columbus is one of the first communities being targeted for this assistance. During the site visit to Columbus in July, the roundtable participants made the same projections, having already targeted 7 units, but voiced concern about paperwork and complexities of the program.

GHVP-PHA transitions

In addition to the balance of State DCA HCV and the LIHTCs projects with project based subsidies, the Atlanta and Columbus Housing Authorities have made commitments to transfer individuals on a GHVP to their HCV programs. Both are "moving to work" PHAs which means they are able to offer more flexible demonstration programs at the local level. DBHDD estimates 100 individuals in Atlanta and 10 in Columbus can transfer per year with these new arrangements, thereby freeing up GHVs for re-use.

In the near future, the DBHDD and DCA will be able to make a more concrete estimate of the approximate number of existing and new resources to report "capacity," as required in this Settlement Agreement. Later this fiscal year, when the Need and Choice Evaluation implementation is satisfactorily underway and further steps are taken with 811 PRA and work with PHAs, this Reviewer will be able to make a reasonably reliable estimate of "need and capacity" per the requirement of this Settlement Agreement.

Infrastructure and Program Capacity

DBHDD has built a solid infrastructure for the GHVP and Bridge Funding program. Seventy seven (77) contract providers are delivering services to people moving into newly developed (or turnover) housing arrangements in 986 different properties. According to DBHDD, over 50 providers have added staff to carry out functions associated with the GHVP, the HCV and other housing initiatives underway. Taking these programs to scale and sustaining them is requiring expanded infrastructure, increased provider capacity and performance, the ability to secure additional safe, decent affordable rental units. The infrastructure issues and overall scalability of the program is heightened exponentially when the State begins adding additional housing resources including, but not limited to, the DCA HCV, additional PHA HCVs and 811 PRA.

DBHDD staff recognizes the Supported Housing program needs to evolve and expand to meet the demands of the program and the Settlement Agreement. As reported previously, staff carries out a range of duties ranging from filing, assuring monthly rent obligations are paid, working with staff in each region--both Regional staff and providers on routine matters -- plus trying to make and manage new housing connections to enable the program to grow. The GHVP, now the 8th largest rental assistance provider in the State, is quite efficient. Checks to landlords are processed quickly, processing times have been streamlined and are very low. The GHVP grew by 140% over the past two years---but when considering the additional program capacity, the overall program grew by nearly 200% during this time period.

As referenced in the February 2015 report, the most encouraging sign of the DBHDD capacity to achieve its targets and sustain the program is the increasing capacity and performance of the Regional Transition Coordinators. In July, visits were made to Thomasville and Columbus to meet with the Housing Coordinators and review their workload and challenges. These visits further confirm that one of the primary reasons the State housing program is succeeding is their performance and creativity. They are also key to the State's ability to strengthen provider capacity, along with the attention the GHVP operations staff in the Office of Adult Services and DCA is giving the program.

Recommendations

February 2015's report contained a summary of seven broad recommendations. This report summarizes the State's progress toward meeting those recommendations and additional steps or further actions recommended for the State to sustain or achieve compliance. Several of the earlier recommendations will be referenced as "Completed," others will be referenced as "In Progress" or "Incomplete." Findings referenced as "in progress" should not be construed as the State unable to demonstrate compliance but rather indicate progress is on track and it is a matter of time before the steps/tasks can be completed so that a more definitive compliance finding can be recommended. "Incomplete" indicates that it is not clear yet that all the steps necessary to meet the Settlement terms are underway. So the distinction between "in progress" and "incomplete" is that "in progress" refers to the State having taken actions that by all indications will likely enable them to meet their obligations and "incomplete" refers to actions still needing to be taken to demonstrate that the State is on track to meet their obligations.

Below is a list of the earlier recommendations and actions. Explanations are provided if the recommendations were modified, developed further, still in progress and/or under review:

1. **Further develop and sustain Supported Housing capacity through the DCA-DBHDD Partnership:** In February's report the State's progress to develop capacity through this joint arrangement was noted along with recommendations for steps to create capacity for up to 9,000 individuals in the target population who are in need of Supported Housing.

   A. DBHDD and DCA should establish a broad written Memorandum of Agreement (MOA) to meet current commitments and set "actionable" goals to expand Supported Housing resources. As stated above, a comprehensive actionable MOA was completed in April, 2015. Over time, this joint effort will do more than any other feasible activity for the State to reach its maximum supported housing capacity. As stated in the discussion section of this Report, the DCA commitment to "furthering fair housing" is both laudable and unique. Likewise the agencies' approaches to maximize resources are both sound and laudable. Completed

   B. **DCA should request an extension of the HUD approved Remedial Tenant Selection Preference Agreement to enable the state to meet their future *Olmstead* obligations including have the capacity to provide Supported Housing to any of the 9000 persons in the target population who need such support.** DCA and DBHDD made this request to HUD to extend the Preference Agreement beyond the June 30, 2015 expiration date. This request was granted on April 23, 2015 for the time period necessary for the State to meet its housing obligation under this Agreement. Completed

   C. **DCA should request Public Housing Authorities to consider a modest set aside of turnover HCVs over a three year period per the TAC report (in addition to preference**

arrangement referenced in the 2014 DCA QAP) to further the state's ability to meet its *Olmstead* obligation and goals. The DCA refined this recommendation in their 2015 QAP as part of their overall QAP strategy for meeting their *Olmstead* obligations and as furthered referenced in E. and F. below. In Progress

D. **DBHDD was asked to examine their current working agreements (across each initiative) and refine them to assure adequate resources are in place to maximize the HUD approved Selection Preference Agreement, to meet the 2013 and the 2014 811 PRA requirements and to meet any additional arrangements to implement the 2014 LIHTC program Integrated Supported Housing and Target Population Preference.** Completed

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

F. **DCA and DBHDD should continuously evaluate the need for expanding housing resources.** As referenced in this report, DCA has added incentives in the QAP and they and DBHDD are working with PHAs to add Project Based Subsidies to LIHTC funded projects (with a disability preference). DBHDD has asked the two "moving to work" PHAs, Columbus and Atlanta, to offer HCVs to individuals in the GHVP. As these initiatives are further developed, the DCA and DBHDD will have more precise projection of their potential expanded capacity for the next 24-48 months depending on award and production schedules. In Progress

G. **The DCA should assume responsibility for GHVP inspections which consolidates this function in one place. There may be other functions that need to be consolidated across agencies to maximize sustainability as the program continues to grow. For example, 811 PRA referral processes should be the same or as similar as possible with HCV referrals. DCA and DBHDD should work out how housing search will work simultaneously across these two programs**. DCA and DBHDD are jointly developing a uniform referral process and DBHDD has suggested the Georgia Mental Health Consumer Network take on responsibility for managing GHVP-HCV transition administrative tasks and reauthorization tasks in concert with service providers. In Progress

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

3. **DBHDD should assess the potential for increasing referrals of individuals who qualify for services from hospitals, intensive residential settings , group homes and personal care homes.** The number of referrals from hospitals and intensive residential settings has increased but the DBHDD depends on referrals from discharge planners and they may not be aware of the potential for making referrals for services and Supported Housing. It is also not clear how many individuals are being referred to group homes or personal care homes who qualify for services and Supported Housing. Hopefully these issues should surface and be addressed as the new needs assessment process takes effect. As referenced in February 2015, DBHDD should be constantly targeting these settings for referrals. Through the newly developed Needs and Choice Evaluation, DBHDD is positioned to track these referrals more closely and provide training and technical assistance where necessary to increase referrals. In Progress

4. **Assess Need**

   4.a. Implement process to determine need now and in the future: The DBHDD is well underway with their Supported Housing Needs and Choice Evaluation but this process is complex and will require at least two to three more months to complete. One issue DBHDD is just now adding to their protocol is a baseline assessment of individuals exiting jails and prisons. In Progress

   4.b. Establish objective criteria for determining need: Based on the June 1, 2015 Policy and in recent discussions and observation, DBHDD is following through on this recommendation and implementation will occur in the Post Baseline Phase of the Needs and Choice Evaluation. In Progress

   4. c. Project Capacity and Need for the future. Based on progress to date and the need for more time to evaluate capacity and need, a finding of meeting Capacity and Need is not being made at this time. However, there are positive signs that this finding can be made during this fiscal year. In Progress

5. **Quality and Performance Improvements.** This report provides relevant touch points for success of this initiative. It is listed as incomplete but this is not a sign the State has failed to complete this item but rather this is a matter of staff needing to give future attention to Quality and Performance as they complete transitions and other tasks. These can be addressed individually but it is recommended that DBHDD put a quality management plan structure in place that includes performance goals and targets. This plan should not be isolated to the DBHDD Supported Housing unit or to DBHDD functions. It should include either service provider fidelity or quality reviews that include random routine site visits. Some items such as shortening the length of time from referral to "move in" and measuring tenure, should be done jointly with DCA. Targeting an increase in the number and type of referrals or successful implementation of the PRA 811 initiative are examples of other options. Developing this type of approach is also a good vehicle for an annual review of the program's progress and for assessing and demonstrating substantial compliance with the

Settlement Agreement. It is recommended that DBHDD and DCA establish performance benchmarks in FY 2016.

6. **Make certain GHVP is resource of last resort.** The State has made good faith efforts to include this provision in their MOA and in their work with PHAs and Regional Transition Coordinators and providers. Making progress.

7. **Develop stronger ties across DBHDD programs**. In the 2014 report, a recommendation was made to link the ACT, Supported Employment and Supported Housing strategies, operations, requirements, care management, fidelity or other reviews, expectations and/or training to build stronger ties among these initiatives to improve overall performance and outcomes. The merger of the housing unit into the Office of Adult Mental Health was viewed as instrumental to building these stronger ties and better service integration. The 2015 site visits reflected the progress being made and reflected the importance the stronger ties across initiatives. Making progress

   The DBHDD is taking the opportunity of the Supported Housing Needs and Choice Evaluation to offer more training and create a curriculum for building provider capacity and doing it in a manner to develop stronger ties. Embedding the DBHDD Supported Housing Unit more deeply in the DBHDD Office of Adult Mental Health is a positive move. It is recommended DBHDD focus on strengthening ties across the forensic initiatives and to add technical assistance to the Housing Needs and Choice Evaluation initiative, as training is important but not likely sufficient to improve overall performance to the level needed for this initiative to succeed.

   DBHDD and DCA are exploring an additional contract with the Georgia Mental Health Consumer Network for critical administrative tasks. This is also an ideal time to further embed supported housing services interventions into the Certified Peer Specialist certification curriculum and to explore additional options for Certified Peer Specialists to be direct service providers in addition to managing administrative and evaluator functions.

   Lastly, the DBHDD has an ideal opportunity with the rollout of the 811 PRA and expansion of PHA involvement to include individuals with intellectual disabilities to this target population as priority populations for these new resources. Making Progress.

   Summary
   One of the most instructive findings in the February 2015 review was the uniform response from staff and participants of the value of Georgia's Supported Housing Program. That report spoke about the broad consensus of the importance of "home" in consumers' recovery. In June and July, this optimism was evident again in meetings with DBHDD and DCA, with Region 4 staff in Thomasville and then with Region 6 staff and three individuals representing community agencies engaged with DBHDD and DCA in Columbus. What has become clearer this year is that creating supported housing is not just a DBHDD central office initiative or a Settlement Agreement requirement and the GHVP is not just a rental

subsidy program but a springboard for building capacity. The DBHDD also made available feedback from individuals who had moved into their new rental unit and each spoke simply but elegantly of the impact of the GHVP saying things like *"I feel like I have a purpose now"* and *"I now have a safe place I can call my own and I don't feel like I'm thrown away."*

No state can meet its *Olmstead* or a Settlement Agreement housing obligations with a state rental subsidy alone. Creating capacity to meet those obligations comes from exploring and creating as many potential housing options as possible. Utilizing the capacity comes from the belief that recovery is possible. Otherwise, the persons moving into supported housing would not have been referred. Even with some providers still questioning this shift, there is a critical mass of people committed to making community integration, especially housing integration, a reality for individuals who choose and need supportive housing.

DBHDD and DCA MOA implementation will keep this high energy effort alive well into the future. Everyone working on this initiative, state and local, spend their days asking a funder, an elected official, an owner, developer, government agency, provider or a landlord to take a chance on a person they would otherwise not do, make a commitment or a decision to broaden the reach of this initiative. Sometimes they may ask when odds are not in their favor that they will get a favorable answer. But they share a common goal: create more supported housing capacity in their community and their State. They have the vision and tenacity to get the job done. It's rare to see this combination of idealism and pragmatism, but it's what it will take to make integration for people with disabilities a reality.

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

August 6, 2015

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United States v. Georgia 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…
>
> (E) By July 1, 2015, the State shall provide Supported Employment services to 550 individuals with SPMI."

While it is beyond the scope of the work of this reviewer to check the validity and the reliability of the specific data provided by DBHDD, the data presented from DBHDD and the information confirmed by a variety of stakeholders (including providers) who were interviewed do indicate that DBHDD is in compliance with the Supported Employment provisions of the Settlement Agreement.

As of June 1, 2015, there were 1,270 individuals receiving Supported Employment services, with in excess of 550 identified individuals receiving SE who met the ADA criteria, based on the document received from DBHDD titled "Supported Employment (SE) (Supplemental Information-7/30/15)."

According to data received from Dr. Timberlake, the monthly rate of employment was 51.5 percent across Supported Employment programs in May 2015. It is worth noting that 51.5 percent employment represents a slight increase in the employment rate from last year and it constitutes a reasonable and appropriate rate for people in Supported Employment services.

The SHAY, which was focused on the supported employment “slots” under the Settlement Agreement, may be viewed as an instrument to measure the extent and quality of that compliance.

SHAY Executive Summary

This document provides a summary of the status of the work that has been done by 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 fifth annual SHAY report that has been completed at the request of Elizabeth Jones, Independent Reviewer. The last SHAY report was completed in September 2014.

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 three days in July 2015, specifically; July 06, 07 and 08, reviewing documentation, including: agency fidelity reports, monthly programmatic data for SE programs, SE coalition meeting notes, training documents, fidelity outcomes summary, technical assistance and consultation reports, as well as report summaries from an independent SE consultant. During the three days in July 2015, the reviewer also attended meetings with and interviewed a variety of stakeholders in the State of Georgia. The July 2015 interviews and meetings in Georgia included: staff from DBHDD, providers of SE services for adults with mental illness, family members, consumers participating in Supported Employment services, as well as representatives from consumer and family advocacy organizations and other mental health advocates.

Of particular note, the reviewer also was able to meet in person with Commissioner Frank Berry and Deputy Commissioner Judith Fitzgerald during the July 2015 visit. In addition to the July 2015 visit, the reviewer made one interim visit to Georgia in October 2014.

The reviewer was asked to assess the extent to which 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 kindly 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 ("ADA" or "DOJ") 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

DBHDD 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. While DBHDD has completed the development of a formal written SE plan, the current strong concerns raised by SE providers across the state warrants revisiting the same recommendation provided in this section last year.

> "Given the approaching end of the "Settlement Agreement," it is strongly recommended that DBHDD leadership develop a concise SE plan that focuses exclusively on sustaining the progress that the Department and its partners have made in the development of SE services and the infrastructure to support those services. This plan should describe all efforts and strategies underway to diversify and secure funding for SE providers after the completion of the "Settlement Agreement" as well as other activities at the state-level to secure and develop strategic partnerships with agencies like the Georgia Vocational Rehabilitation Agency."

2. Financing: Adequacy

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

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

Narrative

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

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

> The target population for the community services described in this Section (III.B) shall be approximately 9,000 individuals by July 1, 2015, with SPMI who are currently being served in the State Hospitals, who are frequently readmitted to the State Hospitals, who are frequently seen in Emergency Rooms, who are chronically homeless, and/or who are being released from jails or prisons.
>
> b. Individuals with serious and persistent mental illness and forensic status shall be included in the target population, if the relevant court finds that community service is appropriate.

The most prominent concern among SE providers remains, specifically, that payments for SE services will be radically reduced at cessation of the Settlement Agreement. As one SE provider stated, “We are all waiting to see if we still have jobs ourselves after the Settlement Agreement ends.”

Another area of prominent concern for SE providers is how the new VR funding will be merged with other State funds to provide financial stability for SE services after the Settlement Agreement is completed.

Additionally, SE providers continue to express anxiety and angst with the ongoing attempts by DBHDD to implement Task Oriented Rehabilitation Services (TORS) as another funding mechanism for SE services. Providers state they have received little technical support and few answers to concerns that using TORS funding via Medicaid will create significant documentation complications as well as a requirement to “focus on diagnosis and symptoms rather than strengths and abilities which is what Supported Employment is supposed to be about,” as one provider stated. Another provider stated, “The Medicaid requirements will be so different that the only way we will be able to provide SE services and bill Medicaid is to hire specific different employment specialists.” It appears the fears and concerns about the use of TORS as a funding mechanism is even stronger this year than last year.

Once again, it is recommended that DBHDD consider developing a written post-settlement SE document that describes the planned funding integration methods. It is also recommended that DBHDD continue its existing outreach efforts to engage SE providers in a hearty dialogue about TORS funding and SE services.

3. Financing: Start-Up & Conversion Costs

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

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

Narrative

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

4. Training: Ongoing consultation and technical support

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

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

Narrative

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

Staff from several SE programs commented on the current level of training and consultation being provided by DBHDD in collaboration with Doug Crandall and the University of Georgia; some described the training as extremely helpful. Several people described the current model as “being quite effective.” Others commented that the level and quality of the training being provided “Started out good and has been getting better.”

Numerous SE providers cited the training and consultation that they received from Ms. Meka McNeal, an independent SE trainer and consultant from Maryland who has been contracted by GA DBHDD to provide onsite consultation and training to SE sites, as being an excellent resource to help them improve their SE programs.

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
Present	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

DBHDD has continued their ongoing training relationship with the Institute on Human Development and Disability at the University of Georgia. One frequently praised change in the delivery of training resources includes the opportunity for SE programs with good fidelity scores to act as shadow or demonstration sites for other SE programs. DBHDD has worked diligently to become a partner in the training process for staff at SE provider agencies across the state. Maintaining the quality and consistency of the training resources will play an important role in sustaining good employment outcomes from SE programs.

6. Training: Infrastructure / Sustainability

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

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

Narrative

As previously recognized, DBHDD has made some enhancements regarding the provision of SE trainings and consultation services for SE providers in the state. The continuation of these training resources will be critical to the sustainability of good quality SE services for the citizens of Georgia. One part of the sustainability for training that would benefit from some investment is the area of developing provider agencies' own ability to train staff to provide SE services. Some states have developed "train-the-trainer" programs where designated provider agency staff are trained on how to train their own new staff to provide good quality SE services.

7. Training: Penetration

What percent of sites have been provided high quality training

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

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

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

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

Narrative

DBHDD has dedicated funds and developed important local resources in order to provide SE trainings to provider agencies in their communities. All providers agree they have access to good basic SE training now, thanks to the work done at DBHDD and in partnership with the Institute on Human Development and Disability at the University of Georgia.

8. SMHA Leadership: Commissioner Level

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

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

Narrative

The Commissioner of the Georgia Department of Behavioral Health and Developmental Disabilities is Frank Berry who, along with Chief of Staff Judith Fitzgerald, was interviewed in person during the review. Nearly all stakeholders describe Commissioner Berry as a leader, "Who talks about Supported Employment and Recovery every chance he gets." Some SE providers cited recent visits to their agencies by the Commissioner as being very supportive.

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

DBHDD has worked to develop better communication, collaboration and leadership regarding Supported Employment services in Georgia over the past few years. During that time, Mr. Vernell Jones has developed a sound reputation in the community as the Central Office SE Leader. One staff member from an SE provider seemed to speak for many when she described Mr. Jones as, “very approachable, accessible and always responds when asked for something.”

Providers were also clear that they now have a variety of resources they can contact regarding SE services, including Dr. Timberlake and staff from the Regional Offices. Several agencies described receiving good consultation and supports for SE services from DBHDD staff at their local Regional Offices.

10. Policy and Regulations: Non SMHA State Agencies

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

Examples of supporting policies:

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

Examples of policies that create barriers:

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

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

Narrative

The Georgia Department of Behavioral Health and Developmental Disabilities and the Georgia Vocational Rehabilitation Agency (GVRA) have developed a positive collaboration over the past two years. Through their work together, they have signed and implemented a Memorandum of Understanding (MOU) regarding how SE services can partner with Vocational Rehabilitation services. They piloted the MOU to work out the implementation of this process in two sites and took the lessons learned from the pilot statewide. They have also been able to identify fourteen local Vocational Rehabilitation Counselors who are considered liaisons to SE programs and have received shared training with SE providers.

Leadership at GVRA appears genuinely passionate and excited regarding providing collaborative employment services to some of Georgia's must vulnerable citizens.

The collaborative partnership, and the resulting changes in shared services with GVRA, received praise from all stakeholders in Georgia.

Several providers described some differences in how their partnership is being rolled out on the ground level. However, the most pronounced concern was the lack of such identified liaisons at other GVRA offices across the state. Many providers commented that they serve several counties and have only one county where the local GVRA office has an SE liaison. Providers nearly universally described their concern that the improved collaboration and partnership has not spread beyond the fourteen offices with designated SE liaisons. As one SE provider stated, "We have made some significant progress, but it is time for another SE and VR roundtable discussion."

11. Policies and Regulations: SMHA

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

Examples of supporting policies:

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

Examples of policies that create barriers:

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

Present

Score:

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

Narrative

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

As previously described, many providers are concerned about how the use of TORS funding will affect SE services. A number of SE providers voiced concerns about this becoming a significant SE policy barrier.

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 Supported Employment toolkit. This information is shared with SE providers at some of the Supported Employment Coalition Meetings that occur in the State regularly.

11. Quality Improvement: Fidelity Assessment

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

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

Narrative

Over the past few years, DBHDD has identified, recruited and trained a small group of staff to provide fidelity reviews for SE providers across the State. During that time, the fidelity team worked to improve provider relationships during the review process and to approach fidelity reviews as a collaborative quality improvement process. During the past year, there have been some changes in staffing and in how fidelity reviews were provided at a few agencies.

When asked about fidelity reviews in the past year, SE providers noted some changes in how the reviews are being conducted. Several providers, who had been very positive regarding

last year's fidelity reviews, stated there was a significant change in the tone and manner in which reviews were completed at agencies. A number of SE providers commented on the conduct of the DBHDD reviewers. Many agencies reported comments from reviewers about their needing to leave agencies early and not completing the review thoroughly. As one provider stated, "I spend days pulling together information and scheduling for the review and they (reviewers) were more worried about their commute home than about assessing the quality of our program." Staff from other agencies echoed the same comments and concerns. Additionally some programs also stated the reviewers have returned to conducting the review more in audit fashion. Several people experienced the reviewers as having the "we got you" approach to reviews rather than the collaborative approach that has characterized reviews in the past two years.

On the other hand, some agencies reported their reviews were much like last year in that they were, as described by one SE supervisor, "Very fair and consistent. The reviewers at our agency were very open with us and receptive, they took lots of time with us to do the review."

A handful of agencies were given the opportunity to participate in "desktop" reviews where the fidelity reviewers were off-site and gathered information via web-based video meetings and other electronic means. The agencies that experienced these reviews found them to be less intrusive and a much less complicated process. It will be important for DBHDD to carefully watch outcomes at agencies where a desktop review is permitted to ensure the desktop reviews are capturing all the critical quality improvement information for SE services.

Given the significantly increased concerns and comments regarding the DBHDD SE fidelity review process, it is worth revisiting the recommendation made in this section in 2014:

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

14. Quality Improvement: Client Outcomes

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

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

Narrative

DBHDD has made some progress in this area. Outcome reports are now made available to providers on a regular basis. Providers were aware of the general outcomes for people in SE services across the state. However, the outcomes for SE programs (specifically the percent of people in SE service who are competitively employed at a point in time) do not appear to be available on the DBHDD website where SE fidelity reports remain accessible.

It is not clear how outcomes are being used by the leadership at DBHDD or by specific SE providers as a mechanism for quality improvement. For example, SE fidelity reports are being used to identify which providers should provide shadowing opportunities for other providers

who are struggling in identified areas. A similar process has not been established regarding employment rates or outcomes.

15. Stakeholders

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

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

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

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

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

Narrative

The support and engagement among providers, consumers and family members in Georgia for Supported Employment continues to develop based on the successes that have occurred.

The improved partnerships between DBHDD and provider organizations; the vocal active leadership from the Commissioner's office; the collaborative training and shadowing programs; an increased presence at the Georgia APSE conference; and a significantly improved relationship between Georgia Vocational Rehabilitation and DBHDD have all contributed to strong support for Supported Employment services for Georgia's citizens whose lives are affected by mental illness.

Summary Table of Georgia SHAY Scores 2015

1. EBP Plan	5
2. Financing: Adequacy	3
3. Financing: Start-up and Conversion Costs	3
4. Training: Ongoing Consultation & Technical Support	5
5. Training: Quality	5
6. Training: Infrastructure / Sustainability	5
7. Training: Penetration	5
8. SMHA Leadership: Commissioner Level	5
9. SMHA Leadership: EBP Leader	5
10. Policy and Regulations: Non-SMHA	5
11. Policy and Regulations: SMHA	4
12. Policy and Regulations: SMHA EBP Program Standards	5
13. Quality Improvement: Fidelity Assessment	5
14. Quality Improvement: Client Outcome	4
15. Stakeholders: Average Score (Consumer, Family, Provider)	5
Total SHAY Score	69
Average SHAY Item Score	4.6

Summary Table of Georgia SHAY Scores 2012 – 2015

SHAY Item	2012 score	2013 score	2014 score	2015 score
1. EBP Plan	4	5	5	5
2. Financing: Adequacy	3	3	3	3
3. Financing: Start-up and Conversion Costs	1	2	3	3
4. Training: Ongoing Consultation & Technical Support	2	4	4	5
5. Training: Quality	3	4	4	5
6. Training: Infrastructure / Sustainability	3	4	5	5
7. Training: Penetration	1	5	5	5
8. SMHA Leadership: Commissioner Level	4	5	5	5
9. SMHA Leadership: EBP Leader	3	5	5	5
10. Policy and Regulations: Non-SMHA	2	3	4	5
11. Policy and Regulations: SMHA	4	4	4	4
12. Policy and Regulations: SMHA EBP Program Standards	3	5	5	5
13. Quality Improvement: Fidelity Assessment	3	4	5	5
14. Quality Improvement: Client Outcome	3	3	4	4
15. Stakeholders: Average Score (Consumer, Family, Provider)	4	5	5	5
Total SHAY Score	43	61	66	69
Average SHAY Item Score	2.9	4.0	4.4	4.6

Sustainability

Over the past five years, DBHDD has worked effectively at improving their infrastructure, policy and resource allocations to better facilitate the adoption and practice of evidence-based Supported Employment services by a wide range of providers in the State. During that time, DBHDD has developed its own internal SE team that provides leadership, support, consultation, regular communication and fidelity reviews to ensure the quality of SE services in the State. DBHDD has also written a comprehensive State plan regarding SE services and developed a multi-media training and consultation partnership with the Institute on Human Development and Disability at the University of Georgia. DBHDD has also instituted regular SE coalition meetings with providers and has been developing a much more collaborative partnership with SE agencies regarding the provision of good quality Supported Employment services. Most recently, DBHDD has made noteworthy progress in their collaborative relationship with the Georgia Vocational Rehabilitation Agency. All stakeholders noted the benefits and effects of this collaboration during a recent visit. Most, if not all, of these changes, would not have happened without the committed and focused leadership support that SE has received at all levels of DBHDD, including the Commissioner.

It is incumbent on the leadership at DBHDD to carefully and regularly monitor these significant improvements and transformative changes for erosion. As was demonstrated by the provider feedback regarding changes in the staffing of fidelity reviews, some positive changes can be quickly lost (i.e. several providers commented that the reviews were back to the tone of compliance audits versus the desired tone of collaboration and partnership) and recovering from those changes presents a new challenge.

Some areas that appear to be at high risk for potentially losing progress include the improvement to the fidelity process and the partnership around ongoing funding mechanisms and strategies for SE services. Providers have expressed, over the past two years, a strong reservation and many misgivings regarding the use of Medicaid dollars to fund SE in GA.

The training and consultation work through the Institute of Human Development and Disability at the University of Georgia has been well received and has given agencies the chance to have staff trained in providing SE services which is critical to the success of the service.

Fortunately, Georgia has a pool of experienced SE providers, effective leadership at DBHDD regarding Supported Employment, and a system now built to capture useful ongoing quality improvement data at many levels, all of which will be critical to sustaining the opportunity for Georgia's citizens who live with mental illness to have effective services to help them further their own recovery through competitive employment in their communities.

REVIEW OF CRISIS SERVICES

The purpose of this report is to determine the compliance of the Department of Behavioral Health and Developmental Disabilities (DBHDD) with the requirements for crisis services as described in the State of Georgia's Settlement Agreement with the Department of Justice. In addition, this report offers an assessment as to how well the different components of the crisis requirements are integrated to form a comprehensive crisis service system for individuals with behavioral health needs and/or developmental disabilities.

Introductory Comments

In developing this report, I reviewed the Settlement Agreement between the State of Georgia and the Department of Justice, had an opportunity to meet with the leadership and senior managers of DBHDD, reviewed Departmental data reports and visited a number of programs around the State. Specifically, I met twice with Commissioner Berry and his Chief of Staff Judy Fitzgerald. I also met a number of senior managers individually or in group settings. All of these meetings were in person with the exception of a phone conversation with Ms. Atkins. The following are the members of the Department I met with:

- Dr. Emile Risby, Chief Medical Officer
- Ms. Monica Parker, Director of Behavioral Health
- Dr. Chris Gault, Director of Performance Management and Quality Improvement
- Dr. Terri Timberlake, Director of Adult Mental Health Services
- Mr. Dan Howell, Director of Developmental Disabilities
- Mr. Eddie Towson, Developmental Disabilities Quality Management Director
- Mr. Mark Baker, Director of Recovery and Transformation
- Mr. Charles Fetner, Region 1 Coordinator
- Ms. Debbie Atkins, the newly appointed Director of Crisis Services.

I also visited the following programs around the State:

- GCSS's Crisis Respite Home in Rome; I met with their mobile crisis staff
- Highland Rivers Community Service Board's Assertive Community Treatment Team where I met with members of the ACT Team
- Benchmarks Human Services's mobile crisis team where I met with their regional manager and members of the mobile crisis team
- The Georgia Crisis and Access Line (GCAL) where I met with their Executive Director
- Grady Health Systems' main site; I toured their Emergency Department and short-term inpatient unit and met with the Executive Director of their mental health services and his staff
- McIntosh Trail Community Service Board's Behavioral Health Crisis Centers (BHCC); I met with staff and observed their admission process and crisis stabilization unit
- Advocates in a meeting convened by legal advocates.

I am grateful to Pamela Schuble, Director Settlement Services, for her assistance in providing me with a number of documents that described the various crisis services as well as data reports on service utilization. In addition, Ms. Schuble was very helpful in arranging my various meetings and visits throughout the State.

Findings

Developmental Disabilities

1. Mobile Crisis Teams for individuals with Developmental Disabilities

(A) By July 1, 2012, the State will have six mobile crisis teams for persons with developmental disabilities.

The State does have six crisis teams, one for each region of the state, which are operated by four providers. In FY'15, the mobile crisis teams provided 1,128 episodes of care to 556 individuals. The data provided indicated that just over 80% of the mobile crisis calls resulted in crisis stabilization and that 225 or 20% of the interventions led to a referral for inpatient services. All of the developmentally disabled individuals admitted to an inpatient setting had a co-occurring psychiatric diagnosis.

2. By July 1, 2014, the State will have established twelve Crisis Respite Homes with four beds each. These forty-eight beds will provide respite services to persons with developmental disabilities and their families.

The purpose of the Crisis Respite Homes is to offer time-limited services to an individual due to their need for support and protection. Homes are required to have capacity for four or less individuals and each individual is to have their own bedroom. The Crisis Respite Homes are designed to offer a stay of up to seven days. If an individual requires a longer length of stay, the Regional Office can provide authorization for an extended stay.

In my review of the data for the Crisis Respite Homes, there are concerns about utilization of these beds. The State only established eleven Crisis Respite Homes and is not in compliance with this Provision of the Agreement. Therefore, the Crisis Respite Homes have a total of forty-four beds that are to provide an average length of stay of up to seven days. I have calculated the annual capacity of the Crisis Respite Homes by using the following methodology:

> Dividing 365 by 7, each bed can have 52 admissions; however, there will be reasons such as an extended length of stay or other reasons that a bed will not be available. Therefore, I have used a 75% expected utilization rate which would equal 39 admissions/per bed/year and multiplying that by 44 would provide a capacity of 1,721admissions per year.

The State reported a total of 109 admissions for 88 individuals to the Crisis Respite Homes for FY'15 which would be 6% of the admissions capacity. Another way to look at the Crisis Respite Home utilization is to analyze the bed occupancy rates:

> The 44 beds have the capacity to offer 12,045 bed days, which was determined by multiplying 44 beds x 365 days x 75%.

In FY'15, the State reported that there were 9,045 bed days used in crisis beds or 75% of the capacity bed days. The reason for the difference between admissions and bed utilization is that there are a number of individuals who are staying in the Crisis Respite Homes for long periods of time, some for years. The average length of stay for all admissions in FY'15 was sixty-eight days. There were sixteen individuals who had more than one admission. (Dr. Heick has documented a more in-depth review of six of these individuals.) The data were also analyzed to get an understanding of how the utilization of the beds compared to the intended goal of a 7 to 10 day stay. The data were presented in a manner that only allowed for an accurate analysis of length of stay per admission episode for individuals with just one admission. The one admission population represented the majority of users as they were 72 or 82% of the 88 individuals who used the crisis beds. The analysis of the data found the following:

- 9 of the individuals or 12.5% had stays of 250 days or more
- 30 of the individuals or 42% had stays of 90 days or more
- 55 of the individuals or 76% had stays of more than 10 days

Therefore, less than a quarter of those admitted to the crisis beds had stays within the intended use of the service. This data should encourage the State to review the intended purpose of the crisis beds to determine the reason(s) for the extended stays and determine if there is a need for a different type of service to better serve the relatively small number of individuals using the crisis beds.

Other components of the crisis system for individuals with development disabilities do not appear to be serving a significant number of individuals. In-home services for individuals served by the mobile team and who did not require a crisis home admission accounted for 58 individuals who received 138 in-home services during the course of FY'15.

Mental Health

3. Crisis Service Centers (CSCs) are to provide walk-in services, staffed by clinicians, 24 hours per day, 7 days per week to serve individuals in crisis, including individuals with co-occurring illness. The obligation is that the State will have six CSCs in operation by July 1, 2015.

CSCs are now known as Behavioral Health Crisis Centers (BHCCs). As of June 30, 2015, the State had six BHCCs opened. They are:

- River Edge Crisis Service Center opened 4/12
- Bradley Center opened 7/1/13
- Aspire opened 8/1/13
- Georgia Pines opened 1/17/14
- BHS of South Georgia opened 1/17/14
- McIntosh Trail opened 6/4/15
- Pathways opened 6/30/15

The BHCCs are all operated by a Community Service Board (CSB) provider and are full service crisis centers that provide assessments for individuals who voluntarily walk-in as well as for individuals brought by law enforcement for an involuntary evaluation; provide observation beds; and offer short-term (7-10 day) crisis stabilization beds.

In addition to the development of the BHCCs, the Department is making a concerted effort to improve the system's ability to serve, in an outpatient clinic setting, individuals experiencing a behavioral health urgent need. In early FY'15, the Department contracted with MTM services to provide year-long technical support to both Regional staff of the Department as well as Community Service Boards (CSBs). An aspect of the technical assistance was training on both clinical and financial strategies for the CSBs to offer open and timely access to the residents in their community seeking immediate services. To support this commitment of expanding same day services, the State's policy encourages the CSBs to have open access as stated in Policy 01-201 "DBHDD strongly encourages same day access to services."

In addition to the open access initiative, the State tracks the time it takes for an individual referred for Assertive Community Treatment (ACT) to be admitted to an ACT program. The goal is 70% or more should be admitted within three days. The State's performance exceeds this expectation. In the first three quarters of FY'15, approximately 73% of the referrals were accepted into the program within three days.

4. By July 1, 2014, the State was to establish a total of three additional Community Stabilization Programs (CSPs). As of July 1, 2015, there are twenty agencies that provide 448 CSP beds. All CSPs are operated by CSBs and six of the programs are contained within a BHCC. A major goal of the CSPs is to offer community-based services as an alternative to the use of a state hospital.

A critical component of the CSPs is their ability to accept involuntary admissions. In many states, general hospitals provide acute psychiatric care for both voluntary and involuntary admissions. In Georgia, there appears to be a minimum number of acute psychiatric units within general hospitals. While there are a number of private psychiatric hospitals in the State, their capacity to provide acute inpatient care to Medicaid recipients is limited by the Institutions for Mental Diseases (IMD) restrictions, as IMDs are prohibited from receiving Medicaid reimbursements for individuals aged twenty-two to sixty-four. Therefore, the CSPs perform many of the functions that you would find in a general hospital and the average length of stay of just fewer than eight days is very similar to acute general hospital length of stays.

5. As of July 1, 2011, the State shall retain funding for thirty-five beds in non-State community hospitals.

The vast majority of the thirty-five contract beds are used in Region 1 and they provide on average 2,200 episodes of care and a length of stay of just around six days.

It appears that the use of the CSPs and State contracts with hospitals have been successful in shifting the locus of acute care from the state hospital to the community. Using data from Region 1 as an example, as capacity of the CSPs and community hospital beds has increased, state hospital admissions declined. Region 1 reported: "In FY'10, of the people who needed inpatient level of care or that of a CSU, 25% were served in a state hospital. In FY'15, less than 2% of the Region 1 people were admitted to a State Hospital."

6. The State shall establish a statewide Crisis Call Center that shall be staffed by skilled professionals.

Such a call line exists and is operated by Behavioral Health Links (BHL) and known as the Georgia Crisis & Access Line (GCAL). GCAL receives on average between 20,000 and 25,000 calls per month. GCAL is well known among the behavioral health providers in the State and is an essential component of the Georgia crisis system. GCAL publishes regular reports on its website (www.behavioralhealthlink.com) that document the reasons for calls, time of the call, demographics about the callers, locations of the callers, and the timeliness of services, including the number of business days for a scheduled appointment. GCAL and the providers have established procedures that allow GCAL staff to schedule appointments at the most appropriate Community Service Board location. In addition, GCAL deploys the mental health mobile crisis teams and the teams stay in close contact with GCAL during their response and report back to GCAL when the crisis situation is resolved. This allows GCAL to report on the amount of time it takes for a crisis episode to be resolved and to provide telephonic assistance to the team. GCAL is well integrated into Georgia's public behavioral health system and, as of July 1, 2015, GCAL is a component of Georgia's new Administrative Services Organization (ASO) contract.

7. By July 1, 2015, the State shall have mobile crisis services within all 159 of its counties and the teams should have an average response time of one hour or less.

The data for the first eleven months of FY'15 indicate that the State has met this objective. The data through May 2015 indicate the following:

- There is an average of just over 1,500 mobile crisis deployments per month.
- The average response time in FY'15 was 55 minutes with only one month having an average response of more than 60 minutes, which was 73 minutes for the first month of the fiscal year. Between December and May of this past fiscal year, the average response time was slightly above fifty-one minutes, which would be a 30% improvement from July of 2014.
- Regions 2 and 3 represent 46% of all mobile crisis responses.

8. By July 1, 2015, the State will establish a total of eighteen crisis apartments with the capacity to serve two individuals with Serious and Persistent Mental Illness (SPMI) at a time.

Based on reporting from the State, there are nineteen apartments that provide thirty-seven beds. In FY'15, 313 individuals accessed these beds. Based on a one day survey for June 30, 2015, twenty of the thirty-nine beds were occupied.

Grady Health Systems plays a major role in providing acute care and crisis services to residents of Fulton and Dekalb Counties. In FY'13, its comprehensive services provided almost 40,000 episodes of care to a population that is either uninsured (65%) on Medicaid (30%) or Medicare (5%). The majority of the behavioral health clients served through Grady enter care through the emergency room, brought by either the Emergency Medical Service (EMS), law enforcement or voluntarily walk-in. In any given month, approximately 700-800 individuals are seen in the emergency room and about 40% are diverted to a more appropriate level of care. Grady also operates a thirty-two person capacity short-term unit (up to 72 hours) that serves between 400-

500 episodes of care per month and operates its own twenty four bed inpatient unit. In addition, Grady Health Systems operates very active outpatient services that include same day urgent care access, Assertive Community Treatment (ACT) teams as well as psychosocial rehabilitation and peer support programs. Since there is no CSB in Fulton County, Grady Health Systems works directly with the State's regional structure.

Recommendations

1. The management of crisis services has been dispersed throughout the Department and there has not been a single person whose job is to manage and help develop a crisis system. The Department's senior management is aware of these issues and has recently created a new position to manage all of the crisis services. This new hire began her employment the first week of July 2015 and, hopefully, with the right support, she will be able to provide the much needed leadership and organization of the crisis system. There is a wealth of data available as well as a number of significant activities taking place to ensure that Georgia residents have access to timely quality crisis services. It is now up to the Department leadership to ensure that there is a robust comprehensive crisis system in place that produces regular data reports that are widely shared; that the reports measure the critical components of the system including, but not limited to, timely access to care and the utilization of community based crisis services; that problems are identified in a timely manner and addressed; and that roles and responsibilities for problem solving are well known throughout the Department, with other State agencies, as well as with family members, advocates, law enforcement and other key stakeholders.

2. Addressing the crisis service needs for individuals with a developmental disability must be a priority.

- Based on the relatively small number of individuals seen more than once by the mobile crisis teams (556) as well as the number of individuals staying far more than the initial seven day limit of the Crisis Respite Homes, a process needs to be put place for formal planning and problem solving for individuals with developmental disabilities who have complex needs and challenges that must be addressed in order for them to have a positive quality of life in the community.
- While recognizing the geographic challenges of a large state such as Georgia, the State should evaluate if it is offering the right range of services to meet the crisis and immediate needs demands of individuals with developmental disabilities. The State should re-evaluate the way it offers services to see what services are missing and what should be retained. For example, is it cost effective to offer forty-eight beds through the Crisis Respite Homes that have such low utilization rates or are there more efficient ways to utilize these resources that could better address the needs of individuals with developmental disabilities.

3. The Department should continue to support the CSBs to provide open access. The State should determine if it should strengthen its current policy of strongly encouraging same day access to services and, if it does, the State needs to understand the fiscal impact to CSBs as well as the possible return on this investment to the State on using less costly ambulatory services that have some potential to reduce more expensive services offered by BHCCs, CSPs, or other acute inpatient service.

4. The State should determine the number of CSP beds needed statewide and also review if there is any potential revenue from third-party payers that may be available to CSPs.

5. Finally, I also want to note that in meeting with about fifteen individuals representing providers, family members, law enforcement, advocates and interested parties there was an overwhelming negative sentiment expressed about challenges related to access to care, the lack of data available and the perceived absence of a formal process for problem solving. A number of the participants noted that if they reached the right person in the Department that the immediate concern would get addressed but reported not being aware of formal problem solving processes. It would be very beneficial for the Department to address these concerns about access and information and develop viable ways of sharing data about the use of crisis services and their effectiveness with the larger community.

Based on my review of the crisis system, it appears that there has been significant progress made on meeting the mental health objectives established by the Settlement Agreement. The locus of care has undergone a major shift from the state hospital to community services; the range of community-based services has greatly expanded; and the State has a structure in place to track the critical components of a crisis system. However, there is still much work to be done for individuals with a developmental disability. Hopefully, with the establishment of the new Director of Crisis Services, there will be a focused and intensive effort to most effectively address the needs of the developmentally disabled individuals who are in need of a community based crisis service.

Stephen T. Baron

Consultant to the Independent Reviewer

September 12, 2015

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

Angela L. Rollins, PhD
August 12, 2015

Introduction

The purpose of this report is to inform the Independent Reviewer regarding Georgia's compliance with their Settlement Agreement with the US Department of Justice, regarding implementation of Assertive Community Treatment (ACT). The Independent Reviewer requested comments on the following specific topics:

- Assessment of Georgia's compliance with the Settlement Agreement with the US Department of Justice
- Assessment of Georgia's support for Assertive Community Treatment (ACT) services using the State Health Authority Yardstick (SHAY)
- Georgia's overall progress with ACT implementation over the past year (including progress on recommendations in the 2014 report), as well as more broad reflections regarding progress over the past five years
- Recommendations for further improvements and sustainability of progress.

Key recommendations in the 2014 report that were a focus in this year's assessment, included:

- Improving sustainability: focus attention on being able to answer key questions about ACT's impact and improving financial sustainability by maximizing federal funding sources for ACT (e.g., Medicaid reimbursement)
- Encouraging teams to use independent living housing options for consumers
- Improving recovery potential for ACT consumers by maximizing various ACT specialist positions (e.g., employment specialists work on competitive employment placements for ACT consumers; maximizing the use of peer specialists), including onsite technical assistance
- Strengthen the consequences within corrective action plans, asking for agencies to demonstrate progress on the DACTS item that is deficient.

Data Collection Informing this Report:

The author of this report spent four days in July 2015 completing a series of interviews with a variety of stakeholders in the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) system, including:

- Commissioner, DBHDD
- Chief of Staff, DBHDD
- Director, Division of Behavior Health, DBHDD
- Director, Adult Mental Health, within Division of Behavioral Health, DBHDD
- DOJ ADA Settlement Coordinator
- ACT fidelity assessment team, DBHDD
- Director, Office of Performance Analysis (under new Division of Performance Management and Quality), DBHDD
- Former APS and now current Beacon (external Medicaid monitoring agency) care managers for ACT services, their team leader
- Director, Office of Recovery Transformation, DBHDD
- External trainers who provided ACT-specific recovery 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 but not limited to:

- State Plan for ACT (from 2013)
- ACT service definition
- Georgia Program Toolkit for ACT
- ACT fidelity reports and fidelity score tracking tables, ACT consumer census tables; ACT team plans of correction for low fidelity and correspondence, corrective action plan updates
- Log of all ACT-related trainings, webinars, team leader retreat (with sign-in sheets) and some ACT training materials; documentation of ACT team technical assistance consultations and shadowing experiences
- ACT client outcomes reporting templates and reports
- APS audit tool items and sample reports; Summary of APS ACT authorizations by team and statewide
- Agendas and minutes for each ACT Coalition meeting held during the last fiscal year
- Memos documenting ACT policy changes during the last fiscal year

During the July 2015 visit, the author conducted site visits for three ACT teams, including interviews with team leader, supervisors, team staff, and consumers. In total from October 2014 to July 2015, the author conducted site visits in all six regions covering ten separate teams (one team visited twice for eleven total visits). Most teams were selected for review based on low fidelity scores or other performance concerns, while some teams were selected to establish broader coverage of site visits to extend beyond Region 3 (Metro Atlanta).

Given the 2014 recommendations, additional contact with DBHDD staff this fiscal year included a series of conference calls regarding improving consumer outcomes monitoring for ACT, a key recommendation in previous annual reports for quantifying ACT's impact and influencing potential sustainability of the program after the Settlement Agreement period.

As in previous years, interviews with both DBHDD staff and with various stakeholders outside DBHDD were productive, frank, and emphasized a willingness to discuss struggles with ACT implementation and openness to ideas about improvements. Much emphasis in this author's inquiries are not a concern over basic ACT implementation, which has been solidly in place since about 2012, but on continuing to improve existing supports to strengthen weak areas and to think more strategically about sustainability for ACT after the Settlement Agreement period ends.

Brief Summary of Report Findings:
Although it does not impact a SHAY score or compliance with the Settlement Agreement, I observed repeatedly that consumers served in the metro Atlanta area have a higher level of functional losses in a variety of life domains that compound psychiatric symptom acuity. For example, in metro Atlanta, consumers often are coming to teams in a state of chaos, having been discharged from institutions (e.g., jail, prison, hospitals) that often present limitations in housing options (e.g., landlords do not like to rent to persons with felonies), with no identification, no income, no insurance of any kind, and often with no experience with the provider organization. In contrast, this may occasionally happen in less urban areas of Georgia, but it seems that their new clients are more likely to be previously known to the providers (e.g., consumers experienced hospitalizations while receiving the provider's less intensive services or consumers enrolled after long periods of discharge planning with state hospital staff– both examples still of a very appropriate use of ACT services). Of course, every ACT team experiences enrolling consumers across this spectrum, but the proportions of the client base in each category seem to be where the distinctions emerge in my observations. These observations could offer important context for thinking about the future penetration of ACT, supports needed for various types of teams (e.g., urban, forensic-focused), and time needed to engage consumers properly. Stakeholders should be aware of the fidelity standard to take no more than six new clients each month (with less being ideal). This is particularly important in cases where newly enrolled ACT consumers require extensive time in relationship building and supplying basic necessities as the foundation for recovery. The role of peer specialists on these teams is critical for engaging consumers and building strong helping relationships. One recommendation is to encourage these teams to use multiple peers for engaging consumers.

The state is in compliance with regard to ACT implementation, though several opportunities for improvement remain.

Staff turnover seemed to be a recurring theme in both fidelity scores and in observations of teams. In some cases, turnover has a cascade effect on other ACT fidelity items, such as low staffing results in lower frequency of contacts or loss of some programming (e.g., loss of the substance abuse specialist has an impact on other substance abuse service items). Teams are encouraged to offer or require shadowing experiences prior to making job offers to ensure that candidates know what they mean by community-based services (e.g., it is more than just non-hospital based care). In some cases, however, turnover of staff who are a poor fit for ACT or recovery-oriented ACT followed by the hire of staff who are a better fit has resulted in positive overall change for at least a couple of teams in the state.

Frequency of contact and work with informal support network items could also be improved across the state. As stated above, frequency of contact is likely impacted by high turnover. In addition, the DACTS scoring for this particular item are quite stringent. However, further technical assistance with teams could identify other barriers to frequent contacts needed for ACT. DBHDD documentation of technical assistance for

some teams indicates discussion of collaborative documentation techniques which can reduce the burden of documentation outside of clinical contacts and "free up" some time for direct work with consumers. More work in identifying barriers to frequent contact and possible solutions at the individual team level is warranted. Work with informal support network is another item where the DACTS standard is very high and difficult to meet for even good teams. In my July visits, I observed two ACT teams engaging with consumers' families in important and meaningful ways, dampening my concern about this particular item. These teams might be great examples to highlight to other teams in an ACT coalition meeting or another gathering (e.g., the team leader retreat) to bolster other teams' meaningful contact with informal support networks of consumers in support of recovery.

Strengths of ACT implementation include a steadily progressing infrastructure largely supportive of ACT:

- Robust fidelity monitoring system and team that are found to be competent and helpful to providers, as well as regional office staff who spend a great deal of time onsite providing support and guidance to ACT teams
- Continuous improvement in state-level fidelity indicators, including improvements in the state mean and median fidelity scores and reduction in the number of teams scoring below a 4.0
- Strong leadership and attention focused on ACT policies from DBHDD team
- Strong funding package for ACT services remain, although there is concern about the potential for changes with no fee-for-service contracting and the end of the Settlement Agreement
- Statewide emphasis on using ACT to serve the intended population, i.e., to serve the state's most vulnerable consumers with ACT, including consumers with substantial histories of long-term state psychiatric hospitalizations (see case example described under SHAY item 4) or other forms of institutional care.

Areas for improvement remain, including:

- Sustainability concerns with regard to outcomes monitoring and Medicaid.
    - Although the State did a small evaluation of the impact of ACT on hospitalization over time, this work needs to continue, with an examination of other outcomes, wider sampling methods, and answering other key questions from stakeholders. In addition, I met several consumers with success stories that exemplify the personal impact on consumers underlying the quantitative outcomes in graphs. Both methods should be highlighted for various stakeholder groups in a way that depicts what ACT services can do in Georgia.
    - Some sites reported improvements in Medicaid penetration across ACT caseloads, while others still struggle. The State should continue to work with providers using tools developed for fiscal planning and offering Medicaid enrollment support via regional office staff.
- Recovery orientation of ACT should continue to be a focus, although much effort was exerted in training and onsite technical assistance and found useful this past year by several teams. Future work could include engaging teams or individual

staff that exemplify recovery-oriented ACT to work with other teams, such as offering peers the opportunity to network and shadow strong peers in the field (e.g., one peer observed on a site visit was particularly good at engaging a new consumer)
    - Emphasize independent living options for ACT consumers – some teams still seem resistant to this idea while others appear to be doing a good job of helping consumers live independently, or semi-independently after periods of long hospitalization.
    - Emphasize supported employment and good job development skills for ACT employment specialists. Although the role of the ACT employment specialist was properly clarified this year, most ACT employment specialists continue to struggle with how to do this work (e.g., how to perform proper job development for this population) and maintain productivity standards.
    - Re-emphasize the goal of ACT services as person-centered, relationship-centered, intensive mental health services as opposed to getting consumers to take medications. These sentiments vary widely across teams and across staff within a single team.
- Although progress in the specification and follow-up with corrective action plans was noted this year, continued progress should be to define consequences for repeated non-compliance with DACTS standards in the event this becomes necessary

Comment on Compliance with Settlement Agreement

This author finds that 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 2015, the twenty-two teams collectively were serving 1,477 consumers, according to the state's tracking report, an increase over 2013 and 2014 census data. One team reported that these census tracking methods are conservative and exclude other ACT consumers served by teams, such as when an ACT authorization is pending but the consumer is actively receiving ACT services. From the APS authorization decisions report received from DBHDD covering FY15, five hundred ninety seven consumers were newly authorized for ACT services, while three thousand thirty-four received ongoing authorizations and sixteen received an updated authorization. Although in combination these authorization figures would overestimate the number of unique consumers served by ACT teams over FY15 (i.e., some new enrollees may also be counted when renewed under an ongoing authorization), we could estimate that 1,409 on census in June 2014, plus 597 new ACT enrollment authorizations in FY15, would total over 2,000 unique ACT consumers likely served by the twenty-two ACT teams in FY15. The twenty-two teams have an average Dartmouth Assertive Community Treatment Scale fidelity score of 4.2, a slight improvement over FY13 and FY14 averages (4.1). Only two of the twenty-two teams scored below a 4.0, another improvement over previous years where at least 5 teams would score below 4.0. No single team scored below 3.9, which is still a respectable ACT score on the DACTS. As indicated in my FY14 report, a score of 3.9 is a high score to obtain for any non-ACT

program. 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. Despite finding evidence for compliance, several improvements to ACT services are still recommended based on both fidelity scores and observations by this author and/or other stakeholders and are summarized above and detailed in individual SHAY items below.

Findings from the State Health Authority Yardstick

Background on the SHAY Assessment:
The 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's DBHDD has been identified as the State Health Authority.

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

1. EBP Plan

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

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

Score

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

Comments:

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

2. Financing: Adequacy

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

Score:

	1. No components of services are reimbursable
	2. Some costs are covered
2014 – losses reported by two agencies (5 teams)	3. Most costs are covered
2015 – no specific losses were reported	4. Services pays for itself (e.g. all costs covered adequately, or finding of covered components compensates for non-covered components)
2013	5. Service pays for itself and reimbursement rates are attractive relative to competing non-EBP services.

Comments:

At each of the ten team visits, I attempted to make contact with at least one provider representative knowledgeable about ACT financing and contracting. While a couple of ACT providers had estimated financial losses on ACT services in FY14, I received no specific loss estimates when speaking with provider agency managers this year. Most managers did express some fear that with new contracting policy changes at DBHDD, they may struggle to "break even" on ACT services, but I received no reports of specific loss totals to date in this fiscal year. Several teams indicated that rates of Medicaid for ACT consumers continue to be a concern, although many teams reported continued, gradual improvements in these rates. Many teams continue to appreciate the efforts of Medicaid Eligibility Specialists at each DBHDD regional office (an example of State technical assistance regionalized). A couple of teams also indicated some ACT

consumers have a form of Medicaid that does not cover ACT services. One example given to me was Wellcare, meant for children and families. Although some agencies were not concerned about the new redesign and accountability measures included in DBHDD's redesign, a few expressed concerns that much of the details of new contracting procedures have yet to be articulated. Other agencies continue to cite the expense of some positions required by ACT services (e.g., psychiatrist effort) and whether they can sustain ACT services over the long-term with even minor cuts to state contracts because of these expenses required by the model.

Given that the majority of concerns expressed this fiscal year seemed to come from fears about future reductions in revenue, rather than current revenue, I am concluding that ACT services are currently cost neutral for the majority of ACT teams. I continue to recommend DBHDD guard the financial sustainability of ACT. Examples include: continuing to use staff financial planning tools with agencies statewide (moving beyond piloting with a few teams), considering urban/rural contextual differences that impact Medicaid penetration rates (i.e., urban consumers who may require months of ACT services simply to get documentation in place to apply for Medicaid, in addition to time spent appealing a denial or waiting for approval), identifying some mechanism for presumptive Medicaid eligibility for ACT consumers, and continuing to document the value of ACT services (e.g., statewide quantitative reports on hospitalizations as well as rich, qualitative stories about recovery with ACT services – see my example under SHAY item 4) for stakeholders to protect Georgia's current fiscal supports for ACT.

3. Financing: Start-Up & Conversion Costs

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

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

Comments:

As mentioned in previous reports, ACT start-up costs appear to be covered with larger State contracts in Year 1 supplemented by ACT Medicaid reimbursement. The teams reporting losses in FY14 were in their second year of implementation or beyond.

4. Training: Ongoing consultation and technical support

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

X	1) Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training)
X	2) Initial agency consultation re. implementation strategies, policies and procedures, etc. (e.g. 1 - 3 meetings with leadership prior to implementation or during initial training)
Getting better but still needs support for key areas	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)
More this year, will need to continue	4) On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months)
X (ACT Coalition)	5) Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (minimum of 3 months, e.g. monthly X 12 months)

Score

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

Comments:

In the last year, I heard several reports from the field regarding more training and ongoing consultation being provided to teams. Documentation provided by DBHDD indicated more than ten different training event topics in addition to the community mental health symposium, the ACT team leader retreat, and technical assistance offerings. Some topics of note that indicate a response to the FY14 report: ACT vocational specialist training and shadowing experiences, motivational interviewing, integrated dual disorders treatment, forensic ACT, housing first, and recovery-oriented systems of care.

Representatives from the Office of Recovery Transformation worked onsite with many teams during the course of fidelity assessments. For instance, they spent time working with some peer specialists to try to bolster their confidence and define their role within the team. Jon Ramos was invited back to Georgia to work with some struggling teams and continued to hold conference calls to help them strategize engaging more resistant consumers. Teams spoke positively of this ongoing consultative relationship. Teams highlighted the responsiveness and competence of DBHDD fidelity assessors and regional office staff who work directly with the teams. Building this potential to provide consultation and training with existing Georgia staff is ideal and increases sustainability.

Work should continue in areas outlined in last year's report: improving the general recovery culture of teams, improving the function and skills of ACT employment specialists, improving the function and integration of peer specialists, and emphasizing independent living options over congregate living situations.

For recovery culture, ongoing work should include emphasis on person-centered culture of the ACT team, including an emphasis on relationship building as the foundation for ACT (as opposed to a sole emphasis on medication or other treatment compliance). Teams might also benefit from work on strengths-based assessment methods. Recovery trainers hired by DBHDD also suggested engaging some of the ACT teams with higher recovery orientation to lead initiatives and provide examples for other Georgia teams, as opposed to out of state trainers bringing out of state examples.

Employment specialist roles were a point of contention this past year that was cleared up by DBHDD. Work should continue to help guide agency leadership in thinking about how best to use these positions for supported employment work, as opposed to case management. Some SE specialists, for example, reported difficulty working on employment issues for ACT consumers because their agency's productivity standards would not be met (i.e., many SE tasks would not be billable services under ACT Medicaid). Other employment specialists will require ongoing consultation and training to bolster their skills in job development. Many SE specialists are still simply searching for existing open positions as opposed to creatively networking with employers around consumer job skills and preferences.

Some teams continue to struggle with placing consumers in independent housing while others seem to do well with identifying independent housing options. In one positive case example, I observed a consumer with both psychiatric and developmental disabilities who had spent most of the last fifteen years in a state hospital with a few periods in the community lasting no more than three months. During her last four-year stay in the state hospital, the ACT team, their agency's hospital liaison, DBHDD regional staff, and hospital staff worked on a discharge plan that included ACT services, DD services (gradually decreased from several hours in the evening offered daily to just a few days per week offered currently), and her own apartment in a complex with some minimal staffing on evenings and weekends (36 hours per week). This consumer proudly took me on a tour of her apartment and talked about how well she was doing living on her own with ACT services. Although she wants to move and graduate from

ACT services eventually, she is proud of her progress. The team reported that DD service providers were hesitant to transition her out, but everyone (including the hospital staff) agreed to try to discharge with the addition of ACT services. The ACT team made ample use of the State's Community Transition Planning funding mechanism to fund their discharge planning and engagement efforts with the consumer. Also, in the six months since her discharge from the state hospital, she has only had one emergency room visit for a medical issue (i.e., no hospitalizations). This was a touching example of how ACT and other services provided by the Settlement Agreement have profoundly changed a life. This was just one example of many I have observed over the last five years, but one that I am sure would be compelling to Georgia stakeholders, if disseminated more widely. A few teams have requested additional help with serving consumers with both psychiatric and developmental disabilities, some with extensive legal histories and behavioral issues. In the case above, the various providers had to coordinate and layer various services, but the ACT team leadership seemed to be key in instigating the discharge to community placement. Relevant to this SHAY item, this particular ACT team could be asked to talk about their approach for this person and how teams can capitalize on ACT services to serve consumers who might otherwise remain institutionalized and persuade skeptical hospital staff or other providers into trying out creative placements.

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:

Progress on this area of support for ACT has been maintained in FY15. Training topics were varied and noted SHAY item 4 above. Many topics addressing areas needing improvement (e.g., recovery orientation, SE, housing philosophy, integrated dual disorders treatment). ACT staff and their supervisors in the field continue to speak highly of the quality of training offered.

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
Improved	5) offers technical assistance and booster trainings in existing EBP sites as needed
Non-state funded teams	6) expansion plan beyond currently identified EBP sites
X	7) one or more identified model programs with documented high fidelity that offer shadowing opportunities for new programs
Some	8) SMHA commitment to sustain mechanism (e.g. center of excellence, university contracts) for foreseeable future, and a method for funding has been identified

Score

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

Comments:

As noted above, ACT staff and supervisors generally have given positive reactions to the training offered by DBHDD in support of ACT. Greater attention this year was focused on both didactic/seminar trainings on recovery-oriented ACT and on-site technical assistance provided to teams by the Office of Recovery Transformation. ACT recovery trainers I spoke with (Hawkins and Stayne, both out of state trainers) also discussed ideas for incorporating Georgia ACT teams who do well with some recovery concepts (e.g., strengths-based assessments, person-centered planning rather than exclusive focus on medication compliance) to engage in training and technical assistance efforts. This suggestion would also address the issue of sustainability as some of this expertise would then be packaged and disseminated with existing in-state

human resources. I encourage DBHDD to brainstorm with Hawkins, Stayne, and/or others about these ideas for future work.

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:

Penetration of basic ACT trainings is high. Some sites are looking forward to repeated offerings of other non-basic trainings (e.g., recovery-oriented services) so that more staff is able to attend.

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,
Yes	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:

No concerns on state-level leadership. The Commissioner, Chief of Staff, and others have a strong grasp of policies to support ACT services. I did recommend to these leaders, and want to reiterate in this report, that the State work to continue to develop, refine, and disseminate both quantitative and qualitative reports on ACT's positive impact for Georgia consumers. This information will be key in sustaining ACT services over the long-term.

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

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

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

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

Comments:

The DBHDD Director of Adult Mental Health continues to be a strong leader for ACT, devotes more than 10% effort to ACT, has and exercises her authority to make policy changes related to ACT, and is observed to be very responsive to consumer, provider, and other community stakeholders with regard to ACT.

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:

The State has worked this year on helping teams secure Medicaid eligibility for consumers whenever possible, such as providing regional office staff to help problem-solve Medicaid issues.

During the course of FY15, we also noted some confusion among ACT teams regarding the use of their supported employment specialists to provide the full array of supported employment services. After some discussion, DBHDD provided better guidance to ACT staff on this issue and the role of SE programs in supporting ACT SE specialists around skill building (i.e., SE programs outside of the ACT team are not to provide job placement or follow-along services to ACT consumers directly – this is the role of the ACT SE specialist).

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:

	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 policies are clearly supportive of high quality ACT. Policy updates in FY15 included clarification on expectations for use of the Community Transition Planning funding mechanism and other standards of care for transitioning consumers out of institutions (e.g., hospitals and jails). This policy change addressed an ongoing concern from stakeholders that some ACT teams were active enough in engaging consumers in these locations, sometimes as a result of no ability to bill for engagement services prior to discharge. Another policy change added the ability to receive reimbursement from DBHDD for consumer transportation needs for recovery goals when unable to be provided by Medicaid or other sources. One SE specialist highlighted the helpfulness of this policy change for consumers who needed help getting to work (i.e., a recovery goal for this consumer) during hours when public transportation is not available in their area. Previous policy changes (mostly from 2012 and 2013 – included here for a comprehensive summary of progress):

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

12. Policies and Regulations: SMHA EBP Program Standards

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

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

Comments:

Following recommendations made last year, corrective action plans and follow-up on those plans were improved in terms of detail and follow-up for low scoring teams. Teams with corrective action plans have monthly follow-up from DBHDD which mostly consisted of phone calls or submission of updated reports with information regarding deficient items. What remains an issue (keeping the fourth component from being satisfied on this SHAY item) is that there is still no clear indication of what would happen if a team does not correct the action. The teams I spoke with were not entirely sure at what point a severe consequence may occur, such as losing the state contract, etc. I recommend thinking about a probationary status of some sort if a team is not able to correct performance to meet the State's overall standard. I gave examples of states where teams can only bill at a partial rate until they perform at the criterion level, after which the final step is removal of contract or ability to bill for ACT services.

13. Quality Improvement: Fidelity Assessment

There is a system in place for conducting ongoing fidelity reviews by trained reviewers characterized by the following components:
(Use boxes to indicate criteria met.)
Note: If fidelity is measured in some but not all sites, answer for the typical site.

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

Fidelity reviews have improved over time. The GOI is still omitted but not necessarily something I would choose to focus on. As I stated in my report last year, focus on the quality of recovery oriented services, supported employment practices on the team, and other roles for team members would be a much better use of time for ACT fidelity assessors and other DBHDD staff.

In past years, I have recommended that the fidelity review team split up ACT team fidelity assessments to gain some efficiencies in their effort and to also make more time to visit teams in between annual fidelity visits. I want to reiterate this recommendation since all three staff are now fully trained in fidelity assessments. One assessor and someone from the Office of Recovery Transformation, for instance, could perform the basic assessment, followed by a visit at a later date to provide more on-site technical assistance or training on areas of weakness found in the report or self-identified by the team. In terms of sustainability, this modification may help DBHDD be able to support ongoing support of quality ACT (including and expanding beyond the DACTS criteria) with existing resources and personnel. Several teams also highlighted the competent and helpful input of DBHDD regional staff who could also continue to be engaged for fidelity assessments to "stretch" central office staff resources.

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 made considerable effort to produce a hospitalization report on a subsample of consumers receiving ACT services, reporting on reductions in hospitalization events and days after ACT enrollment (as opposed to team-wide reports on hospitalization in

each quarter, regardless of tenure on the team). I commend the State for taking on this step forward in documenting the impact of ACT within Georgia. The report was produced recently and may need to be vetted to stakeholders for key questions or clarifications and be published publicly. Several ACT stakeholders had questions regarding this report and the sample selection, as well as ideas on other outcomes of interest. With the re-organization of DBHDD to include the Office of Performance Analysis (under new Division of Performance Management and Quality), DBHDD is well-positioned to expand on this work. DBHDD is also anticipating data to be managed by Beacon (the new administrative services organization). My only caution is that systems data is always difficult to collect and report in a meaningful way, especially if data systems are not in place to capture critical consumers (e.g., consumers served by ACT regardless of Medicaid status) or their outcomes (e.g., hospitalizations of any kind, whether funded by state contract, Medicaid, other insurance, or no insurance). As mentioned previously, having a field in the state data system noting when an episode of ACT services starts and stops will be a key element of any new tracking system. For instance, even on the DBHDD-provided census of ACT consumers, teams told me that this report excludes consumers whose ACT authorization is pending but are still being served by the team. This sort of glitch can certainly impact systems reporting if the method for collecting the data in the numerator and/or denominator is prone to errors that cannot be addressed in some other way. DBHDD should be prepared to refine and extend their existing methods in the event that their new ASO cannot deliver data-driven reports right away. Low tech and simple methods may suffice while waiting on bigger systems to get up and running properly. The critical next step is to circulate the hospitalization report to teams and stakeholders to see if it makes sense to them, and revisit methods if needed.

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.

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 ACT providers continue to have a sense of strong partnership with DBHDD around ACT services. Even when concerns were expressed around the sustainability of ACT funding and infrastructure supports, one agency leader stated: “If we get to keep even 80% of what we have gotten from the Settlement, I would be happy.” Consumer, family, and other advocate groups continue to express much support for ACT services, but do express concern over the sustainability of ACT and whether DBHDD has built a strong enough case for retaining ACT after the Settlement Agreement period ends.

Summary of SHAY Scores Over Time

	2012	2013	2014	2015
1. EBP Plan	3	5	5	5
2. Financing: Adequacy	5	5	3	4
3. Financing: Start-up and Conversion Costs	3	5	5	5
4. Training: Ongoing Consultation & Technical Support	2	4	4	4
5. Training: Quality	3	4	4	4
6. Training: Infrastructure / Sustainability	1	4	4	4
7. Training: Penetration	4	5	5	5
8. SMHA Leadership: Commissioner Level	5	5	5	5
9. SMHA Leadership: EBP Leader	3	5	5	5
10. Policy and Regulations: Non-SMHA	3	4	4	4
11. Policy and Regulations: SMHA	2	5	5	5
12. Policy and Regulations: SMHA EBP Program Standards	3	5	4	4
13. Quality Improvement: Fidelity Assessment	1	4	4	4
14. Quality Improvement: Client Outcome	1	4	4	4
15. Stakeholders: Aver. Score (Consumer, Family, Provider)	4	4	4	4
SHAY average = average over all 15 items	3.58	4.53	4.33	4.40

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