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

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Introduction

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

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

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

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

The author also reviewed relevant documentation provided, including:

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

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

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

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

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

Summary

Strengths and improvements in ACT implementation:

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

Challenges and recommendations for further improvements in ACT implementation:

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

Findings

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

1. EBP Plan

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

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

Score

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

Comments:

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

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

2. Financing: Adequacy

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

Score:

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

Comments:

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

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

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

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

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

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

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

3. Financing: Start-Up & Conversion Costs

Are costs of start up and or conversion covered, including: 1) Lost productivity for staff training, 2) hiring staff before clients enrolled (e.g. ACT), 3) any costs associated with agency planning and meetings, 4) changing medical records if necessary, 5) computer hardware and/or software if necessary, etc. *Note: If overall fiscal model is adequate to cover start-up costs then can rate 5. If financing is variable among sites, estimate average. Important to verify with community EBP program leaders/ site program managers.*	
	Score:
	1. No costs of start-up are covered
	2. Few costs are covered
	3. Some costs are covered
	4. Majority of costs are covered
X	5. Programs are fully compensated for costs of conversion

Comments:

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

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

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

4. Training: Ongoing consultation and technical support

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)
X	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)
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:

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

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

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

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

5. Training: Quality

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

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

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

Score

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

Comments:

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

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

6. Training: Infrastructure / Sustainability

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

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

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

Score

X

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

Comments:

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

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

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

7. Training: Penetration

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

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

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

<u>Ongoing training</u> should include 3 or more of the following components:

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

<u>Score:</u>

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

Comments:

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

8. SMHA Leadership: Commissioner Level

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

Note: Rate existing Commissioner, even if new to post.

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

Score

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

Comments:

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

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

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

There is an identified EBP leader (or coordinating team) that is characterized by the following:
(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:

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

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

10. Policy and Regulations: Non SMHA State Agencies

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

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

Examples of supporting policies:

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

Examples of policies that create barriers:

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

Score

X

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.
4. On balance, policies that support/promote the EBP outweigh policies that create barriers.

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

Comments:

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

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

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

11. Policies and Regulations: SMHA

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

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

Examples of policies that create barriers:

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

X

Score:

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

Comments:

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

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

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

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

12. Policies and Regulations: SMHA EBP Program Standards

The SMHA has developed and implemented EBP standards consistent with the EBP model with the following components:
(Use boxes to identify which criteria have been met)

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

Score

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

	4. 3 components
X	5. 4 components

Comments:

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

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

13. Quality Improvement: Fidelity Assessment

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

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

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

Comments:

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

14. Quality Improvement: Client Outcomes

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

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

Score

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

Comments:

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

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

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

15. Stakeholders

The degree to which consumers, families, and providers are opposed or supportive of EBP implementation. *Note: Ask - Did stakeholders initially have concerns about or oppose EBPs? Why? What steps were taken to reassure/engage/partner with stakeholders? Were these efforts successful? To what extent are stakeholders currently supportive this EBP? Opposed? In what ways are stakeholders currently supporting/ advocating against this EBP? Rate only <u>current</u> 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 providers clearly and explicitly expressed feeling like they have a strong partnership with DBHDD staff in providing high quality ACT services following the Dartmouth Assertive Community Treatment Scale. In some cases, managers wanted to start off meetings with me stating how positive and responsive state leaders and fidelity assessors in ACT have been. The exception to the typical provider response during the last year came when one provider expressed some trepidation about voicing complaints for fear of reprisal. Because that was mentioned earlier in the year and not during the July visit, I cannot tell whether this is an ongoing concern. As noted above, this view was not typical.

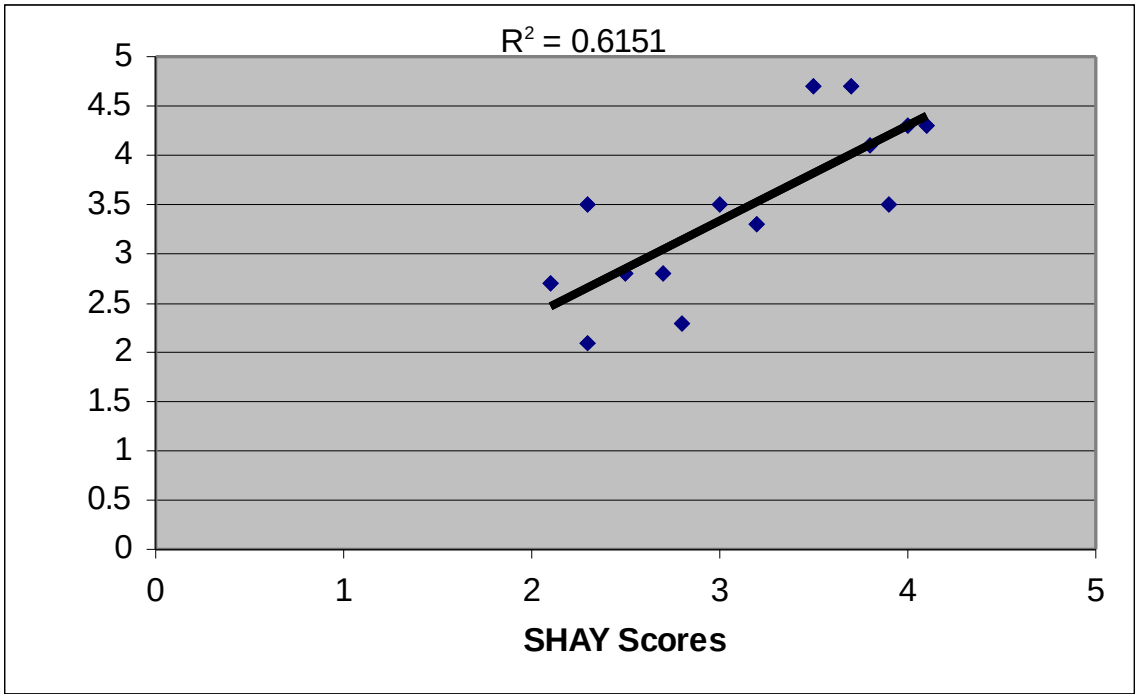
Consumer and family advocate groups also continue to be supportive of ACT, though their role is less of an active partnership. These stakeholders do echo providers' statements about the state's responsiveness to concerns. For instance, stakeholders have made requests of state officials and obtained "four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

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

National Implementing Evidence Based Practices Project Perspective

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

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



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

Summary of SHAY Scores

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

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