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

Angela L. Rollins, PhD
August 12, 2015

Introduction

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

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

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

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

Data Collection Informing this Report:

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

- Commissioner, DBHDD
- Chief of Staff, DBHDD
- Director, Division of Behavior Health, DBHDD
- Director, Adult Mental Health, within Division of Behavioral Health, DBHDD
- DOJ ADA Settlement Coordinator
- ACT fidelity assessment team, DBHDD
- Director, Office of Performance Analysis (under new Division of Performance Management and Quality), DBHDD
- Former APS and now current Beacon (external Medicaid monitoring agency) care managers for ACT services, their team leader
- Director, Office of Recovery Transformation, DBHDD
- External trainers who provided ACT-specific recovery trainings during the course of the last year

- Community stakeholders including representatives from a number of mental health advocacy organizations and criminal justice system representatives (e.g., public defender's office)

The author also reviewed relevant documentation provided, including but not limited to:

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

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

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

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

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

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

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

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

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

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

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

Areas for improvement remain, including:

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

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

Comment on Compliance with Settlement Agreement

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

program. The State is also in compliance with regards to additional requirements related to the composition of ACT teams with multidisciplinary staff, including a dedicated team leader, and the range of services to be provided by the team, including the availability of 24/7 crisis services. Despite finding evidence for compliance, several improvements to ACT services are still recommended based on both fidelity scores and observations by this author and/or other stakeholders and are summarized above and detailed in individual SHAY items below.

Findings from the State Health Authority Yardstick

Background on the SHAY Assessment:
The SHAY was designed by a group of mental health researchers and implementers who were interested in assessing the facilitating conditions for the adoption of Evidence-Based Practices (EBPs) created by the State's (mental) health authority. The focus of this report is the state's implementation of Assertive Community Treatment (ACT) services.

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

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

1. EBP Plan

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

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

Score

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

Comments:

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

2. Financing: Adequacy

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

Score:

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

Comments:

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

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

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

3. Financing: Start-Up & Conversion Costs

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

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

Comments:

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

4. Training: Ongoing consultation and technical support

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

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

Score

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

Comments:

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

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

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

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

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

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

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

5. Training: Quality

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

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

Score

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

Comments:

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

6. Training: Infrastructure / Sustainability

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

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

Score

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

Comments:

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

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

7. Training: Penetration

What percent of sites have been provided high quality training (score of 3 or better on question #5, see note below), and ongoing training (score of 3 or better on question #4, see note below).

Note: *If both criteria are not met, does not count for penetration. Refers to designated EBP sites only.*

High quality training should include 3 or more of the following components:

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

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

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

Score:

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

Comments:

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

8. SMHA Leadership: Commissioner Level

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

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

Score

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

Comments:

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

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

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

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

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

Comments:

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

10. Policy and Regulations: Non SMHA State Agencies

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

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

Examples of supporting policies:

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

Examples of policies that create barriers:

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

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

Comments:

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

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

11. Policies and Regulations: SMHA

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

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

Examples of policies that create barriers:

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

Score:

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

Comments:

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

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

12. Policies and Regulations: SMHA EBP Program Standards

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

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

Comments:

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

13. Quality Improvement: Fidelity Assessment

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

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

Score

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

Comments:

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

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

14. Quality Improvement: Client Outcomes

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

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

Score

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

Comments:

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

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

15. Stakeholders

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

Scores:

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

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

Comments:

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

Summary of SHAY Scores Over Time

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

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