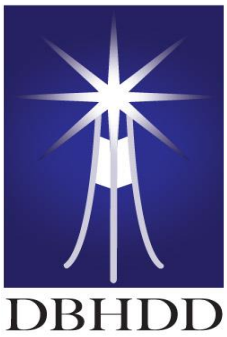
Georgia Department of Behavioral Health & Developmental Disabilities



2015 INTERIM QUALITY MANAGEMENT REPORT

Prepared by the DBHDD Office of Quality Management
August 2015

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Introduction

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) serves as the single state authority for the provision of direct services, administration, and monitoring of all facets of the state's publicly funded behavioral health & developmental disabilities service system. DBHDD's role as a direct service provider is limited to the operation of five state hospital campuses. Outpatient services are delivered by a network of private and public providers with whom DBHDD contracts. DBHDD Contractors are community-based organizations which administer behavioral health & developmental disabilities services throughout the state and are responsible for the provision of comprehensive services for children and adults with substance abuse disorders, serious and persistent mental illness (SPMI) and developmental disabilities.

This report is DBHDD's August 2015 Interim Quality Management (QM) System Report. The report and the summary of activities contained herein comprise a review of quality management activities that have taken place in the hospital, community behavioral health and developmental disabilities systems of care, as well as a review of QM activities at the State Office. It is the intent of DBHDD to share this report with Department staff and stakeholders.

The primary purpose of this Interim Report is to synthesize and communicate the DBHDD QM activities taking place across the Department. As a result of data availability, the analysis and discussion contained within this report will vary, but generally focuses on activities and data between January 2015 – June 2015.

Activities of the Quality Councils

Executive Quality Council

The Executive Quality Council (EQC) is the governing body for the QM program providing strategic direction and is the ultimate authority for the entire scope of DBHDD QM activities including the QM plan, the DBHDD work plan and the annual evaluation. The EQC is the highest-level quality committee in DBHDD. The EQC met in March 2015 and a summary of some of the key EQC activities that took place during that meeting includes:

- Performed its annual review of the QM system.
- Discussed the Hospital System revision of their Annual Key Performance Indicators.
- The new chairperson of the Community Behavioral Health (CBH) Program Quality Council (PQC) discussed her vision for the PQC.
- Discussed the re-engineering of the DBHDD DD service system.
- Reviewed the Office of Incident Management and Investigation's (OIMI) trends and patterns.
- Received updates from the Hospital, CBH and DD PQCs regarding the quality management-related work that each functional area prioritized.

Between January and June 2015, the DBHDD conducted significant work related to functional realignment of many activities of the Department. As a part of this work, two new Divisions, the Division of Performance Management and Quality Improvement (PMQI) and the Division of

Accountability and Compliance (DAC), were created. The Department's executive team and the Division Directors for PMQI, DAC, Behavioral Health, Developmental Disabilities and the Hospital System met regularly and defined the scope of responsibilities for each Division. The two new Divisions presented and received approval for plans for establishing their offices and realignment of staff from within the state office and all DBHDD Regional Offices (now Field Offices) began to occur. The organizational structure for the Division of PMQI includes an integrated Office of Quality Improvement and the Department created a new Director-level position to provide oversight and began a national recruiting effort to fill this position. The individual selected for this position will assume responsibility for the future design and development activities related to the organization-wide, integrated Quality Management system.

During January and June 2015, the Department's executive team also made the decision to adopt the National Quality Strategy and engaged a national expert to assist the Division Director for Performance Management and Quality Improvement by providing consultation and recommendations regarding the Department's quality framework and providing input on the job description, minimum qualifications, recruiting strategies, and feedback on candidates for the Director of Quality Improvement.

The Division of PMQI also includes and Office of Performance Analysis and a Director was hired and a plan for staffing the office with statistical experts and data managers was created. Three staff have been realigned from other areas within the Department and recruitment began for a performance analyst position to better meet the needs for statistical and analytical technical expertise. Additional realignment of staff from other areas is expected. This Office provides research and data analytical support to the Offices of Quality Improvement and Provider Network Management as well as to other Divisions and Offices where quality improvement or program evaluation activities are essential to inform decision-making and planning.

Hospital System Program Quality Council

The Hospital System PQC meets bimonthly, and has held 3 meetings between January 2015 and June 2015. During this period, the HSPQC developed additional Key Performance Indicators (KPIs) for the Hospital System. In addition, two new discipline committees were created, Activity Therapy and Environment of Care & Safety to support quality improvement goals of the Hospital System. As determined by the committees, discipline-specific performance measures may be created. In the bimonthly meetings, the Hospital System PQC continues to address patient safety and other performance measures. A brief summary of some of the key Hospital System PQC activities that took place during those meetings includes:

- Reviewed PI initiatives focused on management of aggression, restraint and seclusion, polypharmacy, consumer satisfaction and other performance measures.
- Focused on PI initiatives aimed at reducing incidents of aggression and use of restraint and seclusion.
- Reviewed and modified strategies being utilized by hospital-based PI teams to improve patient safety.
- Addressed data collection methodologies and data integrity issues that affected reporting timeliness and quality.

- Reviewed and discussed the Triggers and Thresholds report data, the Hospital System dashboard measures and specific Hospital System KPI trends and patterns and made suggestions/recommendations for program/service changes.

Community Behavioral Health Program Quality Council

The Community Behavioral Health PQC held one meeting between January 2015 and June 2015. A brief summary of some of the key CBH PQC activities that took place during that meeting includes:

- Discussed preparations for transitioning some of the quality related work to the new Administrative Services Organization (ASO).
- Discussed strategies to maximize the PQC's time with relationship to the ASO.
- Discussed the national quality framework.
- Received an update from the Office of Incident Management and Investigations comparing community incident data from 2014.

In lieu of the usual monthly BH PQC meeting schedule, BH leadership committed their time to staff the joint DBHDD/Georgia Collaborative ASO QM Committee whose goal it is to ensure that the quality management activities of the Georgia Collaborative ASO are implemented in a manner that is consistent with the Department QM plan, the ASO Request for Proposal (RFP) and the vendor's proposal. This workgroup's meeting schedule is very intensive and includes joint meetings twice per week with additional ad hoc meetings and workgroups as needed.

The work of this committee during this process involved planning and specification of detailed IT requirements for the collection of individual outcome indicators (e.g. housing, employment, functional status, use of hospital services, criminal justice involvement, etc.), creation of new quality review tools for BH and DD services and designing the methods and processes that will be used to collect, summarize, and report on information gathered during these quality reviews. The DD leadership and staff worked alongside the BH leadership and staff to integrate the quality review processes for BH and DD services as much as was practical and appropriate and to provide their unique expertise and experience in the development of the Georgia Collaborative' s QM activates, tools and processes. The activities during this period concluded with the performance of the QM Readiness Review in preparation for the go-live of quality reviews in July 2015.

Developmental Disabilities Program Quality Council

The DD Program Quality Council did not meet in the first half of 2015 however quality data was shared with DD Leadership. Like the Division of BH, leadership and staff from the Division of DD, devoted significant resources to the joint DBHDD /Georgia Collaborative ASO QM workgroup during this review period. See above for description of these activities during this period.

Each of the Regional and Statewide QI Councils met at least once during the period of January 2015 through June 2015. All the Councils convened in October for their annual group conference. Data from the FY14 Quality Assurance Report was shared and discussed with the Councils. Each Council had a chance to begin developing their 2015 work plans based on their

respective regional data. Additionally, each Council presented on the quality improvement projects that they completed in FY14. Examples of those presentations can be found at: http://www.dfmc-georgia.org/quality_improvement_council/project_plan_presentations/index.html.

The Statewide Quality Council met once between January and March 2015. In partnership with the Division of DD, the Statewide Council began work on the development of a QI Council Communication Plan. This plan will improve the dissemination of information regarding the activities of the Statewide and Regional Councils. The plan will also improve communication among the Councils themselves. All Regional QI Council Co-Chairs continue to participate in the Statewide Council meetings. An invitation was extended to all Regional QI Council Co-Chairs to become members of the Statewide QI Council. The Regional Co-Chairs attended the December 2014 Statewide Council meeting.

The Statewide QI Council continued to provide support to the Division concerning the Transition Plan for the Home and Community Based Waivers. Support included education of community stakeholders and providers concerning the plan and data collection.

Regional QI Council Initiative Updates**:**

Region 1 Researching the implementation of peer-to-peer support groups for IDD providers and possibly partnering with an advocacy agency on this initiative.

Region 2: Working with the Abuse, Neglect, and Exploitation (ANE) Advocators to work on Choice.

Region 3: Doing a mini pilot of a training program to educate individuals and families on Choice.

Region 4: Developing resources in each county to share with people who have limited access to services.

Region 5: Conducting Provider fairs to educate individuals and families on the type of supports and services that are available in the region.

Region 6: Working with local physicians and health professionals to provide technical assistance on education concerning the needs of individuals transitioning to the community.

Status of Quality Management Work Plan Goals

Each Program Quality Council developed a work plan to guide the quality management activities within its area of responsibility. The EQC defines the work plan for the Department through the DBHDD QM Work Plan and then the Program Quality Councils develop program-specific work plans for the hospital system, the community behavioral health and developmental disabilities service delivery systems**.**

Below are descriptions of the status of each functional area's work plan and the progress toward achieving the work plan goals for each Quality Council:

DBHDD QM Work Plan

As of July 2015 the DBHDD QM Plan and Work Plans were in the process of being updated. For the purposes of this Interim Report the existing QM Plan and Work Plans have been utilized. Overall, the tasks in the first goal related to accurate, effective and meaningful performance indicators have been met.

The second goal is related to the education of stakeholders regarding QM. As of July 2015 the DBHDD QM Learning Plan will be delayed pending the hiring of a new Director of QI, but once finalized will be included in a revised QM Plan.

The third goal related to implementing the outcomes framework has been completed but it is anticipated that it will be revised during the latter part of 2015 using the National Outcomes Framework as a model.

Component parts of the fourth goal related to IT data systems have been completed but as the result of IT leadership changes there have been changes in tasks and projects, which will be reflected in an updated QM Plan.

The following are summaries of the activities related to each PQC's QM work plan which support the goals of the DBHDD's QM Work Plan. See Appendix A.

Hospital System QM Work Plan

The Hospital System is working to maintain and improve quality as it assists in DBHDD's strategic direction toward building community-based services while reducing its dependence on state hospitals. As the System's hospitals are reduced in size, closed and/or repurposed, it is essential that an effective quality management system is maintained so that those transitions are managed in a way that assures that individuals receive the quality of service they deserve. At the time of this report, the progress with regard to the identified goals was consistent with the current plan. See Appendix B.

CBH QM Work Plan

Progress towards meeting the goals is consistent with the plan except for the items in Goal 2 related to QM training plans for providers and individuals served and for Goal 4, which is related to integration of QM data systems. Progress on Goal 4 is behind schedule due to the ASO implementation, which will provide enhanced data integration and reporting to support the Department and providers' QM systems. See Appendix C for the CBH QM Work Plan.

DD QM Work Plan

The Developmental Disabilities quality management work plan continues to support the DBHDD QM work plan and addresses the need to ensure that individuals with I/DD who transition out of state hospitals receive the highest quality of services and achieve their goals once in the community. The I/DD Work Plan strives to assure that individuals living in the

community receive the highest quality services and supports in the least restrictive environment. Progress toward meeting the goals of the DD work plan is consistent with the plan's targeted timelines. Some Target Completion dates were extended based on the Georgia Collaborative Timeline, See Appendix D.

The Division of DD continues with its Re-Engineering Project that is evaluating how IDD functions at both a systemic and support provision level. The Division formed the following five workgroups:

- Health and Wellness: The Health and Wellness committee has focused on developing policies for both new Behavioral Support and Consultation Services and Nursing services. The committee has formed two sub-committees for these two clinical areas. The committee has also drafted policies for use of the HRST and assisted in the development and implementation of the new Integrated Clinical Support Team.
- Support Coordination: Reviewed present support coordination responsibilities, and developed a "Pioneer Project" to improve the quality of transitions from State Hospitals to the Community. More information on the Pioneer Project can be found under "DD Transition Quality Review Analysis". Additionally, a program was developed for the improvement of Support Coordination which was entitled "Enhanced Support Coordination." This was to include pre-transition and post transition activities. A key component of this was early engagement by Support Coordination and also included broader service delivery post transition. A new model of monitoring identified as "Recognize and Refer" was used to encourage collaboration and improvement of service delivery rather than punitive ratings. Referrals could be of the clinical or nonclinical nature.
- Continuous Quality Improvement: Reviewed current QM practices, developed draft IDD Performance Indicators with the input from external and internal stakeholders; developed a Mortality Review Report that will be disseminated in the latter half of Calendar Year 2015; and assessed current data collection protocols.
- Competency-Based Training: Reviewed current training practices; assessed training needs; provided training supports to the five workgroups, plus regional and state staff.
- Individual and Community Supports: Conducted quarterly sample reviews of transitions that have occurred utilizing standardized performance assessment tools; developed an efficient process to ensure funding transfers for community placements; analyzed trends in provider data to determine key courses of action to be taken by Performance Management Unit or other relevant units. See Appendix D for the DD work plan.

Key Performance Indicators and Outcomes

Data Collection Plan/Data Definition Document

The data definition document is used by each of the three functional QM areas within the Department and provides guidance on how each element and attribute of KPIs should be used. It gives details about the structure of the elements and format of the data. Additionally the Performance Measure Evaluation Tool (PMET) is used when evaluating existing or developing new KPIs.

Dashboards

The KPI dashboard format incorporates KPI data in table and graph form, provides measure definition & explanation, a numerator and denominator explanation and an analysis of the KPI for the time period. The KPI dashboards can be found in Appendices E, F and G.

Hospital System Key Performance Indicators

The key performance indicators utilized by the Hospital System are a combination of quality measures that support the System's value of three priority areas:

1. The use of consumer feedback to reflect the quality of our services
    a. Client Perception of Outcome of Care
        i. Summary comments and analysis: The DBHDD Hospital System facilities have consistently scored higher than the baseline established on the basis of the national averages for the same survey tool. The hospital Quality Management departments are looking at ways to improve the consistency and timeliness of reporting and the consistency and quality of the methods of administration of the survey instruments.
    b. Client Perception of Empowerment
        i. Summary comments and analysis: The DBHDD Hospital System facilities have consistently scored higher than the baseline established on the basis of the national averages for the same survey tool. The hospital Quality Management departments are looking at ways to improve the consistency and timeliness of reporting and the consistency and quality of the methods of administration of the survey instruments.
2. The importance of continuity of care with regard to the transition of consumers between hospital and community services
    a. Continuing Care Plan Created (Overall)
        i. The Hospital System has managed to reduce the variation it experienced in the previous six month period, and achieved a more consistent overall improvement trend to a level that is well within the target range for this measure.
3. The importance of supporting the recovery of individuals receiving BH hospital services
    a. Individual Recovery Plan Audit - Quality Measure
        i. Summary comments and analysis: As was reported in the previous QM system review, the Hospital System has continued to achieve a gradual overall positive trend. While the gradual improvements reflected in these data indicate that the current strategy has been effective, the Hospital System PQC is currently looking to develop new qualitative measures that will provide additional information on the extent to which the System is meeting its goal of being a recovery-oriented system of care.

The Hospital System plans to continue to monitor and improve the quality of care measured by these KPIs and to utilize additional measures to provide feedback on other aspects of quality. The hospital system dashboard can be found in Appendix E.

Community Behavioral Health Program Key Performance Indicators

Summary and Recommendations for the current CBH KPIs:

1. Georgia Housing Voucher Program adult individuals with serous and persistent mental illness (SPMI) in stable housing
    - Summary comments and analysis: The number of individuals receiving Georgia Housing Vouchers who are in stable housing has significantly exceeded the HUD standard of six months and DBHDD's target of 77% for the January 2015 to June 2015 time period, and appears to be stable at approximately 92%.
2. Georgia Housing Voucher Program adult individuals with SPMI who left stable housing under unfavorable circumstances and have been reengaged and reassigned vouchers
    - Summary Comments and analysis: DBDD tracks Georgia Housing Voucher individuals who left stable housing under unfavorable circumstance and were reengaged in services. Between January – June 2015 this KPI appears stable averaging between approximately 18 – 19% which exceeds the target of 10%. This KPI will continue to be monitored.
3. Adult Mental Health supported employment providers that met a caseload average on the last day of the calendar month of employment specialist staff to consumer (1:20 and under):
    - Summary Comments and analysis: The target of 85% or more has not been met during this reporting period. Between January – March 2015, two providers indicated that they will be performing additional training with their clinical staff about SE options for consumers who indicate the desire to work as they have not been receiving internal referrals from new clinicians.
4. Individuals who had a first contact with a competitive employer within 30 days of enrollment
    - Summary Comments and analysis: The overall percentage of consumers who had first contact slightly decreased in comparison to the previous two quarters, but still exceeded the target of 75%. This measure is analyzed on a 30 day lag and April 2015– June 2015 data was not available for analysis as of the date of this report.
5. Assertive Community Treatment consumers who are received into services within 3 days of referral
    - Summary Comments and analysis: The target of 70% was met during the months of February, March, April and May 2015 (June data was not available at the time this report was released).
6. Assertive Community Treatment consumers with a Psychiatric Inpatient admission within the past month
    - Summary Comments and analysis: The target of 7% or less was not met for this reporting period but shows a slight downward trend in hospital utilization for the month of May. Some providers indicate that new or acute consumers may be admitted more frequently and may benefit from respite in place of psychiatric admission.

7. Average number of jail/prison days utilized per enrolled Assertive Community Treatment consumer
    - Summary Comments and analysis: The target of 1 day or less was met for January, February and May 2015. There was a slight spike in jail utilization during the month of April.
8. Intensive Case Management consumers with a Psychiatric Inpatient admission within the past month
    - Summary Comments and analysis: For this reporting period overall the target of 5% or less was not met for the months of February, April and May, however the percentages appear slightly better than previous quarters.
9. Intensive Case Management consumers housed (non-homeless) within the past month
    - Summary Comments and analysis: Overall the target of 90% or more was met during this reporting period.
10. Average number of jail/prison days utilized per enrolled Intensive Case Management consumer
    - Summary Comments and analysis: The target of .25 days or less was not met for this reporting period. This KPI will continue to be monitored.
11. Community Support Teams with a Psychiatric Inpatient admission within the past month
    - Summary Comments and analysis: Overall the target of 10% or less was met during this reporting period.
12. Community Support Team consumers housed (non-homeless) within the past month
    - Summary Comments and analysis: Overall the target of 90% or more was met during this reporting period.
13. Average number of jail/prison days utilized per enrolled Community Support Team consumer
    - Summary Comments and analysis: Overall the target of 0.75 days or less was met for all months during this reporting period except for May which shows a slight upward trend. This trend pattern is consistent with the same time period from 2014.
14. Case Management consumers with a Psychiatric Inpatient admission within the past month
    - Summary Comments and analysis: Overall the target of 5% or less was met during this reporting period.
15. Case Management consumers housed (non-homeless) within the past month
    - Summary Comments and analysis: Overall the target of 90% or more was met during this reporting period.
16. Average number of jail/prison days utilized per enrolled Case Management consumer
    - Summary Comments and analysis: Overall there continues to be some variability in the average number of jail/prison days utilized during this time; which was met for all months except April which at .26 just missed the target of .25 days or less.
17. Percent of Adult Addictive Disease consumers active in AD treatment 90 days after beginning non-crisis stabilization services
    - Summary Comments and analysis: This KPI became effective in July 2013 and is collected on an annual basis. It is anticipated that 2015 data will become available in October 2015.

18. Percent of Adult Addictive Disease consumers discharged from crisis or detoxification programs who receive follow-up behavioral health services within 14 days.
    - Summary Comments and analysis: This KPI became effective in July 2013, is collected on an annual basis. It is anticipated that 2015 data will become available in October 2015.
19. Percent of Individuals who are enrolled in services and were included in a review or audit who state they are satisfied with the services they are receiving
    - Summary Comments and analysis: This measure was met during the time frame.
20. Percent of Individuals who are enrolled in services and were included in a review or audit who feel their quality of life has improved as a result of receiving services
    - Summary Comments and analysis: This measure was not met during the time frame. A review of individual's answers did not indicate a particular pattern and responses to why they felt their quality of life had not improved were varied.
21. Percent of youth with an increase in functioning as determined by a standardized tool
    - Summary Comments and analysis: The Department is transitioning from the Child and Adolescent Functional Assessment Scale (CAFAS) to the Child and Adolescent Needs and Strengths (CANS). The implementation of the CANS is scheduled for October 2015. Data collection for this KPI will begin in FY16.
22. Percent of families of youth satisfied with services as determined by their parent or legal guardian using a standardized tool
    - Summary Comments and analysis: This data is collected and analyzed on an annual basis. In 2014, 84% of families of youth were satisfied with the community mental health services they received.

The Community Behavioral Health dashboard can be found in Appendix F.

Developmental Disability Programs Key Performance Indicators

In July of 2014, the Division of DD convened a stakeholder work group which included representation from providers, self-advocates, family members, support coordination, advocacy agencies, and DBHDD staff, to recommend quality Outcome and Performance Indicators. The indicators focus on the quality of services provided by DD Providers and the Division itself. DD will use some of these indicators as KPIs for Providers and the DD system itself. At the time of this report, the indicators were being finalized. Examples of draft outcomes and indicators include:

- Outcome: People have timely access to needed services
    - Performance Indicator: Average number of days between approval of a Prior Authorization and services beginning
- Outcome: People are connected to their community
    - Performance Indicator: Proportion of individuals who have established at least one non-paid/non-family community relationship.

The Performance Indicators are currently undergoing review by DBHDD Leadership. Once approved, the goal is to begin gathering data from various sources. An example of a data source would be Quality Enhancement Provider Reviews that are conducted by the Georgia Collaborative ASO.

Person Centered Supports

Each individual's team of supports meets annually to develop an ISP that is person centered and supports the individual's needs and desired goals. An ISP QA Checklist tool was initially developed by the Department to ensure the ISP includes all necessary requirements as dictated by DBHDD, and that it helps ensure the individual has a healthy, safe, and meaningful life. Please see Section entitled *DD Individual Support Plan Quality Assurance (ISP QA) Checklist* on page 40 for a detailed description on ISP Quality Assurance.

Health and Safety

The Division of DD utilizes the National Core Indicator Survey to gather directly from individuals and their families, the satisfaction they feel with their services and supports and to gather additional data on the health and safety of those individuals. The Division of DD received the latest Georgia NCI data, which is for 2012 – 2013, in mid-July 2014.

In 2014, 40 states participated in the NCI Project. The latest Georgia NCI data (2013-2014) was released in January 2015. Georgia's NCI reports can be found at:

http://www.nationalcoreindicators.org/states/GA/

Georgia is performing at or above the National Average in the majority of the sub-domains for the NCI Consumer Survey.

- Georgia is above NCI Average in Choice, Community Inclusion, Work, and Health and Safety.
- Georgia is below the National Average for individuals who are self-directing their services; individuals who have had Vision-Hearing Screenings; and annual dental examinations. DBHDD continues to educate individual/families and support coordination agencies on the option of self-directing services. DBHDD has implemented processes to conduct hearing assessments on all individuals currently in service who report having some form of hearing impairment, as well as all individuals entering into services.

Georgia is below average on several indicators for NCI Adult Family Survey. These areas include service coordinators informing families of services available, individuals having service plans, services and supports changing when family needs change, and transition from school to adult services.

Efficiency of Services

In 2011, as part of the Settlement Agreement and as a direct result of the prohibition on DD individuals being admitted to state hospitals, the Division of DD created the Georgia Crisis Response System for Developmental Disabilities.

The goal of this system is to provide time-limited home and community based crisis services that support individuals with developmental disabilities in receiving crisis supports in the least restrictive environment possible, and provide alternatives to institutional placement, emergency room care, and/or law enforcement involvement (including incarceration). These community based crisis services and homes are provided on a time-limited basis to ameliorate the presenting

crisis. The system is to be utilized as a measure of last resort for an individual undergoing an acute crisis that presents a substantial risk of imminent harm to self or others.

The Georgia Crisis Response System (GCRS) includes intake, dispatch, referral, and crisis services components. An essential part of this system is the assessment of the individual situation to determine the appropriate response to the crisis. Entry into the system takes place through the Single Point of Entry (SPOE) system. Intake personnel determine if an individual meets the requirements for entry into the system and initiate the appropriate dispatch or referral option. If a Developmental Disability (DD) Mobile Crisis Team is dispatched to the crisis location, this team assesses the need for a referral or crisis services. Crisis services include intensive on-site or off-site supports.

Two main components of the system are Intensive In-Home Supports and Intensive Out of Home Supports.

The intent of Intensive In-Home Support is to stabilize the individual through behavioral intervention strategies provided under the recommendations of the DD Mobile Crisis Team. The services are provided in the individual's home and may be provided 24/7 for a limited period of time. During the first half of 2015, 5% of crisis incidents resulted in the need for intensive in-home supports. Utilization of the intensive in-home supports has been consistent (5%-6%) over the last 12 months.

The intent of Intensive Out-of-Home Supports is to stabilize the individual through nursing and behavioral supports, on a time-limited basis. Intensive Out-of-Home Supports are provided in one of 11 Crisis Support Homes strategically located across the state. An additional 12th Crisis Support Home is currently in development, and will become operational in the latter half of calendar year 2015. During the first half of 2015, 8% of crisis incidents resulted in the need for intensive out-of-home supports. This was a drop of 4% Utilization of Crisis Support Homes compared to last quarter of 2014, but the drop was not significant compared with the last three quarters of data. The use of the homes continues to be higher than the use of Intensive In-home Supports, which is not a goal of the crisis system. A new Crisis Services Coordinator has recently been hired. One of the responsibilities of this position is to review the entire DBHDD crisis system and address areas where improvement is needed. The work of this position will be reported in the 2015 Annual Report.

Crisis data shows that the system is operating as it should, with the individual receiving crisis supports in the least restrictive environment as possible; however, there is a statewide lack of Respite (Emergency and Planned) Services. This lack of services directly results in individuals being placed in Crisis Support Homes, when there are no other supports available. The Division is currently evaluating and attempting to increase its Respite Services capacity.

DBHDD continues with the challenging work of supporting dually diagnosed individuals. The Department has implemented a statewide Mobile Crisis Response System for individuals with behavioral health issues, and the Division of DD is partnering with the Division of Behavioral Health to address this shared population. The implementation of the Georgia Collaborative will help with addressing the person as a whole, with the capacity to review all supports and needs of

an individual. A Director of Crisis Services Coordination was hired in June of 2015. This new position will be responsible for the coordination of both the BH and DD Crisis System. It is a goal of DBHDD that eventually there will be an integrated Crisis System to address both populations of individuals.

Administrative Services Organization (ASO)

A key goal of the Georgia Department of Behavioral Health and Developmental Disabilities is to improve access to high-quality and effective services for individuals with developmental disabilities (DD) and/or behavioral health (BH) conditions. To help achieve this goal, in September of 2014 the Department completed the procurement of an Administrative Services Organization (ASO). The Department contracted with ValueOptions, which has undergone a merger and is now Beacon Health Options.

This contract combined several important functions that were previously provided in several distinct contracts. Those functions include:

- BH External Review Organization
- Georgia Crisis and Access Line
- DD Quality Management System
- DD Consumer Information System

Some highlights of the ASO functions include:

- Maintaining a 24/7 crisis and access line for behavioral health and developmental disability services.
- Creating a single information technology system for behavioral health and developmental disability services.
- Using state-of-the-art technologies to create efficiencies and improve the quality of care.
- Performing on-site quality reviews of both behavioral health and developmental disabilities services.
- Providing an integrated and effective platform for monitoring the department's quality management plan.
- Providing focused utilization management and review services for intensive services and a streamlined process for less intensive services.

One of the Georgia Collaborative ASO's initiatives is to design and develop a new case management system for the Division of DD. One aspect of the new system will be the development of a new electronic Individual Support Plan or "eISP". In the first half of 2015, the Division of DD implemented 9 teams of internal stakeholders to review the existing case management system and ISP, and make recommendations for the new case management system development. For example, one team was tasked with reviewing all current assessment templates and making changes where needed. Another team was tasked with reviewing and updating the current Support Coordination monitoring tools. There is also a team specifically focused on the development of the new eISP. All teams have a goal of completing their work prior to the end of 2015. All recommendations will then be submitted to the Georgia Collaborative ASO to begin programming the new system.

For additional information about the ASO please click on the following link: https://dbhdd.georgia.gov/administrative-services-organization. The ASO began a phased go-live with operations beginning on July 1, 2015.

Quality Monitoring Activities

Complaints and Grievances

Constituent Services is a function of the Office of Public Relations (OPR) and serves as the liaison to consumers, families, advocates, and the general public for assistance with complaints, grievances, and inquiries relative to the department and community services. In addition, the office collects and reports data to executive staff via the Executive Quality Council regarding issues and resolutions of consumer concerns.

Constituent Services staff received 79 complaints, grievances and inquiries between January 1, 2015 and June 1, 2015. Of the 79 complaints received there were 21 issue categories, as illustrated in the following table:

Issue Categories	
Addictive Diseases	**Human Resources**
• Adult services and community care placement • DUI Intervention	• Termination – Hospital employee
Developmental Disabilities	**Mental Health**
• Complaint about provider services • Exceptional Rate • NOW & COMP Waiver need for funding • NOW & COMP Waiver eligibility • Planning List • Residential placement • Request to change services or provider • Self-Directed Services - budget	• Access to services • Complaint – Community psychologist • Complaint - provider services • General Information about services • Housing • Inpatient evaluation /discharge • Long-term intensive patient treatment • Residential placement
Provider Network Management	
• Provider application process • Provider certification	

Mental health services was the most frequent issue category cited during this time, totaling forty (40) cases or fifty-one percent (51%) of all inquiries received. Of the forty cases, twenty-eight (28) were triaged and sent to the six regional offices, as well as state office staff, to address and respond to OPR within 5 to 7 business days. The other twelve mental health inquiries were triaged to Georgia Regional Hospital in Atlanta, East Central Regional Hospital in Augusta and West Central Georgia Regional Hospital in Columbus. The primary concerns of individuals advocating for mental health services on behalf of another person were access to community services, access to inpatient treatment and the need for long-term intensive inpatient treatment.

The second most frequent issue of concern was related to developmental disabilities services. Thirty-four percent (34%) of the developmental disability complaints/inquiries were pertaining to the need the New Options Waiver (NOW) and the Comprehensive Supports Waiver (COMP) program. Thirty-one (31) inquiries received were related to developmental disabilities and were received from family members, friends or an advocate of the individual who was the subject of the inquiry.
Thirty-nine percent (39%) of all inquiries were referred from the Governor's Office or by members of the Georgia General Assembly. In some instances, individuals contacted the Governor's Office as well as their legislator resulting in duplicate inquiries. Many of these inquiries cited the need for additional waiver funding.

In efforts to improve the overall constituent services process, the Department's Office of Information Technology is currently developing a secure case-management system to manage all incoming constituent service inquiries. The system will incorporate a user-friendly, web-based intake form on the department's website. Additionally, the system will protect against data-loss, provide status updates to those making inquiries, and provide staff with the ability to produce customized reports of cases managed.

OPR and Constituent Services will continue to analyze complaint/grievance trends and patterns, which can be used for service and program improvement.

Hospital and Community Incident Data January 2015 – June 2015

DBHDD requires its contractors to report incidents per Policy 04-106, Reporting and Investigating Deaths and Critical Incidents in Community Services, and DBHDD hospitals per Policy 03-515, Incident Management in Adult Mental Health and Forensic Units and Policy 03-615, Incident Management in DBHDD Skilled Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities. Contractors and Hospitals are required to report significant and/or adverse incidents for all individuals served. These reports are submitted to DBHDD, Office of Incident Management and Investigations (OIMI). OIMI staff review all submitted reports for identification of potential quality of care concerns. The quality of care concerns are triaged for investigation either at the State or Contractor level.

The following incident review covers critical incident reports received in the Office of Incident Management and Investigations from January 1, 2015, through June 30, 2015. The total incidents received by month for hospitals and community providers are included in Tables 1 and 3 below. The tables also provide a comparison for the current report period (January 2015 – June 2015) with the prior six-month period (July 2014 – December 2014).

Hospital Incident Data

As Table 1 indicates, the total number of hospital incidents for the report period was 4,144, or a rate of 20.32 per 1000 patient days, compared to the prior 6 months of 3,427, or rate of 16.45 – an increase in the rate of incidents of 20.9%. A contributing factor to the rate increase between the two report periods is a spike in reporting A42-Minor Occurrence Injuries which increased from 121 to 387 or 219.8% - the preponderance reported by ECRH. It is hypothesized that this increase is due to training related to identification and reporting of minor occurrence injuries.

Another category that saw an 89.3% increase from the prior report period was A2-Aggressive Act to Self - increasing from 206 to 309 across all hospitals.

NOTE: *The rate is used to adjust for differences in the size of the patient population by taking total incidents divided by Occupied Bed Days (OBD) multiplied times 1000. OBD was not available for June 2015 at the time of this report so an average of the previous bed days was used. All rates in this report have been rounded to the nearest tenth or hundredth; therefore, any calculations performed using the rounded numbers presented here will result in minor differences when compared with the numbers within this report.*

Table 1: Total Incidents by Month

HOSPITAL Incidents

Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Total Jul-Dec 2014
532	544	548	615	605	582	3427
Jan-15	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Total Jan-Jun 2015**
704	641	691	678	652	778	4144

HOSPITAL RATE (Incidents per 1000 patient days)

Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Avg. Jul-Dec 2014
14.98	15.48	16.07	17.57	17.96	16.72	16.45
Jan-15	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Avg. Jan-Jun 2015**
20.18	20.31	19.84	19.94	18.81	22.89	20.32

The five hospital incidents most frequently reported during this review period are listed below in Table 2. Incident types A04 and A03, "Aggressive act to staff-Physical" and "Aggressive act to another individual-Physical", occurred more often than all others and account for 47% of the total number of incidents reported. The incident rate for "Aggressive act to staff-Physical" increased from a rate of 4.25 per 1000 patient days to a rate of 4.84 compared to the prior six months – a 14.1% increase. "Aggressive acts to another individual-Physical" increased from 4.08 per 1000 patient days to 4.63 – an increase of 13.5%. Incident Types A02 "Aggressive act to self", A01 "Accidental Injury", and A42 "Minor Occurrence Injury", round out the most frequently reported hospital incidents. These five incident types account for 74% of the total number of incidents reported.

Table 2: Most Frequently Reported Hospital Incidents (updated 7/6/2015)

Hospital Incident Type	Total	Rate (incidents per 1000 patient days
A04-Aggressive act to staff-Physical	988	4.85
A03-Aggressive act to another individual-Physical	945	4.63
A02-Aggressive act to self	390	1.91
A42-Minor Occurrence Injury	387	1.90

A01-Accidental Injury	381	1.87

Community Incident Data

Unlike the Hospital System data, which uses patient days as a (common) denominator, there is no such equivalent on the Community provider side. It is much more challenging and less reliable to estimate the "patient population" for the diverse and changing numbers of community programs. Therefore, any interpretation of the comparison data reported in this section should be done with that caveat in mind.

The total community incidents for the report period were 1,930 compared to the previous 6 months of 1,949, reflecting a decrease of less than 1% (reporting as of 7/6/2015).

Table 3: Total Community Incidents by Month

Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Total
320	314	317	344	318	336	1,949
Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	
324	308	336	350	341	271	1,930

See Table 4 below for the five most frequently reported community incident types.

Table 4: Most Frequently Reported Community Incidents (updated 7/6/2015)

Community Incident Type	Total
C-Hospitalization of an Individual in a community residential program	655
C-Incident occurring in the presence of staff which requires intervention of law enforcement services*	325
C-Individual injury requiring treatment beyond first aid	310
C-Alleged Individual Abuse-Physical	278
C-Individual who is unexpectedly absent from a community residential program or day program	267

*The second most frequently reported incident type is actually C-Deaths (Category III); however these deaths are not investigated, therefore they are not included here. NOTE: Category I and Category II deaths are investigated per policy. See definitions below from policy, 04-106, Reporting and Investigating Deaths and Critical Incidents in Community Services for definitions of each.

Death-Unexpected (Category I): An unexpected death is when the cause of death is not attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation of the outcome is death.
Includes the death of any individual:

Receiving residential services or receiving 24/7 community living support
Occurring on site of a community provider
In the company of staff of a community provider
Absent without leave from residential services.

Death-Expected (Category II): An expected death is when the cause of death is attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation of the outcome is death.
Includes the death of any individual:

Receiving residential services or receiving 24/7 community living support
Occurring on site of a community provider
In the company of staff of a community provider
Absent without leave from residential services.

Death (Category III) Death: The death of any individual enrolled with DBHDD and actively receiving services. Excludes deaths defined as Category I-Unexpected, Suicide and Category II-Expected. Includes the death of an individual receiving DD self-directed services.

Community Incident Data – Behavioral Health Services

Community behavioral health providers reported 579 critical incidents during this report period or 30% of the total number of community incidents. The incident types requiring an investigation and reported most frequently for Behavioral Health were: "Hospitalization of an Individual in a community residential program", "Incident occurring in the presence of staff which requires intervention of law enforcement services", "Individual who is unexpectedly absent from a community residential or day program", "Alleged Individual Abuse-Physical", and "Individual injury requiring treatment beyond first aid".

"Hospitalization of an individual in a community residential program" was reported more frequently than all other community incident types and decreased 22% from the prior six-month period. Review of these reports indicates that most are reports of appropriate transfers of individuals from crisis stabilization units to state hospitals when additional treatment is needed. With the closure of an additional state hospital in December 2013 and the increase in availability of crisis stabilization units, this increase is not considered to be significant or unexpected. Consideration is being made to whether this type of transfer from crisis residential care to state hospital care should continue to be classified as an incident because it is not consistent with the original intent of the indicator. The indicator was intended to capture instances in which individuals in non-crisis residential settings required treatment in an inpatient facility.

Reports of "Incidents occurring in the presence of staff which required intervention of law enforcement services" increased 17.6%. Reports of an "individual who is unexpectedly absent from a community residential program or day program" increased 7.4%; Reports of "Alleged Individual Abuse-Physical" increased 140% (*substantiated* individual abuse-physical actually decreased by 50%). Reports of "individual injury requiring treatment beyond first aid" increased 29.4%. Further analysis of these numbers will take place at the program level and/or at the appropriate program quality council.

Community Incident Data – Developmental Disability Services

Community developmental disability providers reported 1,351 deaths and critical incidents or 70% of all incidents during this report period. The incident types requiring an investigation and

reported most frequently for developmental disabilities were "Hospitalization of an Individual in a community residential program", "Individual injury requiring treatment beyond first aid", "Alleged Individual Abuse-Physical", "Incident occurring in the presence of staff which requires intervention of law enforcement services", and "Alleged Neglect". Each of the above five most frequently reported incident types realized a decrease over the prior report period. Hospitalizations of individuals served increased in the IDD service line from 506 in the prior 6 month period to 529 in the most recent 6 month period. "Incidents occurring in the presence of staff requiring intervention of law enforcement services" were the same-107 for both report periods.

Reports of "Hospitalization of an Individual in a community residential program" increased 4.5%. Reports of "Individual injury requiring treatment beyond first aid" decreased 19.3%; Reports of "Alleged Individual Abuse-Physical" decreased 6.3% (substantiated individual abuse-physical decreased 32%); Reports of an "Incident occurring in the presence of staff which requires intervention of law enforcement services" did not change, and reports of "Alleged Neglect" decreased 10.4% (substantiated Neglect decreased 57%).

Community Mortality Reviews

The Department developed a community mortality review process in FY 13 to achieve the following goals:

- To conduct mortality reviews utilizing a systematic interdisciplinary review of the investigative report of all suicides and all deaths where the cause of death is not attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation of the outcome is death. This includes the death of any individual receiving residential services or receiving 24/7 community living support, death that occurred on site of a community provider, or occurred in the company of a staff member of a community provider, or death when the individual was absent without leave from residential services,
- To review the quality of services and supports provided to the individual,
- To identify factors that may have contributed to the death and/or indicate possible gaps in services,
- To recommend corrective actions to improve the performance of staff, providers and systems,
- To assess support systems and programmatic operations to ensure reasonable medical, educational, legal, social, or psychological interventions were being provided prior to deaths, and
- To review the investigative reports to assure that a comprehensive systemic approach was taken in the investigation.

The DBHDD Community Mortality Review Committee (CMRC) was established to ascertain whether all necessary and reasonable interventions were taken to provide for the health, safety, and welfare of the individual receiving services by a DBHDD provider and to identify and mitigate any findings that could affect the health, safety and welfare of other individuals receiving supports and services from DBHDD community providers.

The CMRC is chaired by the DBHDD Director of the Division of Hospital Operations/Chief Medical Officer (CMO). Other members of the committee include the DBHDD Director of Quality Management, the DBHDD Suicide Risk Prevention Coordinator, a community

physician, a Registered Nurse who is experienced and understanding of the needs of individuals who are receiving services through DBHDD, the Director of DD QM, the OIMI Director, representatives of the Office of AD, the Division of BH and others as appointed by the CMO. There must be a minimum of five committee members present with three (or at least 51%) clinicians and at least one physician. The Department is currently reevaluating the purpose and membership of the committee and considering additional DBHDD leadership involvement and expertise outside of DBHDD. The Department is also developing training for all CMRC members and increasing the meeting times to reflect the importance of this activity.

The CMRC meets approximately 10 times during the year or as often as is necessary to meet the timeframes for conducting reviews. The CMRC reviews the causes and circumstances of all unexpected deaths through available documentation and uses the findings to further enhance quality improvement efforts of the Department. Through a review of each unexpected death by clinical and professional staff, deficiencies in the care or service provided or the omission of care or a service by DBHDD employees and/or contractors may be identified and corrective action taken to improve services and programs. Trends, patterns and quality of care concerns are shared with the appropriate quality council and addressed with the applicable program leadership for resolution.

During this review period (January – June 2015) the Community Mortality Review Committee met six times to review all reported unexpected deaths (as defined by the community incident management policy) of all individuals receiving DBHDD services (BH, DD, and AD). A total of 52 deaths were reviewed during this period. Of the 52 reviews, 36 reviews had recommendations. When there were outstanding issues identified by the Community Mortality Review Committee related to the investigative report, those issues were addressed with the appropriate party. Based on these reviews, recommendations were made related to the following:

- OIMI using the investigative report and CMRC questions/recommendations to improve the thoroughness of investigations,
- Creating or modifying existing policies, procedures, provider manual or other guidance regarding service provision,
- Requesting additional Corrective Action Plans (CAPs) related to the provision of clinical oversight of staff, revision of a provider's risk assessment, follow up for missed clinical appointments, seizure protocol/plan, communication issues
- Requesting a special review from the Provider Performance Unit,
- Consulting with the Suicide Prevention Coordinator,
- Conducting additional investigative work regarding agency neglect,
- Conducting additional reviews of a provider's policies
- Reviewing how LPNs function in a provider's organization.

For FY 15, DBHDD contracted with external providers with expertise in Developmental Disabilities and Suicide Prevention: Columbus Medical Services, LLC, to provide mortality reviews of all deaths from the ADA population that has transitioned from a hospital setting to the community. DBHDD has also contracted with Barbara Stanley, PhD, and Gregory Brown, PhD, both nationally recognized suicide experts and trainers, to conduct mortality reviews of suicide

deaths. These objective reviews by external authorities will help provide additional expertise in these two critical areas of clinical practice.

The CMRC reviews the external mortality reports to identify trends and patterns and to identify whether systems issues are raised by the cause or circumstances surrounding an individual's death. Systems issues may be at the individual, program and/or system or state level. The CMRC determines whether, based on the findings, actions should be taken to improve the health and safety of individuals served by the Department. Future enhancements to the process include a CMRC policy, training for CMRC members, additional membership for the Committee and a database for tracking to completion any recommendations made.

The following two tables provide mortality data for both hospital and community providers for current report period January-June 2015 and prior report period July-December 2014:

Years	2014 & 2015
Source	Hospital

	Values				
Incident Type	**July - Dec 2014**	**Jan – June 2015**	**Change**	**% Change**	**Total**
A16-Death-expected	7	4	-3	-43%	11
A17-Death-unexpected	6	3	-3	-50%	9
A34-Suicide	0	1	1		1
Grand Total	**13**	**8**	**-5**	**-38%**	**21**

Years	2014 & 2015
Source	Community

		Values				
Disability	**Incident Type**	**July – Dec 2014**	**Jan – June 2015**	**Change**	**% Change**	**Total**
BH	C-Death	138	139	1	0.7%	277
	C-Suicide	15	18	3	20.0%	33
	C-Death-Unexpected	2	4	2	100.0%	6
BH Total		**155**	**161**	**6**	**3.9%**	**316**
DD	C-Death	33	43	10	30.3%	76
	C-Death-Unexpected	33	41	8	24.2%	74
	C-Death-Expected	8	7	-1	-12.5%	15
DD Total		**74**	**91**	**17**	**23.0%**	**165**
Grand Total		**230**	**252**	**23**	**9.6%**	**481**

Hospital Peer Review and Credentialing

The hospitals' Clinical Directors along with the Program Directors and discipline chiefs provide oversight and direction to the professional staff. Audit tools are also used to monitor the quality of clinical services. Auditors are assigned to audit the work of their peers so the audits also function as peer reviews for the clinical staff. The auditors receive training on audit criteria and methodology in their respective areas of responsibility in order to achieve inter-rater reliability. The criteria for those audits include system-wide criteria developed and administered at all hospitals, as well as any that may be hospital-specific. Responsibilities for audits are assigned by each hospital's discipline chief (physicians, nurses, social workers and psychologists). The results of the peer review/audits are reviewed by the appropriate supervisor who will provide feedback and, as needed, address any quality issues. Data from those audits are also entered into a system-wide audit database that permits aggregation and analysis. Discipline-specific monthly reports are generated and distributed to the respective discipline chiefs. Facility and Hospital System data are also aggregated and shared through the hospitals' respective quality councils.

Hospital Utilization Review

The Hospital System and Regions continue to monitor and address issues related to rapid readmissions (less than 30 days), as well as those with 3 or more admissions in a year. The overall trend for the 30 day readmissions have shown a slight downward trend during the last 12 months. The monthly rate reported for 3 or more admissions in a year has shown a decline for six straight months, as well as a slight downward trend over the last 12 months.

Adult Mental Health Fidelity Reviews

Assertive Community Treatment Fidelity Reviews are conducted annually for all twenty-two state-contracted ACT teams and all 6 Medicaid-funded ACT teams. Between January 2015 and June 2015, a DACTS (Dartmouth Assertive Community Treatment Scale) fidelity review was conducted on sixteen state-contracted ACT Teams. The review typically takes 3 days with one day of on-site technical assistance built in on the last day after the review. Once the DBHDD ACT & CST Services Unit completes the fidelity review, results of the Fidelity Review are given to the ACT team, leadership within the agency, the regional office in which the team operates, and the DBHDD Adult Mental Health Director and other departmental leadership. Results are also provided to the ACT Subject Matter expert hired as part of the Independent Reviewer's review of the Settlement. This is followed by a detailed discussion of the report inclusive of each scale and the rating for each scale along with any explanation or recommendation for the rating. This occurs during the exit interview, which is attended by the ACT provider, regional and state office staff. Review items that are found to be below the acceptable scoring range: a score of 1 or 2, result in a Corrective Action Plan which each team develops and submits for acceptance to the regional and state office. ACT teams are contractually required to obtain a DACTS mean score of 4.0 and total score of 112. Of the sixteen teams that have received a fidelity review, fourteen achieved a score within the acceptable range of fidelity, indicating that they are serving the appropriate population, maintaining an acceptable caseload, delivering the service with intended frequency and intensity, providing crisis response, conducting effective daily team meeting discussion of consumers, engaging formal and informal supports, being involved in hospital admissions and/or discharges and delivering 80% of the teams services in the community. At the time of the review, two teams scored below the acceptable range of fidelity. Some of those areas of needed attention are: strengthening delivery and documentation of contacts with consumer's informal support system, increasing the stability of staffing and

reducing turnover, and developing more effective daily schedules to increase face-to-face contacts between the ACT team and the individuals that each team serves. Both teams have submitted CAPs, and have received technical assistance and have both demonstrated improvements in the following areas; substance abuse group provision, staffing, involvement with informal supports.

Supported Employment Fidelity Reviews are conducted annually for all twenty-one state contracted SE providers. During FY15, fidelity reviews were conducted during October 2014 – June 2015, 21 fidelity reviews were completed using the 25-item IPS model for supported employment. Once the 2-day SE fidelity review is completed and findings are scored, the results are given to the SE provider, the regional office in which the team operates, the DBHDD Adult Mental Health Director and other departmental leadership. Results are also provided to the SE Subject Matter Expert hired as part of the Independent Reviewer's review of the Department's performance related to the ADA Settlement Agreement. This is followed by an exit interview inclusive of provider, regional and state staff with a detailed discussion of the review outcome and report. Outcomes are also discussed with the CBH PQC. Review items that are found to be below the acceptable scoring range; a score of 1 or 2 will result in a Quality Improvement Plan (QIP) which each team develops and submits for acceptance to the regional and state office. SE providers are contractually expected to minimally obtain an IPS total score of 74. Of the twenty-one providers who have received a fidelity review, twenty-one achieved a score within the acceptable range of fidelity, indicating that they are effectively integrating SE and mental health, maintaining collaboration with Georgia Vocational Rehabilitation Agency (GVRA), demonstrating clearly defined employment duties for SE staff, implementing zero exclusion, rapidly engaging consumers in competitive job search, assessing consumer's interests and making job placements based on identified interests and skills.

Quality Service Reviews of Adult Behavioral Health Community Providers

The DBHDD Quality Management Team completed a review of individuals who frequently utilize crisis and inpatient services in both the community and through the State Hospital System. The reviews combined a focus of the State Hospital services along with community-based crisis and therapeutic services allowing for a comprehensive look at the services individuals receive or are referred to for treatment.

The project focused on an individual's treatment, level of satisfaction, and unmet needs or barriers to successful treatment, and followed the individual through their continuum of care, including their transition process into community behavioral health services. In keeping with past quality audit/service reviews conducted by the QM Department, records were reviewed and individuals and staff were interviewed. The project focused on all six DBHDD Regions and a sample of 127 individuals who were the highest utilizers of crisis and inpatient services in each region. The review was completed June 2015 and findings were shared in a presentation to DBHDD program leadership in July 2015 and will be discussed in a future CBH PQC meeting.

The following is a summary of some of the issues identified:

- Homelessness is a recurrent factor associated with high utilization of crisis and inpatient services. Some homeless individuals reported using the crisis service as a temporary

shelter. Multiple factors appear to impact placement of individuals in appropriate housing, including consumer choice to be discharged to shelters.

- Substance abuse is also a recurrent factor associated with high utilization of crisis and inpatient services. Some of the highest utilizers of crisis services diagnosed with a substance abuse disorder were not participating in community-based treatment for their addiction. Aside from the individual refusing the treatment, other factors influencing a lack of follow through to outpatient services included relapse soon after discharge; inadequate housing options; and lack of available residential treatment options, available beds, or admission criteria that the individual did not meet.
- The review identified special populations that appeared underserved and/or who needed more thorough assessments in order to gain additional information about their service needs. Examples included: emerging young adult (males) diagnosed with SPMI, individuals with borderline intellectual functioning or IDD, the homeless population, and transient users of crisis services.
- The financial status of individuals also was associated with high utilization of crisis and inpatient services as multiple people were unable to afford medications, housing, transportation, and treatment such as residential substance abuse.
- Limitations in resources within the community were identified for all regions. Examples included: safe housing, transportation, SA residential programs, gender specific SA treatment for women, and an array of intensive treatment options in rural areas.

This review identified a variety of issues specific to this population as well as issues that may inform how the Department's behavioral health programs could be more responsive to this population. Providers throughout the state were eager to participate in this review and interested in successful ways to address recidivism to better serve individuals in their communities. Many of the concerns identified impact the entire population of individuals served, not just those who were the highest utilizers of crisis and inpatient services. Providers also shared innovative strategies they are using to address the needs of the individuals in their services.

Division of Addictive Diseases (AD) Quality Management Activities

The Office of Addictive Diseases provides leadership for adult and adolescent substance abuse treatment services. The Office's responsibilities include: program oversight; grants management; ensuring compliance with federal and state funding requirements; maintaining collaborative relationships with advocacy groups and other stakeholders; providing data and information at the regional and local levels to impact policy decisions; statewide technical assistance to providers and the six DBHDD Regional Offices; developing and maintaining collaboration among private and public sector providers and stakeholders; providing training and information on best practices for substance abuse treatment; coordinating collaborative efforts in increasing best practices models; assisting community and faith-based groups in developing capacity and training; overseeing HIV Early Intervention Services among substance abusers and their families and significant others; overseeing men's residential treatment services throughout Georgia and the Ready for Work women's programs.

Program staff assigned to the Office's State office are responsible for conducting provider site reviews to ensure fidelity/compliance to service guidelines and federal block grant requirements.

Listed in the chart below is an overview of each program area and the QM activities conducted by staff along with the frequency:

AD Service/ Description	QM Activities/On-site reviews	Frequency	Outcomes
Women's residential treatment and recovery support services	Site visits are currently conducted by Women's Treatment Coordinator. Staff reviews provider compliance with standards and overall performance in providing gender specific substance abuse treatment services. In addition, TCC vendor conducts reviews of all Therapeutic Childcare programs offering services to children. Clinical reviews of these programs against requirements are conducted by addiction credentialed staff with gender specific training and historical context of programs and interaction with child welfare agencies.	1x every 2 years	During this report period 14 Residential providers were reviewed for compliance with policy/procedure standards, evidenced based practices, staff training, clinical documentation, and authorization of appropriate services. Of the 14, all were in compliance and only 3 were in need of technical assistance (TA) in terms of clinical documentation and treatment planning which included training of staff and support of leadership. For the TCC component, 5 reviews/audits were completed in this reporting period and all were in compliance, with only 1 provider needing TA. The TCC consultant will be implementing additional TA for a new provider opening July 1, 2015
Women's outpatient treatment and recovery support programs	Site visits are currently conducted by Women's Treatment Coordinator. Staff reviews provider compliance with standards and overall performance in providing gender specific substance abuse treatment services.	1x every 2 years	During this report period 11 outpatient providers were reviewed for compliance policy/procedure standards, evidenced based practices, staff training, clinical documentation, and authorization of appropriate services. Of the 11, 1 was not in compliance but not in need of a corrective action plan. TA was provided immediately and the provider was able to correct authorization patterns for enrolled individuals. Follow up was completed 30 days later and the provider was in compliance with all required authorizations for this service.
Women's transitional housing supports	Site visits are currently conducted by Women's Treatment Coordinator.	1x every 2 years	During this reporting period 8 Transitional Housing programs were reviewed for compliance policy/procedure standards, documentation, case management and authorization of appropriate services. All 8 were in compliance.
Recovery Support Services for youth (Clubhouses)	Site visits conducted by C&A program staff to ensure program design and requirements are being followed. Staff person is 7 Challenges trained.	1x every 2 years	During this reporting period 3 recovery support programs were reviewed for compliance. All 3 were in compliance and met the

			standard for performance delivery. 1 recovery support program has been visited and technical support provided as they are in the process of relocating. 3 recovery support programs are scheduled for review during the month of June.
Recovery Centers	Site visits conducted by Adult program staff to ensure program design and requirements are being followed. Clinical review of these programs against requirements are conducted by addiction credentialed staff	1x every 2 years	There were no reviews completed during this time, however, a Programmatic Report is submitted and reviewed every month addressing contract deliverables and the amount of unduplicated individuals served.
IRT (Intense Residential Treatment) Programs	Site visits conducted by C&A program staff to ensure program design and requirements are being followed. Staff person is 7 Challenges trained.	1x every 2 years	Both IRT Programs have been reviewed during this reporting period and both were in compliance.
Transitional/IOP	Site visits conducted by Adult program staff to ensure program design and requirements are being followed. Clinical review of these programs against requirements are conducted by addiction credentialed staff	As needed basis if monthly reports indicate an issue	There were no reviews completed during this time, however, a monthly reporting form is submitted and reviewed identifying the number of admissions, the number of discharges, length of stay and identified referring agencies.
HIV testing and education (HIV/EIS)	Site visits conducted by vendor to ensure program design and requirements are being followed.		No site visits during this period. They will be completed in the months of August and September. Quarterly reports are submitted providing information on the number of individuals tested, number of post-test counseling sessions, number of HIV positive, and number of individuals referred and connected to treatment.
AD Treatment Courts	None.	N/A	N/A
Opioid Maintenance	Site visits conducted by State Opioid Maintenance Treatment Authority to providers within the DBHDD network.	1x every 2 years	No site visits during this period. They will be completed in the next quarter. This report identifies the current EBP, number of indigent individuals receiving care, number of individuals with take home, number of individuals completing the program, number of individuals in aftercare, and the current number of individuals titrating off methadone.
Adult Residential Treatment Services	Site visits conducted by Adult program staff to ensure program design and requirements are being followed. Clinical reviews of these programs against requirements are conducted by addiction credentialed staff.	1x every 2 years	There were no reviews completed during this time, however, a monthly reporting form is submitted and reviewed identifying type of service, number of individuals served, number of admissions, number of discharges, referring agencies,

			and length of stay.

In addition to site reviews, program staff process contract payments and monthly programmatic reports which are received monthly from providers, to ensure service guidelines are being met from a contractual standpoint. Once reviews are completed, the results are shared with the Regions and providers to review performance/progress and identify any areas in need of improvement.

Office of Addictive Diseases Training

The Office of Addictive Diseases also ensures that training is offered to providers to improve quality of services. Trainings initiated by the Office during this reporting period include the following;

Advanced Clinician Training - DUI Intervention Program
Understanding and Utilization of ASAM Criteria; Legal and Ethical Issues in Addictions and Avoiding Malpractice
STAR BH Military Culture Training (Tier One)

Children, Young Adults and Families Community Mental Health Programs (CYFMH)

DBHDD's Office of Children, Young Adults, and Families (CYF) works directly with the Georgia State University Center of Excellence (COE) for Children's Behavioral Health to ensure quality improvement and ongoing evaluation among CYF services, as well as to provide specialized workforce development for the department's network of child and adolescent behavioral health providers. The COE also provides ongoing support and facilitation to Georgia's Interagency Directors Team (IDT) (a sub-committee of the Behavioral Health Coordinating Council), evaluates interagency pilot initiatives, and provides evaluation services for Georgia's System of Care Expansion grant.

In an effort to ensure quality management among CYF's provider network, the office in partnership with the COE hold quarterly quality consortium meetings for each specialized service provider. The meetings are held with the state's seven psychiatric residential treatment facilities, four crisis stabilization units, two care management entities, and 11 resiliency support clubhouses, more commonly referred to as mental health clubhouses. During each quality consortium meeting, quarterly fidelity monitoring reports are reviewed. Dialogue about trended data, issues that may have arisen with the data collection process, suggestions for how to improve or change fidelity monitoring, and any other matters regarding quality improvement data is facilitated. Quality management activities provided across CYF's continuum of services include: fidelity monitoring reports, trended fidelity monitoring reports, and quality assurance workgroups.

Since January 1st, 2015, CYF in partnership with the COE has also provided a host of workforce development opportunities in an effort to ensure high-quality services. One of these trainings is for professionals delivering high-fidelity Wraparound. Georgia adopted the Innovations Institute implementation model, which includes a core curriculum comprised of *Introduction to Wraparound,* (2) *Engagement,* (3) *Intermediate Wraparound and* (4)

Advancing Wraparound Practice. In an effort to continue quality practice the COE developed an assessment to identify additional training needs. The Georgia local coaches created five additional curricula: (1) Strengths Training, (2) Needs and Outcomes, (3) Family Support Partners in Wraparound, (4) Transitions in Wraparound, and (5) Creative Styles of Crisis and Safety Planning.

In addition to high-fidelity Wraparound training, CYF has also provided Trauma-informed Systems training throughout the state. This workforce development opportunity is designed to teach basic knowledge, skills, and values about working with children who have experienced traumatic stress and may have been involved in the child welfare and juvenile justice systems.

Finally, during this reporting period CYF has worked directly with the COE and the IDT in planning for the 8th Annual System of Care Academy: Embracing Transition. The theme for this year's academy is based on CYF's new focus on the transition-age youth and young adult population. This year's academy will be held July 14th-16th, and will feature speakers such as SAMHSA's Dr. Gary Blau, CDC's Dr. Ileana Arias, and global speaker, advocate, and mental health advocate Kevin Hines. An anticipated 400 individuals, including professionals, families, and youth will be in attendance for this event.

Behavioral Health Mobile Crisis Response System Performance and Quality Monitoring

Mobile Crisis Response Services (MCRS) for behavioral health has been statewide since July 1, 2014. Each region is covered by one of two vendors, Benchmark Human Services and Behavioral Health Link, both of whom have been participating in the MCRS Quality Management System since the beginning of the contracts. There are 20 data points that the vendors report on monthly to the regions. This data is reviewed quarterly at a MCRS Quality Consortium. Through these meetings, a quarterly data template has been created, barriers to implementation have been resolved, and processes have been put into place to improve the quality of the service.

Between January and June 2015, 8,415 calls were received. The table below shows the average (mean) response time for mobile crisis teams. Response time is defined as the amount of time in between being dispatched to a location where the individual is located until the time of arrival at that location.

Month	Average Response Time (in minutes)
Jan 2015	52
Feb 2015	51
Mar 2015	50
Apr 2015	50
May 2015	52
Jun 2015	52
Average	51

Mental Health Coalition Meetings

A gathering of all Supported Employment providers and a gathering of all Assertive Community Treatment providers are facilitated on an every other month basis by DBHDD staff. Community Support Team providers gather every other month as well. Case management and Intensive Case Management providers gather once a month for a Coalition call. These meetings are vehicles for disseminating and gathering information, maintaining open communication, promoting provider collaboration and fostering the partnership between the Department and provider agencies. This forum allows for discussion of programmatic operations and performance (including key performance indicators), informal presentations/in-service, discussion of Departmental policies and any other matters of relevance for these evidence-based practices. Coalition meetings have functioned as forums of discussion that have provided an impetus for policy adjustments, including: increasing units of group therapy per authorization, and increasing allowable number of monthly enrollment prior to requiring a waiver. The majority of service specific coalition meeting are held in Macon for ease of access; a call in number is provided for all coalition meetings for those unable to be present. Adult Mental Health staff, regional staff, providers and members of APS, and the external review organization, participate in Coalition meetings. There were three ACT Coalition meetings held between January 2015 and June 2015. There were three SE Coalition meetings held between January 2015 and June 2015. There were two Coalition calls and one ICM/CM Coalition meeting between January 2015 and June 2015.

Residential Support Services Coalition Meeting

The Office of Adult Mental Health (AMH) held its first Residential Support Services (RSS) and Crisis Respite Apartments (CRA) joint coalition meeting in October 2014. The meeting had 70+ attendees representing state and regional staff, contracted community providers and local stakeholders. The coalition meeting created a platform for residential providers to promote open dialogue in the discussion of challenges and solutions to providing housing supports and options for individuals living with SPMI across the state. The agenda was comprised of information on the forthcoming residential redesign including Medicaid billing and a focus on recovery transformation and individual movement and transition throughout the levels of residential care. In January 2015, all contracted RSS and CRA providers participated in the AMH combined coalition meeting that provided information on the array of community based services offered by the Department. The second RSS and CRA joint coalition meeting was held in April 2015. The agenda was comprised of information related to Forensics and Community Integration Home placement, the Peer Forensic Specialist Initiative, Data Review and Compliance, Residential Medicaid Billing and Fee for Service, and a presentation by New Horizons focused on Housing First. The June 2015 RSS and CRA joint coalition meeting focused on the FY 2016 contract deliverables including the Residential Cost Analysis that will be conducted during the first quarter of the fiscal year. The coalition reviewed the newly implemented DBHDD *Supported Housing and Needs and Choice Evaluation Policy, 01-120.*

Behavioral Health Contracted External Review Organization (ERO)

APS Healthcare is the External Review Organization (ERO) for DBHDD behavioral health services through June 2015. Many of the established functions and products provided by this

vendor continued to contribute to the Department's management of the provider network. These elements include training, technical assistance, prior authorization for services, provider audits, and provider billing and service provision data. In July 2015, the Georgia Collaborative ASO assumed these functions.

Audits:
The ERO conducted 102 audits of community BH providers from January 2015 through June 2015. Audit information has been crucial for the Department's continued implementation of *Policy 01-113, Noncompliance with Audit Performance, Staffing, and Accreditation Requirements for Community Behavioral Health Providers* and for the management of providers which fail to achieve compliance with DBHDD audit score, staffing, and accreditation requirements. Audit results can be found at: www.apsero.com

Training:
The ERO has provided training opportunities to the network during the report period—a total of 538 hours (including audit exit interviews). In addition to the onsite technical assistance provided at each Audit Exit Interview, APS has also offered both broad and targeted information to the provider network:

- In support of the implementation of the additional crisis services in Regions 4 and 6, APS has continued to provide technical assistance to support collaboration among providers, State-operated hospitals, community-based hospitals, and GCAL;
- Participation and training as an element of the Georgia Certified Peer Specialist training;
- Multiple trainings for documentation and treatment planning for recovery-based services, such as the following:
    - Georgia Mental Health Consumer Network Certified Peer Specialist trainings
    - Georgia Council on Substance Abuse (C.A.R.E.S.) Certified Peer Specialist—Addictive Disease training
    - Supported Employment and Task Oriented Rehabilitation Services;
- Care Management and Audits staff have attended all ICM/CM/CST and ACT coalition meetings in order to provide training specific to audits, authorization, treatment planning, and care management or authorization based on provider need;
- Continued offering of the Ambassador Program for new providers and providers' new staff members.

Service Utilization & Authorization:
During the report period, licensed clinicians at the ERO have manually reviewed 17,061 authorization requests for community services. Of those, 1,828 authorization reviews were specific to ACT services.

Implementation and Results of Best Practice Guidelines:

Beck Initiative

The Beck Initiative is a collaborative clinical, educational and administrative partnership between the Aaron T. Beck Psychopathology Research Center of the University of Pennsylvania (UPENN) and DBHDD to implement recovery-oriented Cognitive Therapy (CT-R) training and consultation throughout the DBHDD network. Fusing the recovery movement's spirit and

cognitive therapy's evidence base, CT-R is a collaborative treatment approach that prioritizes attainment of patient-directed goals, removal of obstacles to the goals, and engagement of withdrawn patients in their own psychiatric rehabilitation. Through intensive workshops and ongoing consultation, tangible tools to help remove roadblocks to recovery of people with severe mental illness are placed in the hands of care providers across the network. CT-R provides the fabric for promoting continuity of care with the goal of helping affected individuals achieve sustained integration in the community.

Broad Project Goals

- To promote hope, autonomy, and engagement in constructive activity, for individuals served by agencies in the DBHDD network;
- To establish CT-R as a standard practice of care for people served within DBHDD agencies;
- To promote the sustained implementation of CT-R into the DBHDD network;
- To improve the professional skills of therapists in the DBHDD system;
- To conduct program evaluation to examine outcomes such as client attrition, service use, recidivism, therapist turnover, and the sustainability of high-quality CT in DBHDD settings;
- To utilize the evidence-based practice of CT-R in the Department as roadmap for delivering recovery-oriented care; and
- To serve as a model for other large mental health systems.

FY: 15 - Project Plan

Providers in Regions 2 & 5 will receive this training September 2014 – August 2015. The CT-R Training Program consists of workshops (Phase 1) and 6-month consultation (Phase 2). Participants in the trainings included individuals from the DBHDD state hospitals and the community based providers (e.g. assertive community treatment teams, community support teams and outpatient providers).

FY: 16 - Project Plan

Activities scheduled for July 1, 2015 – December 2016:

CT-R trainings will continue within regions 2 and 5 during this fiscal year as described above. In addition to completing the trainings sustainability activities will begin in this fiscal year.

Local expertise for CT-R training will be transitioned to the Center of Excellence (COE) at Georgia State University. This is a key part of the sustainability plan to ensure sustainability of future trainings, support for current trainees and ongoing evaluation efforts. DBHDD has a contract in place with the COE that has been underway for the past several months to begin transition work. The COE will work collaboratively with the University of Pennsylvania (the Beck Team) to jointly plan the sustainability effort to ensure continuity. Activities will include training to the COE team by the Beck Team, shadowing by the COE team, and joint evaluation planning by both the Beck Team and the COE team. The COE will hire elite trainers that will facilitate the future CT-R trainings and a coordinator to oversee the overall project.

Data Workshops/Trainings Participation Outlined Below

Region 2:
Total number of general workshop participants:
Total: 89

Total number of trainees that also participated in the consultation phase:
Total: 66

Region 5:
Total number of general workshop participants:
Total: 91

Total number of trainees that also participated in the consultation phase:
Total: 65

Suicide Prevention Program

DBHDD recognizes suicide as a significant public health issue in the State of Georgia and has developed a suicide prevention program. The program's goals include:

- preventing suicide deaths,
- reducing other suicidal behaviors including attempts,
- reducing the harmful after-effects associated with suicidal behaviors, and
- improving the mental health of Georgians through primary prevention activities, access to care, early intervention, crisis treatment and continuing care.

A foundation of suicide prevention is providing awareness to communities and groups about the crisis of suicide and engaging citizens to work in their communities. In 2014 the Suicide Prevention Program adopted the focus of Suicide Safer Communities to encourage multiple activities and multiple community partners in suicide prevention. The Suicide Prevention Program now works with over 12 suicide prevention coalitions throughout Georgia to support local collaboration to prevent suicide and is working with Bartow and Oconee county stakeholders to develop new coalitions. Between January and June 2015 three awareness events were held with a total of 185 people attending.

The Georgia Suicide Prevention Information Network (GSPIN) website www.gspin.org supports awareness, coalitions, survivors groups and the interested public. Between January and June 2015 the website had over 600,000 hits and the broadcast network had 2,850 members who received 9 email blasts with information and activities. During this period 290 people registered as new members of GSPIN.

With a more aware general public, there is a need to identify people at high risk of suicide in the general public and assist them in accessing care. In order to address the access to care issue, the Suicide Prevention Program supported two evidence based gatekeeper trainings. Gatekeepers act as outreach liaisons that provide their community with information about how to identify someone at high risk of suicide, how to encourage the person to get help, and how to access behavioral health and crisis services. The programs are called: *Question, Persuade, and Refer*

(QPR) and *Mental Health First Aid (MHFA)* and are for both adults and youth. These programs teach community members to recognize the signs of suicidal behavior and direct individuals to assistance. Between January 1, 2015 and June 30, 2015, DBHDD trained at least 150 Georgia citizens in QPR and 250 citizens in mental health first aid. The training was provided throughout the State and included 8 QPR trainings, 7 adult Mental Health First Aid trainings and 5 Youth Mental Health First Aid trainings in counties to community members in churches, schools, libraries and other community settings. Additionally, there was a SAMSHA grant opportunity to support Youth Mental Health through the school systems that was awarded to the Department of Education to support three counties and another two counties.

To help to expand the use of QPR in Georgia communities and support its sustainability, between January and June 2015, the Suicide Prevention Program staff provided 3 QPR Instructor Training events in Decatur, Dublin, and Moultrie. Fifty-five new certified trainers were added to the existing group of over 200 certified QPR trainers throughout the state. These new trainers were recruited from our coalitions, colleges and universities, the schools and agencies that serve the refugee population.

The Suicide Prevention Program, through its contractor, The Suicide Prevention Action Network of Georgia (SPAN-G), has revised the suicide prevention training segments in the Crisis Intervention Team (CIT) trainings coordinated by the National Alliance on Mental Illness (NAMI) that is given to law enforcement and first responders throughout Georgia. In addition to identification of suicide, the program now contains information about supporting and managing suicide survivors at the scene of a death and on self-care. This module has been expanded into two modules, the first on suicide and the second on self-help and peer to peer support. Between January and June 2015 SPAN-GA gave 11 trainings in the revised Suicide module during CIT trainings to approximately 330 personnel from The Georgia Bureau of Investigation (GBI), Sheriff's Offices, Police Departments, High School Security, Pardons and Parole, Emergency Medical Service (EMS) and Fire Departments. The self-help and peer support module is now being given by first responder peers.

DBHDD's Suicide Prevention Evidence Based Practice (SPEBP) Initiative called A.I.M. (Assessment, Intervention, and Monitoring) with the outcome of identification, brief intervention and monitoring of consumers who are at high risk of suicide move toward the goal of helping them become securely situated in services and more empowered to act in their own self-interest continues to train providers in the use of the Columbia Suicide Severity Rating Scale, the Stanley and Brown Suicide Safety Plan and the monitoring questions developed by Stanley and Brown for use until consumers are securely into care. During the first six months of 2015, the Suicide Prevention Program provided four A.I.M. trainings for 74 behavioral health providers in Albany, Columbus, Dublin and Augusta. During this time period, training focused on the need for information about assessment skills, two *Assessing and Managing Suicide Risk for Mental Health Professionals* trainings provided by the SAMHSA funded Suicide Prevention Resource Center were taught to clinical leadership in DBHDD provider organizations (72 attendees) bringing the total of clinical leadership trained to over 225. From this group of attendees 15 New Leaders were trained and certified. Each New Leader has agreed to provide three trainings and the Suicide Prevention Program anticipates that by the end of 2015 at least 300 more clinicians will be trained in this foundation program.

Work with other state agencies was focused on the Department of Education (DOE) during this reporting period. During the 2015 legislative session, House Bill 198 (HB 198), the Jason Flatt Act, was passed and signed into law by Governor Deal. The new law mandates that all certificated school personnel receive annual training in suicide prevention, including resources in the community, and that each school system develop a suicide prevention policy including prevention, intervention, and postvention. The bill mandates that a committee including representatives of the Board of Education and the DBHDD Suicide Prevention Program develop a list of approved curriculum and a model suicide prevention policy. During May and June 2015 the Suicide Prevention staff met with designated representatives of the DOE to work on the development of the list of approved curriculum and the model protocol.

To support the work of student support personnel, the Suicide Prevention Program again provided training in the LIFELINES: Intervention Programs. During March and April 2015 two LIFELINES: Intervention Programs were given to over 30 school and allied personnel. The Suicide Prevention Program also provided ongoing postvention suicide training to the schools through its LIFELINES: Postvention programs. Two LIFELINES: Postvention trainings were provided to teams of school personnel and community professionals who work with school staff after a suicide death of a young person. This program trained 32 school and behavioral health personnel to respond effectively to suicide deaths in the schools. As part of its consultation to other agencies in Georgia, there were two on-site visits with a school system experiencing a cluster of deaths, including suicide deaths.

Additionally, DBHDD and the Garrett Lee Smith Youth Suicide Prevention Program provided the Extended Gatekeeper Initiative in 28 schools in 12 school districts in the Atlanta Independent School System (formerly Atlanta Public Schools), Calhoun City Schools, Gwinnett County Schools, Montgomery County Schools, Laurens County Schools, Dublin City Schools, Dodge County Schools, Floyd County Schools, Gordon County Schools, Lowndes County Schools, Fannin County Schools, and Camden County Schools (through the Camden Community Alliance). In the third year of the 3 year grant funding these schools have received Question, Persuade and Refer (QPR) gatekeeper training, Sources of Strength peer leadership groups, and training in intervention and postvention through LIFELINES.

Additionally, DBHDD provides training to teams of survivors of suicide and other committed individuals and technical assistance to these teams in developing and running groups. Between January and June 2015 there were 25 active Survivors of Suicide Groups (SOS) operating in Georgia covering all 6 DBHDD regions. Training was held to prepare new SOS group leaders in June 2015 and 10 new group leaders were trained. During this period a group was established in Midtown Atlanta and a group in Decatur is being developed. Additionally, 3 people were trained or retrained to deliver the family survivor program for communities called Starfish. Again in 2015, Camp SOS, a weekend camp for families, was held for eleven families with 42 members aged 4 to 70. Fourteen volunteers were trained as well.

Educational and outreach materials (purple packets) were designed that included materials from the Link Counseling Center, the American Association of Suicidology, identification of crisis service providers and crisis telephone numbers. Purple packets are disseminated to survivors of suicide by first responders, mental health professionals, funeral directors, clergy and others who

encounter survivors of suicide death. Purple packets were provided to DBHDD providers who attended gatekeeper and A.I.M. trainings and supplies of purple packets were given out at the Coalition. During the first six months of 2015 4,385 purple packets were disseminated throughout the state. Also, during this period the Rockdale/Newton Suicide Prevention Coalition developed an education and outreach packet for youth who have attempted suicide and their families to be disseminated by first responders. The packets are currently being piloted by first responders in Rockdale County with an initial group of 100 packets.

The DBHDD Suicide Prevention staff continues to provide on-site and telephone consultation with providers who have experienced the death of a consumer by suicide, participate in meetings of the EQC, the CBH PQC, and the Community Mortality Review Committee. Consultation to providers included focus on their setting and death reviews as well as introduction to the Zero Suicide in Healthcare Initiative and A.I.M. program.

During the first six months of 2015, the Suicide Prevention Program staff actively worked on a draft suicide prevention policy for screening, assessment, and monitoring for DBHDD providers.

Office of Deaf Services

In April 2014, the Office of Deaf Services (DS) began the process of obtaining the information needed to ensure quality provision of behavioral health & developmental disabilities services to individuals with hearing loss. These efforts continue with the development of new policies and operational procedures, hiring of two additional staff, and ongoing development of project management plans.

Goals of Deaf Services include:

- gathering information and developing a baseline array of statewide community based behavioral health and developmental disability services for deaf individuals
- promoting best practices in behavioral health American Sign Language (ASL) interpreting
- increasing percentage of behavioral health therapy and case management services provided by professionals with fluency in American Sign Language and training in deaf culture
- increasing communication access for individuals with developmental disabilities in both community and residential settings
- developing behavioral health-related educational materials to increase public information and community outreach
- developing opportunities for stakeholder input on DS goals and activities

An initial standard/performance indicator was developed in July 2014 and was included in the Comprehensive Community Provider (CCP) requirements. The intent of this standard was to require that community based providers offer accessible services to deaf and hard of hearing individuals. The first task of this standard requires providers to notify the DS at intake of all newly enrolled individuals with any level of hearing loss. In response, the DS provides a brief communication screening and if necessary, a full communication assessment and incorporates the results within the individual's treatment plan. The second task requires that providers and the DS work together to gather data to develop further performance indicators and to establish,

provide, and oversee the quality of accessible services. In June 2015, it was determined that this standard/key performance indicator six month data reporting timeline did not gather data often enough to meet the goals of DS. Instead, we will incorporate the standard into a policy with more frequent data reporting requirements.

From January to June of 2015, trainings were provided on the following topics: understanding the diagnostic process using DSM IV & V (February); how interpreters can lessen the incidence of secondary trauma (March and April); how to put all the previous trainings together in real life situations (May). With the last session in May, those who were using the training as an entryway into the practicum were able to do so. Currently there are fifteen interpreters in various steps of the practicum. One individual is awaiting the results of their evaluation. Georgia currently has five interpreters who hold the Georgia Behavioral Health Interpreter (GaBHI) certification. The shift from using generalist ASL interpreters toward using those who have specialized training in providing Behavioral Health services has been successful. In January 2015, ASL interpreting for approximately 20% of providers' 62 Behavioral Health appointments with deaf individuals was provided by outside agencies; the Office of Deaf Services has been able to decrease that to 4% of 71 appointments during May. (Data for June 2015 are not available as of the date of this report.)

Division of Developmental Disabilities

Transitions to the Community and Pioneer Project

The Division of DD initiated the Pioneer Project in August 2014 to accomplish goals of stabilizing the community and ensuring that transitions from hospitals to the community are safe and result in high quality care in the community. It was determined to begin implementation in one Region in order for the following assumptions to be tested, before going statewide: a) community stability means that individuals are receiving quality health and wellness services and are living integrated lives in the community based upon their own wishes and desires; b) assessments must drive the ISPs; c) person-centeredness and increasing individuals' connections to communities will improve outcomes for individuals; d) engaging providers in change processes and meeting their individual needs for TA and support will improve performance; e) providing support to providers will improve the net outcome to individuals they serve; f) the reported lack of availability of professional clinical services in the community contributes to less than desirable outcomes for individuals; g) early engagement of Support Coordination in the transition process and enhancement of Support Coordination services following transition will lead to better transitions from state hospitals and increased stability following transition. Region 2, which is comprised of 33 counties in the middle part of Georgia, was chosen as the first implementation location due to the fact that the majority of hospital transitions remaining are likely to be moving to one of the counties in the Region. CRA Consulting has assisted the Division in guiding the Pioneer activities, which have included:

- Developing a core team of Regional, State Office, Hospital, Support Coordination leadership, Clinical Staff, and Consulting Staff to guide the changes made in the transition process and stabilization activities.
- Engaging providers who are currently serving individuals that have transitioned from hospitals since October 2010 in activities, including individual and group meetings, activities involving individuals, and training. Technical assistance was provided by Regional and CRA staff to providers who presented with a wide variety of unique challenges, such as financial/organizational issues, individuals with complex needs, and

programmatic issues. In addition, providers from all 6 Regions who are interested in serving individuals transitioning from hospitals into Region 2 in the future, were asked to complete a Request for Information/Request for Application. This information is being used to develop a database of provider characteristics, capabilities, capacities, and their interests in providing identified services in specified geographic areas. As a part of the RFI/RFA process, providers agree to participate in special meetings and training.

- Establishing the Integrated Clinical Support Team (ICST): CRA Consulting contracts with Benchmark, Inc. to provide clinical professionals, including nurses, speech and language pathologists, occupational therapists, registered dietitians, behavioral specialists, a pharmacist, and an M.D. These clinicians receive referrals from Support Coordination and the Region and can provide assessments, make recommendations, and train provider and Support Coordination staff. The ICST is working to help providers develop community relationships and resources so that individuals they serve are able to access the services they need.
- Meeting with individuals and family members to update their person-centered descriptions, utilizing the MyLife tool, completing 105 MyLife reviews in Region 2. The primary purpose of the meeting was to have a discussion about whether the individual was living an integrated life, was engaging with members of the community, and had opportunities to accomplish his or her goals.
- Reviewing the current status of the individuals in Region 2 by updating the Joint Monitoring Tool reviews. The Regional Quality Review team completed 92 reviews with 8 additional scheduled to be completed by the end of July 2015.
- Reviewing each individual's HRST, SIS and MyLife/Person-Centered Plan in comparison to the current ISP to determine if the ISP accurately reflected the recommendations from each and if recommendations from assessments had been implemented. This was called the ISP Fidelity Review, and 103 of these reviews were completed for individuals in Region 2.
- Providing assessments and ISP updates. Support Coordination has worked with providers and the Integrated Clinical Support Team to ensure that individuals receive needed assessments and that ISPs are being updated to include the recommendations made in any new assessments. To date, 176 assessments have been provided for 50 individuals.
- Coordinating with Support Coordination to implement Early Engagement for individuals within at least 60 days of transition. In addition, enhanced SC is provided to all individuals in the ADA population who have transitioned from State Hospitals since October 2010.
- Developing transition tools and processes to ensure that all transitions are thoroughly planned and reviewed prior to the actual move to the community. New processes include:
    - Review of homes being considered for individuals utilizing a Housing Checklist focused on the environment, including the community the home is in, and determining whether the home is ADA compliant or can be made ADA compliant (as required).
    - Completion of a Housemate Matching Process that includes documented meetings with each individual and discussions with the individual's support system to thoroughly describe preferred characteristics of potential housemates and to identify

if the individual knows someone with whom they wish to live. A Housemate Matching questionnaire was developed to guide and document the information. In addition, individuals who are planned housemates have the opportunity to meet in person on more than one occasion and to have multiple visits to new homes prior to the transition.

- Ongoing documentation and review of transition planning for each individual by the core team and Director of the Office of Transitions through weekly meetings and documentation on the Transition Process Overview tool.
- Developing a new Guide to Community Transitions from State Hospitals that captures the new processes and allows documentation in detail.
- Developing a Manual that describes Pioneer Processes.
- Developing and utilizing an Individual Support Plan Narrative (ISPN) comprised from a review of all updated assessments and detailing the needs identified in the assessments. The ISPN is used in transition planning and informs the ISP and the allocation of funding for supports. The ISPN is also used in transition planning to help inform Support Coordination regarding issues that need to be monitored, to assist the provider in identifying personnel requirements for their staffing, and to assist in assuring that adequate training is completed for provider personnel.
- Providing community focused risk assessments for individuals transitioning from Forensic units with special needs and requirements.
- Developing criteria for individuals to enter active transition planning. While it is recognized that all individuals in state hospitals are eligible for transition, the transition team must focus its work. An Active Transition List is maintained by the Office of Transitions and the status for each individual is tracked.
- Coordinating with Support Coordination to implement Early Engagement for individuals within at least 60 days of transition and providing Enhanced Support Coordination to all individuals in the ADA population who have transitioned from State Hospitals since October 2010. Support Coordinators become an active part of transition planning for the individual and develop the ISP.
- Engaging the Integrated Clinical Support Team in the transition planning process so that they are aware of individuals' health needs and able to offer training and support to the provider needed immediately upon transition.
- Providing ongoing support for the provider before, during and after the transition, including training by the Office of Learning and Development (OLOD) and hospital staff, follow-up visits by the RQR Team within 24 hours and continuing at a schedule of 48 hours, 9 days, 30 days, and monthly thereafter for six months. Enhanced Support Coordination begins the day of transition and continues on a weekly basis for the first 90 days and follow the frequency described based on HRST Score:
- < 2 – Once a month,
- 3-4 – Twice a month,
- 5-6 – Three times a month but always monthly at a minimum per service definitions.

There have been 16 transitions this FY, (4) of which utilized Pioneer processes. The first was July 7, 2014. Certain transitions occurred that were underway prior to the development of the Pioneer Project, were required by the court, or were requested by individuals, families or guardians. Of the (4) transitions that occurred under the Pioneer processes, 2 transitions

occurred in December of 2014, which were successful, followed by 2 additional transitions on June 22, 2015, which are still being monitored. Although the 2 transitions in December were successful, there were refinements of processes that needed to occur before transitioning the next individuals, including development of the Housing Checklist and the Housemate Matching process, and inclusion of the ICST in the transition planning. Presently, there are 23 individuals on the Active Transition List and more are being recommended.

DD Reviews of Individuals Served

The purpose of the Person Centered Review (PCR) is to assess the effectiveness of and the satisfaction individuals have with the service delivery system. The Division of DD's external quality review organization (Delmarva Foundation) uses interviews, observations and record reviews to compile a well-rounded picture of the individual's circle of supports and how involved the person is in the decisions and plans laid out for that person. Data is reported on a quarterly basis.

The time period for DD data reported here is July 1, 2014 through March 21, 2015. Data for the second quarter of 2015 (April through June) was not available at the time of the writing of this report, but will be included in the 2015 Annual QM Report. Below, are results for:

- Individuals who recently transitioned from an institution to the community (IRTC) and participated in a Person Centered Review (PCR);
- A group of randomly selected individuals who were receiving waiver services, already established in the community (Established) and participated in a PCR;
- The previous year's IRTC interviews;
- Quality Enhancement Provider Reviews (QEPR), including the Qualification and Training, as well as provider Strengths and Barriers;
- Follow up with Technical Assistance (Follow Up w/TA) and the Follow Up with Technical Assistance Consultation (FUTAC).

Between July1, 2014 and March 21, 2015 a total of 87 new IRTC interviews and 449 Established individual interviews have been completed. The following tables display results for IRTC individuals compared to the Established individuals, as well as the previous year's IRTC results when appropriate.

Information in Table 1 provides a general description of the 612 individuals interviewed through a Person Centered Review (PCR, N = 423) or Quality Enhancement Provider Review (QEPR, N= 189) process between July 2014 and March 2015. The largest proportion of individuals interviewed to date resides in Region 3 (27.9%). Males continue to represent a larger proportion of the sample and most individuals have a primary diagnosis of Intellectual Disability.

Table 1: Demographic Characteristics		
July 2014 - March 2015		
Region	**PCR and QEPR**	
1	87	14.2%
2	91	14.9%
3	171	27.9%

4	85	13.9%
5	88	14.4%
6	90	14.7%
Gender		
Female	270	44.1%
Male	342	55.9%
Age Group		
18-25	58	9.5%
26-44	266	43.5%
45-54	150	24.5%
55-64	103	16.8%
65+	35	5.7%
Disability		
Autism	10	1.6%
Cerebral Palsy	1	0.2%
Intellectual Disability	533	87.1%
Profound Intellectual Disability	68	11.1%
Total	612	

Individual Interview Instrument (III)

Two different interview tools are used in the DD QM process to collect information from individuals: the NCI Consumer Survey and the Individual Interview Instrument (III). The focus of the NCI survey is on the system—the unit of analysis is the service delivery system. The focus of the III is the individual, if desired goals and outcomes are being addressed through the service delivery system, including both paid and unpaid supports and services. Together they help provide a clear picture of service delivery systems and provider performance. The person's participation in this process is voluntary and the Quality Improvement Consultant confirms whether he/she would like to participate before beginning the interview.

The Individual Interview Instrument is comprised of 15 elements designed to evaluate individuals' services and well-being through nine different Expectations—each scored as Present or Not Present. Quality Improvement Consultants use the III tool as a guide to determine if the expectations are being met for the person interviewed. These are summarized below, with the number of elements included in each Expectation given in parentheses.

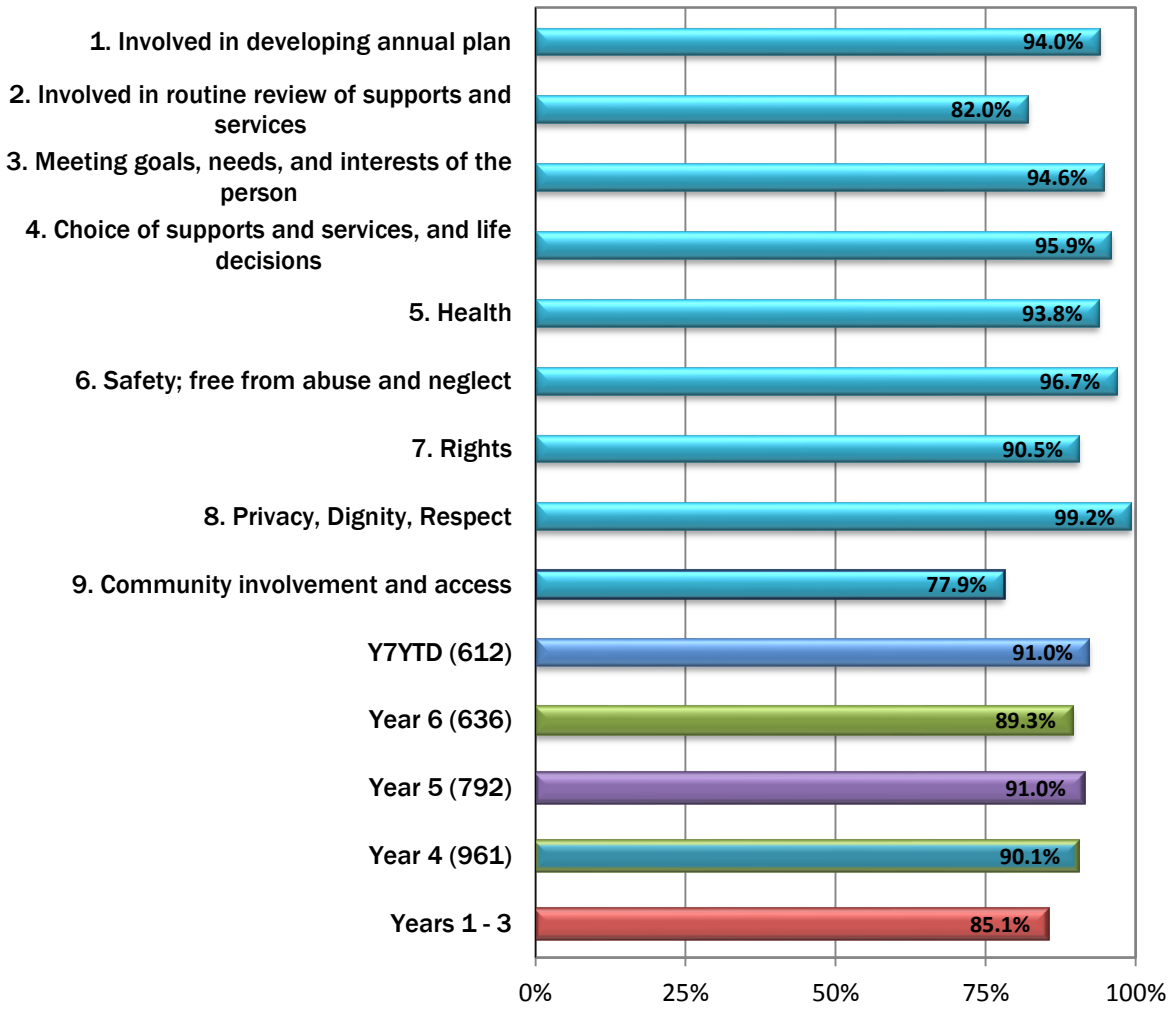
1. **Involvement in Planning** (2): Is the person involved in the development of his/her annual plan and identification of supports and services? Does the person direct the design of the service plan, identifying needed skills and strategies to accomplish desired goals?
2. **Involvement in Development and Evaluation** (1): Is the person involved in the development and ongoing evaluation of supports and services? Does the person participate in the routine review of the service plan and direct changes as desired to assure outcomes are achieved?
3. **Meeting Goals and Needs** (2): Is a personal outcome approach used to design person-centered supports and services and assist the person to achieve personal goals? Is the

person achieving desired outcomes and goals, or receiving supports that demonstrate progress toward these outcomes and goals?

4. **Choice** (2): Is the person afforded choices related to supports and services (paid and unpaid) and is the person involved in life decisions relating to the level of satisfaction? Does the person actively participate in decisions concerning his or her life? Is the person satisfied with the supports and services received?
5. **Health** (1): Does the person feel healthy and does the person get to see a doctor when needed? Are there things about the person's health that could be better?
6. **Safety** (2): Consultant identifies the person's knowledge of self preservation, what is done in case of an emergency. Included in this expectation is if the person is free from abuse, neglect and exploitation.
7. **Rights** (1): Is the person educated and assisted by supports and services to learn about rights and fully exercise them, particularly rights that are important to that person?
8. **Privacy/Dignity/Respect** (2): Is the person treated with dignity and respect and are the person's privacy preferences upheld?
9. **Community Involvement and Access (Community)** (2): Is the person provided with opportunities to receive services in the most integrated settings that are appropriate to the needs and according to the choices of that person? Is the person also developing desired social roles?

Results for the III are presented by Expectation in Figure 3. The average results have been approximately the same since Year 4 of the Quality Management System. Also, consistent across the years, the individual's involvement in the review of supports and services and community involvement were least likely to be present. However, results to date this year indicate at least a five percentage point increase in the following: person's involvement in the design of the service plan, goals and dreams reflected in supports and services, exercising rights, and developing social roles.

Figure 3: Individual Interview Instrument (III)
Percent Present by Expectation (N=612)
July 2014 – March 2015



DD Individual Support Plan Quality Assurance (ISP QA) Checklist

Each individual's team of supports should meet annually to develop an ISP that supports the individual's needs and desired goals. The ISP QA Checklist was initially developed by the state, and revised in Year 4, to ensure the ISP includes all necessary requirements as dictated by the state, and that it helps ensure the individual has a healthy, safe, and meaningful life. Delmarva Quality Improvement Consultants use the ISP QA Checklist form to evaluate the various sections of the ISP, rating them on the degree to which they address all requirements.

Delmarva QICs determine an overall rating for each individual reviewed, based upon the degree to which the ISP is written to provide a meaningful life for the individual receiving services. There are three different categories for each ISP.

Service Life: The ISP supports a life with basic paid services and paid supports. The person's needs that are "important for" the person are addressed, such as health and safety. However, there is not an organized effort to support a person in obtaining other expressed desires that are "important to" the person, such as getting a driver's license, having a home, or acting in a play. The individual is not connected to the community and has not developed social roles, but expresses a desire to do so.

Good But Paid Life: The ISP supports a life with connections to various supports and services (paid and non-paid). Expressed goals that are "important to" the person are present, indicating the person is obtaining goals and desires beyond basic health and safety needs. The person may go out into the community but with only limited integration into community activities. For example, the person may go to church or participate in Special Olympics. However, real community connections are lacking, such as singing in the church choir or being part of an organized team, and the person indicates he or she wants to achieve more.
Community Life: The ISP supports a life with the desired level of integration in the community and in various settings preferred by the person. The person has friends and support beyond providers and family members. The person has developed social roles that are meaningful to that person, such as belonging to a Red Hat club or a book club or having employment in a competitive rather than segregated environment. Rather than just going to church the person may be an usher at the church or sing in the choir. Relationships developed in the community are reciprocal. The ISP is written with goals that help support people in moving toward a

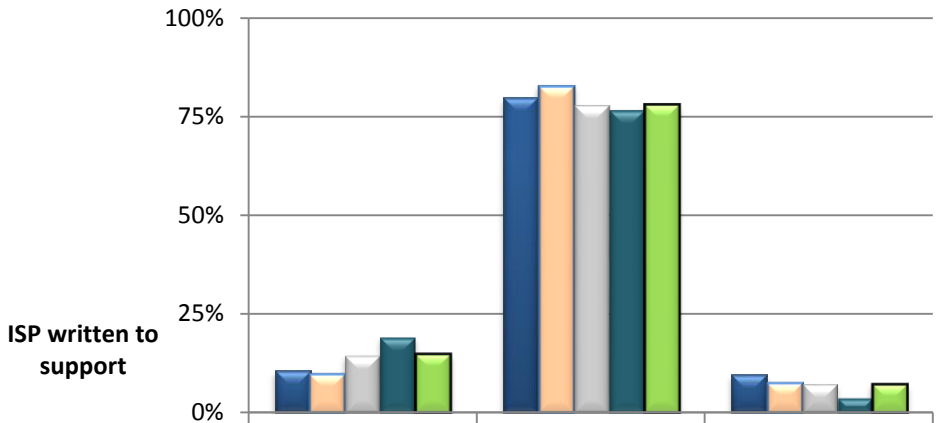
Community Life: The ISP supports a life with the desired level of integration in the community and in various settings preferred by the person. The person has friends and support beyond providers and family members. The person has developed social roles that are meaningful to that person, such as belonging to a Red Hat club or a book club or having employment in a competitive rather than segregated environment. Rather than just going to church, the person may be an usher at the church or sing in the choir. Relationships developed in the community are reciprocal. The ISP is written with goals that help support people in moving toward a Community Life, as the person chooses.

The distribution of the ISP rating for results to date this year is presented in Figure 4, with findings from Year 1 through Year 6 provided. Findings to date indicate:

- An upward trend in the percent of ISPs written to support a Community Life, up to Year 4 and 5 levels
- Individuals in Regions 5 and 6 were much more likely to have ISPs written to support a Service Life
- Individuals in Region 1 were more likely to have ISPs written to support a Community Life
- Individuals living in their own place or with a parent were most likely to have an ISP written to support a Community Life
- However, close to 20 percent of individuals living with a parent had an ISP written to support a Service Life, higher than any other setting

- Elderly people, age 65 and over, were most likely to have an ISP supporting a Community Life

Figure 8: ISP QA Checklist Results
July 2008 – March 2015

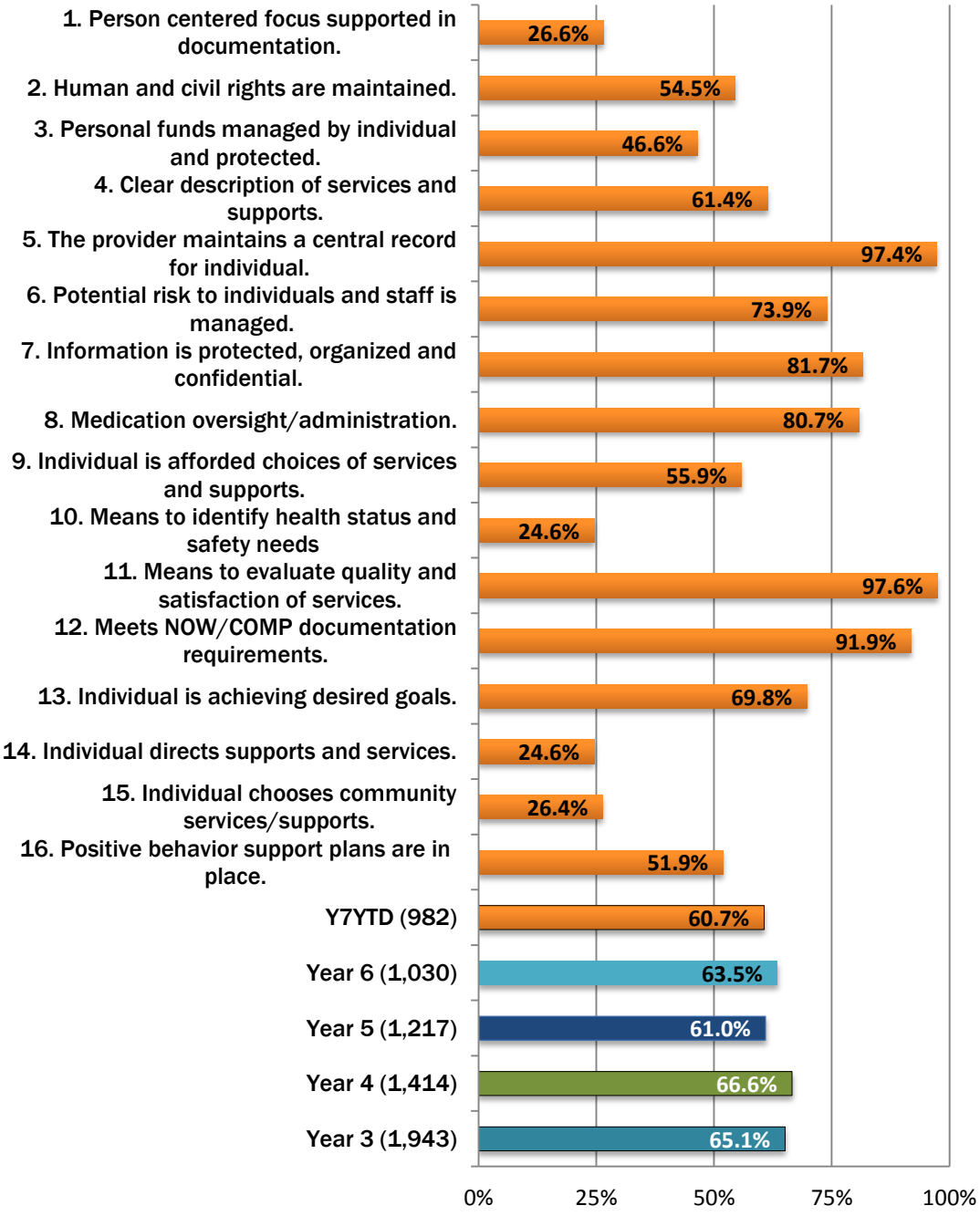


	Service Life	Good But Paid Life	Community Life
Yrs 1-3 Average	10.5%	79.9%	9.6%
Year 4 (961)	9.8%	82.7%	7.5%
Year 5 (792)	14.6%	77.9%	7.4%
Year 6 (636)	19.3%	76.7%	3.9%
Y7YTD (611)	14.9%	77.9%	7.2%

Provider Record Review (PRR)

During the Person Centered Review process, a Provider Record Review (PRR) is completed for all Providers offering supports and services to the individual the time of the Review Figure 5 displays the percent present for each PRR Expectation for all providers working with the 612 individuals who participated in a PCR or QEPR between July 2014 and March 2015. A record review is completed for each service received by the individual, with a total of between 104 and 982 records reviewed for each PRR Expectation to date this year.

Figure 5: Provider Record Review (PRR)
Percent Present by Expectation
July 2014 – March 2015



DD Person Centered Review Results

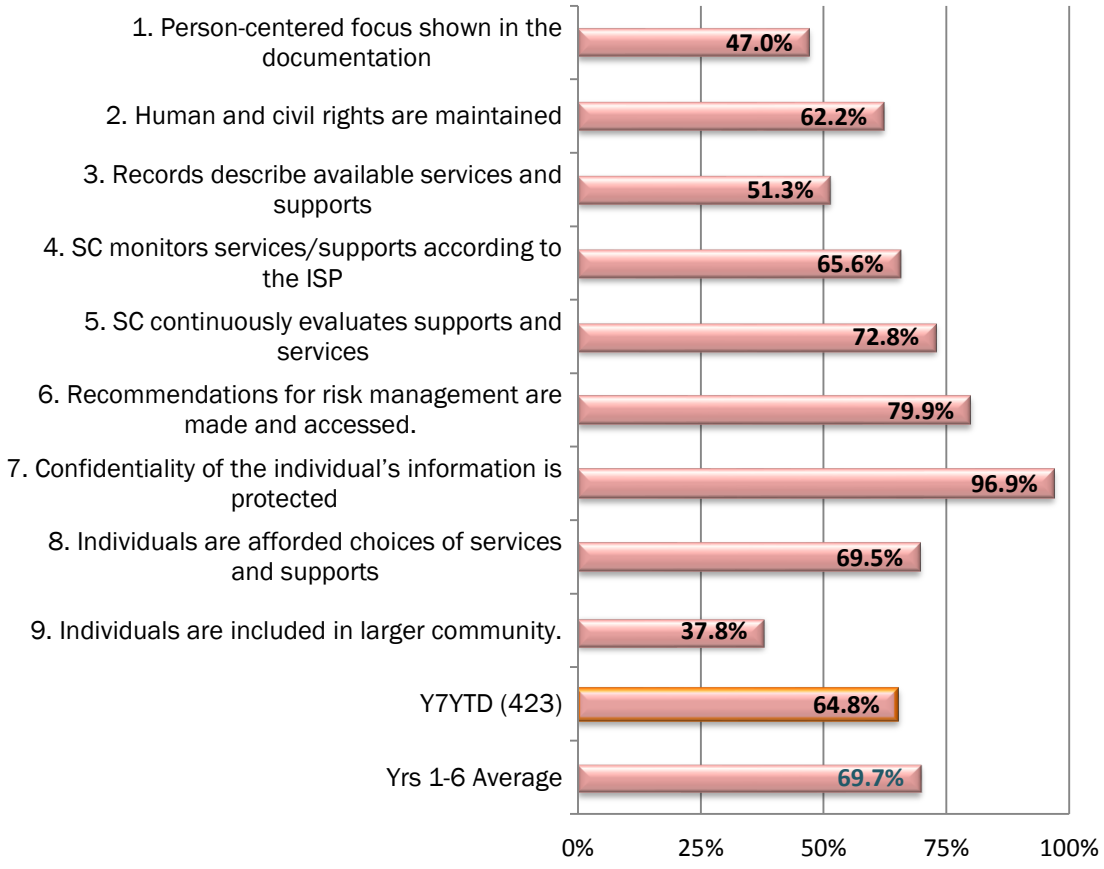
Support Coordinator Record Review (SCRR)
Each individual who is eligible for services through one of the waivers selects a support coordinator to act as an advocate and help identify, coordinate, and review the delivery of

appropriate services, based on specific goals, needs and requirements of the individual. During each PCR, the QICs review the individual's record maintained by the individual's support coordinator. Information from the record is used to score the support coordinator on nine different Expectations (scored as Present or Not Present):[1]

1. A person centered focus is supported in the documentation.
2. Human and civil rights are maintained.
3. Documentation describes available services, supports, care, and treatment of the individual.
4. Support coordinator monitors services and supports according to the ISP.
5. Support coordinator continuously evaluates supports and services.
6. The support coordinator has an effective approach for assessing and making recommendations to the provider for improving supports and services related to risk management.
7. The support coordinator maintains a system of information management that protects the confidentiality of the individual's information.
8. Individuals are afforded choices of services and supports.
9. Individuals are included in the larger community.

[1] Go to Delmarva's GQMS website for a detailed description of each expectation and the type of probes used to determine the appropriate outcome. (http://www.dfmc-georgia.org/person_centered_reviews/index.html)

Figure 6: Support Coordinator Record Review Results (SCRR)
Percent Present by Expectation
July 2014 – March 2015



Quality Enhancement Provider Review

The purpose of the Quality Enhancement Provider Reviews is to monitor providers to ensure they meet requirements set forth by the Medicaid waiver and Division of DD and to evaluate the effectiveness of their service delivery system.

QEPR Administrative Review

Each provider receives one Administrative Review to determine if providers have adequately documented Qualifications and Training (Q&T) for themselves and all relevant employees. The Q&T component includes a review of a sample of personnel records to determine if staff has the necessary qualifications, specific to services rendered, and if the training was received within required timeframes. Due to the degree of revisions implemented in the Administrative tools, procedures, and the Standards for All Providers, comparisons to Years 1 through 3 are not appropriate. In addition, five Expectations were recently revised.

The Administrative Qualification and Training Checklist is used to score providers on 11 Expectations pertaining to service specific qualifications and receiving training within

appropriate timeframes. The average compliance score for the 27 providers reviewed to date in Year 7 was 50.1 percent. Most of the employee records reviewed for these providers did not have job descriptions in place and most employees did not have training requirements completed. Background screening compliance indicates only 64.8 percent of providers reviewed had all components of the critical requirement in place.

Figure 7: Administrative Qualifications and Training Elements
Average Percent Present
July 2014 - March 2015 (N=27)

Number Questions	Expectations	Y7YTD
4	The type and number of professional staff attached to the organization are properly trained, licensed, credentialed, experienced and competent.	59.2%
2	The type and number of all other staff attached to the organization are properly trained, licensed, credentialed, experienced and competent.	85.2%
6	Job descriptions are in place for all personnel.	36.4%
2	There is evidence a National Criminal Records Check (NCIC) is completed for all employees.	64.8%
4	Orientation requirements are specified for all staff. Prior to direct contact with consumers, all staff and volunteer staff shall be trained and show evidence of competence.	56.5%
15	Within the first sixty days, and annually thereafter, all staff having direct contact with consumers shall have all required annual training.	48.5%
7	Provider ensures staff receives a minimum of 16 hours of annual training.	35.8%
1	Organizations with oversight for medication or that administer medication follow federal and state laws, rules, regulations and best practices.	57.7%
1	Provider has a current certification from MHDDAD Division (receives less than $250,000 waiver dollars per year).	75.0%
1	Provider has the required current accreditation, if required (receives $250,000 or more waiver dollars per year).	87.5%
2	Providers using Proxy Caregivers must receive training that includes knowledge and skills to perform any identified specialized health maintenance activity.	50.0%
45	**Average**	50.1%

DD Follow-Up Reviews

Follow Up with Technical Assistance Consultation (FUTAC)

Providers are tagged to receive a FUTAC through a referral system. The review process utilizes a consultative approach to help providers increase the effectiveness of their service delivery systems. The focus is to help improve systems to better meet the health and safety needs, communicated choices, and preferences of individuals receiving services. The FUTAC also supplements the PCR and QEPR processes by affording the State of Georgia and contracted providers the opportunity to solicit technical assistance for specific needs within the service

delivery milieu. During the first three quarters of the contract year, 294 FUTACs were completed. Results are displayed in Figure 8 and include the following:

- Approximately 90 percent were onsite and most were referred at the individual level (85.4%) and by one of the Regional Office Health Quality Managers (89.1%)
- Most FUTAC were completed in Region 3 (60.5%)
- The Support Coordinator monthly score of a 3 or 4 was the primary reason for the referral (87.8%). A score of 3 or 4 requires that a provider submit a corrective action plan to the Region. Regional staff may implement a "look behind" review to determine is CAP has been met, or FUTAC may be submitted to Delmarva for additional review.
- Health, Safety, and the Provider Record Review documentation were most often the Focused Outcome Area addressed
- Technical assistance most often included discussion with the provider and brainstorming

Figure 8: Follow Up with Technical Assistance Consultation Number and Percent by Type and Referral Information July 2014 - March 2015

Type	Number	Percent
Desk	31	10.5%
Onsite	263	89.5%
Referral Level		
Individual	251	85.4%
Provider	43	14.6%
Referral Source		
Division	2	0.7%
Health Quality Manager (HQM)	262	89.1%
Internal	10	3.4%
Other Regional Office Staff	7	2.4%
Provider	13	4.4%
Referral Reason		
SC Monthly Monitoring Scores of 3 & 4s	258	87.8%
Corrective Action Plan (CAP)/Critical Incident	3	1.0%
Provider Self Request	23	7.8%
Complaints/Grievance	9	3.1%
QEPR Alert	0	0.0%
PCR Alert	1	0.3%
Compliance Review	0	0.0%
Support Plan Needing Improvement	0	0.0%
Level of Care Registered Nurse (LOC RN) Review	0	0.0%
Total	294	

Focused Outcome Recommendations

Recommendations are intended to help offer insight for providers to improve their organizational systems and practices. Recommendations following a FUTAC often include keeping health and medication records current and providing ongoing safety education. A total of 548 recommendations have been provided as a result of the QEPR. The following were provided to 12 or more of the 27 providers reviewed, indicating the provider should:

Develop ongoing methods to evaluate supports and services providing an opportunity for continuous quality improvement

Assist individuals in developing more person centered goals that matter most to the person.

Identify ways to expose individuals to new experiences in their communities.

Consider the use of communication books, picture books or other means of communication to ensure individuals who communicate in different ways are afforded choice (s).

Develop practices of ongoing learning on the individuals' preferences for exercising rights.

Explore alternate rights educational materials to accommodate individuals with different communication and learning styles.

Summary of Developmental Disability Findings

In the first half of 2015 The Division of DD accomplished the following. Each Regional Quality Improvement (QI) Council has provided representation on the state QI Council to enhance the connectivity of all initiatives, with Choice selected as the overarching theme for improvement activities. Due to changes in DBHDD priorities, the training plan is being revised to address current needs of the state. The training Calendar is dependent on the implementation of the Georgia Collaborative ASO timeline. Additional information will be provided in the 2015 Annual Report

The quality review processes show multiple areas where providers appear to be improving their service delivery systems and individuals' lives are being positively impacted. Findings indicate most providers are not only receptive to improving the quality of their services but are flexible, dependable, respectful, embrace a teamwork approach, have an attitude of putting the person first, and individuals express satisfaction with supports and services.

Compared to 2014, individuals were more likely to be involved in the design of the service plan, a key method for ensuring a person centered approach to services. Individuals were also more likely to be developing desired social roles, an essential component of the new CMS community

life requirements. The person's goals and dreams were more likely to be reflected in supports and services and individuals were more likely to indicate they are educated on and assisted to exercise their rights. These were also reflected in the ISPs reviewed to date this year, for which the proportion written to reflect a Community Life has increased for the first time since FY 2012. The percent of ISPs with all goals written with a person centered approach has increased by 12 percentage points since Year 6.

The average Support Coordination documentation score has improved for the first time since FY2008. It is hypothesized that the increase could be a result of additional technical assistance provided by DBHDD and Delmarva, or increased documentation QA provided internally by each Support Coordination agency. Compared to 2014, Support Coordination documentation is much more likely to show how individuals are afforded choice of services and supports, and more likely to reflect a person centered approach to services. While PRR results on average have not improved since 2014, providers were somewhat more likely to protect the person's personal information. Twenty-three of the 27 providers reviewed through the QEPR were properly trained or credentialed in the professional field as required and 23 were experienced and competent in the services, supports, care and treatment they provide.

Health and Safety Findings

ISP QA checklist results indicate continued issues with signed medication consent forms, signed Behavior/Crisis/Safety plan(s), and updates to the HRST as required. In addition, only about one quarter of providers documented a means to identify the person's health status and safety needs and about 25 percent of providers had not adequately documented potential risk to individuals and staff (PRR results). While staff interviews show high compliance for health on average, close to 20 percent of the staff interviewed were not providing individuals with ongoing education on self-reliance in healthcare and self-preservation. Health and safety were often the Focused Outcome Area for a FUTAC and of the 27, Administrative Q&T results indicated**:**

- 10 providers had staff that did not have the required training for recognizing and reporting suspected abuse, neglect or exploitation of any individual
- 17 had staff not properly trained on the holistic care of the individual
- 16 to 18 providers did not document annual training for Emergency and disaster plans and procedures, specific individual medications and their side effects, fire safety, and/or the organization's infection control policies and procedures
- 11 providers did not have proper training for medication oversight and administration

The new eISP process will be implemented with the Georgia Collaborative ASO. As this process is implemented, requirements will be developed to ensure proper assessments are completed and all required documentation including consents and behavior support plans are signed before completing the ISP process.

Person Centered Practices

Positive results noted previously indicate some improvement has been seen in the area of Person Centered Practices. However, because this is instrumental to meeting new CMS standards and assurances, it is important to continue to address areas where the data suggest Providers fall short. III results indicated individuals (18%) were not always involved in the routine review of service plans. In a population of approximately 20,000 individuals, this represents 3,600

individuals. Close to 21% of ISPs had only up to one of four expectations present supporting the person's Dreams and Visions.

Provider Record Review results indicate providers continue to struggle with using a person-centered focus in their documentation, suggesting services are not generally implemented with person centered practices. Compliance decreased from a July 2014 rate of 34% to a rate of 27% by the end of the first quarter of 2015. Individuals do not seem to be as likely to manage their own funds as in previous years, which is a key to person-centered practices and also another new CMS expectation. This standard showed a decrease of 24 percentage point to 46.6%, and has shown a downward trend since FFY2010 (92.4%). Provider documentation indicating choice of services and ensuring the person directs supports and services has remained consistently low, 55.9% and 24.6% respectively. DBHDD is embarking on a new Person-Centered Practice training series which will provide quality improvement opportunities to address these inefficiencies

Staff may interact with individuals on a daily basis. Close to 70% of staff interviewed could describe the procedures and responsibilities needed to establish a person-centered approach to service delivery. Fewer than half of Support Coordinators used a person-centered focus in the documentation. Approximately 40% of coordinators documented providing choice of services and supports for individuals. Review results indicate 16 of the 27 providers who participated in a QEPR did not have training in person centered values, principles and approaches within 60 days of direct service provision.

With the implementation of the new eISP, it is expected that with the implementation of the new ISP process, people served will have more opportunity to direct the ISP and goals. However, the new system itself will not generate this type of practice. The Division of DD will take steps to ensure the philosophy, intentions and purpose of person centered planning are integral components of the training on the new ISP process. Additionally, the new eISP will be accessible and easily modified by the person and/or the supports in place to ensure the person is "driving" supports and services, which is also a requirement of the new CMS definition of person centered practices

Community

Many of the standards reviewed indicate continued issues surrounding the person's ability to access and/or have informed choice of community activity. Approximately 32% of individuals interviewed indicated they were not developing desired social roles. In a population of 20,000, that informs us over 6,000 individuals with IDD are not participating in the community as preferred. While there has been a small increase in the proportion of ISPs written to support a community life, only seven percent of plans support real community integration. Therefore, for 20,000 ISPs fewer than 1,500 conform to CMS standards of ensuring individuals can access communities the same as other citizens.

Almost 75% of providers had not documented how individuals are choosing community supports and services and approximately 62% of support coordinators had not documented how individuals are included in the larger community. Staff interview results have traditionally been quite high. However, close to 37% of staff interviewed to date this year did not ensure services rendered in the community promoted integration and the support of desired social roles.

Current data show a small increase in the ISPs written to support a community life, however the overall percent remains quite low. In the second half of 2015, the DBHDD will take steps to develop education curriculum addressing the topic of valuing the person and community involvement and methods to reframe thinking about community inclusion. Newly released CMS rulings require that States document and exhibit community integration for individuals they support. DBHDD has partnered with the Georgia Department of Community Services (Georgia's Medicaid agency) to provide IDD providers with focused training and technical assistance on increasing and maintaining community integration and the new CMS rules governing community integration.

Quality Enhancement Provider Reviews

Administrative review of employee records for the 27 providers who participated in a QEPR reflected relatively low compliance on required qualifications and training, including back ground screening. It is important to note that most of the providers had not ever participated in the QEPR or benefited from the technical assistance provided during the review process. Seven providers had fewer than 30% of the training standards met and seven providers had fewer than 40% of the PRR standards met.

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.

Data Reliability Process

Accurate and reliable data are essential for the success of the DBHDD QM Program. Some of the DBHDDs data integrity activities include:

Hospital System KPI Data Integrity

The Hospital System Quality Management office has utilized the newly developed performance measure evaluation tool (PMET) to identify and assess those KPIs that need additional work in order to assure data integrity. The Hospital System PQC has prioritized data integrity as an important issue and the Assistant Director of Hospital System Quality Management is working with the Hospital Quality Managers committee to make the needed improvements.

Beginning with the reporting period of January 2014, reporting tools were developed to give hospitals the ability to drill down directly to reported data failures and make needed corrections to data that is reported to The Joint Commission (commonly known as the HBIPs measures). Use of that tool resulted in several data-collection methodology changes, which improved the reliability of the data and timeliness of reporting. As reporting requirements by The Joint Commission and Centers for Medicare and Medicaid Services change, these reports are altered and improved in order to give the hospitals the maximum amount of data integrity and reporting capability.

In addition, beginning in December 2013, DBHDD's EMR system was improved to capture needed data directly from the physician electronic record. This improved data collection by eliminating interpretation and data re-entry of the reported data.

Community BH Key Performance Indicator Data Integrity

The majority of the data that comprises the CBH KPIs is received from providers via a monthly programmatic report. These reports are submitted through an online web-portal. Once the data is received by DBHDD the data must pass a logic safeguard validation and is reviewed by staff with programmatic oversight of each specific program before it is accepted. DBHDD Regional Offices also have access to the web-portal and have the ability to give additional comments regarding the validity of the reports. Feedback is given to providers when errors or omissions occur and they are required to re-complete and re-send their data once corrected. Technical Assistance is provided as needed.

DD KPI Data Integrity

Every two weeks, the analyst working with Delmarva runs a report to identify any incorrect or missing data from the database. This process generates a report from data collected as part of the PCR and QEPR processes which is reviewed by managers, who correct any identified errors. In order to ensure proper handling of possible missing data or data errors, a Data Correction Protocol has been developed to track data errors and necessary correction. For approved reviews or reports, all changes in the data are documented in the "Reopen Review Log". This information is reviewed periodically by the quality improvement regional manager for possible trends. After the data in the report have been corrected, a new report is generated and distributed as necessary.

Summary

The sections above reference the multitude of quality related activities taking place across DBHDD. Key activities that have taken place between January 2015 and June 2015 include the annual DBHDD QM system review; a review and updating of the hospital QM system, a review of DBHDD's KPIs, continued training of providers on cognitive therapy (Beck Initiative) and the expansion of suicide prevention activities and the creation of the Department's first Mortality Review Report. The Division of Developmental Disabilities has drafted specific performance and outcome indicators for its providers and the services received by individuals and their families; is undergoing a re-organization to functionally align the supports and services provided; has implemented several QI initiatives to address areas of need; is developing a more person-centered and user friendly ISP; is addressing the weaknesses of its transition process to better support individuals moving from a state hospital to the community; and continues to stress the importance of community integration for all individuals supported by the Division of Developmental Disabilities.

During the upcoming six months, quality management activities will focus on the continued assurance of quality transitioning of individuals from state hospitals to the community, the implementation of the Georgia Collaborative ASO, the DD re-engineering project, finalizing the corrective action plan/enforcement process, submission of the NOW/COM waiver applications, finalizing the IDD rate structure, implementation of a new support coordination process and intensive support coordination for IDD, incorporating independent subject matter expert review

of settlement service consumer deaths, and analyzing & utilizing data trends/patterns to make program decisions and improvements.

Appendix A DBHDD Quality Management Work Plan

Goal 1: Develop accurate, effective and meaningful performance indicators.

Tasks	Responsible Person	Target Completion Date	Status
Determine the criteria for developing the key performance indicators	Carol Zafiratos	June 2013	Completed
Identify and assess current performance indicators for value and applicability	Carol Zafiratos, Steve Holton, Eddie Towson	June 2013	Completed and now ongoing
Collaborate with stakeholders using the identified criteria to develop key performance indicators	Program Quality Councils	July 2013	Completed and now ongoing
Develop and implement data collection plans for KPIs (identify responsible persons for data entry, collection, reporting, etc.)	Carol Zafiratos, Steve Holton, Eddie Towson	August 2013	Completed

Goal: 2 Educate stakeholders regarding QM (includes staff, providers and ultimately individuals and families).

Tasks	Responsible Person	Target Completion Date	Status
Update the current QM Training Plan and ensure inclusion of training for hospitals, CBH and DD	Carol Zafiratos and Training Department	June 2013	Delayed until September 2015
Continue development of web based training materials – three additional modules	Carol Zafiratos and Training Department	December 2013	Completed
Develop and implement methodology to evaluate the effectiveness of the training	Carol Zafiratos and Training Department	December 2013	Completed

Goal: 3 Assess and improve the effectiveness of the QM system and its various components. This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Implement the EQC approved outcomes framework (identify/revise KPIs as applicable, develop a data definition/collection plan for each measure and implement data collection).	Program Quality Council Chairpersons	June 2013	Completed. It is anticipated that the framework will be revised in 2015.
Assess achievement levels of quality goals	Program Quality Council Chairpersons	March 2014	Competed
Assess performance indicator achievement against target thresholds	Program Quality Council Chairpersons	March 2014	Completed
Modify QM system and/or components as needed	Program Quality Council Chairpersons	March 2014	Completed and now ongoing

Goal 4: Integrate QM Data Systems (have access to the data needed that is compatible with the hospital, community BH and community DD systems and which follows an individual and the services they receive across their lifetime, as applicable). This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Perform a comprehensive QM data management needs assessment	Director of IT and Carol Zafiratos, Steve Holton and Eddie Towson	January 2014	Significantly revised. Refer to the updated QM Plan when modified.
Define and develop data sharing partnerships/agreements with other agencies (DCH, DJJ, DOE, DPH, DAS, etc.)	DBHDD Leadership representative(s) [COO & Director of IT]	July 2014	Significantly revised. Refer to the updated QM Plan when modified.
Create a QM information management plan (i.e.: policy and procedure development)	Director of IT	July 2014	Significantly revised. Refer to the updated QM Plan when modified.
Develop a RFP to build a	Director of IT	July 2014	Significantly

DBHDD Enterprise Data Systems (EDS)			revised. Refer to the updated QM Plan when modified.
Develop the DBHDD EDS	Director of IT	2015	Significantly revised. Refer to the updated QM Plan when modified.
Evaluate the effectiveness and efficiency of the newly created system	Director of IT, Carol Zafiratos, Steve Holton and Eddie Towson	2016	Significantly revised. Refer to the updated QM Plan when modified.

Appendix B Hospital System Quality Management Work Plan

Goal 1: Develop accurate, effective and meaningful performance indicators.

Tasks	Responsible Person	Target Completion Date	Status
Determine the criteria for developing the key performance indicators	Carol Zafiratos	June 2013	Completed
Identify and assess current performance indicators for value and applicability	Steve Holton, Dr. Risby, Carol Zafiratos	June 2013	Completed
Modify KPIs, as appropriate	Hospital System Quality Council	July 2013	Completed
Develop and implement data collection plans for KPIs (identify responsible persons for data entry, collection, reporting, etc.)	Steve Holton and Carol Zafiratos	August 2013	Completed

Goal 2: Educate stakeholders regarding QM (includes staff, providers and ultimately individuals and families).

Tasks	Responsible Person	Target Completion Date	Status
Update the current QM Training Plan and ensure inclusion of training for hospitals	Carol Zafiratos, Steve Holton and Training Department	~~June 2013~~ DBHDD reorganization has affected the target dates for this goal and will be adjusted as new leadership has an opportunity to review and revise.	The scope and specificity of the training plan has been modified – refer to the Learning Plan contained within the QM Plan for specifics
Identify desired knowledge, skills, abilities and behaviors for current and prospective quality management facilitators and leaders.	DBHDD Quality Management Director	~~August 2013~~ DBHDD reorganization has affected the target dates for this goal and will be adjusted as new leadership has an opportunity to review and revise.	The revised DBHDD Learning Plan will include Hospital Quality Managers
Assess training needs of QMs This task is no longer a necessary step in this training plan. All QMs, as well as other DBHDD QM team facilitators and leaders will receive the standard QM facilitation curriculum.	Director of Hospital System Quality Management	Sept 15, 2013 DBHDD reorganization has affected the target dates for this goal and will be adjusted as new leadership has an opportunity to review and revise.	The revised DBHDD Learning Plan will include Hospital Quality Managers
Develop training plans and methodology for QMs This task is no longer a necessary step in this training plan. All QMs, as well as other DBHDD QM team facilitators and leaders will receive the standard QM facilitation curriculum.	Director of Hospital System Quality Management, Carol Zafiratos and Training Department	Nov 1, 2013 DBHDD reorganization has affected the target dates for this goal and will be adjusted as new leadership has an opportunity to review and revise.	Completed at the DBHDD level

Goal 3: Assess and improve the effectiveness of the QM system and its various components.

Tasks	Responsible Person	Target Completion Date	Status
Set target values for Hospital System KPIs.	Dr. Emile Risby – Chair Hospital System Program Quality Council	~~June~~ ~~2013~~	Completed
Each hospital creates their data definition/collection plans	Program Quality Council Chairpersons	Dec. 2015	New KPIs have been established, but there are also a few more that we are developing related to Provision of care, budget, and discharge.
Each hospital identifies and submits their KPIs (hospital level) and PI goals to the HS PQC	Program Quality Council Chairpersons	March 2014	Completed
Hospitals update analyses and begin to prepare reports for Hospital System PQC (Quality Management effectiveness review meeting scheduled for Sept 2016).	Program Quality Council Chairpersons	Sept 2016	This has been changed to the Hospital System level.

Goal 4: Integrate QM Data Systems (have access to the data needed that is compatible with the hospital, community BH and community DD systems and which follows an individual and the services they receive across their lifetime, as applicable).

Tasks	Responsible Person	Target Completion Date	Status
Organize a Hospital System information management committee	Director of Hospital System Quality Management	July 15, 2013	Completed
Develop methodology for performing IM needs assessment	Chair of Information Management Committee & Director of Hospital System Quality Management	September 1, 2013	Completed
Perform needs assessment in hospitals and analyze results	Chair of Information Management Committee & Director of Hospital System Quality Management	November 1, 2015	Currently being performed by the OIT consultants.
Set priorities for IM needs and communicate priorities to OIT, as appropriate.	Chair of Information Management Committee & Director of Hospital System Quality Management	December 1, 2015	Revised target date to December 2015
Develop Hospital System IM plan	Chair of Information Management Committee & Director of Hospital System Quality Management	December 31, 2015	Revised target date to December 2015

Appendix C Community Behavioral Health Quality Management Work Plan

Goal 1: Develop accurate, effective and meaningful performance indicators.

Tasks	Responsible Person	Target Completion Date	Status
Distribute Performance Measure Evaluation Tool (PMET) to CBH committee members	Carol Zafiratos	July 2013	Completed
Utilize criteria (from PMET) to assess current KPI's	Chris Gault and CBH Program Staff	September 2013	Completed
Use PEMT and develop new KPI's as indicated	Chris Gault and CBH Program Staff	October 2013	Completed and ongoing
Make recommendations regarding the infrastructure that is needed to ensure data integrity and follow up for new KPIs	Chris Gault and CBH Program Staff	October 2013	Completed
Collaborate with stakeholders to review and provide feedback on new KPI's	Chris Gault and CBH Program Staff	October 2013	Completed and ongoing
Develop data collection plans for new KPIs (identify responsible persons for data entry, collection, reporting, etc.)	Chris Gault and CBH Program Staff	November 2013	Completed
Implement data collection plans for new KPIs	Chris Gault and CBH Program Staff	January 2014	Completed and ongoing
Initiate provider based data integrity reviews	Resources need to be identified	August 2015	Delayed, incorporated into ASO procurement

Goal: 2 Educate stakeholders regarding QM (includes staff, providers and ultimately individuals and families).

Tasks	Responsible Person	Target Completion Date	Status
Develop and implement recommendations for the first three quality management related training modules for State and Regional Office BH staff	CBH PQC and Carol Zafiratos	Start Date = September 2013 Completion Date = January 2014	1st and 2nd modules completed
Once approved implement the training recommendations and monitor compliance for state staff	CBH Program Managers	Start Date = October 2013	Completed
Develop a QM training plan for	CBH PQC, Chris Gault and	January 2014	Delayed, new

providers	Monica Parker		target date October 2015
Develop a QM training plan for individuals served and families	CBH PQC, Chris Gault and Monica Parker	March 2014	Delayed, new target date October 2015

Goal: 3 Assess and improve the effectiveness of the QM system and its various components. This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Using the PMT, annually review all KPI's for efficiency and effectiveness	CBH PQC	March 2015	Delayed, new target date September 2015

Goal 4: Integrate QM Data Systems (have access to the data needed that is compatible with the hospital, community BH and community DD systems and which follows an individual and the services they receive across their lifetime, as applicable). This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Make recommendations based upon KPI selection for future data needs	CBH PQC through Chris Gault	December 2013 and ongoing	Completed and ongoing

Appendix D Developmental Disabilties Quality Management Work Plan

Goal 1: Assess and improve the effectiveness of the QM System and its various components that assures quality person-centered supports and services for individuals with developmental disabilities. **Goal 2**: Develop accurate and meaningful performance indicators.

Tasks	Responsible Person	Target Completion Date	Status
Documentation review (i.e. relevant policies and procedures, recent CMS Waiver changes, DOJ Settlement Agreement, etc.)	Director of DD Quality Management and Contractor	06/30/13	Completed
Assessment of current data collection methods	Director of DD Quality Management and ASO	07/31/13 Revised to 07/01/15	
Assessment of current data utilization	Director of DD Quality Management and Contractor	07/31/13	Completed.
Interview Central and Regional Office staff to identify capabilities of quality practitioners	Director of DD Quality Management and Contractor	07/31/13	Completed.
Conduct Stakeholder interviews to determine capabilities of quality practitioners	Director of DD Quality Management and Contractor	07/31/13	Completed.
Conduct Focus Groups with targeted stakeholders to collect information on strengths, benefits and opportunities for improvement	Director of DD Quality Management and Contractor	07/31/13	Completed.
Conduct Interviews with service provider and service coordination staff	Director of DD Quality Management and Contractor	07/31/13	Completed.
Conduct comparison of requirements generated by DBHDD to CMS and DOJ requirements	Director of DD Quality Management and Contractor	07/31/13	Completed.
Establish QI Council workgroup to design new QM system with participation from DD	Director of DD Quality Management and Contractor	07/31/13 – Revised to 02/01/14	Planning timeline for design of new system has been extended to allow for more thorough

Advisory Council			planning and development
Develop report describing the status of the "as is" system	Director of DD Quality Management and Contractor	08/01/13	Completed. See Attachment 1- Quality Management System Review - Summary of Current Status Report
Develop recommendations for improvements to Georgia's quality system	Director of DD Quality Management and Contractor	08/01/13 – Revised to 02/01/14	In process See Attachment 1- Quality Management System Review - Summary of Current Status Report
As part of Goal 1 DD will establish accurate, effective, and meaningful performance indicators for DD Services and DD Providers	Director of DD Quality Management and Contractor	08/15/13 – Revised to 03/01/14	Completed
Finalize measurements	Director of DD Quality Management and Contractor	09/15/30/13 – Revised to 03/01/14 then to 12/31/14 and revised again to 03/01/15	
Develop comprehensive description of redesign for statewide DD QM system	Director of DD Quality Management and Contractor	10/01/13 – Revised to 03/01/14	Planning timeline for design of new system has been extended to allow for more thorough planning and development

Goal 3: Educate Stakeholders regarding QM (including staff, providers, and individuals and families)

Tasks	Responsible Person	Target Completion Date	Status
Identify core knowledge and skill requirements for each quality role identified.	Director of DD Quality Management and Dept Director of QM	08/31/13. Revised to 05.01.15	Completed.

Review and analyze the instructional system/knowledge and basic skill topics with DBHDD Staff and quality councils.	Director of DD Quality Management and Dept Director of QM	08/31/13 – Revised to 07/01/16	Planning timeline for design of new system has been extended to allow for more thorough planning and development
Develop materials and methods for learning management and curriculum development	Director of DD Quality Management and Dept Director of QM	09/30/13 – Revised to 07/01/16	Development timeline has been extended to allow for more thorough planning and development
Create DD training program draft and review with DBHDD Staff and Quality Councils	Director DD Quality Management	10/31/13 – Revised to 07/01/16	Timeline has been adjusted as a result of extended planning and development period
Finalize training program with input from Quality Councils and Advisory Council	Director DD Quality Management	11/15/13 – Revised to 07/01/16	Timeline has been adjusted as a result of extended planning and development period
Train staff and stakeholders on new DD QM System	Director DD Quality Management and Contractor	12/15/13 – Revised to 07/01/16	Timeline has been adjusted as a result of extended planning and development period
Draft a manual which includes the following sections:	Director of DD Quality Management and Contractor	12/15/13 – Revised to 07/01/16	Timeline has been adjusted as a result of extended planning and development period
• QM and improvement requirements section			
• Roles and responsibilities section			
• Guidance on joint agency collaboration			
• Reporting requirements			
• Tools for data collection and analysis			
Review drafts of each section with DBHDD staff and QI Councils and Advisory Council	Director of DD Quality Management	12/31/13 – Revised to 07/01/16	Timeline has been adjusted as a result of extended planning and development period

Goal 4: Ensure that individuals with DD transitioned out of state hospitals to receive high quality services and to achieve life goals in community.

Tasks	Responsible Person	Target Completion Date	Status
Develop the follow-up and monitoring process	Joseph Coleman, Director of Transitions DD	04/01/13 6/5/13	Completed Revisions completed to incorporate full review of findings/reports by Central Office
Finalize the audit tool	Joseph Coleman, Director of Transitions DD	04/01/13 6/5/13	Completed Revisions completed to utilize full monitoring tool developed by DOJ
Identify the reviewers/auditors	Joseph Coleman, Director of Transitions DD	04/01/13	Completed
Create, hire, train Regional DD Transition Quality Review Team	Joseph Coleman, Director of Transitions DD, and Rose Wilcox. Director of Training and Education DD	7/1/13	Completed
Decide the process of data collection, reporting, and correcting problems identified	Joseph Coleman, Director of Transitions DD	6/10/13	Completed
Review quality of transition for 79 individuals who have transitioned out of state hospitals as of July 1, 2012	Joseph Coleman, Director of Transitions DD	06/20/13	Completed. Results sent to GSU for analysis Provider CAPs generated by reviews submitted by Providers and reviewed/approved by Region Office and Transition Fidelity Committee
Pre-transition review of Provider capacity to ensure quality care for 40 individuals whose planned May/June transitions were postponed until after July 1, 2013	Joseph Coleman, Director of Transitions DD	06/25/13	Completed Provider CAPs generated by reviews submitted by Providers and reviewed/approved by Region Office and Transition Fidelity Committee
Review and revise the current transition process to develop a	Joseph Coleman, Director of Transitions DD	7/1/13Revised to 07/01/16	Work ongoing.

comprehensive process / plan			

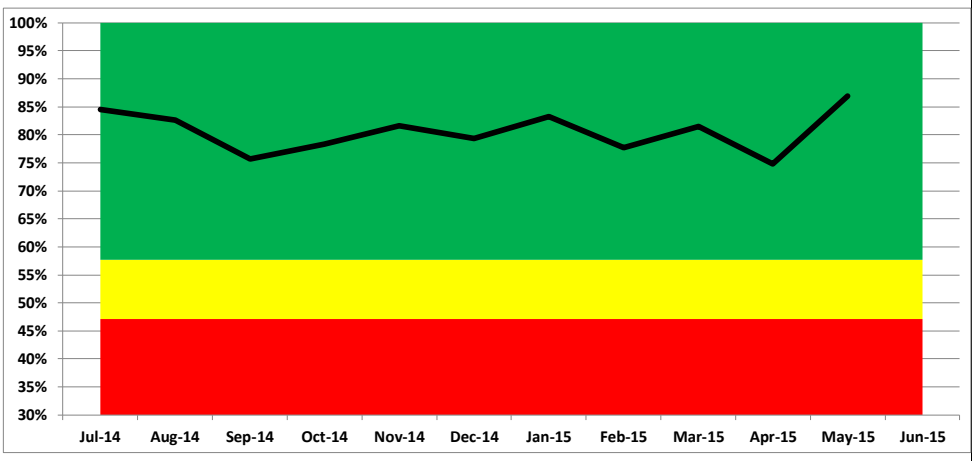
Goal 5: Integrate QM Data Systems in a matter which is compatible with Department data systems (Hospital, Community BH and Community DD) which will allow Division to follow an individual and their services across their lifetime. This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Develop Division DD information management committee	Director of DD Quality Management	08/01/13. Revised to In place and ongoing.	ASO (Georgia Collaborative) has been procured and implementation is underway. There are two teams of DBHDD and Collaborative staff that are responsible for this work. The Collaborative QM Team and the Collaborative IT Team
Assessment current information management systems methods for collection and utilization	Director of DD Quality Management and Division Data Manager	08/01/13 Revised to Ongoing	Ongoing ASO (Georgia Collaborative) has been procured and implementation is underway. DD staff are working with Business Analyst to develop work flows for collection and utilization
Set priorities for IM needs and work with OIT to address those needs as appropriate.	Director of DD Quality Management and Division Data Manager	10/01/13	Completed and ongoing. ASO (Georgia Collaborative) has been procured and implementation is underway. There are two teams of DBHDD and Collaborative staff that are responsible for this work. The Collaborative QM Team and the Collaborative IT Team
Include development of new DD case management	Director of DD Quality	10/01/13 Revised to	Completed

system in the Department's RFP for an Administrative Service Organization (ASO). Revised to: Develop new ISP for inclusion in the Georgia Collaborative Case Management System	Management	07/01/15	
Work with ASO to develop and test new system	Director of DD Quality Management and Vendor	08/01/14 – Revised to 01/01/2016	Timeline adjusted to match ASO implementation timeline.
Train end users on new system	Director of DD Quality Management and Vendor	10/01/14 – Revised to 01/01/2016	Timeline adjusted to match ASO implementation timeline.
Transition data from old case management system to new system	Director of DD Quality Management and Vendor	12/31/14 - Revised to 01/01/16	Timeline adjusted to match ASO implementation timeline.

Appendix E Hospital System KPI Dashboards

Client Perception of Outcome of Care



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	104	114	140	127	111	108	134	80	97	107	133	N/A
Denominator	123	138	185	162	136	136	161	103	119	143	153	N/A
Rate	85%	83%	76%	78%	82%	79%	83%	78%	82%	75%	87%	#N/A
Quarterly Average	80%			80%			81%			Incomplete data		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of clients at discharge or at annual review who respond positively to the outcome domain on the Inpatient Consumer Survey.

Measure explanation: This measure shows client responses to the following questions:
*I am better able to deal with crisis.
*My symptoms are not bothering me as much.
*I do better in social situations.
*I deal more effectively with daily problems.
(Source: NRI) The determination of the line where the red/yellow areas of the graph meet is based on the national average published by NRI for December 2013 through November 2014, less one standard deviation. (Data collection for surveys were started state-wide in February 2012.)

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of clients who respond positively to the outcome domain	**Denominator:** Number of clients completing at least 2 items in the outcome domain Included populations: Clients who were discharged during the period and completed at least 2 questions in the domain. Only clients served in programs associated with Adult Mental Health are surveyed.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection is incomplete for this quarter.

January-March 2015 Analysis

The average positive response remains within the target range. Recommend continued monitoring.

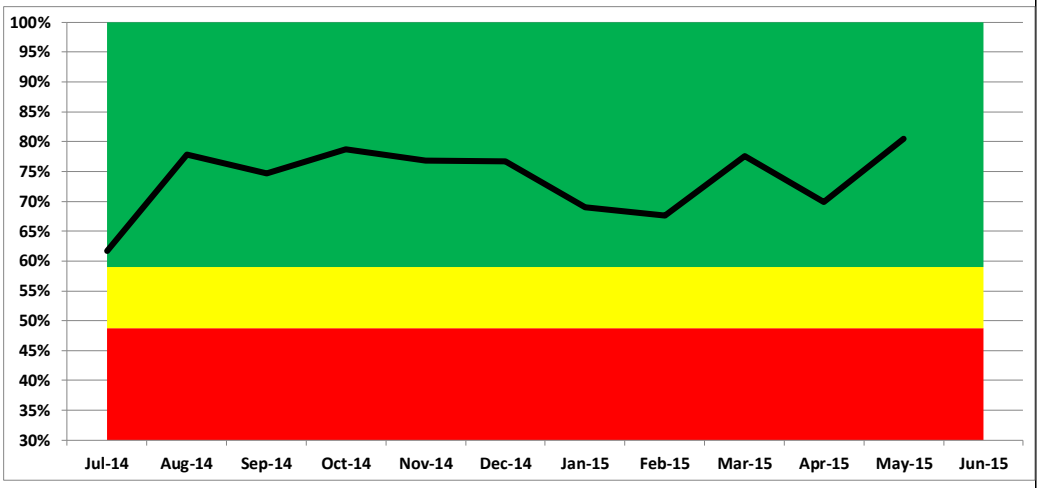
October-December 2014 Analysis

Scores have continued to fall well within the target range during this period.

July-September 2014 Analysis

Respondents still rated DBHDD's service higher than the national average. However, a slight downward trend over the previous four quarters is noted. Recommend continued monitoring and improvement in services.

Client Perception of Empowerment



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	74	109	136	129	106	99	111	69	90	100	120	N/A
Denominator	120	140	182	164	138	129	161	102	116	143	149	N/A
Rate	62%	78%	75%	79%	77%	77%	69%	68%	78%	70%	81%	#N/A
Quarterly Average	72%			77%			71%			Incomplete data		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of clients at discharge or at annual review who respond positively to the empowerment domain on the Inpatient Consumer Survey.

Measure explanation: This measure shows client responses to the following questions:
*I had a choice of treatment options.
*My contact with my doctor was helpful.
*My contact with nurses and therapist was helpful.
(Source: NRI) The determination of the line where the red/yellow areas of the graph meet is based on the national average published by NRI for December 2013 through November 2014, less one standard deviation. (Data collection for surveys were started state-wide in February 2012.)

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of clients who respond positively to the empowerment domain

Denominator: Number of clients completing at least 2 items in the empowerment domain Included populations: Clients who were discharged during the period and completed at least 2 questions in the domain. Only clients served in programs associated with Adult Mental Health are surveyed.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection is incomplete for this quarter.

January-March 2015 Analysis

Clients continue to score the Hospital System's performance in client empowerment above the national average and within the acceptable range.

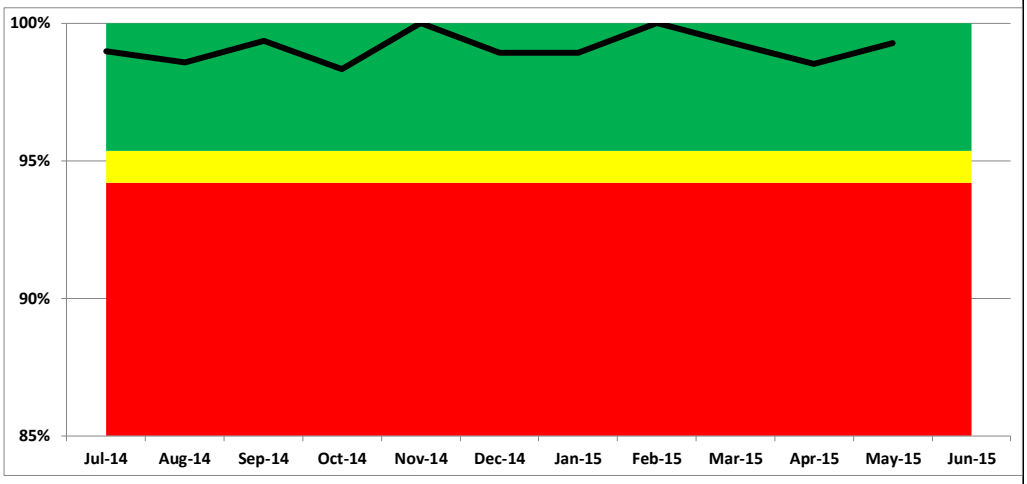
October-December 2014 Analysis

Scores have continued to fall well within the target range during this period, with an overall slight improment trend over the course of the year.

July-September 2014 Analysis

Despite the expected seasonal drop in rate, respondents still rated DBHDD's service higher than the national average.

Continuing Care Plan Created (Overall)



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	293	278	310	295	225	277	276	234	270	267	280	N/A
Denominator	296	282	312	300	225	280	279	234	272	271	282	N/A
Rate	99%	99%	99%	98%	100%	99%	99%	100%	99%	99%	99%	#N/A
Quarterly Average	99%			99%			99%			Incomplete data		

MEASURE DEFINITION AND EXPLANATION

Measure definition: Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan that contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations.

Measure explanation: This measure is a nationally standardized performance measure for behavioral health organizations, reported to The Joint Commission through our partner, NRI, on a quarterly basis. The data are for people who were treated in adult mental health inpatient programs only.
The colored bands represent ranges that indicate level of acceptibility of scores and are based The Joint Comission "Target Rates" published quarterly, 4 to 5 months after the quarter ends. The most recent rates published are used as guides for current data. The red area of the graph indicates the area that is below The Joint Commission's Target Range. The Joint Commission changed the target range in October 2012 from 93.4% to 94.4%.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Psychiatric inpatients for whom the post discharge continuing care plan is created and contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations.
Included Populations: NA
Excluded Populations: None

Denominator: Psychiatric inpatient discharges. Included Populations: Patients referred for next level of care with ICD-9-CM Principal or Other Diagnosis Codes for Mental Disorders. Excluded Populations: The following cases are excluded: • Patients who expired • Patients with an unplanned departure resulting in discharge due to elopement or failing to return from leave • Patients or guardians who refused aftercare • Patients or guardians who refused to sign authorization to release information • Patients discharged to another unit within the same hospital

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection is incomplete for this quarter.

January-March 2015 Analysis

Rate continues to be reported above The Joint Commission guideline rate, including a reported (and rare) 100% score for the month of February. Continued monitoring is recommended.

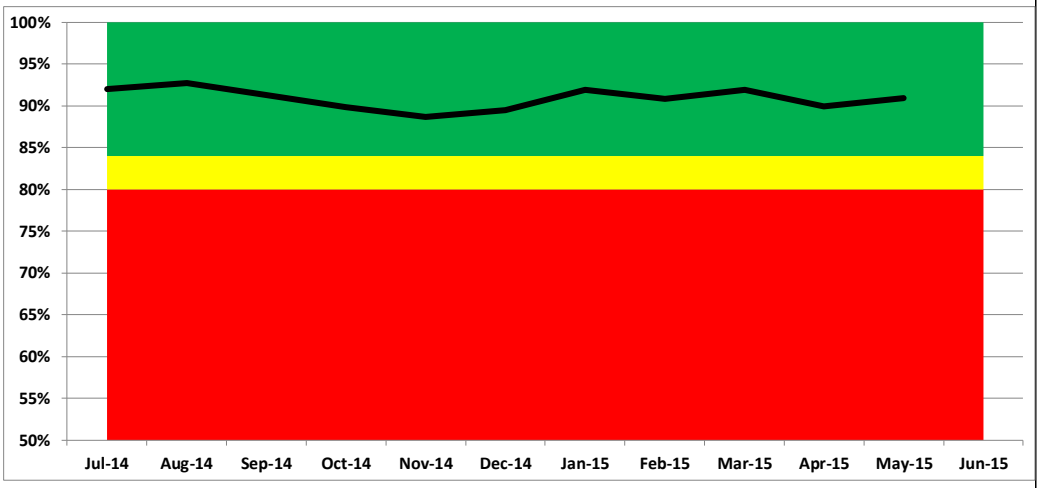
October-December 2014 Analysis

Scores have continued to fall well within the target range during this period.

July-September 2014 Analysis

Rate remains above The Joint Commission guidelines. Continued monitoring is recommended.

Individual Recovery Plan Audit - Quality Measure



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	1570	1717	1627	1466	1563	1576	1621	1602	1584	1532	1499	N/A
Denominator	1706	1851	1782	1631	1762	1762	1763	1763	1723	1704	1648	N/A
Rate	92%	93%	91%	90%	89%	89%	92%	91%	92%	90%	91%	#N/A
Quarterly Average	92%			89%			92%			Incomplete data		

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percent of positive responses to the Individualized Recovery Plan audit's questions on "Quality."

Measure explanation: Chart audit focusing on the quality and internal-consistency of the Individualized Recovery Plan. Audit began January 2012.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Total number of "Yes" responses to questions 2-20 on the IRP audit

Denominator: Total number IRP audits conducted.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection is incomplete for this quarter.

January-March 2015 Analysis

Continued, relatively constent scores reflected in the IRP Quality audit display the emphasis placed on quality IRP creation by DHBDD hospitals.

October-December 2014 Analysis

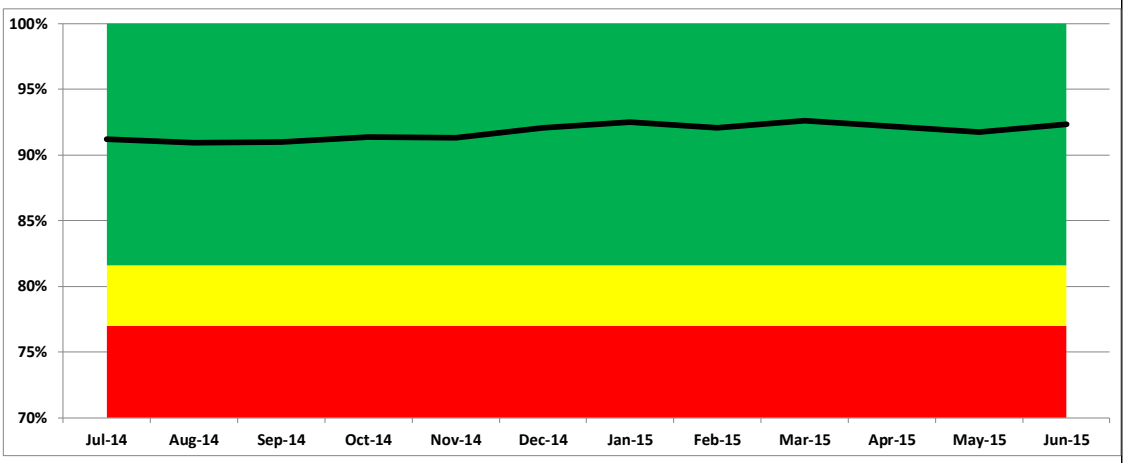
Scores have continued to fall well within the target range during this period. Possible causes for a slight down turn in the current quarter are being addressed and should be reflected in the next quarter's scores.

July-September 2014 Analysis

Rate is holding relatively steady during this quarter. Continued emphasis on the IRP process has kept this rate above the threshold.

Appendix F CBH System KPI Dashboards

Percent of Georgia Housing Voucher Program adult MH individuals in stable housing (greater than 6 months)
Target 77%



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	1089	1134	1159	1251	1302	1383	1454	1425	1601	1627	1684	1756
Denominator	1194	1247	1274	1369	1426	1502	1572	1548	1729	1765	1835	1902
Percent	91.2%	90.9%	91.0%	91.4%	91.3%	92.1%	92.5%	92.1%	92.6%	92.2%	91.8%	92.3%
Quarterly Average	91.0%			91.6%			92.4%			92.1%		

MEASURE DEFINITION AND EXPLANATION

Measure definition: A measure of stable housing based on nationally accepted HUD standard.

Measure explanation: An initial indication of the program's ability to prevent homelessness and re-institutionalization.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of individuals leaving the program less than 6 months.	**Denominator:** Number of individuals in the program greater than 6 months.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data analysis not complete as of the writing of this report.

January-March 2015 Analysis

The quarterly average rose for the third consecutive quarter, indicating continued improvement.

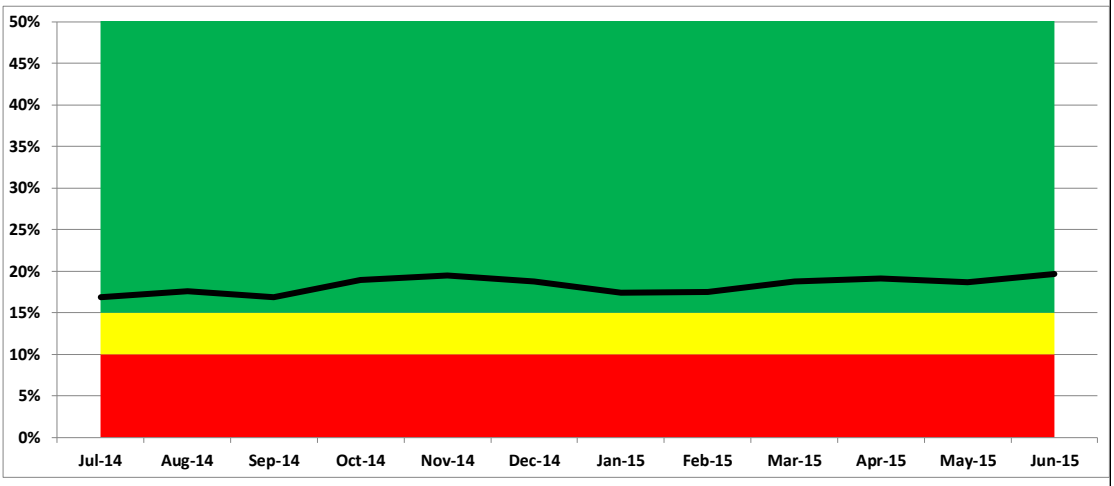
October-December 2014 Analysis

Although monthly averages vary slightly, the quarterly average is an improvement over last quarter, and well within the target rate.

July-September 2014 Analysis

As a rolling average, this measure continues to remain stable as new individuals are added on to the program.

Percent of Georgia Housing Voucher Program adult MH individuals who left stable housing under unfavorable circumstances and have been reengaged and reassigned vouchers
Target 10%



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	49	54	53	63	67	66	65	69	78	81	81	89
Denominator	290	307	314	333	344	352	373	394	415	424	434	453
Percent	16.9%	17.6%	16.9%	18.9%	19.5%	18.8%	17.4%	17.5%	18.8%	19.1%	18.7%	19.6%
Quarterly Average	17.1%			19.0%			17.9%			19.1%		

MEASURE DEFINITION AND EXPLANATION

Measure definition: A measure to determine negative program leavers in order to divert them from homelessness or other more expensive systems of care.

Measure explanation: Reinforces the notion that recovery is not a straight line and that reengagement after initial failure is an important program component.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of individuals that left the program under negative circumstances that reentered the program.	**Denominator:** Number of individuals that left the program under negative circumstances.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data analysis not complete as of the writing of this report.

January-March 2015 Analysis

Although not as high as last quarter, this quarter's rate is still above the target rate set for this measure.

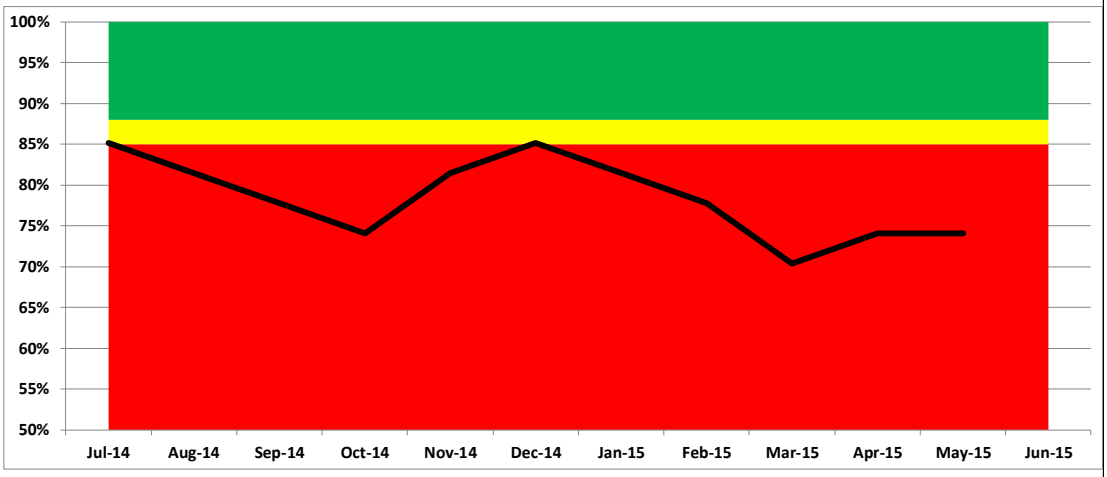
October-December 2014 Analysis

Rates this quarter fall above the target rate and within the rates previously reported.

July-September 2014 Analysis

Over the course of the program this measure appears to be stable hovering between highs of 19% and lows at 16%.

Percent of providers that meet a caseload average consumer to staff ratio 20:1 and under
(Target 85% or more)
KPI activated July 2014



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	23	22	21	20	22	23	22	21	19	20	20	0
Denominator	27	27	27	27	27	27	27	27	27	27	27	0
Percent	85.2%	81.5%	77.8%	74.1%	81.5%	85.2%	81.5%	77.8%	70.4%	74.1%	74.1%	#N/A
Quarterly Average	81.5%			80.2%			76.5%			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of SE consumers who were employed on the last day of the calendar month or who were discharged during the month while employed.

Measure explanation: To examine the percentage of consumers were are able to obtain employment while utilizing Supported Employment services.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers competitively employed at end of month plus the number of consumers competitively employed at discharge that month.

Denominator: Number of consumers served that month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report..

January-March 2015 Analysis

Two providers stated that they have not been getting internal referrals from new clinicans. Both providers indicated that they will be providing more training to their clinical staff about zero Supportive Employment exclusions when it comes to consumers who indicate the desire to work.

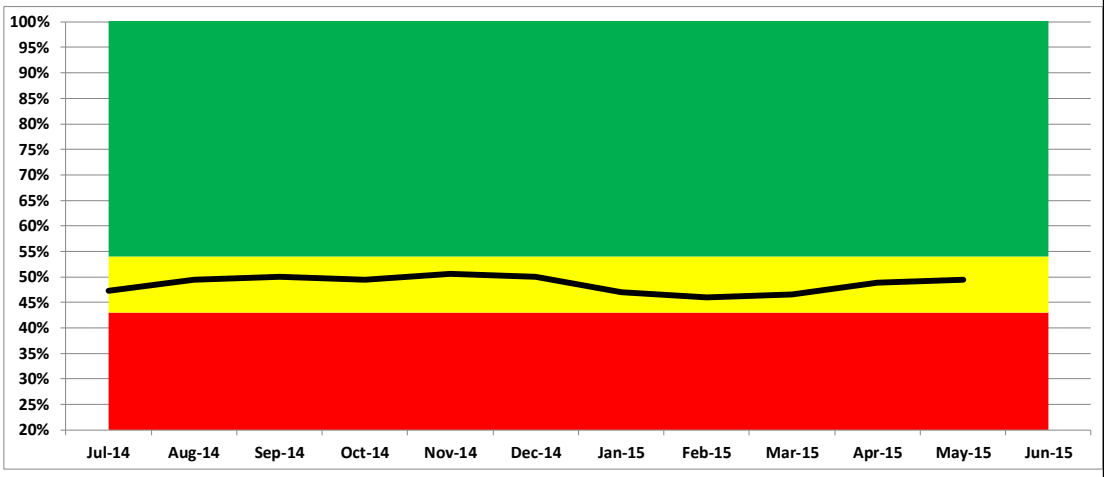
October-December 2014 Analysis

The target was met during one month this quarter. Several providers indicated that staffing chages and turn over impacted their ratios this quarter.

July-September 2014 Analysis

Target was only met during one month this quarter.

Percent of Supported Employment consumers who were employed on the last day of the calendar month or who were discharged during the month while employed
Target (43%) or more
KPI activated July 2014



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	581	609	604	603	604	603	574	579	604	646	655	0
Denominator	1228	1232	1207	1220	1194	1205	1223	1258	1296	1323	1326	0
Percent	47.3%	49.4%	50.0%	49.4%	50.6%	50.0%	46.9%	46.0%	46.6%	48.8%	49.4%	#N/A
Quarterly Average	48.9%			50.0%			46.5%			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of SE consumers who were employed on the last day of the calendar month or who were discharged during the month while employed.

Measure explanation: To examine the percentage of consumers were are able to obtain employment while utilizing Supported Employment services.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers competitively employed at end of month plus the number of consumers competitively employed at discharge that month.

Denominator: Number of consumers served that month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report..

January-March 2015 Analysis

One provider indated they have done a better job of networking with businesses with non-traditional business hours which has increased potential job sites to employ consumers. Providers have continues to utilize step-down plans for persons employed/stable on their jobs which has created some employment rate fluxuation throughout the year.

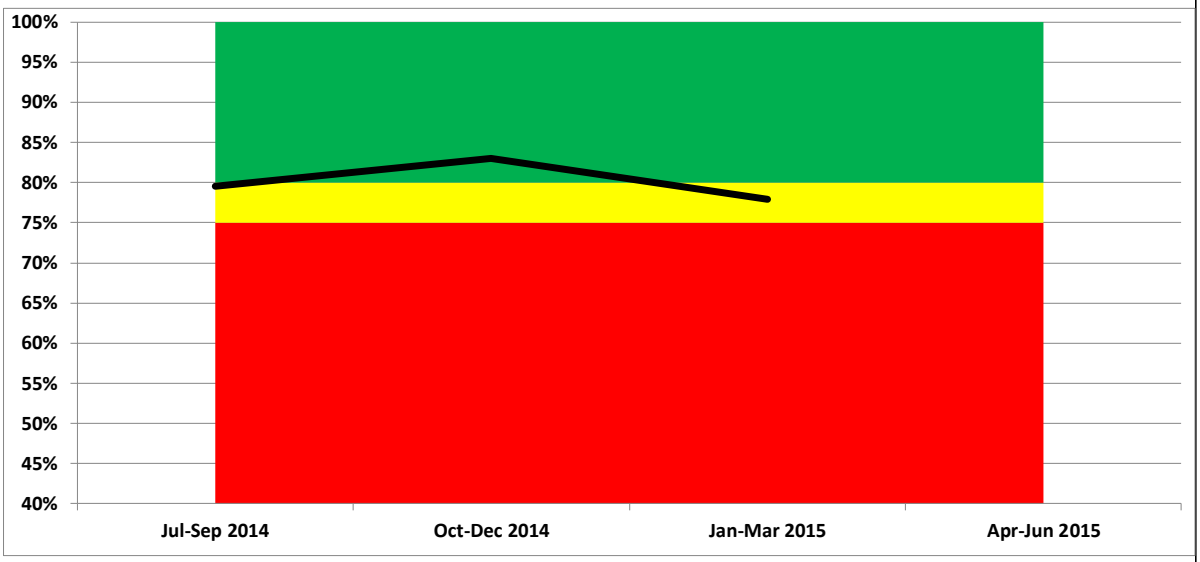
October-December 2014 Analysis

The rate of employment during this quarter appeared to remain steady. Two providers indicated that their services are delivered in a rural areas and many of their consumers do not want employment far away from home due to transportation barriers. Another provider indicated that their percentage was lower this quarter because they were still training their new Supportive Employment Specialist.

July-September 2014 Analysis

There appeared to be a slight upward trend this quarter. At the end of the quarter there was a focus on discharging consumers who have been steady in employment, need minimal supports, and could maintain their employment with a step-down service.

Percent of unduplicated individuals who had 1st contact with a competitive employer within 30 days of enrollment
Target (75%) or more



	Jul-Sep 2014	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015
Numerator	109	83	120	0
Denominator	137	100	154	0
Rate	80%	83%	78%	#N/A

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of individuals meeting settlement criteria that were enrolled during the quarter that had contact with a potential employer in the open job market within 30 days of enrolling in supported employment services.

Measure explanation: To examine the percentage of settlement criteria consumers who are able to have rapid job placement opportunities. Note: Measure is taken on a 30-day lag.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of settlement criteria consumers who started Supported Employment services during the quarter and who had first contact with a competitive employer within 30 days.	**Denominator:** Number of settlement criteria consumers who started Supported Employment services during the quarter.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report.

January-March 2015 Analysis

Target met this quarter.

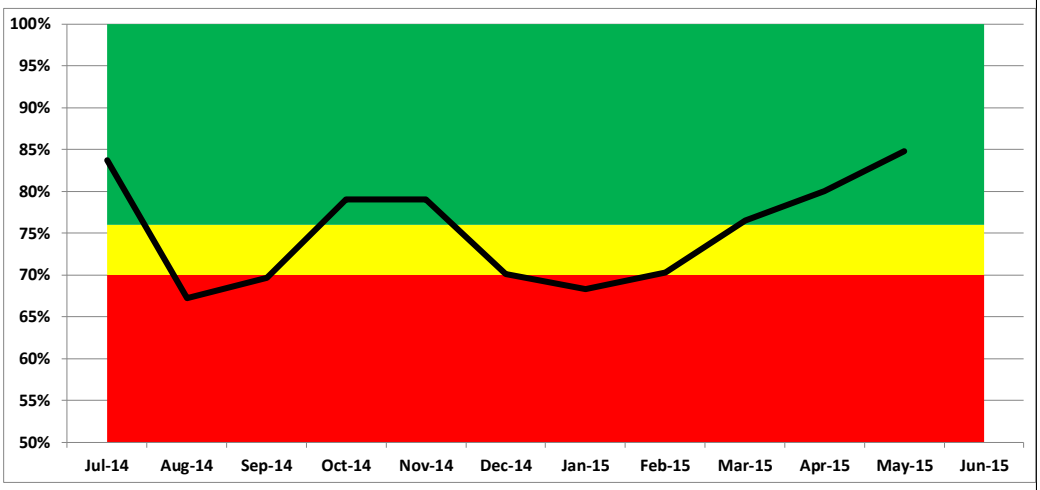
October-December 2014 Analysis

Target met this quarter.

July-September 2014 Analysis

Target met this quarter. There appears to be a slight upward trend in 2014.

Percent of Assertive Community Treatment consumers who are received into services within 3 days of referral
Target (70%) or more
Key Performance Indicator activated July 2013



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	72	78	78	94	102	75	82	71	75	76	78	0
Denominator	86	116	112	119	129	107	120	101	98	95	92	0
Rate	83.7%	67.2%	69.6%	79.0%	79.1%	70.1%	68.3%	70.3%	76.5%	80.0%	84.8%	#N/A
Quarterly Rate	72.6%			76.3%			71.5%			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of ACT consumers who began services during the month that waited three days or less since their date of referral to ACT services.

Measure explanation: To examine the percentage of consumers who are able to access ACT services in a rapid manner.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers received into services within 24 hours of referral date plus number of consumers received into services within 3 days of	**Denominator:** Total number of consumers received into services.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report..

January-March 2015 Analysis

The target was met two months during the quarter. One provider indicated that some barriers were being given incorrect consumer contact information on the ACT referral form and consumers moving upon release/discharge from jails. Other providers have indicated sucess with using Community Transition Planning service to build rapport with the consumers prior to their release/discharge to address this barrier.

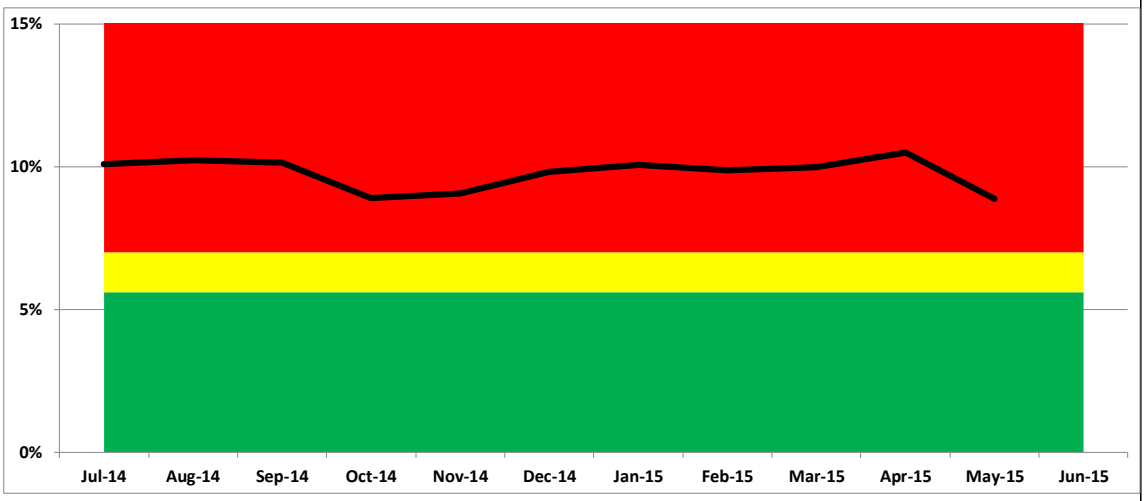
October-December 2014 Analysis

The target was met every month during the quarter. One provider indicated that the addition of listing the admission criteria on their referral form has assisted in reducing the number of inappropriate referrals so that they can focus their efforts on those consumer who are referred and meet criteria. The same provider also indicated that they have a dedicated intake specialist on the team who has assisted in reducing the turnaround time from referral to receiving services.

July-September 2014 Analysis

The target was met one month during the quarter. Some providers indentified that some referral sources do not include all the referral information. It requires additional time to follow up with the referral sources before the individual can be received into services. Providers identified the need to continue to educate referral sources on all the information that is needed.

Percent of Assertive Community Treatment consumers admitted to a Psychiatric Hospital within the past month
Target (7%) or less



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	168	168	168	147	152	160	163	149	162	175	152	0
Denominator	1664	1642	1656	1650	1675	1628	1618	1508	1625	1667	1712	0
Percent	10.1%	10.2%	10.1%	8.9%	9.1%	9.8%	10.1%	9.9%	10.0%	10.5%	8.9%	#N/A
Quarterly Average	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of consumers in ACT services for over thirty days that were admitted to a psychiatric hospital during the month.

Measure explanation: To examine the percentage of consumers who are utilizing psychiatric hospitals for stabilization.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers admitted to Psychiatric Inpatient.	**Denominator:** Census on the last day of the month minus number of enrollments during the month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report..

January-March 2015 Analysis

The target was not met during any month this quarter. Teams identify newer/acute consumers as having psychiatric admissions more frequently. Teams suggest that sometimes caregivers and individuals would benefit from respite in place of psychiatric admissions.

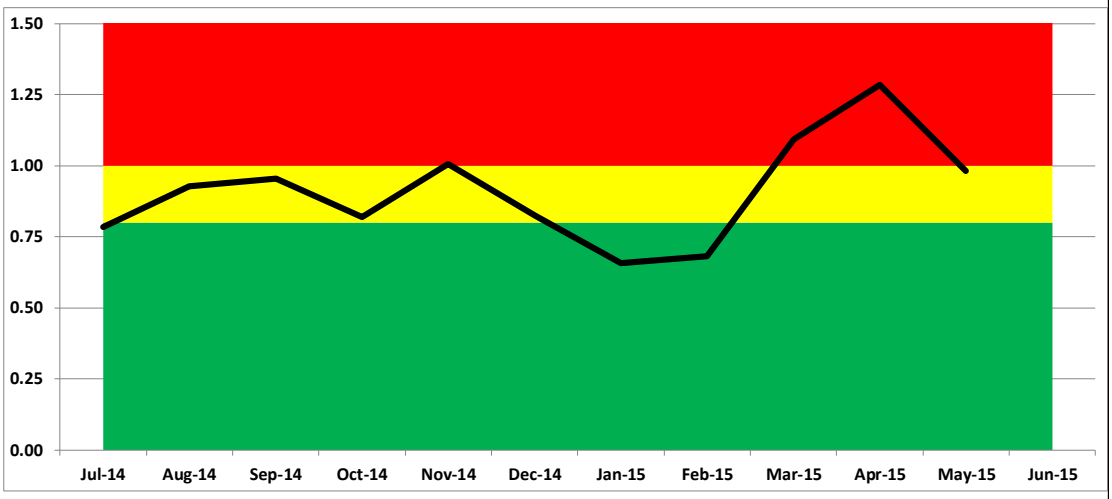
October-December 2014 Analysis

The target was not met during any month this quarter. Several teams indicated that consumers who have both behavioral health and substance abuse conditions are the individuals who cycle the most freqently in inpatient facilities.

July-September 2014 Analysis

The target was not met during any month this quarter. Some teams report that unstable housing has been contributing to the psychiatric admissions.

Average # of jail/prison days utilized
(per enrolled Assertive Community Treatment consumer)
Target (1.0 day) or less



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	1418	1708	1731	1482	1820	1494	1185	1167	1950	1858	1839	0
Denominator	1807	1840	1812	1811	1809	1811	1800	1714	1785	1446	1872	0
Rate	0.785	0.928	0.955	0.818	1.006	0.825	0.658	0.681	1.092	1.285	0.982	#N/A
Quarterly Rate	0.633			0.566			0.808			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The average number of days consumers in ACT services for over thirty days spent in jail/prison during the month.

Measure explanation: To examine the amount of time consumers spend in jail.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of jail days utilized for consumers in services 30 plus days.	**Denominator:** Number of discharges plus census on the last day of month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report..

January-March 2015 Analysis

The target was met two of the three months this quarter.

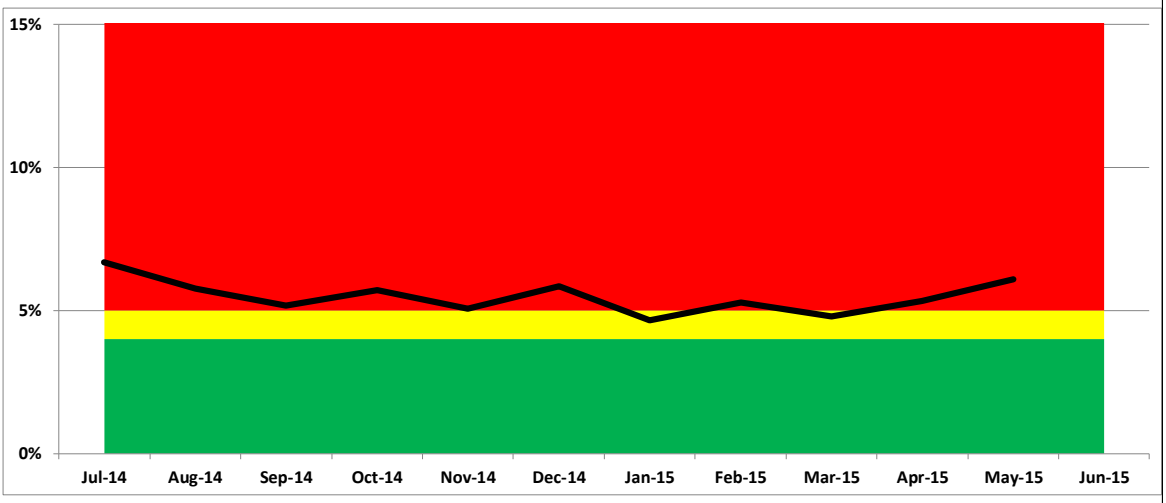
October-December 2014 Analysis

The target was met two of the three months this quarter. One team indicated that the holiday season impacted jail utilization for consumers on their team.

July-September 2014 Analysis

Target was met each month this quarter. One provider cited strong relationship with jails and the ability to advocate for consumers.

Percent of Intensive Case Management consumers with a Psychiatric Inpatient Admission within the past month
Target (5%) or less



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	57	58	56	63	62	67	59	68	64	71	83	0
Denominator	854	1004	1085	1106	1223	1145	1268	1288	1334	1332	1363	0
Percent	6.7%	5.8%	5.2%	5.7%	5.1%	5.9%	4.7%	5.3%	4.8%	5.3%	6.1%	#N/A
Quarterly Average	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of consumers in ICM services for over thirty days that were admitted to a psychiatric hospital during the month.

Measure explanation: To examine the percentage of consumers who are utilizing psychiatric hospitals for stabilization.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers admitted to Psychiatric Inpatient.	**Denominator:** The census on the last day of the month minus number of enrollments during the month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report.

January-March 2015 Analysis

Performance measure met two of the three months this quarter.

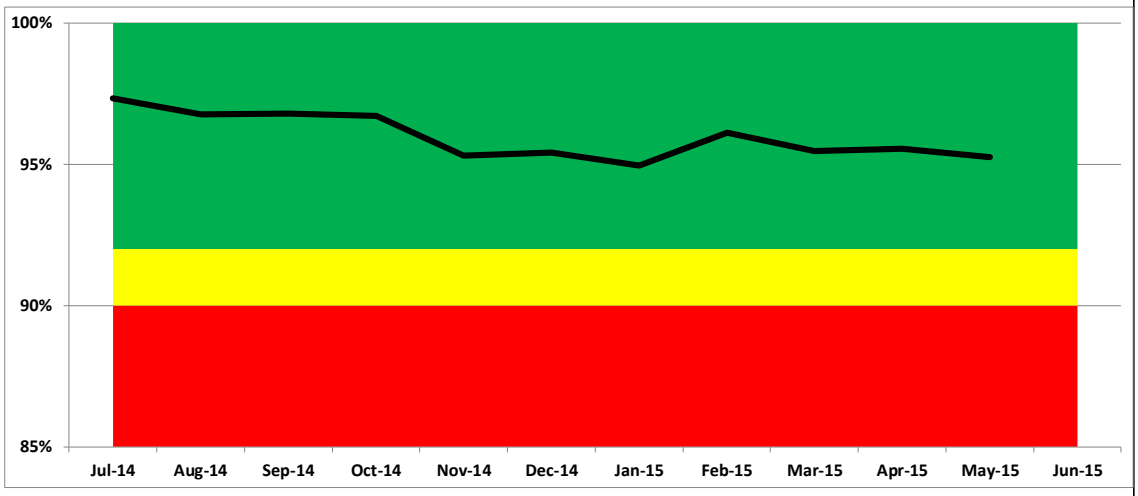
October-December 2014 Analysis

Performance measure not met during any month this quarter.

July-September 2014 Analysis

Performance measure not met during any month this quarter.

Percent of Intensive Case Management consumers housed (non homeless) within the past month
Target (90%) or more



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	948	985	1084	1119	1195	1121	1225	1286	1326	1331	1343	0
Denominator	974	1018	1120	1157	1254	1175	1290	1338	1389	1393	1410	0
Percent	97.3%	96.8%	96.8%	96.7%	95.3%	95.4%	95.0%	96.1%	95.5%	95.5%	95.2%	#N/A
Quarterly Average	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of consumers in ICM services on the last day of the month that were not homeless.

Measure explanation: To examine the percentage of consumers who are not living in homeless shelters or on streets at a single point in time.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers by living arrangement on the last day of the month minus number of homeless: street, homeless shelter.	**Denominator:** Number of consumers by living arrangement on the last day of the month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report..

January-March 2015 Analysis

Measure met every month this quarter.

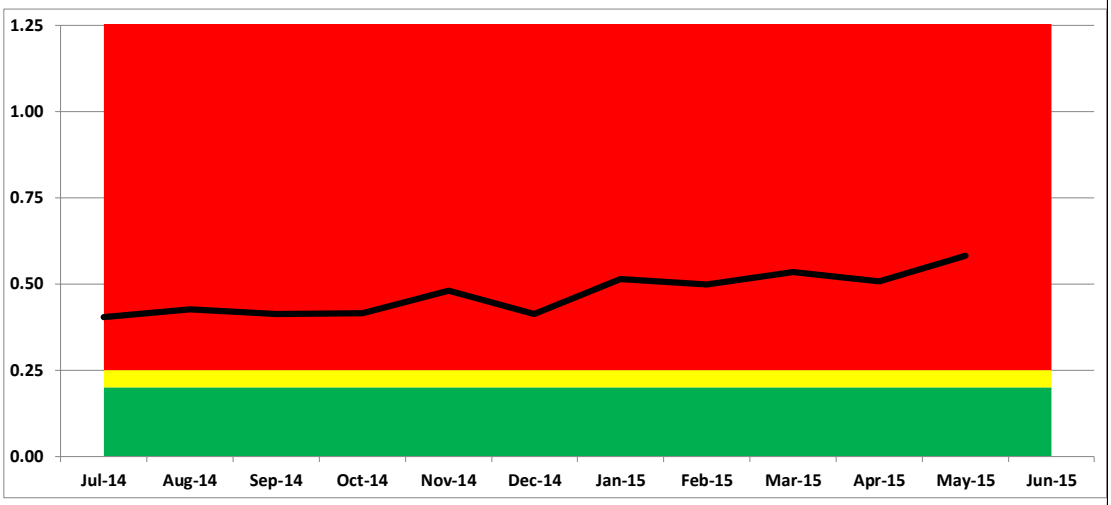
October-December 2014 Analysis

Measure met every month this quarter. ICM providers indicated that Crisis Respite Apartments, the GA Housing Voucher, and natural community supports have assisted in keeping their percentage of consumers housed high.

July-September 2014 Analysis

Measure met every month this quarter.

Average # of jail/prison days utilized
(per enrolled Intensive Case Management consumer)
Target (0.25 days) or less



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	458	524	530	584	678	543	758	761	847	826	921	0
Denominator	1133	1227	1286	1405	1410	1318	1475	1524	1586	1626	1584	0
Rate	0.404	0.427	0.412	0.416	0.481	0.412	0.514	0.499	0.534	0.508	0.581	#N/A
Quarterly Rate	0.357			0.400			0.447			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The average number of days consumers (who have been in ICM services for over thirty days) spent in jail/prison during the month.

Measure explanation: To examine the amount of time consumers spend in jail.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of jail days utilized for consumers in ICM services 30 plus days.	**Denominator:** Number of discharges plus census on last day of month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report.

January-March 2015 Analysis

Performance measure not met during any month this quarter.

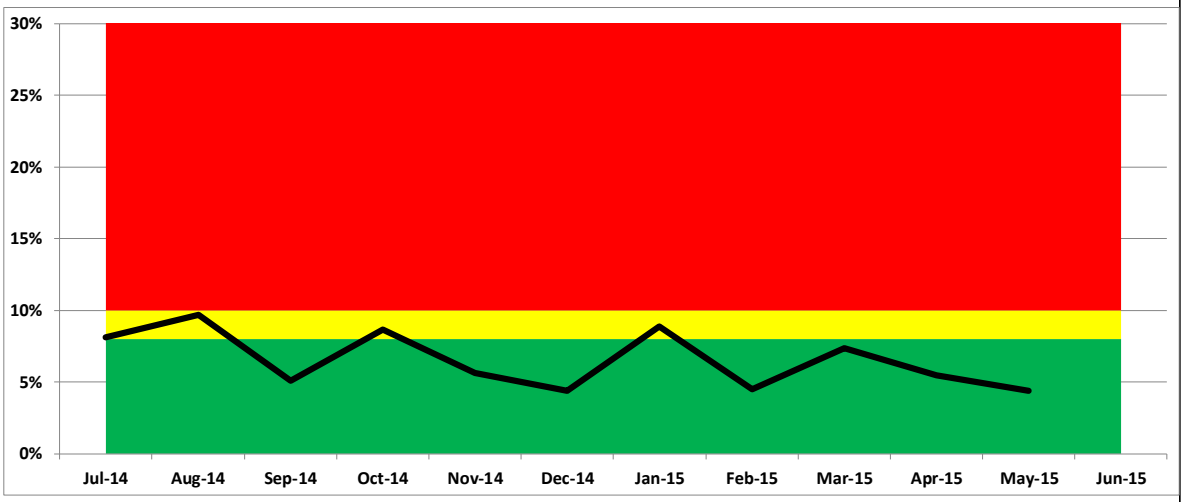
October-December 2014 Analysis

Performance measure not met during any month this quarter.

July-September 2014 Analysis

Performance measure not met during any month this quarter.

Percent of Community Support Team consumers with a Psychiatric Inpatient Admission within the past month
Target (10%) or less



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	20	25	13	23	15	12	25	13	21	15	12	0
Denominator	247	258	256	265	266	274	282	288	286	274	272	0
Percent	8.1%	9.7%	5.1%	8.7%	5.6%	4.4%	8.9%	4.5%	7.3%	5.5%	4.4%	#N/A
Quarterly Average	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of consumers in CST services for over thirty days that were admitted to a psychiatric hospital during the month.

Measure explanation: To examine the percentage of consumers who are utilizing psychiatric hospitals for stabilization.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers admitted to Psychiatric Inpatient.	**Denominator:** Census on last day of month minus the number of enrollments during month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report..

January-March 2015 Analysis

The target was met each month this quarter. Some providers indicated that the variability of percentages month-to-month could be related to the lack of housing choices in the rural areas. Providers also indicated it could be related to consumers having a high level of comfort going to the hospital versus utilizing available community supports. Providers continually educate consumers and their support systems regarding utilizing available community supports.

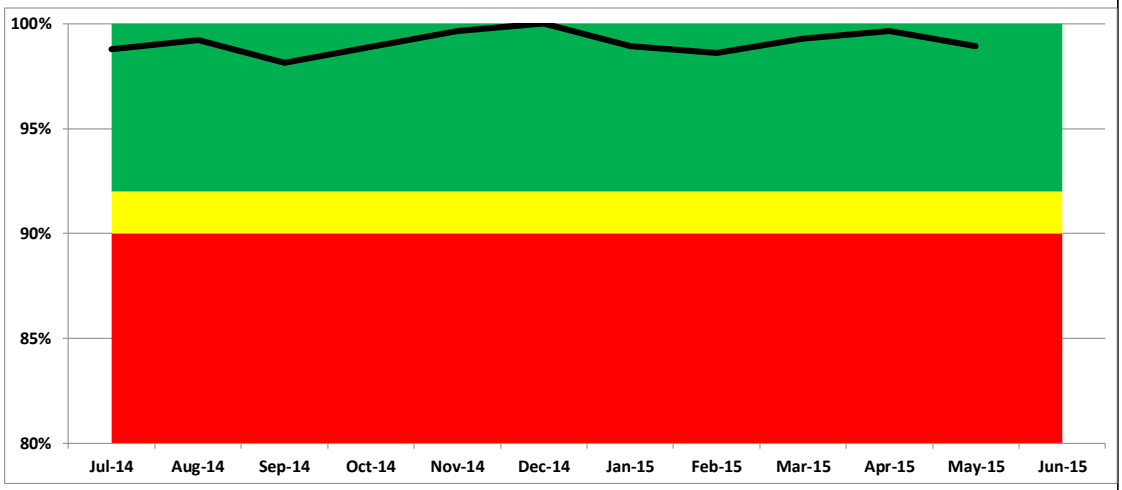
October-December 2014 Analysis

The target was met each month this quarter.

July-September 2014 Analysis

There appears to be a decrease in the month of September. One provider indicated that they are using more proactive coping mechanisms with consumers to reduce admissions. Another provider indicated that the DBHDD funded Beck Initiative training has been very helpful to assist staff in engaging with clients early in treatment.

Percent of Community Support Team consumers housed (non homeless) within the past month
Target (90%) or more



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	244	257	262	269	278	279	280	286	285	278	277	0
Denominator	247	259	267	272	279	279	283	290	287	279	280	0
Percent	98.8%	99.2%	98.1%	98.9%	99.6%	100.0%	98.9%	98.6%	99.3%	99.6%	98.9%	#N/A
Quarterly Average	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of consumers in CST services on the last day of the month that were not homeless.

Measure explanation: To examine the percentage of consumers who are not living in homeless shelters or on streets at a single point in time.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers by living arrangement on last day of month minus number of homeless: street, homeless shelter.	**Denominator:** Number of consumers by living arrangement on last day of month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report..

January-March 2015 Analysis

The target was met each month this quarter.

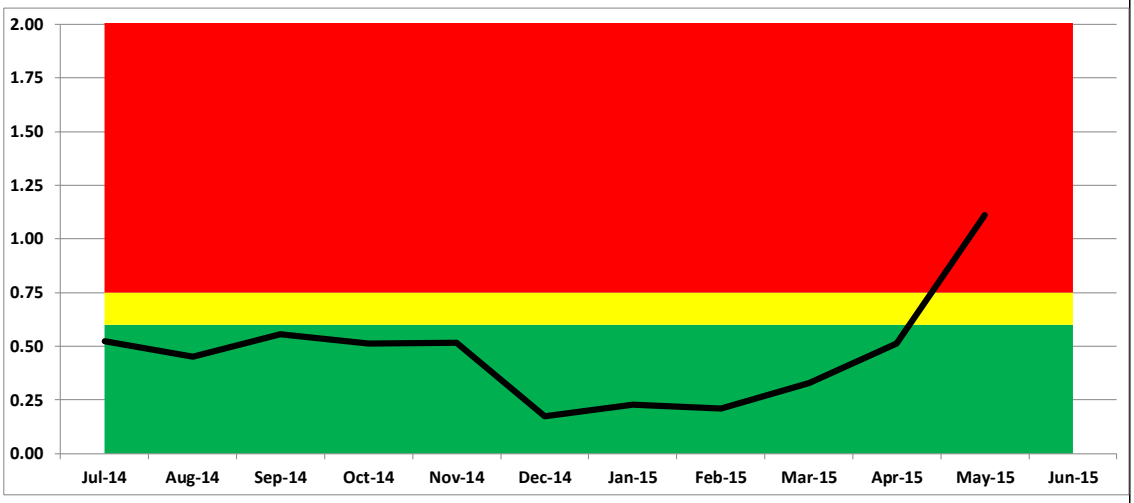
October-December 2014 Analysis

The target was met each month this quarter.

July-September 2014 Analysis

Consistent with previous quarters, the percentage appeared to remain consistent during the quarter. Teams did not report any barriers. Several teams reported that they find family members are willing to take in consumers.

Average # of jail/prison days utilized
(per enrolled Community Support Team consumer)
Target (0.75 days) or less



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	154	135	166	154	158	54	72	67	106	164	341	0
Denominator	294	300	298	301	307	310	315	319	322	319	307	0
Rate	0.524	0.450	0.557	0.512	0.515	0.174	0.229	0.210	0.329	0.514	1.111	#N/A
Quarterly Rate	0.510			0.399			0.256			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The average number of days consumers (who have been in CST services for over thirty days) spent in jail/prison during the month.

Measure explanation: To examine the amount of time consumers spend in jail.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of jail days utilized for consumers in CST services 30 plus days.	**Denominator:** Number of discharges plus census on the last day of the month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report..

January-March 2015 Analysis

The target was met each month this quarter.

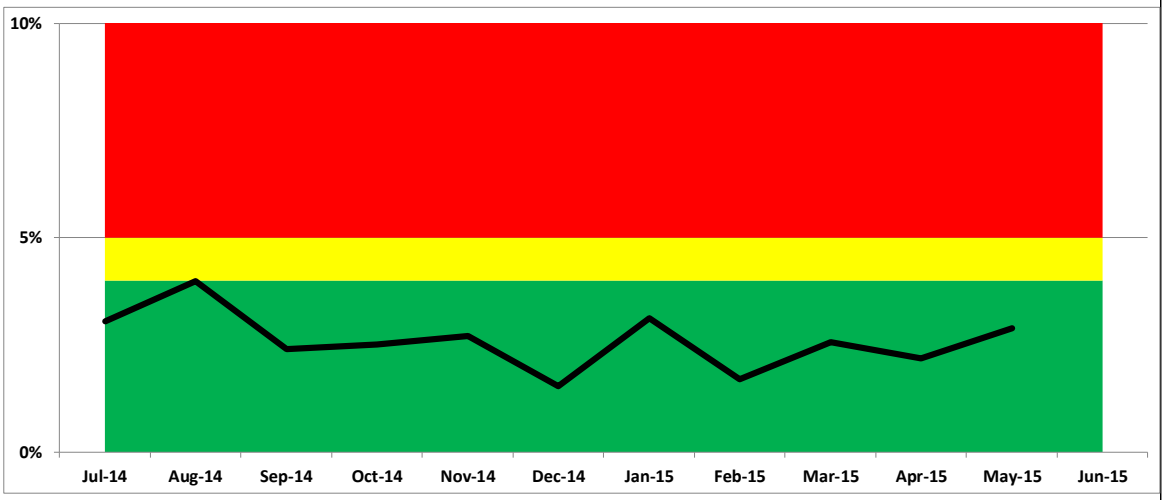
October-December 2014 Analysis

The target was met each month this quarter.

July-September 2014 Analysis

The percentages were below target through the quarter.

Percent of Case Management consumers with a Psychiatric Inpatient Admission within the past month Target (5%) or less



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	21	30	20	23	27	16	33	19	30	26	36	0
Denominator	689	753	833	914	998	1039	1060	1122	1168	1190	1249	0
Percent	3.0%	4.0%	2.4%	2.5%	2.7%	1.5%	3.1%	1.7%	2.6%	2.2%	2.9%	#N/A
Quarterly Average	3.1%			2.2%			2.4%			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of consumers in CM services for over thirty days that were admitted to a psychiatric hospital during the month.

Measure explanation: To examine the percentage of consumers who are utilizing psychiatric hospitals for stabilization.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers admitted to Psychiatric Inpatient.	**Denominator:** Census on last day of month minus the number of enrollments during month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report..

January-March 2015 Analysis

Measure met each month this quarter. Some CM providers may have had an increase in the number of psychiatric admissions due to retaining case managers, especially in rural areas.

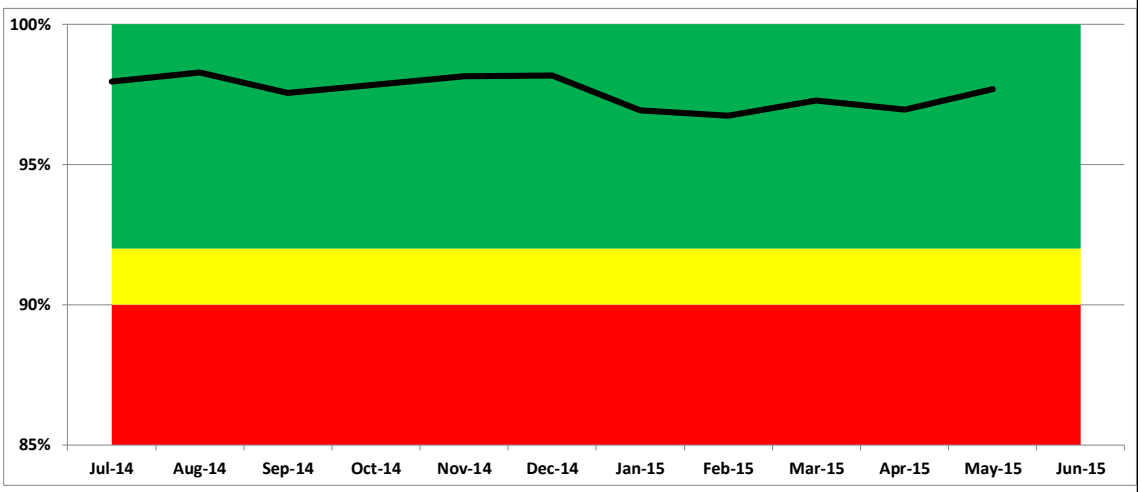
October-December 2014 Analysis

Measure met each month this quarter.

July-September 2014 Analysis

Measure met each month this quarter.

Percent of Case Management consumers housed (non homeless) within the past month
Target (90%) or more



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	718	800	875	913	999	1068	1077	1127	1184	1178	1258	0
Denominator	733	814	897	933	1018	1088	1111	1165	1217	1215	1288	0
Percent	98.0%	98.3%	97.5%	97.9%	98.1%	98.2%	96.9%	96.7%	97.3%	97.0%	97.7%	#N/A
Quarterly Average	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of consumers in CM services on the last day of the month that were not homeless.

Measure explanation: To examine the percentage of consumers who are not living in homeless shelters or on streets at a single point in time.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of consumers by living arrangement on last day of month minus the number of homeless: street, homeless shelter.	**Denominator:** Number of consumers by living arrangement on last day of month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report..

January-March 2015 Analysis

Measure met each month this quarter. At the DBHDD January Combined Coalition Meeting providers were introduced to the Projects for Assistance in Transition from Homelessness (PATH) Teams in their area and encouraged to partner with them in accessing housing for individuals experiencing chronic homelessness and SMI. PATH is an added resource for CM providers who are able to benefit from PATH's established relationships with HUD funded and private housing providers.

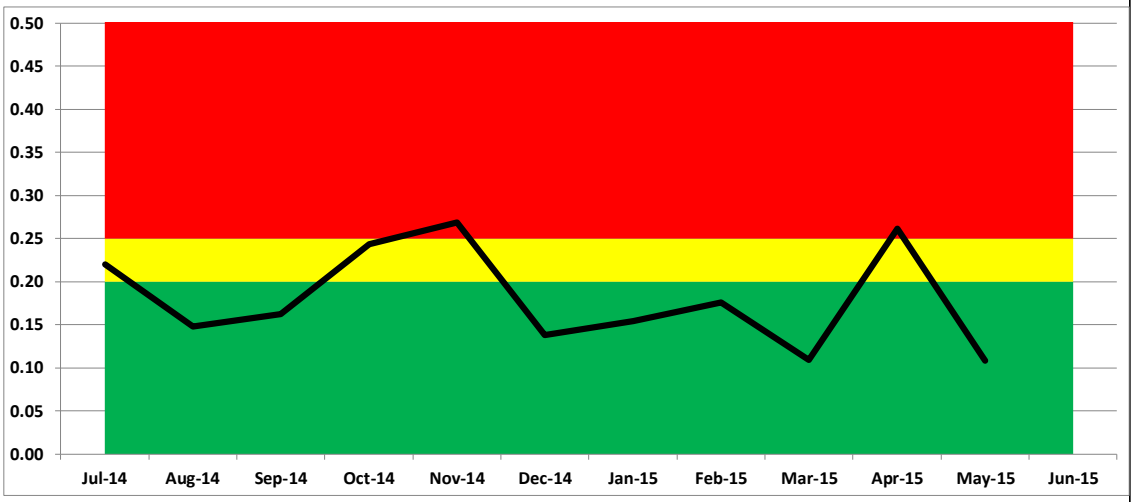
October-December 2014 Analysis

Measure met each month this quarter. CM providers indicated that Crisis Respite Apartments, the GA Housing Voucher, and natural community supports have assisted in keeping their percentage of consumers housed high. One CM provider indicated that they have built relationships with landlords. The provider indicated that landlords are more likely to call them when the consumer has a crisis versus moving towards eviction.

July-September 2014 Analysis

Measure met each month this quarter.

Average # of jail/prison days utilized
(per enrolled Case Management consumer)
Target (0.25 days) or less



	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Numerator	193	145	173	273	319	175	200	233	162	373	160	0
Denominator	876	982	1068	1120	1187	1265	1297	1325	1484	1425	1476	0
Rate	0.220	0.148	0.162	0.244	0.269	0.138	0.154	0.176	0.109	0.262	0.108	#N/A
Quarterly Rate	0.175			0.215			0.145			Quarterly data not complete		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The average number of days consumers (who have been in CM services for over thirty days) spent in jail/prison during the month.

Measure explanation: To examine the amount of time consumers spend in jail.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of jail days utilized for consumers in CM services 30 plus days.

Denominator: Number of discharges plus census on the last day of month.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

Data collection and analysis not complete as of the writing of this report..

January-March 2015 Analysis

Measure was met each month this quarter. Providers commented that they see a decrease in the number of jail days utilized when the Case Manager is known by law enforcement to be responsive to requests for assistance. Several providers have begun providing education about available services to their local law enforcement. One provider has a newsletter that they distribute to law enforcement which describes services and provides contact information.

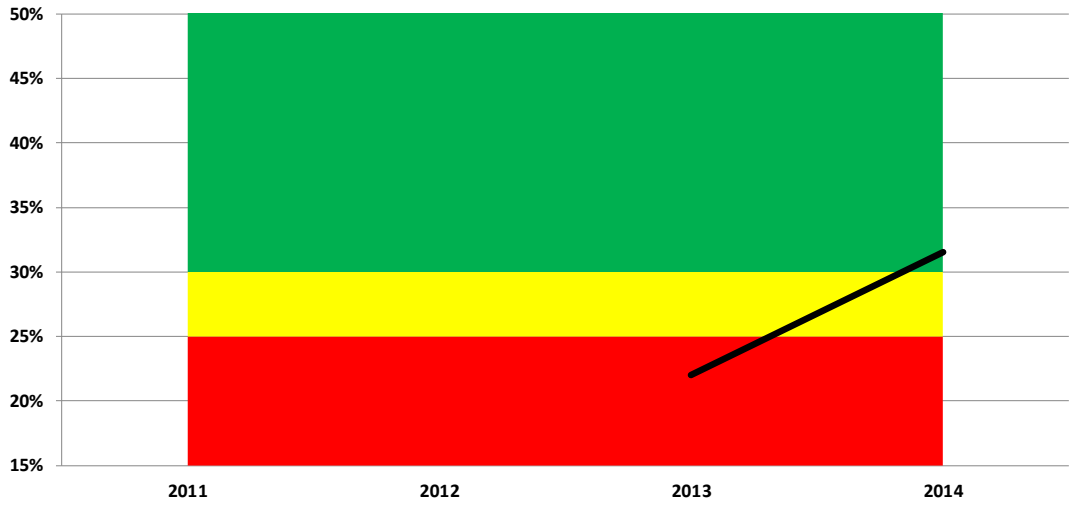
October-December 2014 Analysis

Measure was met two out of the three months this quarter. CM providers indicated that jail utilization is lower in counties where they have built relationships with the local jails. Providers indicated that county jails are more likely to release consumers when they know they are being released with appropriate community mental health supports.

July-September 2014 Analysis

Measure met each month this quarter.

Percent of adult clients active in AD treatment 90 days after beginning non-crisis stabilization services.
Target 25%



	2011	2012	2013	2014
Numerator			22	3714
Denominator			100	11784
Percent			22.0%	31.5%

MEASURE DEFINITION AND EXPLANATION

Measure definition: This measure captures how many individuals in AD services remained engaged in treatment 90 days after beginning community based treatment services.

Measure explanation: The purpose of this measure is to determine level of engagement and retention of individuals involved in AD community based treatment.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The unduplicated count of individuals entering non-crisis stabilization services identified by having a Registration or New Episode MICP who had Medicaid claims or State Encounters for community Based Treatment services, excluding Crisis Stabilization and Detoxification (Residential and Ambulatory) between 90 - 120 days after entry	**Denominator:** The unduplicated count of individuals who received Community Based Treatment services where the authorization (MICP) for service had Adult Addictive Diseases selected as the Primary Diagnostic Category.

COMMENTS AND/OR ANALYSIS PER YEAR

Annually 2015

Data collection and analysis not complete as of the writing of this report.

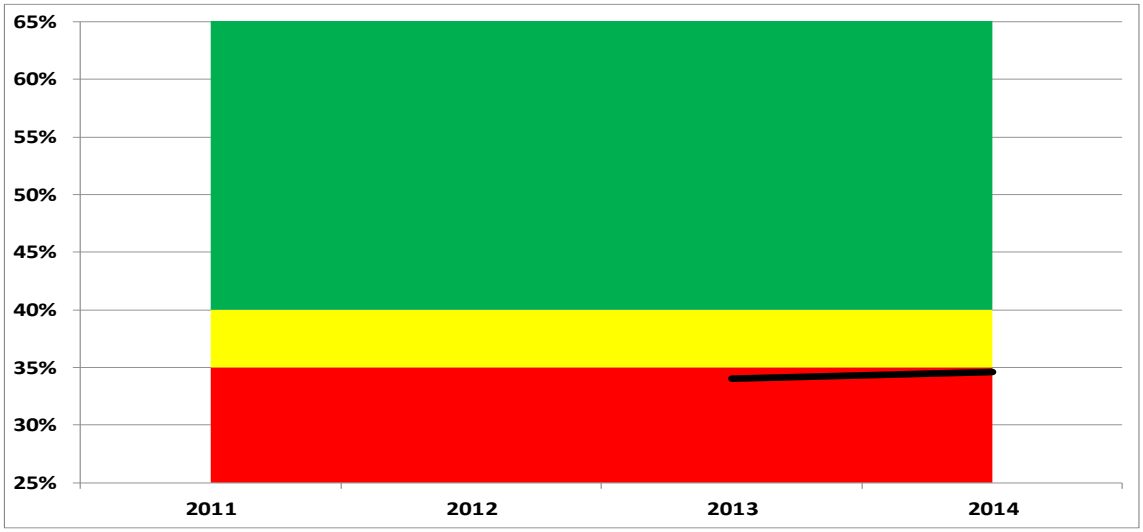
Annually 2014

There was an increase from 2013 to 2014 indicates an increase in the number of individuals still active in treatment 90 days after starting services which seems to offer some statistical support that engagement of individuals has improved. However, other factors/data is not available for a full analysis to reach a conclusive cause and effect determination.

Annually 2013

The previous KPI, Percent of adult AD consumers who abstain from use or experience reduction in use (while in treatment) Target (40%), was replaced with this KPI.

Percent of clients discharged from crisis or detoxification programs who receive follow-up behavioral health services within 14 days.
Target 35%



	2011	2012	2013	2014
Numerator			34	2427
Denominator			100	7014
Percent			34.0%	34.6%

MEASURE DEFINITION AND EXPLANATION

Measure definition: This measure captures how many individuals who were discharged from detox and/or crisis received follow-up services in the community within 14 days.

Measure explanation: The purpose of this measure is to determine if those served in these higher levels of care were provided follow-up services in community based treatment.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The unduplicated count of individuals who had Medicaid Claims or State Encounters for any Community Based Treatment service excluding Crisis Stabilization and Detoxification (Residential and Ambulatory) within 14 days of the last Crisis encounter.	**Denominator:** The unduplicated count of individuals who received Crisis Stabilization services where the authorization (MICP) for service had Adult Addictive Diseases selected as the Primary Diagnostic Category.

COMMENTS AND/OR ANALYSIS PER YEAR

Annually 2015

Data collection and analysis not complete as of the writing of this report.

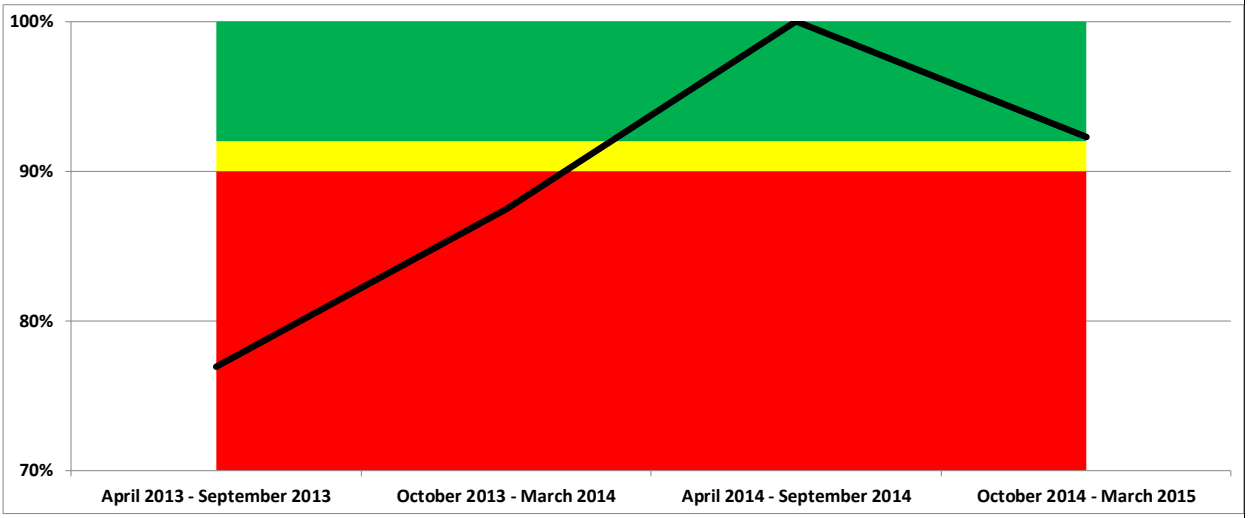
Annually 2014

There was a slight increase from 2013 to 2014 but not statistically significant to warrant any analysis at this time.

Annually 2013

The previous KPI was inactivated after FY2012 and replaced with the current KPI. The threshold of 35% was not met in 2013.

Percent of individuals receiving community or hospital based services who stated they are satisfied with the services they are receiving
Target 90% or more



	April 2013 - September 2013	October 2013 - March 2014	April 2014 - September 2014	October 2014 - March 2015
Numerator	40	7	9	24
Denominator	52	8	9	26
Rate	77%	88%	100%	92%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Those individuals who were chosen by the QM review team to be interviewed as part of a review or audit who stated they are satisfied with the services they are receiving.

Measure explanation: The purpose of this measure is to determine one of the impacts services may have on the target population.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The number of individuals who answered yes.	**Denominator:** The total number of individuals responding to the question.

COMMENTS AND/OR ANALYSIS PER PERIOD

October 2014 - March 2015

The measure was met during this time frame.

April 2014 - September 2014

Conclusions could not be drawn from the few surveys that were completed during this reporting period.

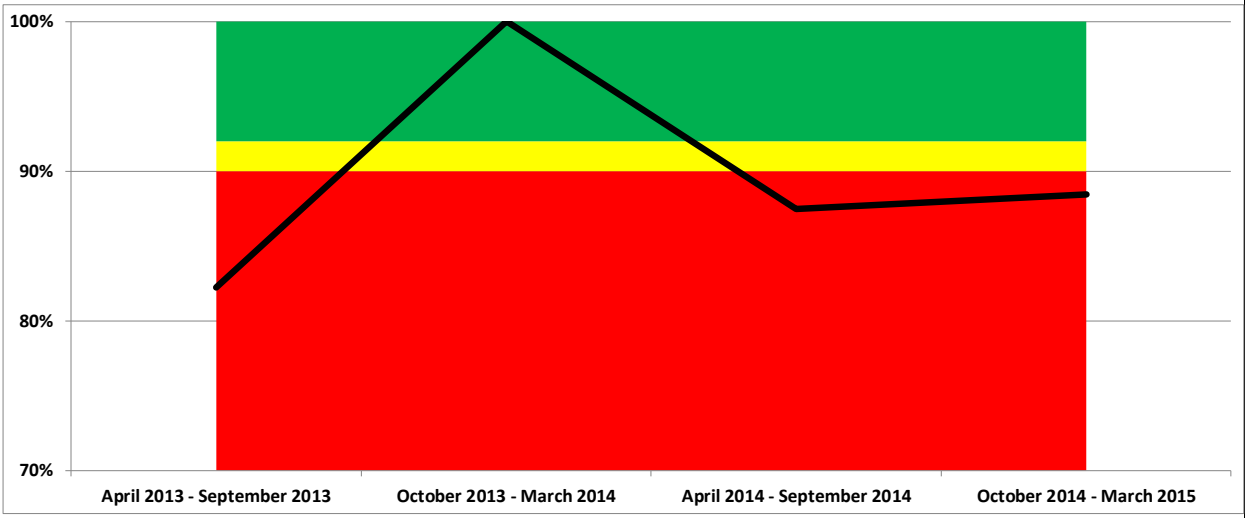
October 2013 - March 2014

Conclusions could not be drawn from the few surveys that were completed during this reporting period.

April 2013 - September 2013

The most common comment related to an individual not being satisfied with their services was a desire to interact with their team more frequently.

Percent of individuals receiving community or hospital based services who feel their quality of life has improved as a result of receiving services
Target 90% or more



	April 2013 - September 2013	October 2013 - March 2014	April 2014 - September 2014	October 2014 - March 2015
Numerator	37	8	7	23
Denominator	45	8	8	26
Rate	82%	100%	88%	88%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Those individuals who were chosen by the QM review team to be interviewed as part of a review or audit who stated their quality of life has improved since receiving services.

Measure explanation: The purpose of this measure is to determine one of the impacts services may have on the target population.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The number of individuals who answered yes.

Denominator: The total number of individuals responding to the question.

COMMENTS AND/OR ANALYSIS PER PERIOD

October 2014 - March 2015

There was no common link regarding why individuals felt their quality of life hadn't improved. It appeared to be an individualized experience. Further data is needed to see if trends develop.

April 2014 - September 2014

Conclusions could not be drawn from the few surveys that were completed during this reporting period.

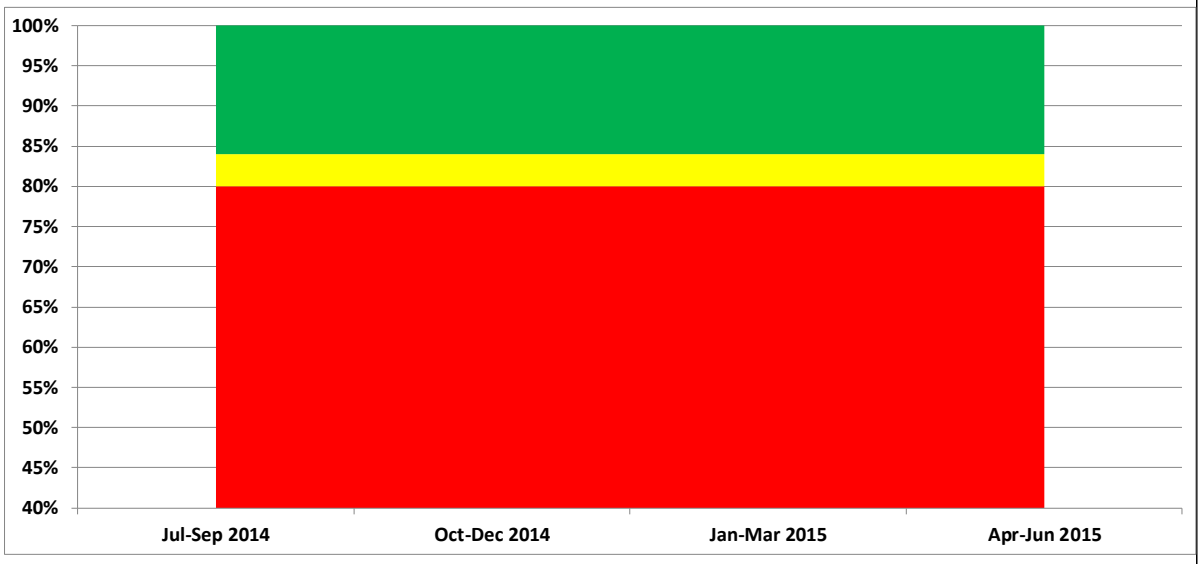
October 2013 - March 2014

Conclusions could not be drawn from the few surveys that were completed during this reporting period.

April 2013 - September 2013

There was no common link regarding why individuals felt their quality of life hadn't improved. It appeared to be an individualized experience. Further data is needed to see if trends develop.

Percent of youth with an increase in functioning as determined by a standardized tool
Target 80%



	Jul-Sep 2014	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015
Numerator	0	0	0	0
Denominator	0	0	0	0
Rate	N/A	N/A	N/A	#N/A

MEASURE DEFINITION AND EXPLANATION

Measure definition: This measure provides retrospective data on the effectiveness of the services provided by community providers, as measured by the standardized tool.

Measure explanation: To determine the effectiveness of the services provided, the results of subsequent assessments should reflect improved functioning.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of youth who have reported increased scores on the standardized tool.	**Denominator:** Number of youth that completed the standardized tool assessment.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2015 Analysis

The Department is in the middle of a standardized tool transition from the Child and Adolescent Functional Assessment Scale (CAFAS) to the Child and Adolescent Needs and Strengths (CANS). The implementation of the CANS is scheduled for October 2015. Data collection for this KPI will begin in FY16.

January-March 2015 Analysis

N/A

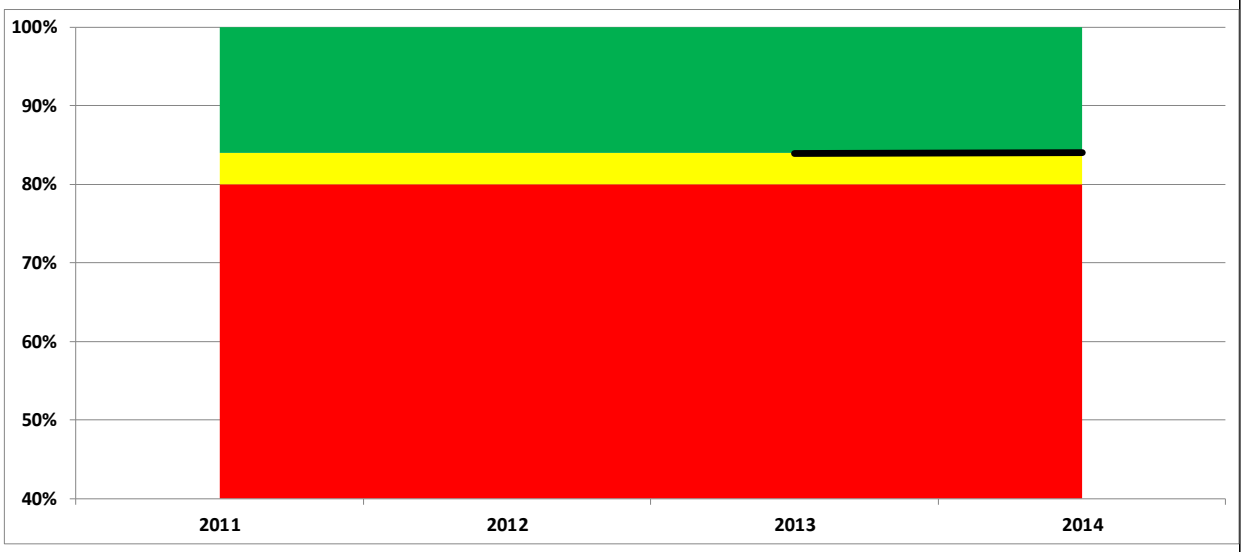
October-December 2014 Analysis

N/A

July-September 2014 Analysis

N/A

Percent of families of youth served by CMEs who are satisfied with services as determined by their parent or legal guardian using a standardized survey tool (YSS-F) Target 80%



	2011	2012	2013	2014
Numerator			491	468
Denominator			585	557
Rate			84%	84%

MEASURE DEFINITION AND EXPLANATION

Measure definition: This measure identifies families of youth who are being served by the Care Management Entities who respond to satisfaction questions on the YSS-F standardized survey instrument.

Measure explanation: To examine the general satisfaction with services received while being served by a CME.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Percentage of respondents with an agverage score >3.5 from the statisfaction questions.	**Denominator:** Number of respondents to YSS-F questions related to general satisfaction.

COMMENTS AND/OR ANALYSIS PER QUARTER

Annually 2014

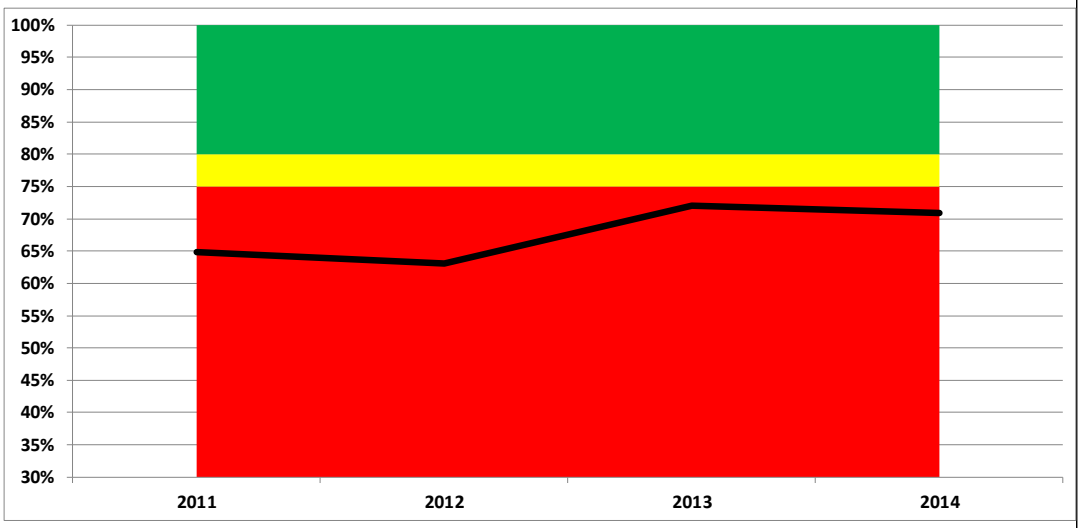
Responses to the satisfaction survey surpassed the target rate.

Annually 2013

Responses to the satisfaction survey surpassed the target rate.

Appendix G Developmental Disabilities KPI Dashboards

Percentage of Individuals Who Have Had a Flu Vaccine in Past Year
Target 75%



	2011	2012	2013	2014
Numerator	270	260	358	266
Denominator	416	412	497	375
Rate	64.9%	63.1%	72.0%	70.9%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage on individuals surveyed through the National Core Indicator Survey who report having a flu shot in past year.

Measure explanation: Allows for additional monitoring of the health of individuals.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that they have had a flu shot in the last year. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Georgia enters data in the ODESA database which HSRI uses for analysis. In 2014, 40 states participated in the NCI Survey.

Denominator: The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or we aware is they had a flu shot or not. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Georgia enters data in the ODESA database which HSRI uses for analysis.

COMMENTS AND/OR ANALYSIS PER YEAR

Annually 2014

71% of respondents from Georgia reported that they received a flu shot in the past year. Georgia remains within the average range of the NCI average of 78%.

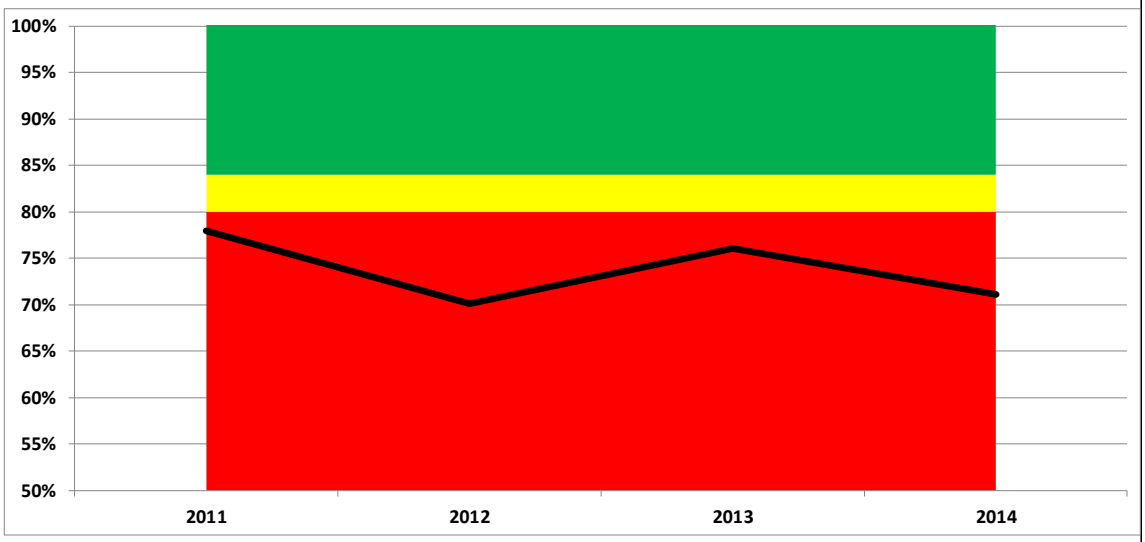
Annually 2013

72% of respondents from Georgia and 76% of respondents across NCI States were reported to have had a flu vaccine in the past year. This is up significantly from 63% last year; however Georgia remains within the average range of NCI States.

Annually 2012

63% of respondents from Georgia were reported to have had a flu vaccine in the past year. This is slightly down from 65% for the previous year. 63% is significantly below the national average (77%) of all NCI States.

Percentage of Individuals Who Have Had a Dental Examine in Past Year
Target 80%



	2011	2012	2013	2014
Numerator	326	312	391	283
Denominator	418	445	514	398
Rate	78.0%	70.1%	76.1%	71.1%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage on individuals surveyed through the National Core Indicator Survey who report having a dental exam.

Measure explanation: Allows for additional monitoring of the health of individuals.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that they have had a dental examination in the last year. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Georgia enters data in the ODESA database which HSRI uses for analysis. in 2014, 40 states participated in the NCI Survey.

Denominator: The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or were aware if they had a dental exam or not. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Georgia enters data in the ODESA database which HSRI uses for analysis.

COMMENTS AND/OR ANALYSIS PER YEAR

Annually 2014

71% of respondents from Georgia reported that they had a dental examination within the last year. Georgia scored significantly below the NCI average of 79%, ranking 9th among the 40 NCI states.

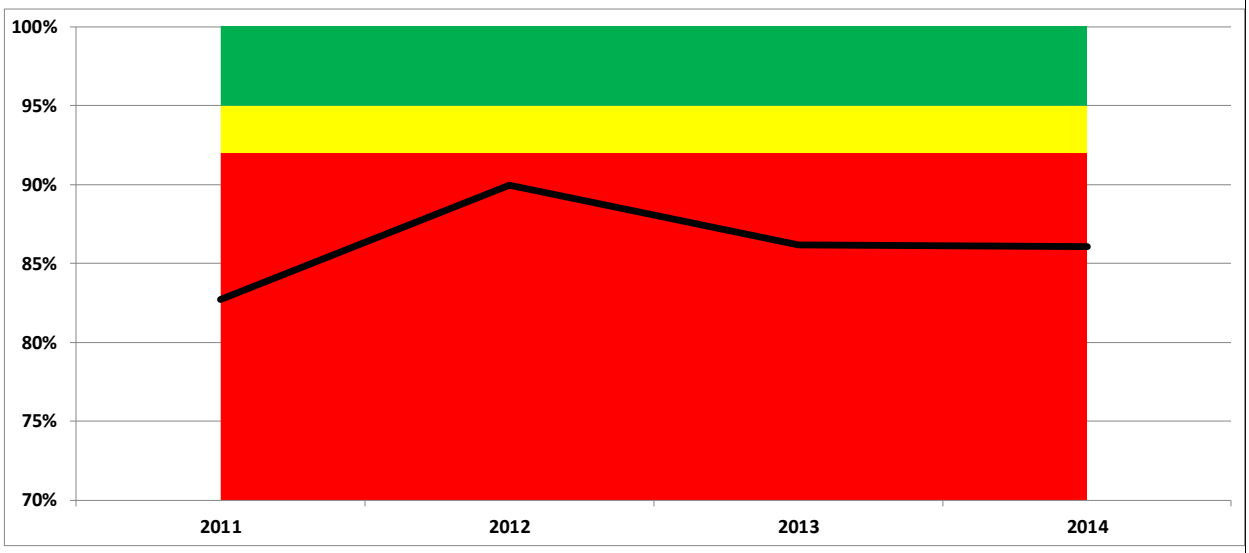
Annually 2013

76% of respondents from Georgia and 80% of respondents across NCI States were reported to have had a dental exam in the past year. This is up significantly from 70% last year; however Georgia still remains within the average range of NCI States

Annually 2012

70% of respondents reported having a dental exam in the past year. This is down significant from 78% the previous year. 70% is also significantly lower that the national average (80%) for all other NCI States. This KPI has been given Departmental priority and solutions to improve this KPI are being reviewed.

Percentage of Individuals Who Have Had an Annual Physical in Past Year
Target 92%



	2011	2012	2013	2014
Numerator	373	466	448	389
Denominator	451	518	520	452
Rate	83%	90%	86%	86%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage on individuals surveyed through the National Core Indicator Survey who report having a physical exam.

Measure explanation: Allows for additional monitoring of the health of individuals.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that they have had an annual physical examination in the last year. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Georgia enters data in the ODESA database which HSRI uses for analysis. In 2014, 40 states participated in the NCI Survey.	**Denominator:** The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or we aware is they had a physical exam or not. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Georgia enters data in the ODESA database which HSRI uses for analysis.

COMMENTS AND/OR ANALYSIS PER YEAR

Annually 2014

86% of respondents from Georgia reported that they had completed a physical exam in the last 12 months. Georgia remains with the average range of the NCI average of 88%.

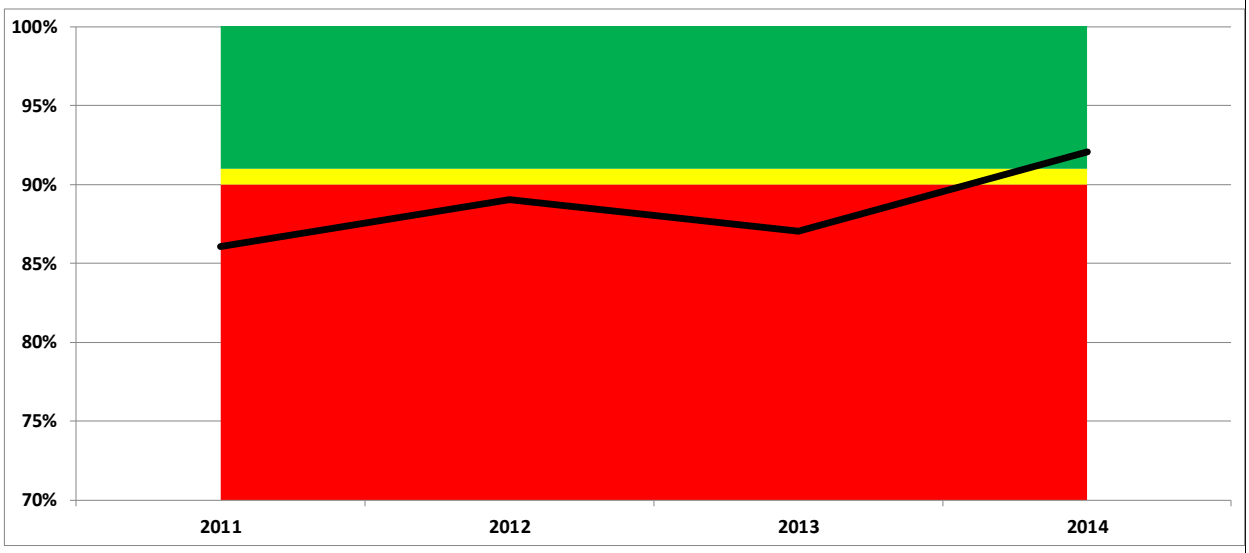
Annually 2013

86% of respondents from Georgia and 89% of respondents across NCI States were reported to have had a physical exam in the past year. This is down slightly from 90% last year; however Georgia still remains within the average range of NCI States

Annually 2012

90% of respondents reported having had a physical exam in this past year. This is slightly down from the previous year which as reported at 91%. 90% is in line with the national average (90%) for all other NCI States.

Percentage of Individuals Who Feel Safe in Their Home
Target 90%



	2011	2012	2013	2014
Numerator	291	342	336	268
Denominator	338	384	386	291
Rate	86%	89%	87%	92%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage on individuals surveyed through the National Core Indicator Survey who report feeling safe in their residential environment.

Measure explanation: Allows for additional monitoring of the safety of individuals

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that they either feel safe in their home or never feel afraid in their home. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Georgia enters data in the ODESA database which HSRI uses for analysis. In 2014, 40 states participated in the NCI survey.

Denominator: The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or were willing to answer this question. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Georgia enters data in the ODESA database which HSRI uses for analysis.

COMMENTS AND/OR ANALYSIS PER YEAR

Annually 2014

92% of respondents from Georgia reported that they feel safe in their home environment. Georgia scored well above the NCI average of 82%, ranking 8th among the 40 NCI states.

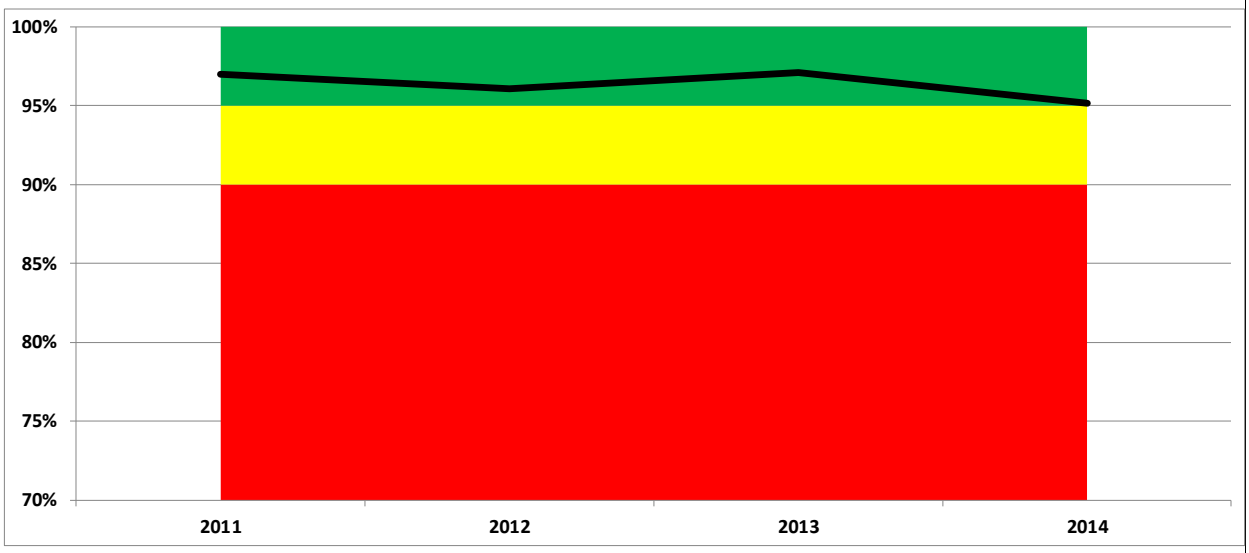
Annually 2013

87% of respondents from Georgia and 81% of respondents across NCI States reported they never feel scared at home. This is down slightly from 89% last year; however Georgia's average is significantly about the average range of NCI States.

Annually 2012

89% of respondents reported they never feel scared at home. This is an improvement from the previous year which was reported at 86%. 89% is in line with the national average (82%) for all other NCI States.

Percentage of Individuals Who Report They are Treated with Dignity and Respect
Target 90%



	2011	2012	2013	2014
Numerator	194	170	302	274
Denominator	200	177	311	288
Rate	97%	96%	97%	95%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage on individuals surveyed through the National Core Indicator Survey who report staff and family treat them with respect.

Measure explanation: Allows for additional monitoring of the safety of individuals.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that their staff treat them with dignity and respect. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Georgia enters data in the ODESA database which HSRI uses for analysis. In 2014, 40 states participated in the NCI survey.	**Denominator:** The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or were willing to answer this question. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Georgia enters data in the ODESA database which HSRI uses for analysis.

COMMENTS AND/OR ANALYSIS PER YEAR

Annually 2014

95% of respondents from Georgia reported that they are treated with dignity and respect. Georgia is slightly higher than the the NCI average of 93%, ranking 8th among the 40 NCI states.

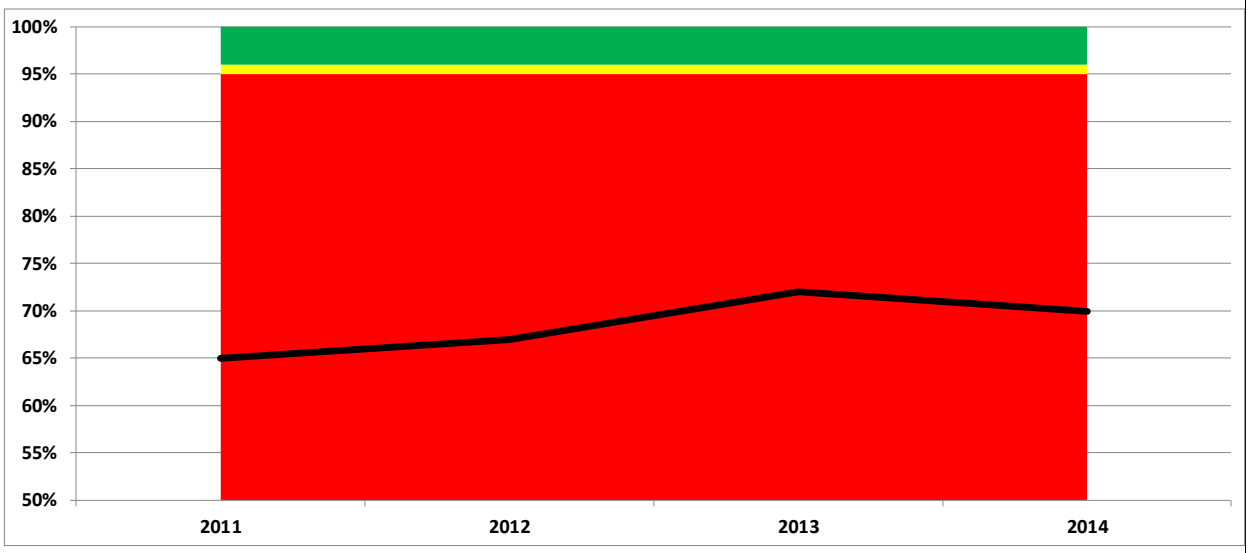
Annually 2013

97% of respondents from Georgia and 93% of respondents across NCI States reported they are treated with dignity and respect. This is up slightly from 96% last year, and Georgia ranks top among the NCI States.

Annually 2012

96% of respondents reported that they are treated with dignity and respect. This is slightly down from the previous year when 97% reported they felt that they were treated with dignity and respect. 96% is in line with the national average (94%) of all other NCI States.

Percentage of Individuals Who Report They have a Choice of Supports and Services
Target 95%



	2011	2012	2013	2014
Numerator	297	349	432	309
Denominator	457	521	600	442
Rate	65%	67%	72%	70%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Individuals report that they have choice in the supports they receive.

Measure explanation: Division of DD strives to support individuals to have a choice in all supports and services.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that they had a choice in the supports and services they receive.NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Georgia enters data in the ODESA database which HSRI uses for analysis. In 2014, 40 states participated in the NCI survey.

Denominator: The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or were willing to answer this question. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Georgia enters data in the ODESA database which HSRI uses for analysis.

COMMENTS AND/OR ANALYSIS PER YEAR

Annually 2014

70% of respondents from Georgia reported that they have a choice of supports and services. Georgia is well above the NCI average of 57%, ranking 2nd among the 40 NCI states.

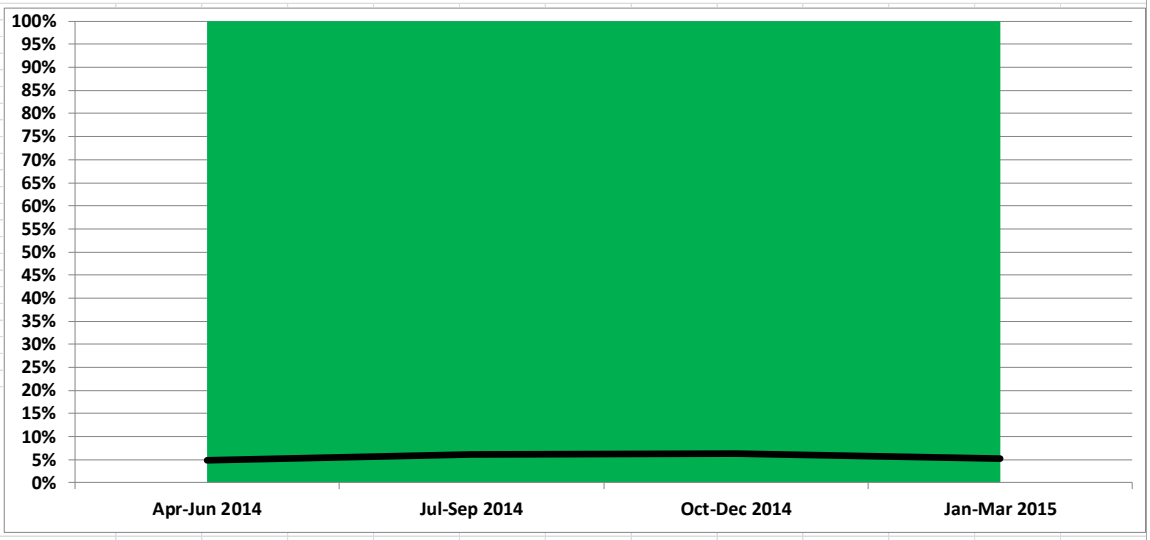
Annually 2013

72% of respondents from Georgia and 52% of respondents across NIC States reported that they have a choice of support and services. This is up significantly from 67% last year, and Georgia ranks top among the NCI States

Annually 2012

67% of respondents reported that they have a choice of supports and services which is 2% improvement from the previous year. 67% is significantly above the national average (54%) of all other NCI States.

Percentage of Crisis Incidents that Resulted in Intensive In-Home Supports



	Apr-Jun 2014	Jul-Sep 2014	Oct-Dec 2014	Jan-Mar 2015
Numerator	34	41	41	35
Denominator	703	665	650	681
Percentage	5%	6%	6%	5%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage of crisis incidents that could warrant additional in-home supports for the individual or family in crisis.

Measure explanation: Most crisis episodes can be sufficiently addressed by a Mobile Crisis Team at the time of the crisis. Some crisis episodes, however, may need additional supports or training for the individual or family that will hopefully lessen or eliminate the chance of such a crisis happening again. These supports or trainings may be provided in the person's home for up to 24 hours a day and 7 days a week.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator	Denominator
Numerator: Number of crisis episodes statewide that resulted in the need for additional intensive in-home supports.	**Denominator:** Total number of crisis episodes statewide.

COMMENTS AND/OR ANALYSIS PER QUARTER

January-March 2015 Analysis

Utilization of intensive in-home supports dropped 1% from last quarter but remained stable compared last three quarters.

October-December 2014 Analysis

Provision of intensive in-home supports remained the same for the last two quarters of 2014, and relatively the same all year long.

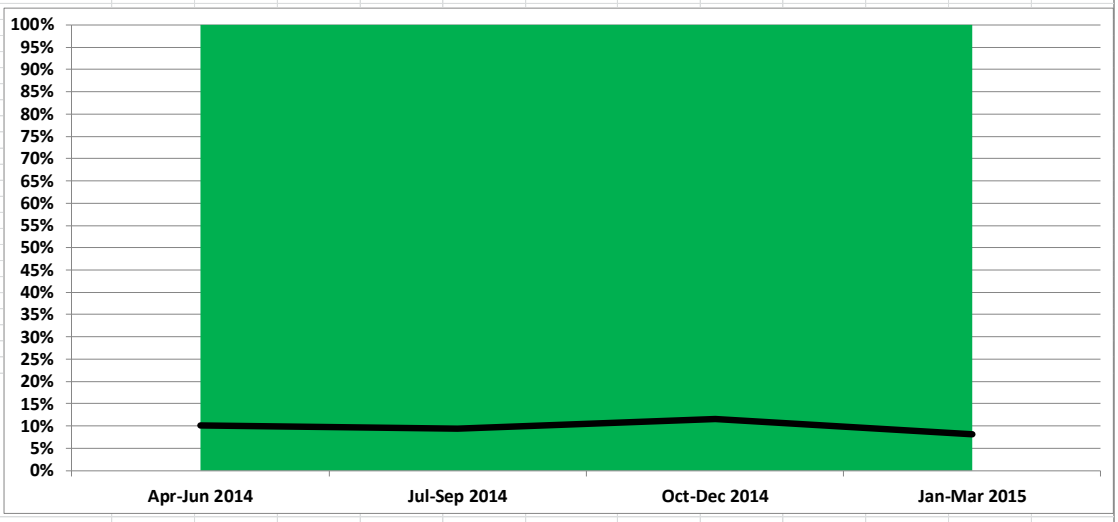
July-September 2014 Analysis

Utilization of intensive in-home supports increased 1.2% during this quarter. The Temporary Intensive Supports (TIS) home that supported children and adolescents, was closed in July. Analysis showed that the closing did not contribute to the slight increase in utilization

April-June 2014 Analysis

Utilization of intensive in-home supports decreased slightly during this quarter; however, the decrease was not significant.

Percentage of Crisis Incidents that Resulted in Placement of the Individual in a Crisis Support Home



	Apr-Jun 2014	Jul-Sep 2014	Oct-Dec 2014	Jan-Mar 2015
Numerator	71	63	75	56
Denominator	703	665	650	681
Percentage	10%	9%	12%	8%

MEASURE DEFINITION AND EXPLANATION

Measure definition: Percentage of crisis incidents that could warrant placement in a crisis support home while the crisis was addressed.

Measure explanation: Most crisis episodes can be sufficiently addressed by a Mobile Crisis Team at the time of the crisis. Some crisis episodes, however, may need additional supports or training for the individual or family that will hopefully lessen or eliminate the chance of such a crisis happening again. From time to time it may be in the best interest of the individual and family that these supports and trainings be provided out of the individuals home and in a crisis support home. Placement in a crisis home should be the option of last resort for dealing with a crisis episode.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of crisis episodes statewide that resulted in the need for an individual to be removed from their home and place in a crisis support home.	**Denominator:** Total number of crisis episodes statewide.

COMMENTS AND/OR ANALYSIS PER QUARTER

January-March 2015 Analysis

Utilization of Crisis Support Homes dropped 4% compared to last quarter but the drop was not signficant compared with the last three quarters of data. The use of the homes continues to be higher than the use of Intensive In-home Supports, which is not a goal of the crisis system.

October-December 2014 Analysis

Provision of in-home supports remained the same during this quarter, but utilization of the crisis homes increased by 3 percentage points. The increase was not significant however when compared to the first three quarters of 2014. DBHDD has continued in its efforts to recruit additional respite and emergency respite providers to reduce the to use the crisis homes.

July-September 2014 Analysis

Utilization of the crisis homes remained basically the same as last quarter. There again only a 1 percentage point drop in utilization from last quarter. DBHDD has been seeking possible providers of emergency respite as an alternative to out of home crisis placement.

April-June 2014 Analysis

Utilization of the crisis homes remained basically the same as last quarter. There was only a 1 percentage point drop in utilization from last quarter. DBHDD has been seeking possible providers of emergency respite as an alternative to out of home crisis placement.