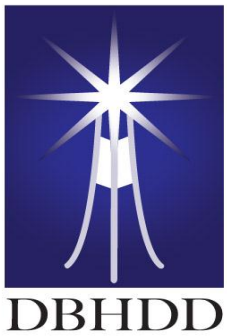
Georgia Department of Behavioral Health & Developmental Disabilities



2014 INTERIM QUALITY MANAGEMENT REPORT

Prepared by the DBHDD Office of Quality Management
August 2014

Contents

Introduction

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

This report is DBHDD's August 2014 Interim Quality Management (QM) System Report. The report and the summary of activities contained herein comprise a review of quality management activities that have taken place in the hospital, community behavioral health and developmental disabilities systems of care, as well as a review of QM activities at the State Office. It is the intent of DBHDD to share this report with Department staff and stakeholders.

The primary purpose of this Interim Report is to synthesize and communicate the DBHDD QM activities taking place across the Department. As a result of data availability, the analysis and discussion contained within this report will vary, but generally focuses on activities and data between January 2014 – June 2014.

Activities of the Quality Councils

Executive Quality Council

The Executive Quality Council (EQC) meets six times per year and acts as the governing body for the QM program providing strategic direction and is the ultimate authority for the entire scope of DBHDD QM activities including the QM plan, the DBHDD work plan and the annual evaluation. The EQC is the highest-level quality committee in DBHDD. The EQC met every other month from January 2014 – June 2014 for a total of three meetings.

A brief summary of some of the key EQC activities that took place during those meetings includes:

- Performed its annual review of the QM system.
- Discussed information that should be reported to the EQC.
- Discussed the re-engineering of the DBHDD DD service system.
- Reviewed and monitored the Office of Incident Management and Investigation's (OIMI) trends and patterns.
- Received updates from the Hospital, CBH and DD PQCs regarding the quality management-related work that each functional area prioritized and reviewed trends/patterns from their KPIs.
- Received an update from the CBH PQC regarding the setting of recovery oriented KPIs.
- Received an update and discussed the Hospital System CRIPA Transition Plan.

- Received updates from the ADA Settlement Director regarding DBHDDs compliance with the ADA Settlement Agreement.
- Prioritized the development of and received updates regarding the progress of a PI project related to corrective action plans, performance improvement and remedies for poorly performing and non-compliant community providers.

Hospital System Program Quality Council

The Hospital System PQC meets quarterly, and has held 2 meetings between January 2014 and June 2014. During that period, the HSPQC consolidated and improved the integration of the QM functions that had previously been managed in different meeting structures into the existing quality management system. It should be noted that during this report period the Hospital System satisfied the terms of the voluntary compliance agreement with the Department of Justice under CRIPA. In the quarterly meetings, the Hospital System PQC addressed patient safety and other performance measures. A brief summary of some of the key Hospital System PQC activities that took place during those meetings includes:

- Reviewed PI initiatives focused on management of aggression, restraint and seclusion, polypharmacy, consumer satisfaction and other performance measures.
- Focused on PI initiatives aimed at reducing incidents of aggression and use of restraint and seclusion.
- Reviewed and modified strategies being utilized by hospital-based PI teams to improve patient safety.
- Addressed data collection methodologies and data integrity issues that affected reporting timeliness and quality.
- Reviewed and discussed the Triggers and Thresholds report data, the hospital system dashboard measures and specific hospital system KPI trends and patterns and made suggestions/recommendations for program/service changes.

Community Behavioral Health Program Quality Council

The Community Behavioral Health PQC meets monthly and has held five meetings between January 2014 and June 2014. A brief summary of some of the key CBH PQC activities that took place during those meetings includes:

- Reviewed and discussed the selected incident trends and patterns for community based providers.
- Reviewed and discussed the results, trends and/or patterns of the CBH KPIs and as a result of those reviews:
    - modified some of the target thresholds
    - determined additional KPIs that needed to be developed and/or revised
    - made suggestions/recommendations for program/service changes
- Discussed and recommended recovery-oriented and suicide prevention KPIs.
- Reviewed and discussed the results of a statewide Deaf Services' survey.
- Received an update/overview of the Child and Adolescent program's quality management system.

- Received periodic updates regarding the findings of the fidelity reviews (for Supported Employment Assertive Community Treatment).
- Received an update regarding the progress of the Suicide Prevention Program.
- Discussed and recommended solutions to assist with improving the integrity of the data submitted to DBHDD by community BH providers.
- Reviewed and discussed transition reports received from the Office of Transition Services
- Reviewed and discussed the 2013 Adult and Youth Consumer Satisfaction Survey Reports.

Developmental Disabilities Program Quality Council

The Developmental Disabilities PQC meets quarterly and held one face-to-face meeting during January 2014 to June 2014. A brief summary of some of the key DD PQC activities that took place during those meetings includes:

- The project between DBHDD and the Department of Public Health concerning dental examinations and treatment for individuals with Intellectual/Developmental Disabilities (I/DD), did not see significant progress during the first half of calendar year 2014. The dental clinics at state hospitals will remain functional and will provide services and supports to individuals with I/DD who are currently receiving services and supports from DBHDD.
- The President of Human Services Research Institute (HSRI) reported on the new expectations from CMS concerning community integration. The Chief Policy Analyst for HRSI cross walked CMS expectations with the new ISP and NCI survey. Gaps were determined and based upon this information; the ISP workgroup will need to be reconvened.
- Last Quarter Data Review: A lead scientist for the DD external quality review organization (Delmarva) reviewed key data from the second quarter reviews. The council discussed documentation issues. In the past, documentation templates were designed to help providers meet documentation requirements while still remaining person-centered. The DBHDD Office of Learning and Organizational Development has contracted with an entity to develop web-based interactive training to enable direct support staff in completing various trainings. The Council supported the utilization of this training format to help more direct support staff to obtain documentation training.
- Health and Safety data taken from reviews were shared with Council. The DD Director of QM stated that the new version of the Health Risk Screening Tool (HSRT) will begin to collect historical data. Training on the tool was provided to Providers during the first half of calendar year 2014.
- Community Inclusion Project Plan: The Council decided that as part of their annual QI project, they would assist the Department in defining Community Inclusion. This project will help to address the new CMS requirements. Data also show that this is a major area for improvement. If a uniform definition could be developed with examples, it could help the State and service delivery system implement true inclusion.
- Supported Employment Guide: the guide (see attachment 1) developed last year by the Council has been approved by all appropriate stakeholders. The Guide will be shared

with Support Coordination Agencies, Regional Offices, Advocacy Agencies, and individuals and families.

- Evaluation of I/DD Quality Management System was reviewed by Council and DBHDD leadership. Next steps will be developed and reported on in the 2014 Annual Report.
- Monitored the status of Quality Management Work Plan Goals and adjusted as needed.
- Reviewed the ADA transition process and data in order to improve the quality of transitions from State Hospitals to the Community. This work continues as part of the upcoming DD Re-Engineering Project which began July 2014. Project plan and outcomes will be discussed in detail in the 2014 Annual Report.
- Reviewed the ongoing work of the DD Advisory Council which included quality improvement efforts in the DD system structure, system performance, and customer focus.
- Members of the Council participated in the evaluation of the proposals submitted to DBHDD in response to a Request for Proposals (RFP) for an Administrative Services Organization (ASO) that was released in March 2014. Part of the RFP included a rebidding of the current Quality Improvement Organization contract for the Division of DD. Results will be discussed in the 2014 Annual Report.
- The Statewide Quality Improvement Council focused on re-defining their role in the State system. Redesign efforts continue to be addressed and will be discussed further in the July 2014 meeting.
- As a result of the *Joint Filing of the Supplemental Report of the Independent Reviewer*; which can be found at: https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Dkt.%20184%20Joint%20Filing%20of%20Independent%20Reviewer%20Report%203.24.2014.pdf the Division of DD will be undertaking a Re-Engineering Project. The project started July 1, 2014 and will be discussed in more detail in the 2014 Annual Report.

Status of Quality Management Work Plan Goals

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

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

DBHDD QM Work Plan

As of July 2014 the DBHDD QM Plan and Work Plans were in the process of being updated. For the purposes of this Interim Report the, QM Plan and Work Plans from 2013 have been utilized. The first task of the first goal related to developing accurate, effective and meaningful performance measures has been met and will continue to be reviewed and updated on an annual basis. The third task of the first goal requires obtaining input from stakeholders to develop the KPIs. This is periodically taking place during quality management-related discussions at the

community based consortium meetings, regular meetings with the Georgia CSB Association's Benchmarking Committee and through DD quality management meetings.

The second goal is related to the education of stakeholders regarding QM. As of July 2014 the DBHDD QM Learning Plan was in the process of being updated and once finalized will be included in a revised QM Plan. In May of 2014, the second in the series of QM web-based training modules was released to all DBHDD staff with the requirement for a June 2014 completion.

The third goal related to implementing the outcomes framework has been completed. A data definition document which includes data collection plans has been developed. Additionally, as potential new KPIs are considered, the Performance Measure Evaluation Tool (PMET) is being used. Also, on at least an annual basis, KPIs are assessed for achievement against target thresholds and those components of the system that need to be revised or modified have been.

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

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

Hospital System QM Work Plan

The Hospital System is working to maintain and improve quality as it assists in DBHDD's strategic direction toward building community-based services while reducing its dependence on state hospitals. As the System's hospitals are reduced in size, closed and/or repurposed, it is essential that an effective quality management system is maintained so that those transitions are managed in a way that assures the consumers receive the quality of service they deserve. At the time of this report, the progress, with regard to the identified goals was consistent with the current plan with the exception of some components of the QM Training Plan which are being modified in the revised DBHDD QM Learning Plan. Additionally, some components of the integration of the QM data are being revised due to strategic changes in DBHDD's IT development strategy. See Appendix B.

CBH QM Work Plan

Progress towards meeting the goals is consistent with the plan except for the items in Goal 2 related to QM training plans for providers and individuals served and for Goal 4 which is related to integration of QM data systems. Progress on Goal 4 is behind schedule due to IT staff changes and the procurement of an Administrative Services Organization which will provide enhanced data integration and reporting to support the Department's and providers' QM systems. See Appendix C for the CBH QM Work Plan. Additionally the 2014 CBH Work Plan is in the process of being updated.

DD QM Work Plan

The Developmental Disabilities quality management work plan continues to support the DBHDD QM work plan and addresses the need to ensure that individuals with I/DD who transition out of state hospitals receive the highest quality of services and achieve their goals

once in the community. The I/DD Quality Plan also attempts to assure that individuals living in the community receive the highest quality services and supports in the least restrictive environment. Progress toward meeting the goals of the DD work plan is consistent with the plan's targeted timelines. See Appendix D.

Key Performance Indicators and Outcomes

Data Collection Plan/Data Definition Document

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

Dashboards

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

Hospital System Key Performance Indicators

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

1. The use of consumer feedback to reflect the quality of our services
    a. Client Perception of Outcome of Care
        i. Summary comments and analysis: The DBHDD Hospital System facilities have consistently scored higher than the baseline established on the basis of the national averages for the same survey tool. The hospital Quality Management departments are looking at ways to improve the consistency and timeliness of reporting and the consistency and quality of the methods of administration of the survey instruments.
    b. Client Perception of Empowerment
        i. Summary comments and analysis: The DBHDD Hospital System facilities have consistently scored higher than the baseline established on the basis of the national averages for the same survey tool. The hospital Quality Management departments are looking at ways to improve the consistency and timeliness of reporting and the consistency and quality of the methods of administration of the survey instruments.
2. The importance of continuity of care with regard to the transition of consumers between hospital and community services
    a. Continuing Care Plan Created (Overall)
        i. The Hospital System has managed to reduce the variation it experienced in the previous six month period, and achieved a more consistent overall improvement trend to a level that is well within the target range for this measure.

3. The importance of supporting the recovery of individuals receiving BH hospital services.
    a. Individual Recovery Plan Audit - Quality Measure
        i. Summary comments and analysis: As was reported in the previous QM system review, the Hospital System has continued to achieve a gradual overall positive trend. While the gradual improvements reflected in these data indicate that the current strategy has been effective, the Hospital System PQC is currently looking to develop new qualitative measures that will provide additional information on the extent to which the System is goal of being a recovery-oriented system of care.

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

Community Behavioral Health Program Key Performance Indicators

Summary and Recommendations for the current CBH KPIs:

1. Georgia Housing Voucher Program adult individuals with serous and persistent mental illness (SPMI) in stable housing
    - Summary comments and analysis: The number of individuals receiving Georgia Housing Vouchers who are in stable housing has significantly exceeded the HUD standard of six months and DBHDD's target of 77% for the January 2014 to June 2014 time period, and appears to be stable at approximately 92%.
2. Georgia Housing Voucher Program adult individuals with SPMI who left stable housing under unfavorable circumstances and have been reengaged and reassigned vouchers
    - Summary Comments and analysis: DBDD tracks Georgia Housing Voucher individuals who left stable housing under unfavorable circumstance and were reengaged in services. A target has been established based upon trend data (approximately 17%) to base future efforts at the provider level. This KPI will continue to be monitored.
3. Adult Mental Health supported employment providers that met a caseload average on the last day of the calendar month of employment specialist staff to consumer (between 1:15 to 1:20) :
    - Summary Comments and analysis: Although the target of 85% or more has not been met during this reporting period, analysis reveals that several providers had lower ratios than 1:15. This means that those providers had smaller caseloads per staff member. The CBH PQC discussed this indicator and determined that if providers have a smaller ratio, that is not detrimental to the consumer, therefore this measure ended on 6/30/14 and was replaced with a target ratio not to exceed 1:20 starting on 7/1/14.
4. Individuals who had a first contact with a competitive employer within 30 days of enrollment
    - Summary Comments and analysis: The overall percentage of consumers who had first contact increased in comparison to the previous two quarters. This measure

is analyzed on a 30 day lag and April 2014– June 2014 data was not available for analysis as of the date of this report.

5. Assertive Community Treatment consumers who are received into services within 3 days of referral
    - Summary Comments and analysis: The target of 70% was met during the month of May 2014 but the data displayed varying percentages. Some of the ACT teams have identified challenges with the three day target such as receiving an increase in referrals for homeless consumers (which increases the amount of time to locate the consumer) and consumers that move directly after the referral (which also increases the time it takes to identify new contact information).
6. Assertive Community Treatment consumers with a Psychiatric Inpatient admission within the past month
    - Summary Comments and analysis: The target of 7% or less was not met for this reporting period and shows a slight upward trend in hospital utilization. Some providers indicate that consumers are sometimes discharged from hospitals prior to achieving stability, which may lead to decompensation in the community and re-hospitalization. Other providers reported that consumers may be discharged from the hospital without their knowledge, limiting their involvement in supportive discharge planning.
7. Average number of jail/prison days utilized per enrolled Assertive Community Treatment consumer
    - Summary Comments and analysis: Overall the target of 1 day or less was met for all months during this reporting period except for March 2014 which minimally exceeded the threshold.
8. Intensive Case Management consumers with a Psychiatric Inpatient admission within the past month
    - Summary Comments and analysis: For this reporting period overall the target of 5% or less was met except for the months of March and April 2014. The percentages generally appear to be consistent with previous quarters.
9. Intensive Case Management consumers housed (non-homeless) within the past month
    - Summary Comments and analysis: Overall the target of 90% or more was met during this reporting period.
10. Average number of jail/prison days utilized per enrolled Intensive Case Management consumer
    - Summary Comments and analysis: Except for April of 2014 the overall target of .25 days or less was not met for this reporting period. This KPI will continue to be monitored.
11. Community Support Teams with a Psychiatric Inpatient admission within the past month
    - Summary Comments and analysis: Overall the target of 10% or less was met during this reporting period.
12. Community Support Team consumers housed (non-homeless) within the past month
    - Summary Comments and analysis: Overall the target of 90% or more was met during this reporting period.
13. Average number of jail/prison days utilized per enrolled Community Support Team consumer

- Summary Comments and analysis: Overall the target of 0.75 days or less was met during this reporting period. The exception is the month of May 2014 which shows a slight upward trend.

14. Case Management consumers with a Psychiatric Inpatient admission within the past month
    - Summary Comments and analysis: Overall the target of 5% or less was met during this reporting period.
15. Case Management consumers housed (non-homeless) within the past month
    - Summary Comments and analysis: Overall the target of 90% or more was met during this reporting period.
16. Average number of jail/prison days utilized per enrolled Case Management consumer
    - Summary Comments and analysis: Overall there continues to be some variability in the average number of jail/prison days utilized during this time; which was met during the month of April 2014. The overall all average by quarter appears to be consistent with previous quarters.
17. Adult Addictive Disease consumers active in AD treatment 90 days after beginning non-crisis stabilization services
    - Summary Comments and analysis: This KPI became effective in July 2013, is collected on an annual basis. It is anticipated that 2014 data will become available in October 2014.
18. Adult Addictive Disease consumers discharged from crisis or detoxification programs who receive follow-up behavioral health services within 14 days.
    - Summary Comments and analysis: This KPI became effective in July 2013, is collected on an annual basis. It is anticipated that 2014 data will become available in October 2014.
19. Individuals meeting Settlement Agreement criteria who are enrolled in settlement funded services who state they are satisfied with the services they are receiving
    - Summary Comments and analysis: Data collection was put on hold during this reporting period secondary to the QM audit team performing a follow-up quality review of a sample of individuals with repeated inpatient hospital re-admissions.
20. Individuals meeting Settlement Agreement criteria who are enrolled in settlement funded series who feel their quality of life has improved as a result of receiving services
    - Summary Comments and analysis: Data collection was put on hold during this reporting period secondary to the QM audit team performing a follow-up quality review of inpatient hospital re-admissions.
21. Percent of youth with an increase in functioning as determined by a standardized tool
    - Summary Comments and analysis: The Department is transitioning from the Child and Adolescent Functional Assessment Scale (CAFAS) to the Child and Adolescent Needs and Strengths (CANS). The implementation of the CANS is scheduled for April 2015. Data collection for this KPI will begin in FY16.
22. Percent of families of youth satisfied with services as determined by a standardized tool
    - Summary Comments and analysis: This data is collected and analyzed on an annual basis. In 2013, 70.2% of families of youth were satisfied with the community mental health services they received. These results were based on a relatively small number of participants (n=346) so they may not generalize to the target population for the survey. The Department is examining how the survey

data is collected and will likely move to additional ways to gather more surveys. Also, due to a recent change in the children's mental health system in which additional youth are receiving services through Medicaid managed care organizations, DBHDD may expand the survey to cover all public mental health services recipients.

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

Developmental Disability Programs Key Performance Indicators

The Division of Developmental Disabilities continues in its efforts of evaluating and improving its Quality Management System and processes. A stakeholder workgroup was formed in the latter part of 2013 to address the need for specific performance indicators for both the Division and IDD providers. This workgroup was put on hold in early 2014, and is planned to reconvene as part of the DD Re-Engineering Project in July 2014. An outcome of the Re-Engineering Project will be a change in the current key performance indicators. See Appendix G.

The remaining current key performance indicators are used to help the Division of DD to determine:

- The level at which individuals are receiving person centered supports and services;
- If the individual is healthy and safe
- The efficiency of specific DD services

Person Centered Supports

Each individual's team of supports meets annually to develop an ISP that is person centered and supports the individual's needs and desired goals. An ISP QA Checklist tool was initially developed by the state to ensure the ISP includes all necessary requirements as dictated by the state, and that it helps ensure the individual has a healthy, safe, and meaningful life. Please see Section entitled *DD Individual Support Plan Quality Assurance (ISP QA) Checklist* on page 36 for a detailed description on ISP Quality Assurance.

Health and Safety

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

Georgia has made significant gains in many of the performance indicators listed below. Georgia ranks well within or higher than the national averages for the listed National Core Indicators. However, even with these gains some of the performance indictors still remain below their Division of DD set target thresholds. Once the new data has been reviewed and analyzed over the next few months, strategies will be developed to address those KPIs which have not met their thresholds. These strategies will be reported in the 2014 QMS Year End Review Report.

Key indicators that have been reviewed include vaccines, dental examinations, annual physicals, and the perception of safety and dignity.

The 2012-2013 National Core Indicator data shows:

- 72% of respondents from Georgia and 76% of respondents across NCI States were reported to have had a flu vaccine in the past year. This is up significantly from 63% last year; however, Georgia remains within the average range of NCI States.
- 76% of respondents from Georgia and 80% of respondents across NCI States were reported to have had a dental exam in the past year. This is up significantly from 70% last year; however, Georgia still remains within the average range of NCI States
- 86% of respondents from Georgia and 89% of respondents across NCI States were reported to have had a physical exam in the past year. This is down slightly from 90% last year; however Georgia remains within the average range of NCI States
- 87% of respondents from Georgia and 81% of respondents across NCI States reported they never feel scared at home. This is down slightly from 89% last year; however Georgia's average is significantly above the average range of NCI States.
- 97% of respondents from Georgia and 93% of respondents across NCI States reported they are treated with dignity and respect. This is up slightly from 96% last year, and Georgia ranks top among the NCI States.
- 72% of respondents from Georgia and 52% of respondents across NIC States reported that they have a choice of support and services. This is up significantly from 67% last year, and Georgia ranks top among the NCI States.

Efficiency of Services

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

The goal of this system is to provide time-limited home and community based crisis services that support individuals with developmental disabilities in the community, and provide alternatives to institutional placement, emergency room care, and/or law enforcement involvement (including incarceration). These community based crisis services and homes are provided on a time-limited basis to ameliorate the presenting crisis. The system is to be utilized as a measure of last resort for an individual undergoing an acute crisis that presents a substantial risk of imminent harm to self or others.

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

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

The intent of Intensive In-Home Support is to stabilize the individual through behavioral intervention strategies provided under the recommendations of the DD Mobile Crisis Team. The services are provided in the individual's home and may be provided 24/7 for a limited period of time. During the first two quarters of 2014 (January 1, 2014 through May 31, 2014) 6% of crisis incidents resulted in the need for intensive in-home supports. This is down significantly from the last quarter of 2013 where the average was 12.3%

The intent of Intensive Out-of-Home Supports is to stabilize the individual using nursing and behavioral supports, on a time-limited basis. Intensive Out-of-Home Supports are to be provided by Crisis Support Homes, which are to serve no more than four adult individuals simultaneously. Individuals under the age of 18 years must not be served in a Crisis Support Home. Those individuals are served in the Divisions Temporary and Immediate Support Home. From January 1, 2014 through May 31, 2014, 12% of crisis incidents resulted in the need for intensive out-of-home supports. This is down significantly from the last quarter of 2013 where the average was 22%

Crisis data shows that the system is operating as it should, with the individual receiving crisis supports in the least restrictive environment as possible. The Division of DD has experienced, however, an ongoing issue when attempting to support dually diagnosed individuals. Behavioral Health has just recently implemented its own Mobile Crisis Response System, and the Division of DD is partnering with Behavioral Health to address this shared population. Issues with serving the dually diagnosed population will be address more thoroughly with the implementation of the Administrative Service Organization.

Quality Monitoring Activities

Complaints and Grievances

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

Constituent Services staff received 162 complaints, grievances and/or inquiries between January 1, 2014 to June 30, 2014. Of the 162 complaints received there were 38 issue categories, as noted below:

Addictive Diseases	**Legal**
Adult services and community care Placement	HIPPA violation Open records request
Developmental Disabilities	**Mental Health**
NOW & COMP Waiver eligibility Change in services Exceptional Rate Planning List	Access to services Residential placement Inpatient discharge Inpatient evaluation

Self-Directed Services Complaint about provider services Host Homes complaint Residential placement	Inpatient treatment PRTF (Psychiatric Residential Treatment Facility) General Information about services
Investigations	**Provider Network Management**
Allegations of Abuse	Provider certification Enrollment process Complaint about the process
Human Resources	
Termination	

The most frequent issue of concern was related to the developmental disabilities program. Forty-five percent (45%) of the developmental disability complaints were pertaining to funding and eligibility for the New Options Waiver (NOW) and the Comprehensive Supports (COMP) Wavier. Thirty-five percent (35%) of the developmental disability complaints were received from family members or friends of the individual who was the subject of the inquiry. Thirty-six percent (36%) of complaints were initiated with the Governor's office or by members of the Georgia General Assembly. The second most frequent category of concern was mental health services. Sixty (60) complaints relating to mental health services were received in the OPR. Thirty-seven percent (37%) were triaged and sent to the six regional offices, as well as state office staff. Of the sixty cases, Georgia Regional Hospital in Atlanta and West Central Regional Hospital in Columbus accounted for only (2%) two percent of mental health complaints and grievances. Many family members continue to express the need for waiver funding and long term intensive mental health treatment facilities and services for their loved ones.

Regional Offices received and responded to seventy-three percent (73%) of the constituent complaints and grievances. Each individual's concern was addressed within 5 to 7 business days depending on the nature of the complaint or inquiry.

The Director of Legislative Affairs oversees the Office of Constituent Services, and will continue to monitor and review complex or frequent constituent issues to ensure the complaint/grievance process is managed as consistently and as efficiently as possible. One of the key goals of the OPR is to continue to provide constituent grievance and complaint trends and patterns which can be used for service and program improvement.

Hospital and Community Incident Data January 2014 – June 2014

DBHDD requires its contractors to report incidents, accidents and deaths per Policy 04-106, Reporting and Investigating Deaths and Critical Incidents in Community Services, and DBHDD hospitals per Policy 03-515, Incident Management in Hospitals. Contractors and Hospitals are required to report significant and/or adverse incidents for all individuals served. These reports are submitted to DBHDD, Office of Incident Management and Investigations (OIMI). OIMI staff review all submitted reports for identification of potential quality of care concerns. The quality of care concerns are triaged for investigation either at the State or Contractor level.

The following incident review covers death reports and critical incident reports received in the Office of Incident Management and Investigations from January 1, 2014, through June 30, 2014. The total incidents received by month for hospitals and community providers are included in Tables 1 and 3 below. The tables also provide a comparison for the current report period (January 2014 – June 2014) with the prior six month period (July 2013 – December 2013).

Hospital Incident Data

As Table 1 indicates, the total number of hospital incidents for the report period was 3,444, or a rate of 16.7 per 1000 patient days, compared to the prior 6 months of 3,976 (rate = 18.2) – a decrease in the rate of incidents of 8.4%. The rate is used to adjust for differences in the size of the patient population for those two periods. ***NOTE:*** *All rates in this report have been rounded to the nearest tenth or hundredth; therefore, any calculations performed using the rounded numbers presented here will result in minor differences when compared with the numbers within this report.*

Table 1: Total Incidents by Month

HOSPITAL

Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Total
724	783	642	619	622	586	3,976
Jan-14	**Feb-14**	**Mar-14**	**Apr-14**	**May-14**	**Jun-14**	
533	470	696	558	608	579	3,444

HOSPITAL RATE (Incidents per 1000 patient days)

Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Avg.6 Mo. Rate
18.1	19.8	18.6	17.6	18.2	16.7	18.2
Jan-14	**Feb-14**	**Mar-14**	**Apr-14**	**May-14**	**Jun-14**	
15.7	14.9	19.8	16.4	17.2	13.3	16.7

The five most frequent hospital incidents reported during this review period are listed below in Table 2. Incident types A04 and A03, "Aggressive act to staff-Physical" and "Aggressive act to another individual-Physical", occurred more often than all others and account for 50% of the total number of incidents reported. The incident rate for "Aggressive act to staff-Physical" decreased from a rate of 4.94 per 1000 patient days to a rate of 4.46 compared to the prior six months—a 9.8% decrease. "Aggressive acts to another individual-Physical" decreased from 4.94 per 1000 patient days to 3.99—a decrease of 19.1%. A01 "Accidental Injury", A30 "Property Damage", and A02 "Aggressive act to self"round out the most frequently reported hospital incidents. These five incident types account for 76.9% of the total number of incidents reported.

Table 2: Most Frequently Reported Hospital Incidents (updated 7/1/14)

Hospital Incident Type	Total	Rate (incidents per 1000 patient days
A04-Aggressive act to staff-Physical	921	4.46
A03-Aggressive act to another individual-Physical	825	3.99
A01-Accidental Injury	325	1.6
A30-Property Damage	306	1.5
A02-Aggressive act to self	274	1.32

During the past year, the Hospital System, as part of its quality management program, has maintained a special focus on activities intended to reduce the frequency of incidents of aggression and restraint and seclusion. There have been a variety of strategies (policy changes, training, process improvements, etc.) employed by each hospital and the System at large. It is likely that the rate reductions outlined in this section can be attributed to those collective efforts.

During this period, a report was provided to DBHDD's Executive Quality Council that listed, in a chronological fashion, an array of the kinds of initiatives and efforts that have been employed over the two year time frame of calendar years 2012 and 2013. For example: In response to incident reviews, trend analyses, investigations, and scheduled periodic policy revision timeframes, improvements in processes were developed in revisions of the following policies: Observation of Individuals to Ensure Safety (03-501), Suicide, Violence and Victimization Risk Assessment (03-504), Seclusion or Restraint policy (03-510), Suicide, Violence and Victimization Risk Assessment policy (03-504) and the Observation of Individuals to Ensure Safety policy (03-501). Training via formal on-site training programs and supervisor–led policy review conferences was also provided to staff on all policy revisions. The Hospital System is committed to continuing its efforts to make progress in these important areas.

Community Incident Data

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

The total community incidents for the report period were 2,090 compared to the previous 6 months of 1,826, reflecting an increase of 2.65%.

Table 3: Total Community Incidents by Month

Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Total
294	316	293	324	278	321	1,826
Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	
351	292	367	381	348	351	2090

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

Table 4: Most Frequently Reported Community Incidents (updated 7/1/14)

Community Incident Type	Total
C-Hospitalization of an Individual in a community residential program	680
C-Incident occurring in the presence of staff which requires intervention of law enforcement services	219
C-Individual injury requiring treatment beyond first aid	167
C-Individual who is unexpectedly absent from a community residential program or day program	151
C-Alleged Individual Abuse-Physical	126

Community Incident Data – Behavioral Health Services

Community behavioral health providers reported 647 deaths and critical incidents during this report period or 31% of the total number of community incidents. The incident types requiring an investigation and reported most frequently for Behavioral Health were: "Hospitalization of an Individual in a community residential program", "Incident occurring in the presence of staff which requires intervention of law enforcement services", "Individual who is unexpectedly absent from a community residential or day program", "Individual injury requiring treatment beyond first aid", and "Alleged Individual Abuse-Physical".

"Hospitalization of an individual in a community residential program" was reported more frequently than all other community incident types and increased 14.5% from the prior six month period. Review of these reports indicates that most are reports of appropriate transfers of individuals from crisis stabilization units to state hospitals when additional treatment is needed. With the closure of an additional state hospital in December 2013 and the increase in availability of crisis stabilization units, this increase is not considered to be significant or unexpected. Consideration is being made to whether this type of transfer from crisis residential care to state hospital care should continue to be classified as an incident because it is not consistent with the original intent of the indicator. The indicator was intended to capture instances in which individuals in non-crisis residential settings required treatment in an inpatient facility.

Reports of "Incidents occurring in the presence of staff which required intervention of law enforcement services" increased 61%. Reports of "individual injury requiring treatment beyond first aid" increased 3.7%; "Reports of an individual who is unexpectedly absent from a community residential program or day program increased" 16.2%; and reports of "Alleged Individual Abuse-Physical" increased 28.6%. Further analysis of these numbers will take place at the program level and/or at the appropriate program quality council.

In late summer 2013, the CBH PQC determined through an analysis of data from OIMI that a number of community BH providers may not have been reporting incidents as required. This hypothesis was developed through an examination of the providers that had zero (0) reported incidents in the previous year and it was determined that it was unlikely, given the types of services and populations served, that no reportable incidents had occurred. In early October

2013, a memo was sent to community MH and DD providers by the Assistant Commissioners of these programs to remind providers of the incident reporting requirements and processes. This went to all community providers and increases in reporting were expected. The increases in reports in categories above are in categories that are easily identified by staff as a reportable incident and CBH PQC will conduct additional analyses to determine whether the increases are due to an actual increase in incidents or increased reporting of incidents.

Community Incident Data – Developmental Disability Services

Community developmental disability providers reported 1,443 deaths and critical incidents or 69% of all incidents during this report period. The incident types requiring an investigation and reported most frequently for developmental disabilities were "Hospitalization of an Individual in a community residential program", "Incident occurring in the presence of staff which requires intervention of law enforcement services", "Individual injury requiring treatment beyond first aid", "Individual who is unexpectedly absent from a community residential program or day program", and "Alleged Individual Abuse-Physical".

Community Mortality Reviews

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

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

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

The CMRC is chaired by the DBHDD Chief Medical Officer (CMO). Other members of the committee include the DBHDD Director of Quality Management, the DBHDD Suicide Risk Prevention Coordinator, a community physician, a Registered Nurse who is experienced and understanding of the needs of individuals who are receiving services through DBHDD, the Director of DD QM, the OIMI Director, representatives of the Division of AD, the Division of MH and others as appointed by the CMO. There must be a minimum of five committee members present with three (or at least 51%) clinicians and at least one physician.

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

During this review period the Community Mortality Review Committee met five times to review all reported unexpected deaths (as defined by the community incident management policy) of all individuals receiving DBHDD services (BH, DD, and AD). A total of 73 unexpected deaths were reviewed during this period. Of the 73 reviews, 28 reviews had recommendations. When there were outstanding issues identified by the Mortality Review Committee related to the investigative report, those issues were addressed with the appropriate party. Based on these reviews, recommendations were made related to: additional aspects or details to be included in the investigation; actions/recommendations in the investigative report; amending, modifying or training on DBHDD or provider policies; and provider staffing and training. Examples of actions/recommendations include the following: requests for additions to the providers' corrective action plans regarding identified training needs, e.g. conducting CPR, managing medications and behavior needs of individuals, and changes in individuals' diet; consults by the Suicide Prevention Coordinator for educating providers on assessing and managing suicide risk factors; referral to the Regional Offices for a more intense audit or additional monitoring of provider(s); and training of investigative staff in recognition of standards of practice on relevant parameters such as calling 911, oversight and supervision as potential systemic issues, communication with multiple community providers, internal communication within the provider, and staffing resources/caseloads of case managers.

For FY 15, DBHDD has contracted with external providers with expertise in Developmental Disabilities and Suicide Prevention: Columbus Medical Services, LLC, to provide mortality reviews of all deaths from the ADA population that has transitioned from a hospital setting to the community from July 1, 2014, and going forward and a focused review on deaths during FY 13.

DBHDD has also contracted with Barbara Stanley, PhD and Gregory Brown, PhD, both nationally recognized suicide experts and trainers, to review the suicide deaths of 42 individuals who received DBHDD services in FY 13 and to conduct mortality reviews of suicide deaths in FY 15 and going forward. These objective reviews by external authorities will help provide additional expertise in these two critical areas of clinical practice.

Patterns and Trends

During this report period, the Office of Incident Management and Investigations compiled, analyzed and provided information regarding incident patterns and trends to the Community Behavioral Health Program Quality Council, the DBHDD Executive Quality Council, the Division of Developmental Disabilities, the Division of Addictive Diseases, the Division of Community Mental Health, the Suicide Prevention Coordinator, and the Regional Hospital Administrators, Risk Managers and Incident Managers. Based on a review of the data, additional data needs were identified and provided in subsequent meetings. The information has been used for quality improvement purposes to identify providers who may require technical assistance and/or training.

Hospital Peer Review and Credentialing

Several changes have been initiated during the past 6 months in the peer review process for the Hospital System. The Mentoring/Peer review system has been assigned to the chiefs of each respective clinical discipline, which have additional latitude with respect to assignment of mentoring functions within their departments. Additionally, some of the clinical audit functions have been assigned to the Quality Management departments in each hospital for ongoing reporting due to organizational restructuring.

Hospital Utilization Review

The Hospital System and Regions continue to monitor and address issues related to rapid readmissions (less than 30 days), people with 3 or more admissions in a year, and people with 10 or more admissions in a lifetime. The overall trend for the 30 day readmissions have shown a general downward trend during the last 12 months, with no significant additional progress during the past 6 months.

Adult Mental Health Fidelity Reviews

Assertive Community Treatment Fidelity Reviews are conducted annually for all twenty-two state contracted ACT teams. Between January 2014 and June 2014 a DACTS (Dartmouth Assertive Community Treatment Scale) fidelity review was conducted on eighteen State Contracted ACT Teams. The review typically takes 3 days with one day of on-site technical assistance built in on the last day after the review. Once the DBHDD ACT & CST Services Unit completes the Fidelity review, results of the Fidelity Review are given to the ACT team, leadership within the agency, the regional office in which the team operates, and the DBHDD Adult Mental Health Director and other departmental leadership. Results are also provided to the ACT Subject Matter expert hired as part of the Independent Reviewer's review of the DOJ Settlement. This is followed by a detailed discussion of the report inclusive of each scale and the rating for each scale along with any explanation or recommendation for the rating. This occurs during the exit interview which is attended by the ACT provider, regional and state office staff. Review items that are found to be below the acceptable scoring range: a score of 1 or 2, result in

a Quality Improvement Plan (QIP) which each team develops and submits for acceptance to the regional and state office. ACT teams are contractually required to obtain a DACTS mean score of 4.0 and total score of 112. Of the eighteen teams that have received a Fidelity Review, twelve achieved a score within the acceptable range of fidelity, indicating that they are serving the appropriate population, maintaining an acceptable caseload, delivering the service with intended frequency and intensity, providing crisis response, conducting effective daily team meeting discussion of consumers, engaging formal and informal supports, being involved in hospital admissions and/or discharges and delivering 80% of the teams services in the community. At the time of the review, six teams scored below the acceptable range of fidelity. Some of those areas of needed attention are: increasing team involvement in hospital admissions and discharges, strengthening delivery and documentation of contacts with consumer's informal support system, increasing the stability of staffing and reducing turnover and increasing co-occurring disorders treatment. All six teams have submitted or are in the process of submitting QIP's, and have received technical assistance and have demonstrated improvements in most areas.

Supported Employment Fidelity Reviews are conducted annually for all twenty-two state contracted SE providers. Between January 2014 – June 2014, eighteen Fidelity Reviews were completed using the 25-item IPS model for supported employment. Once the 2-day SE Fidelity Review is completed and findings are scored, the results are given to the SE provider, the regional office in which the team operates the DBHDD Adult Mental Health Director and other departmental leadership. Results are also provided to the SE Subject Matter expert hired as part of the Independent Reviewer's review of the DOJ Settlement. This is followed by an exit interview inclusive of provider, regional and state staff with a detailed discussion of the review outcome and report. Outcomes are also discussed with the PQC. Review items that are found to be below the acceptable scoring range; a score of 1 or 2 will result in a Quality Improvement Plan (QIP) which each team develops and submits for acceptance to the regional and state office. SE providers are contractually expected to minimally obtain an IPS total score of 74. Of the eighteen providers who have received a Fidelity Review, seventeen achieved a score within the acceptable range of fidelity, indicating that they are effectively integrating SE and mental health, maintaining collaboration with Georgia Vocational Rehabilitation Agency (GVRA), demonstrating clearly defined employment duties for SE staff, implementing zero exclusion, rapidly engaging consumers in competitive job search, assessing consumer's interests and making job placements based on identified interests and skills. At the time of the review, one provider scored below the acceptable range of fidelity. Some of the areas of needed attention are, increasing collaboration with GVRA, integration of SE and mental health treatment team, vocational unit, work incentives planning, individualized job search, engaging in sufficient employer contacts and diversity of job types. This provider has submitted or is in the process of submitting a QIP and is receiving technical assistance in order to improve operation in areas of deficiency.

Quality Service Reviews of Adult Behavioral Health Community Providers

In October 2013, the DBHDD Executive Leadership focused the QM State Office's quality review work on a new initiative as a result of findings provided by Dr. Nancy Ray regarding data collected and reported from quality reviews for repeat admissions. With input from Dr. Ray the QM Department created a tool and process to review hospital records of high risk individuals who were also repeat users of the State Hospitals to include collecting data on factors impacting

repeat admissions, discharge planning, and transition to community based services, among other criteria. In addition, members of the QM Audit Team visited three State hospitals (Georgia Regional Hospital -Atlanta, Georgia Regional Hospital -Savannah, and East Central Regional Hospital) in order to conduct staff interviews related to a sample of the records reviewed. These audits were completed in May 2014 and a report was submitted to leadership. Some of the key findings from that report included:

- The re-admission rate to State Hospitals has decreased.
- Appointments for follow up mental health care were made 100% of the time.
- Individualized Recovery Plans were completed within policy designated timeframes.
- Behavior Guidelines in all cases were written in an understandable language, individualized to the individual's issues, and based on positive behavioral supports.
- 50% of the individuals chosen for review had issues with substance abuse on at least one admission. Those issues were not assessed thoroughly or addressed consistently throughout treatment. Substance abuse treatment has been identified as a service gap.
- Documentation did not support that issues identified through assessments and/or included in treatment plans were consistently addressed in treatment.
- Individual's medical needs were being consistently addressed while in the hospital; however, appointments with medical providers upon discharge for continued medical monitoring was not consistent. Individuals were often advised to follow up with a physician upon discharge without documented assistance in identifying providers or making appointments.
- More than half the individuals were discharged to placements that previously were unsuccessful or contributed to a readmission. A quarter of the individuals were discharged homeless at least once. Many of these were documented as personal choice.

The QM audit team is now developing and implementing a follow-up quality review designed to expand the review beyond the hospital and follow a sample of individuals with high service utilization, including repeat use of crisis services, to determine potential areas of quality improvement interventions to enhance engagement in community follow-up treatment and reduce recidivism of crisis services. The purpose of this quality review is to identify barriers to serving individuals successfully in the community, service and treatment issues, and systemic issues across and between services and programs. The anticipated implementation date is September of 2014.

Division of Addictive Diseases (AD) Quality Management Activities

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

their families and significant others; overseeing men's residential treatment services throughout Georgia and the Ready for Work women's programs.

Program staff assigned to the Division's State office are responsible for conducting provider site reviews to ensure fidelity/compliance to service guidelines and federal block grant requirements. Listed in the chart below is an overview of each program area and the QM activities conducted by staff along with the frequency:

AD Service/ Description	QM Activities/On-site reviews	Frequency	Outcomes
Women's residential treatment and recovery support services	Site visits are currently conducted by Women's Treatment Coordinator. APS does not audit these programs. Staff reviews provider compliance with standards and overall performance in providing gender specific substance abuse treatment services. In addition, TCC vendor conducts review of all Therapeutic Childcare programs offering services to children. Clinical reviews of these programs against requirements are conducted by addiction credentialed staff with gender specific training and historical context of programs and interaction with child welfare agencies.	1-2 x a year	Providers who are not in substantial compliance with Federal requirements are provided an in-depth review of those requirements and additional training if needed to ensure future compliance.
Women's outpatient treatment and recovery support programs	Site visits are currently conducted by Women's Treatment Coordinator. APS does not audit these programs. Staff reviews provider compliance with standards and overall performance in providing gender specific substance abuse treatment services.	1x a year	Providers who are not in substantial compliance with Federal requirements are provided an in-depth review of those requirements and additional training if needed to ensure future compliance.
Women's transitional housing supports	Site visits are currently conducted by Women's Treatment Coordinator.	1x a year	Providers who are not in substantial compliance with Federal requirements are provided an in-depth review of those requirements and additional training if needed to ensure future compliance.
Recovery Support Services for youth (Clubhouses)	Site visits conducted by C&A program staff to ensure program design and requirements are being followed. Staff person is 7 Challenges trained.	1x a year	Providers who are not in substantial compliance with Federal requirements are provided an in-depth review of those requirements and additional training if needed to ensure future compliance.
Recovery Centers	Site visits conducted by Adult program staff to ensure program design and requirements are being followed. Clinical review of these programs against requirements are conducted by addiction credentialed staff	1x a year	Providers who are not in substantial compliance with Federal requirements are provided an in-depth review of those requirements and additional training if needed to ensure future compliance.
IRT (Intense Residential Treatment) Programs	Site visits conducted by C&A program staff to ensure program design and requirements are being followed. Staff person is 7 Challenges trained.	1x a year	Providers who are not in substantial compliance with Federal requirements are provided an in-depth review of those requirements and additional training if needed to ensure future compliance.
CSU step down programs	Site visits conducted by Adult program staff to ensure program design and requirements are being followed.	1x a year	Providers who are not in substantial compliance with

Housing supports for individuals leaving detox.	Clinical review of these programs against requirements are conducted by addiction credentialed staff		Federal requirements are provided an in-depth review of those requirements and additional training if needed to ensure future compliance.
HIV testing and education (HIV/EIS)	Site visits conducted by vendor to ensure program design and requirements are being followed.	1x a year	Providers who are not in substantial compliance with Federal requirements are provided an in-depth review of those requirements and additional training if needed to ensure future compliance.
AD Treatment Courts	None currently as program serves more of an administrative function.	N/A	N/A
Opioid Maintenance	Site visits conducted by State Opioid Maintenance Treatment Authority.	Every 6 months	Providers who are not in substantial compliance with Federal requirements are provided an in-depth review of those requirements and additional training if needed to ensure future compliance.
Adult Residential Treatment Services	Site visits conducted by Adult program staff to ensure program design and requirements are being followed. Clinical reviews of these programs against requirements are conducted by addiction credentialed staff.	1x a year	Providers who are not in substantial compliance with Federal requirements are provided an in-depth review of those requirements and additional training if needed to ensure future compliance.

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

Division of Addictive Diseases Training

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

Advanced Clinician Training for DUI Clinical Evaluators
Advanced Clinician Training for DUI Treatment Providers
Introduction to Trauma Informed Care for Youth
STAR BH Military Culture Training (Tier 3)

Children, Youth and Families Community Mental Health Programs (CYFMH)

The Georgia State University Center of Excellence for Child and Adolescent Behavioral Health has produced the quarterly report cards related to Quality Improvement data for all programs (PRTFs, CMEs/CBAY, and CSUs except Clubhouses which is monthly). The data was reviewed and data collection processes refined in each of the quarterly programmatic Quality Consortiums.

In August 2013, Community Mental Health held a training and technical assistance symposium in Macon, GA. All Child & Adolescent and Adult Providers were invited to participate and receive training on how to increase and improve the quality of the service(s) they provide.

Topics were varied and included, but were not limited to: cultural competence, improving clinical competence, and trauma-informed systems of care. Approximately 350 people participated in this training. The next symposium will be held August 5 – 6, 2014 in Macon, Georgia.

In June 2014, the Office of Children, Youth and Families, along with the Georgia Interagency Director's Team, a state-level interagency collaboration which is a subgroup of the Department's Behavioral Health Coordinating Council, hosted the 7th Annual System of Care Academy. This 3 day training event was held in Stone Mountain, Georgia. All Child and Adolescent Providers, as well as youth, parents, managed care organization staff, child welfare staff, juvenile justice staff, and other state agency staff were invited and participated. Topics were varied and included, but not limited to: leadership, best practice for treatment of ADHD and youth engagement. Approximately 350 people participated in this training. The next academy will be held in 2015.

Mobile Crisis Response System Performance and Quality Monitoring

In March 2013, the DBHDD procured mobile crisis response services (MCRS) in all 6 of its regions. MCRS began in 100 counties in June 2013 and quickly expanded to 128 counties as of July 1, 2013. MCRS was expanded to state-wide coverage on July 1, 2014.

Two vendors, Benchmark Human Services and Behavioral Health Link, were chosen to cover the state and have been participating in the MCRS Quality Management System since the beginning of the contracts. There are 20 data points that the vendors report on monthly to the regions. This data is reviewed quarterly at a MCRS Quality Consortium. Through these meetings, a quarterly data template has been created, barriers to implementation have been resolved, and processes have been put into place to improve the quality of the service.

Between January and June 2014, 8,184 calls were received. The below table shows the average (mean) response time for mobile crisis teams. Response time is defined as the amount of time in between being dispatched to a location where the individual is located until the time of arrival at that location.

Month	Average Response Time (in Minutes)
January 2014	53
February 2014	49
March 2014	48
April 2014	50
May 2014	49
June 2014	47

Mental Health Coalition Meetings

A gathering of all Supported Employment providers and a gathering of all Assertive Community Treatment providers are facilitated on an every other month basis by DBHDD staff. Community Support Team providers gather every other month as well. Case management and Intensive Case Management providers gather once a month. These meetings are vehicles for disseminating and

gathering information, maintaining open communication, promoting provider collaboration and fostering the partnership between the Department and provider agencies. This forum allows for discussion of programmatic operations and performance (including key performance indicators), informal presentations/in-service, discussion of Departmental policies and any other matters of relevance for these evidence-based practices. Coalition meetings have functioned as forums of discussion that have provided an impetus for policy adjustments, including, increasing units of group therapy per authorization, and increasing allowable number of monthly enrollment prior to requiring a waiver. Each service specific coalition meeting is held in Macon for ease of access, and there is a call in number for those unable to be present. Adult Mental Health staff, regional staff, providers and members of APS the external review organization participate in Coalition meetings. There were three ACT Coalition meetings held between January 2014 and June 2014. There were three SE Coalition meetings held between January 2014 and June 2014.

Behavioral Health Contracted External Review Organization (ERO)

APS Healthcare is the External Review Organization (ERO) for DBHDD behavioral health services. Many of the established functions and products provided by this vendor continue to contribute to the Department's management of the provider network. These elements include training, technical assistance, prior authorization for services, provider audits, and provider billing and service provision data.

Audits:
The ERO conducted 164 audits of community BH providers from January 2014 through June 2014; 17 of these included ACT/CM/ICM/CST records. Audit information has been crucial for the Department's continued implementation of *Policy 01-113, Noncompliance with Audit Performance, Staffing, and Accreditation Requirements for Community Behavioral Health Providers* for the management of providers which fail to achieve compliance with DBHDD audit score, staffing, and accreditation requirements. Audit results can be found at: www.apsero.com

Training:
The ERO has provided training opportunities to the network during the report period. In addition to the onsite technical assistance provided at each Audit Exit Interview, APS has also offered both broad and targeted information to the provider network:

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

- Continued offering of the Ambassador Program for new providers and providers' new staff members.

Service Utilization & Authorization:
During the report period, licensed clinicians at the ERO have manually reviewed 33,543 authorization requests for community services. Of those, 1,813 authorization reviews were specific to ACT services.

Administrative Services Organization (ASO)

A key goal of the Georgia Department of Behavioral Health and Developmental Disabilities is to improve access to high-quality and effective services for individuals with developmental disabilities (DD) and/or behavioral health (BH) conditions. To help achieve this goal, the Department is undergoing the procurement of an Administrative Services Organization (ASO).

This procurement combines several important functions which are currently provided in distinct contracts. The functions include:

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

Implementation and Results of Best Practice Guidelines:

Beck Initiative

The Beck Initiative is a collaborative clinical, educational and administrative partnership between the Aaron T. Beck Psychopathology Research Center of the University of Pennsylvania (UPENN) and DBHDD to implement recovery-oriented Cognitive Therapy (CT-R) training and consultation throughout the DBHDD network. Fusing the recovery movement's spirit and cognitive therapy's evidence base, CT-R is a collaborative treatment approach that prioritizes attainment of patient-directed goals, removal of obstacles to the goals, and engagement of withdrawn patients in their own psychiatric rehabilitation. Through intensive workshops and ongoing consultation, tangible tools to help remove roadblocks to recovery of people with severe mental illness are placed in the hands of care providers across the network. CT-R provides the fabric for promoting continuity of care with the goal of helping affected individuals achieve sustained integration in the community.

Broad Project Goals

- To promote hope, autonomy, and engagement in constructive activity, for individuals served by agencies in the DBHDD network;
- To establish CT-R as a standard practice of care for people served within DBHDD agencies;
- To promote the sustained implementation of CT-R into the DBHDD network;
- To improve the professional skills of therapists in the DBHDD system;

- To conduct program evaluation to examine outcomes such as client attrition, service use, recidivism, therapist turnover, and the sustainability of high-quality CT in DBHDD settings;
- To utilize the evidence-based practice of CT-R in the Department as roadmap for delivering recovery-oriented care; and
- To serve as a model for other large mental health systems.

Outcomes: Regions (6, 1 & 3)

- Number of people trained in Regions 6, 1, and 3: 201
- Total in consultation from Regions 6, 1, and 3: 121
- 85% of the outpatient trainees who have participated and been monitored for competency have achieved it. There have been significant changes in attitude on the part of the individual practitioners working with patients who have severe mental illness by the end of the consultation. The treatment has reached more than 500 individuals with severe mental illness. Many of these people are amongst the most severe (repeatedly going in the hospital; long time in the hospital; not engaging ACT team) adult patients.

FY: 15 - Project Plan

Providers in Regions 2 & 5 will receive this training September 2014 – August 2015. The CT-R Training Program will consist of workshops (Phase 1), 6-month consultation (Phase 2) and sustainability (Phase 3). The training sites and providers receiving the training will be the State Hospital (key providers), the community (e.g. assertive community treatment teams, community support teams and outpatient providers) and supervisors.

Suicide Prevention Program

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

- developing suicide safer communities in Georgia,
- developing a competent workforce of behavioral health providers to serve individuals with suicidal ideation or behaviors, and
- developing a support system for individuals, groups and families who are survivors of the suicide death of a friend or family member.

GSPIN, www.gspin.org , the online Suicide Prevention Information Network continues to operate its interactive website and information blast services garnering over 720,000 hits from January 2014 through June 2014 and sending monthly information blasts to individuals who have indicated they wish to receive them. Within GSPIN, the interactive community for the suicide prevention coalitions, Joining Hands Across Georgia has over 60 online members and a second online community, Campus CONNECT has begun with 25 members.

Locally, the Suicide Prevention Program works through a network of 15 active suicide prevention coalitions serving over twenty counties located in each of DBHDD's six regions. . These suicide prevention coalitions provide a foundation for providing community programming using DBHDD supported evidence-based suicide prevention practices and ongoing planning and development so the communities they serve can become "Suicide Safer Communities".

A key component in developing suicide safer communities is providing gatekeeper training to community members in a wide array of settings such as churches, businesses, and community meetings. Gatekeepers are trained to identify someone at high risk of suicide, to encourage the person to get help, and to refer to and access behavioral health and crisis services. The programs are called: *Question, Persuade, and Refer (QPR)* and *Mental Health First Aid (MHFA)* and are for both adults and youth. Both programs teach community members to recognize the signs of suicidal behavior and direct individuals to assistance. Between January 1, 2014 and June 30, 2014 the Suicide Prevention Program staff trained 220 Georgia school staff in QPR and its partners Mental Health America Georgia and the Georgia Mental Health Consumer Network held 27 trainings in Mental Health First Aid/Youth Mental Health First Aid in every DBHDD region of Georgia for 453 Georgia citizens.

To help expand the use of QPR in Georgia communities and to support its sustainability, the Suicide Prevention Program funded six QPR Train-the-Trainer workshops between January 1 and June 30, 2014. Train the Trainer workshops were held in Macon, Rome, Valdosta, Conyers, Lawrenceville, and Savannah and added 99 new certified trainers to the previous group of approximately 200 certified trainers throughout Georgia. Between January 1 and May 31 2014, two Youth Mental Health First Aid trainers were added to the existing 14 YMHFA trainers supported by DBHDD.

The Suicide Prevention Program, through its contractor, The Suicide Prevention Action Network of Georgia (SPAN-G), has revised the suicide prevention training segments in the Crisis Intervention Team (CIT) trainings coordinated by National Alliance on Mental Illness (NAMI) given to law enforcement and first responders throughout Georgia. In addition to identification of suicidal risk and supporting suicide survivors the program now contains information about supporting and managing suicide survivors at the scene of a death, and information on self-care. Between January and June 2014, 18 CIT trainings, reaching approximately 400 first responders were delivered using the new curriculum segment with very positive reviews. The program is planning to develop train-the-trainer modules for behavioral health providers and survivors of a suicide death so they can deliver the new curriculum modules throughout Georgia.

DBHDD also participates in the federal Garrett Lee Smith Youth Suicide Prevention (GLS) Program. In Georgia the program focuses on developing comprehensive suicide prevention programs within the schools. These programs include gatekeeper training for school staff and developing protocols and referrals for getting young people at risk of suicide to help. Year two brought eight targeted school systems on board. DBHDD received agreements to participate from these school systems: Atlanta Public Schools, Lowndes County Schools, Gwinnett County Schools, Dublin City Schools, Laurens County Schools, Treutlen County Schools, Calhoun City Schools and Floyd County Schools. Selected schools in these systems provided a comprehensive array of services from training all school personnel in QPR, to providing the evidence-based peer leadership program, Sources of Strength, to students to developing protocols for response, intervention and follow-up to suicidal ideation and behavior and training teams of school personnel to respond after a suicide or other traumatic death in the school community.

On May 19, 2014 the Suicide Prevention Program, through GLS, held the 5th Georgia College and University Suicide Prevention Conference. The theme of the conference, attended by teams from 41 colleges and universities across Georgia, was Building Suicide Safer Colleges and Universities. The almost 200 participants heard keynote presentations outlining the pillars of a suicide safer college or university and broke into groups for skill building workshops, giving teams a toolkit of prevention, intervention and postvention techniques to take home and integrate into their own work with suicide prevention on campuses. The work is being sustained by a newly inaugurated Campus Connection Community on the www.gspin.org website that developed a core group of 25 members is a little over a month. Campus team members have access to our evidence-based suicide prevention initiative trainings and conference attendees have already begun attending all of our programs in the EBP Initiative.

Suicide prevention information has also been distributed to Georgia's education leaders, human service providers, professional social workers, and emergency management professionals through workshop and keynote presentation at their spring 2014 conferences.

Continuing the work of developing suicide prevention and intervention competency in Georgia's behavioral health and allied providers the Suicide Prevention Program provided the following 18 trainings to 606 behavioral health and other allied professionals from all areas of the state:

- Assessing and Managing Suicide Risk, 1 training with 19 participants
- Introduction to AIM (Assessment, Intervention, and Monitoring) for Suicide Prevention webinar, 4 webinars with 78 participants
- Introduction to AIM (Assessment, Intervention, and Monitoring) for Suicide Prevention to regional meetings of the Georgia chapter of the National Association of Social Workers, 2 trainings with 53 participants
- Assessment, Intervention, and Monitoring (AIM) Skill Building for Crisis Providers, 2 trainings with 132 participants.
- Assessment, Intervention, and Monitoring (AIM) Skill Building for Behavioral Health Providers, 3 trainings with 75 participants
- LIFELINES: Intervention, 4 trainings with 142 participants
- Working with Those Bereaved by Suicide for Behavioral Health Providers, 2 trainings with 102 participants

Program staff continued to work with experts from the New York State Psychiatric Institute, Dr. Barbara Stanley from the Suicide Intervention Center and Dr. Kelly Posner as well as Dr. Gregory Brown from the University of Pennsylvania and Dr. Doreen Marshall with the American Foundation for Suicide Prevention to design and deliver our array of programming to bring suicide prevention competency to behavioral health and allied providers in Georgia.

Responding appropriately after a suicide or other traumatic death in a community can prevent further suicide deaths. The Suicide Prevention Program continues to provide a variety of resources and technical assistance for postvention activities.

Purple packets are educational and outreach materials that include materials from the Link Counseling Center, the American Association of Suicidology, identification of crisis service providers and crisis telephone numbers and Survivors of Suicide peer group meetings. Purple

packets are disseminated to survivors of suicide by first responders, mental health professionals, funeral directors, clergy and others who encounter survivors of suicide death. Between January and May 2014 7,450 purple packets were disseminated throughout the state to behavioral providers, first responders, law enforcement personnel and survivors of suicide.

Within DBHDD, suicide prevention staff provides on-site and telephone consultation to providers who have experienced the death of a consumer by suicide. Additionally the Suicide Prevention Coordinator participates in meetings of the EQC, the Community Behavioral Health Program Quality Council, and the Community Mortality Review Committee. Consultation to providers who had suicide deaths between January and June 2014 included introduction to the EBP Initiative and A.I.M program. Additionally there were two on-site visits with school systems experiencing a large number of deaths, including suicide deaths.

As well as providing the Working with the Bereaved training for behavioral health providers mentioned above, the Suicide Prevention Program also provides ongoing postvention suicide training to the schools in collaboration with the Society for the Prevention of Teen Suicide through its LIFELINES: Postvention training. Between January and May 2014, two LIFELINES: Postvention trainings were provided to teams of school personnel and community professionals who work with school staff after a suicide death of a young person. Between January 2014 – June 2014, these programs trained over 104 school and behavioral health personnel to respond effectively with care to suicide deaths in the schools. Additionally, the Suicide Prevention Program developed a six week program to be given to young people still suffering from the loss after a suicide or traumatic death after 3 months who do not need to be hospitalized. The program, Growing On After Loss (GOALs) is designed to be given in a middle or high school setting. Over fifty leaders (counselors, psychologists, and social workers) in the Atlanta Public Schools and Lowndes County Schools were trained to lead the GOALS program in February and March of 2014.

During this reporting period the work of supporting survivors of suicide loss in Georgia's communities continues. Through the contracted work of SPAN-GA, Georgia's Survivors of Suicide (SOS) peer support groups continue to be served through training and technical assistance. In February 2014 DBHDD supported 13 new SOS peer support group leaders to be trained at The Link from Savannah, Albany, Columbus, Lawrenceville, Kennesaw and Thompson. These peer leaders will join the group of leaders who support the 28 existing SOS groups and several groups planning to start soon. Another event that continued this reporting period was the third Survivors of Suicide (SOS) Camp. In March, 15 families (children, parents, grandparents, sisters and brothers) participated in this event. Lastly, in June of this year the Suicide Prevention Program held a refresher course for Starfish (which is a support group) family survivor group leaders. The group included community members from the NW Georgia group who had sponsored the Fall 2013 Starfish Group and leaders from two new communities/agencies who wish to start a group in their community or institution.

Office of Deaf Services

In April 2014, the Office of Deaf Services (DS) began the process of obtaining the information needed to ensure quality provision of behavioral health & developmental disabilities services to individuals with hearing loss.

Goals of Deaf Services include:

- gathering information and developing a baseline array of statewide community based behavioral health services for deaf individuals
- promoting best practices in behavioral health American Sign Language (ASL) interpreting

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

To promote best practices in ASL interpreting services for individuals with behavioral health conditions, DS has created a credential for those individuals who provide interpreter services to deaf individuals with BH issues in the state of Georgia. Beginning in August of 2014, specialty practicum training will be initiated for those who have already earned the generalist certification as an ASL interpreter (as awarded by the Registry of Interpreters for the Deaf, Inc.). Those successfully completing an intensive three-pronged process (including the practicum) will earn the credential of Georgia Behavioral Health Interpreter (GaBHI). As the credentialed workforce grows, the DBHDD will first prioritize and then require the use of GaBHIs for direct behavioral health services.

Over the next few months, DS will establish a work plan to guide the quality management activities within its area of responsibility. This work plan will encompass a statewide review of said services and will be based on an interdepartmental effort and guided by stakeholder and provider input.

Division of Developmental Disabilities

DD Reviews of Individuals Served

The purpose of the Person Centered Review (PCR) is to assess the effectiveness of and the satisfaction individuals have with the service delivery system. The Division of DD external quality review organization (Delmarva) uses interviews, observations and record reviews to compile a well-rounded picture of the individual's circle of supports and how involved the person is in the decisions and plans laid out for that person. Data from Division of DD's external review organization, Delmarva, is reported on a quarterly basis. Due to established data reporting timelines, some data reported here may overlap from calendar year 2013. Data at the time of this report includes data from July 1, 2013 through March 31, 2014. Later data will be reported in the 2014 Annual Report.

General Demographic Characteristics

Information in Table 1 provides a general description of the 534 individuals interviewed through a Person Centered Review (PCR, N =409) or Quality Enhancement Provider Review (QEPR, N=125) between July 2013 and March 2014. Demographic information is also presented for the 49 Individuals Recently Transitioned to the Community (IRTC) as part of the Olmstead settlement agreement. The largest proportion of individuals interviewed to date resides in Region 3 (36.9%). Males continue to represent a larger proportion of the sample, and this difference is greater in the IRTC population. The IRTC group is generally older and more likely to have more profound ID than individuals who did not transition from a state hospital.

Table 1: Demographic Characteristics

July 2013 - March 2014

Region	PCR and QEPR		IRTC	
1	78	14.6%	5	10.2%
2	73	13.7%	14	28.6%
3	197	36.9%	12	24.5%
4	65	12.2%	8	16.3%
5	54	10.1%	6	12.2%
6	67	12.5%	4	8.2%
Gender				
Female	213	39.9%	16	32.7%
Male	321	60.1%	33	67.3%
Age Group				
18-25	73	13.7%	6	12.2%
26-44	249	46.6%	8	16.3%
45-54	114	21.3%	12	24.5%
55-64	70	13.1%	15	30.6%
65+	28	5.2%	8	16.3%
Disability				
Autism	13	2.4%	0	0.0%
Cerebral Palsy	3	0.6%	0	0.0%
Intellectual Disability	461	86.3%	19	38.8%
Profound Intellectual Disability	57	10.7%	30	61.2%
Total	534		49	

There are several different types of residences available for individuals who receive services through the waivers. These are grouped into four categories and the percent of individuals living in each type of residence is displayed in Figure 1. The largest proportion of individuals (39.3%) lived with a parent or in a group home (39.1%). The majority of the IRTC group (43 out of the 49) lived in a Group Home, with six individuals living in host homes.

Figure 1: Percent of Indivdiuals by Residential Type
July 2013 - March 2014

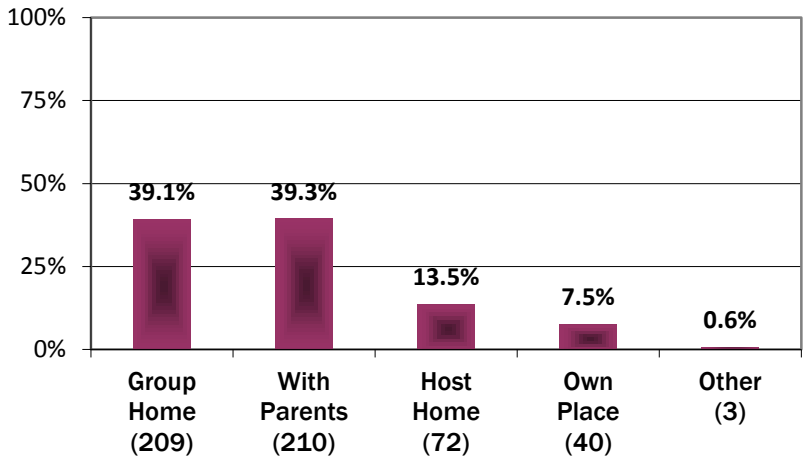
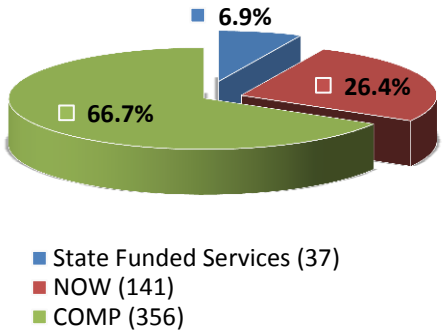


Figure 2 shows the distribution of individuals by waiver through the third quarter of the contract year. Most individuals receive either the Comprehensive Support Waiver (COMP, 66.7%) or the New Option Waiver (NOW, 26.4%). A small proportion of people interviewed received state funded services (GIA). The IRTC population receives services through the COMP waiver.

Figure 2: Percent of Individuals by Waiver Type
July 2013 – March 2014



DD PCR and QEPR Combined Results

The purpose of the PCR is to assess the effectiveness of and satisfaction individuals have with the service delivery system. Delmarva Quality Improvement Consultants (QIC) use interviews, observations and record reviews to compile a well-rounded picture of the individual's circle of supports and how involved the person is in the decisions and plans laid out for that person. The purpose of the QEPR is to monitor providers to ensure they meet requirements set forth by the Medicaid waiver and Division of DD and to evaluate the effectiveness of their service delivery system. In this section results from the combined data from several tools including the Individual Interview Instrument (III), Individual Service Plan Quality Assurance Checklist (ISP QA), Provider Record Review (PRR), Staff Interviews, and Observations are presented. The number of activities for each component, by region and statewide, is presented in the following

table. Throughout this section results from previous years are presented when appropriate.[1] However, it is important to remember these are Year to Date results for Year 6 and may change as information from the total sample of 480 PCRs and 40 QEPRs is collected.

Table 2: All review activities (PCR +QEPR) by Region
July 2013 – March 2014

Region	III & ISP QA Checklist	SCRR	PRR	Staff Interview	Observation	Admin Review
1	78	61	129	110	87	2
2	73	53	137	116	103	4
3	197	148	310	275	260	10
4	65	55	107	101	75	3
5	54	44	91	85	73	4
6	67	48	102	93	72	5
Total	534	409	876	780	670	28

Individual Interview Instrument (III)

Two different interview tools are used to collect information from individuals: the NCI Consumer Survey and the Individual Interview Instrument (III or I3). The focus of the NCI survey is on the system—the unit of analysis is the service delivery system. The focus of the III is the individual, if desired goals and outcomes are being addressed through the service delivery system, including both paid and unpaid supports and services. Together they help provide a clear picture of service delivery systems and provider performance.[1] The person's participation in this process is voluntary and the Quality Improvement Consultant confirms whether he/she would like to participate before beginning the interview.

The Individual Interview Instrument is comprised of 15 elements designed to evaluate individuals' services and well-being through nine different Expectations—each scored as Present or Not Present. Quality Improvement Consultants use the III tool as a guide to determine if the expectations are being met for the person interviewed. These are summarized below, with the number of elements included in each Expectation given in parentheses.[2]

Involvement in Planning (2): Is the person involved in the development of his/her annual plan and identification of supports and services? Does the person direct the design of the service plan, identifying needed skills and strategies to accomplish desired goals?

Involvement in Development and Evaluation (1): Is the person involved in the development and ongoing evaluation of supports and services? Does the person participate in the routine review of the service plan and direct changes as desired to assure outcomes are achieved?

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

Meeting Goals and Needs (2): Is a personal outcome approach used to design person-centered supports and services and assist the person to achieve personal goals? Is the person achieving desired outcomes and goals, or receiving supports that demonstrate progress toward these outcomes and goals?

Choice (2): Is the person afforded choices related to supports and services (paid and unpaid) and is the person involved in life decisions relating to the level of satisfaction? Does the person actively participate in decisions concerning his or her life? Is the person satisfied with the supports and services received?

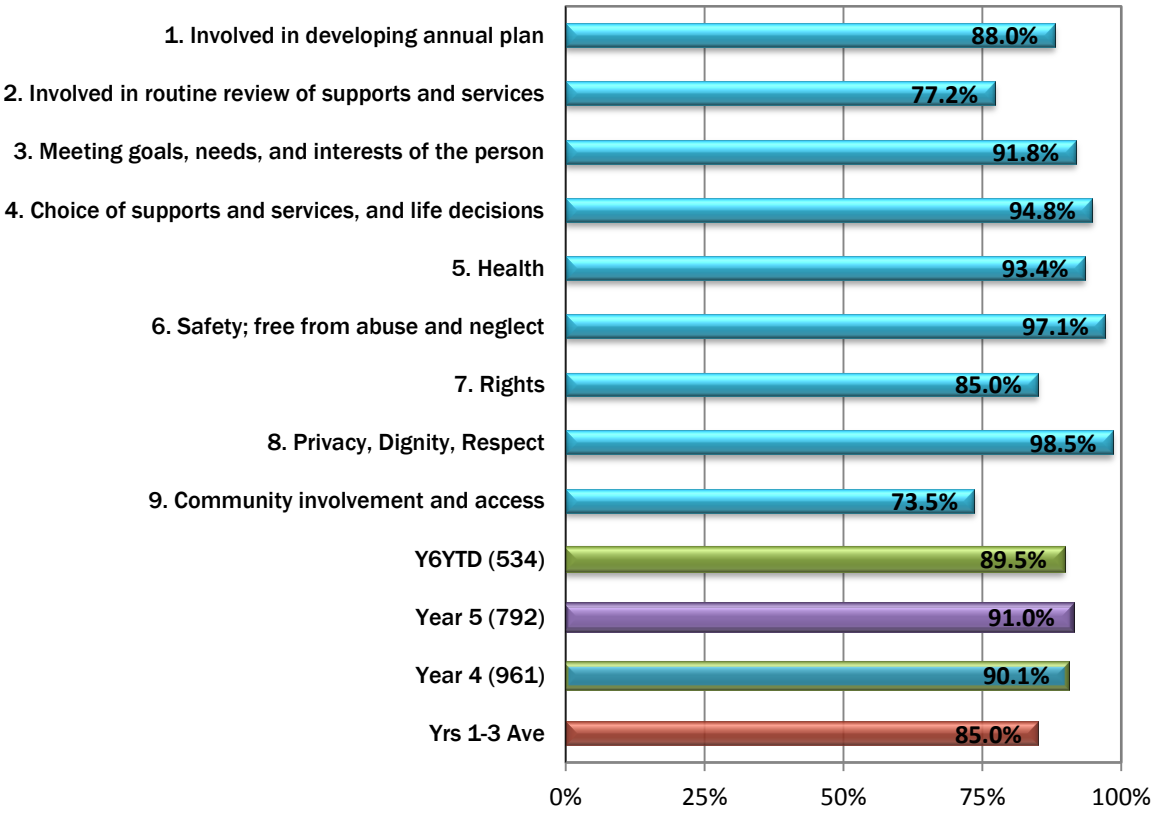
Health (1): Does the person feel healthy and does the person get to see a doctor when needed? Are there things about the person's health that could be better?

1. **Safety** (2): Consultant identifies the person's knowledge of self preservation, what is done in case of an emergency. Included in this expectation is if the person is free from abuse, neglect and exploitation.
2. **Rights** (1): Is the person educated and assisted by supports and services to learn about rights and fully exercise them, particularly rights that are important to that person?
3. **Privacy/Dignity/Respect** (2): Is the person treated with dignity and respect and are the person's privacy preferences upheld?
4. **Community Involvement and Access (Community)** (2): Is the person provided with opportunities to receive services in the most integrated settings that are appropriate to the needs and according to the choices of that person? Is the person also developing desired social roles?

Results for the III are presented by Expectation in Figure 3 and results by indicator and year are presented in Exhibit 5 of the Appendix. For the 534 interviews completed up through the third quarter of the year (July 2013 – March 2014), the following findings are indicated:

- The statewide average of 89.5 percent is similar to Year 5.
- Individual involvement in the review of supports and services and community involvement were least likely to be present.
- Development of social roles (Exhibit 5) has decreased since Year 5.
- Five outcomes were 90 percent present or higher: meeting goals and needs, choice, health, safety, and privacy/dignity/respect.
- Five outcomes were 90 percent present or higher: meeting goals and needs, choice, health, safety, and privacy/dignity/respect.

Figure 3: Individual Interview Instrument (III)
Percent Present by Expectation
July 2013 – March 2014



The number of cases within regions, residential settings, age groups, and services is presented in the next three figures (Figures 4 – 7). Some categories are relatively small, with fewer than 40 individuals. Results vary across regions from 82.9 percent in Region 2 to 98.4 percent in Region 4. Findings vary somewhat across residence and age group and are fairly consistent across the different services.

Figure 4: Individual Interview Instrument (III)
Percent Present by Region
July 2013 – March 2014

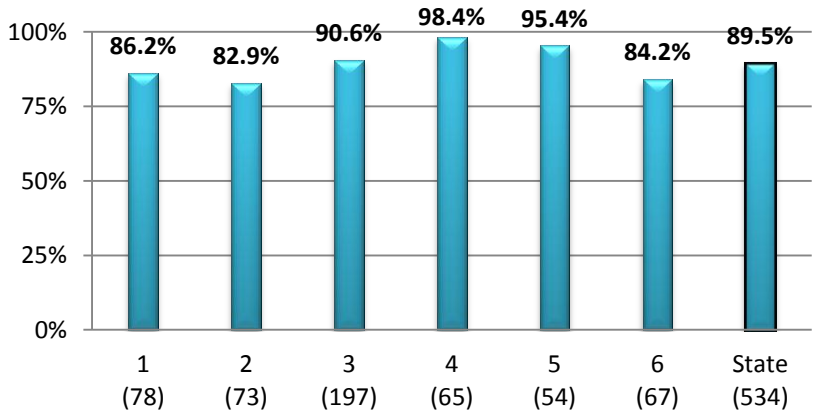


Figure 5: Individual Interview Instrument (III)
Percent Present by Residential Setting
July 2013 – March 2014

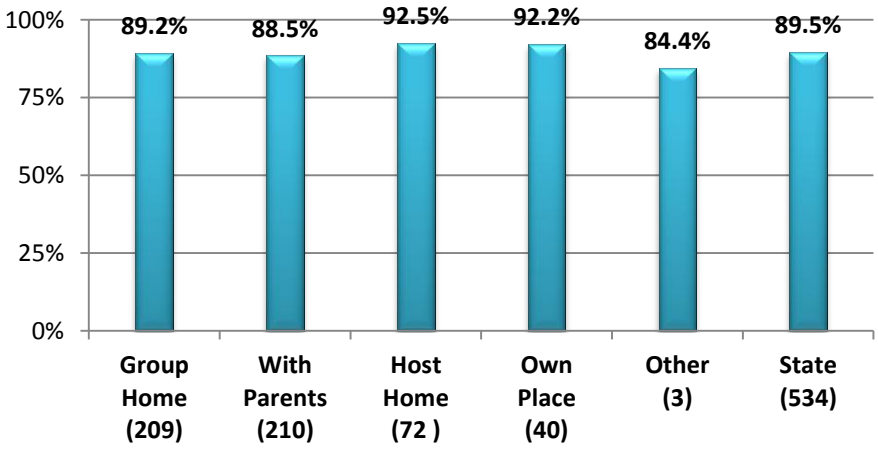


Figure 6: Individual Interview Instrument (III)
Percent Present by Age Groups
July 2013 – March 2014

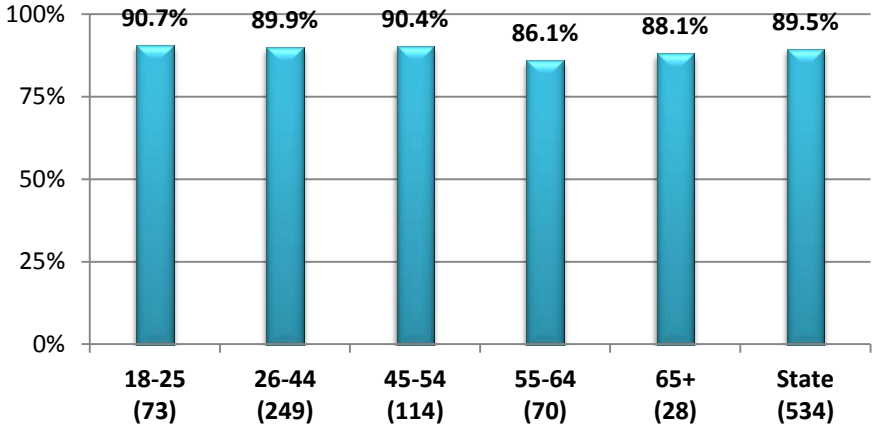
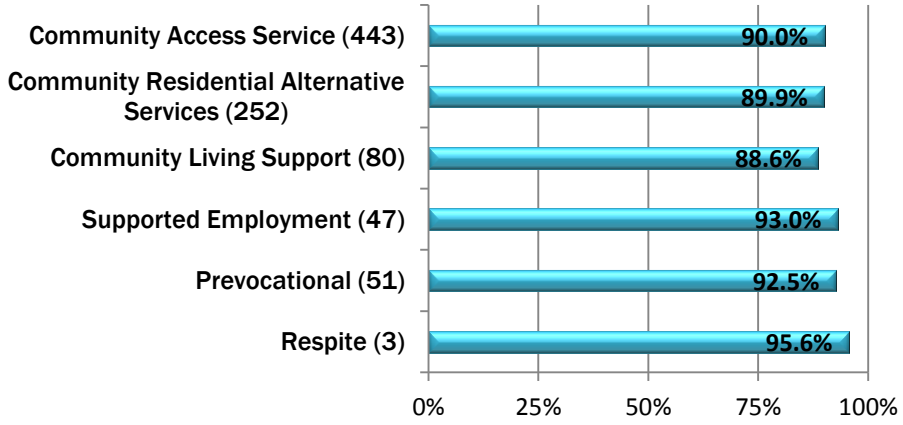


Figure 7: Individual Interview Instrument (III)
Percent Present by Service
July 2013 – March 2014



DD Individual Support Plan Quality Assurance (ISP QA) Checklist

Each individual's team of supports should meet annually to develop an ISP that supports the individual's needs and desired goals. The ISP QA Checklist was initially developed by the state, and revised in Year 4, to ensure the ISP includes all necessary requirements as dictated by the state, and that it helps ensure the individual has a healthy, safe, and meaningful life. Delmarva Quality Improvement Consultants use the ISP QA Checklist form to evaluate the various sections of the ISP, rating them on the degree to which they address all requirements.[3]

Delmarva QICs determine an overall rating for each individual reviewed, based upon the degree to which the ISP is written to provide a meaningful life for the individual receiving services.[4] There are three different categories for each ISP.

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

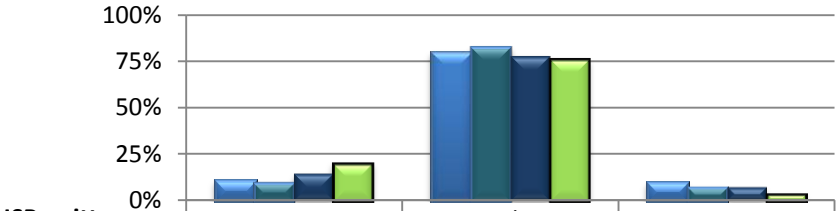
Good But Paid Life: The ISP supports a life with connections to various supports and services (paid and non-paid). Expressed goals that are "important to" the person are present, indicating the person is obtaining goals and desires beyond basic health and safety needs. The person may go out into the community but with only limited integration into community activities. For example, the person may go to church or participate in Special Olympics. However, real community connections are lacking, such as singing in the church choir or being part of an organized team, and the person indicates he or she wants to achieve more.
Community Life: The ISP supports a life with the desired level of integration in the community and in various settings preferred by the person. The person has friends and support beyond

providers and family members. The person has developed social roles that are meaningful to that person, such as belonging to a Red Hat club or a book club or having employment in a competitive rather than segregated environment. Rather than just going to church the person may be an usher at the church or sing in the choir. Relationships developed in the community are reciprocal. The ISP is written with goals that help support people in moving toward a

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

The distribution of the ISP rating for results to date this year is presented in Figure 8, with findings from Year 1 through Year 5 provided for comparative purposes. To date, a trend appears to indicate an increase in the proportion of ISPs written to support a Service Life and a concurrent decrease in the other two categories. The percent of ISPs supporting a Service Life for the 534 ISPs reviewed to date this year is considerably higher than in any other contract year (20.2%).

Figure 8: ISP QA Checklist Results
July 2013 – March 2014



ISP written to support	Service Life	Good But Paid Life	Community Life
Yrs 1-3 Ave	10.5%	79.9%	9.6%
Year 4 (961)	9.8%	82.7%	7.5%
Year 5 (792)	14.6%	77.9%	7.4%
Y6YTD (534)	20.2%	75.8%	3.9%

Information in Figure 9 shows the ISP QA Checklist results by region. Results by residential setting and age groups are presented in Figures 10 and 11. ISP QA results show considerable variation across the regions to date this year, but this may be due to relatively small N sizes. It appears that after transitioning from school, as individuals age support plans are more likely to support a Service Life. Individuals in group homes are also more likely to have plans that support a Service Life.

Figure 9: ISP QA Checklist Results by Region
July 2013 – March 2014

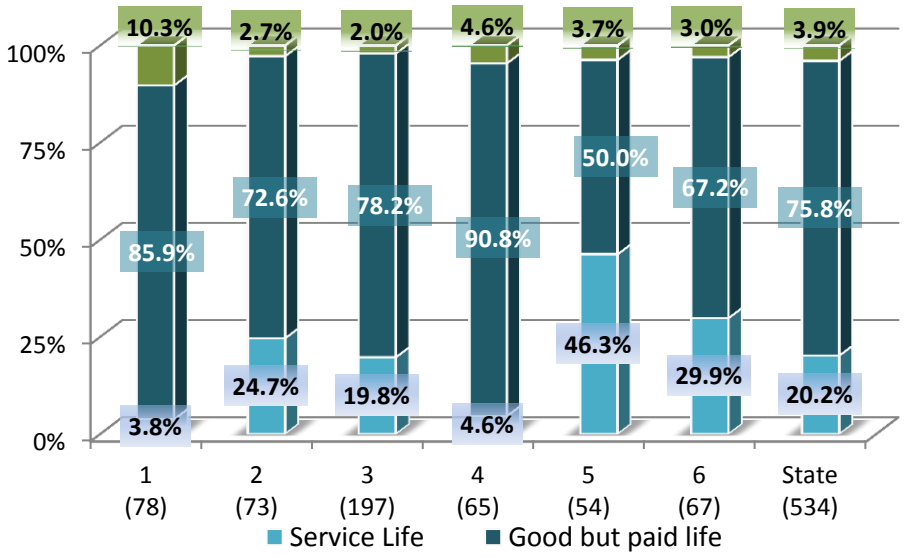


Figure 10: ISP QA Checklist Results by Residential Setting
July 2013 – March 2014

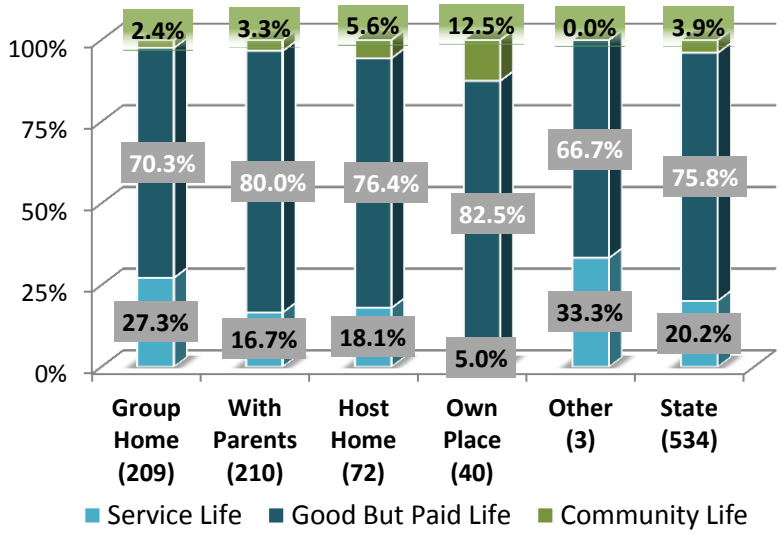
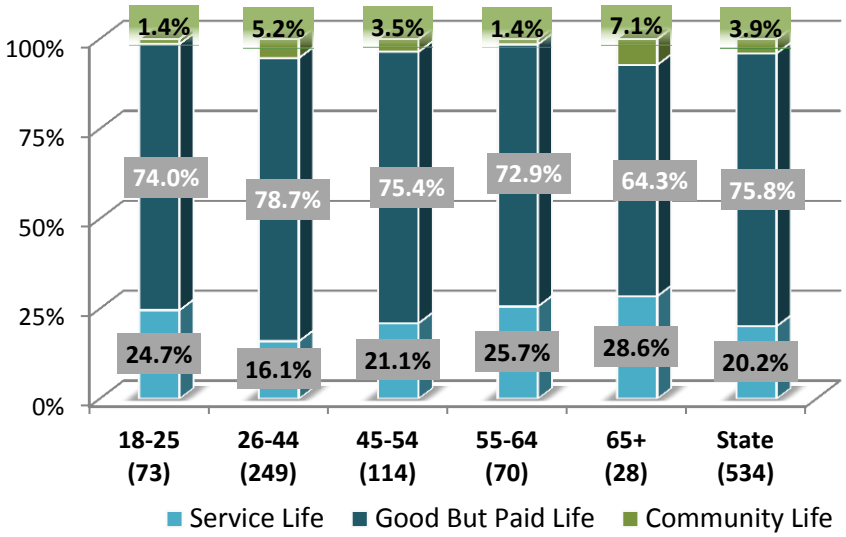


Figure 11: ISP QA Checklist Results by Age Groups
July 2013 – March 2014



The ISP QA Checklist is also used to monitor several other aspects of the support plan. This section of the Checklist has changed somewhat since Year 3 and comparisons to the first years of the contract may not be appropriate. Each criteria scored is presented in Table 3. Preliminary results indicate:

- 100 percent of ISPs had at least one goal per service and a budget present and almost all had at least three goals and a signed signature page
- Many ISPs did not have the annual informed consent for psychotropic medications present in the record, when applicable, (29.6% present, 297 applicable)
- HRSTs were often not appropriately updated (42.5% updated)
- For the 106 ISPs requiring a Behavior Support Plan/Crisis Plan/Safety Plan, most were not signed (26.4% signed)
- In many cases, required assessments were not completed (63.9% met)
- Over 35 percent of ISPs reviewed did not have all person centered goals and 29.1 percent of ISPs did not have a goal that reflected the person's hopes and dreams

Table 3: ISP QA Checklist Additional Criterion
July 2013 – March 2014

Criteria	Percent Present	Number Reviewed
Provider information on demographic page matches POC.	89.4%	530
Budget is present.	100.0%	496
PA matches the service(s) and unit rates on the budget.	97.4%	459
ISP contains a minimum of three goals.	99.6%	531
ISP contains at least one goal/objective per DD service.	100.0%	531
All goals are person centered.	64.2%	531
At least one goal reflects the person's hopes and dreams.	70.9%	530
Signature page is signed by the individual.	99.2%	530
Annual informed consent for psychotropic medications is present.	29.6%	297
Behavior Support Plan/Crisis Plan and/Safety Plan is signed.	26.4%	106

Table 3: ISP QA Checklist Additional Criterion July 2013 – March 2014		
Criteria	Percent Present	Number Reviewed
Signature page of the ISP is in place, identifying that rights have been reviewed with the person.	97.5%	529
All required and applicable assessments are completed: Nursing assessment, Psychosocial review, and Physician summary.	63.9%	277
HRST is updated annually and within 90-120 days prior to the individual service plan expiration date.[5]	42.5%	522
The Health and Safety section includes discussion on HRST training considerations.	88.4%	525
Authorized medical support section is completed, including plans in case of an emergency.	65.2%	529

Delmarva Consultants check 12 different sections on the ISP with the Checklist, rating each on a scale from zero (0) to four (4), zero meaning the section is blank or the section inadequately addresses the requirements and four meaning 100 percent of the "bullets" or requirements in the section are adequately addressed in the ISP. Each section represents an Expectation and has four (4) bullets (ratings are 0, 25%, 50%, 75%, or 100% (0-4)).

Beginning July 2011, a revised ISP QA Checklist was implemented. Because many of the requirements measured for each of the Expectations have changed, comparisons to Years 1 – 3 are not advised. The Expectations are briefly described as follows:[6]

1. **Relationship map and discussion on ways to develop relationships**: The relationship map is a map with four quadrants to identify people, paid and non-paid supports, friends or family members, who are important to the person. In this section QICs check to determine if the ISP has names of people, paid and unpaid supports and if there is documentation on how to build relationships with non-paid supports.
2. **Communication Chart**: The communication chart should identify how the person communicates, which may be with signs, gestures or phrases and what is happening in the environment to cause the reaction/communication. Does the chart reflect the person's communication style, including what others think different gestures or phrases may mean? Does it include how others should respond?
3. **Person Centered Important To/For**: Does the ISP reflect the person's interests, capacities, achievements, and visions that are important both to that person and also for the person? Does it identify ways to further develop the person's capacities and networks and does it include health and safety risks as well as what others say is important for the person?
4. **Dreams and Visions**: This section of the ISP identifies the dream or vision the individual has related to where he/she lives, daily activities, friendships, and community life.

5. **Service Summary**: Does the service section summary include a brief overview of the person's living situation and all services received? Does it provide an overview of changes in needs, health, services, continued concerns, review of the person's accomplishments, and barriers/opportunities to achieving hopes and dreams?
6. **Rights Restriction/Psychotropic Medications/Behavior Support Sections**: If indicated, are any concerns described regarding rights restrictions, medications, challenges, informed consent, or a need for a positive behavior support plan, crisis plan or safety plan?
7. **Meeting Minutes**: The ISP team should meet annually to update and modify the ISP. Meeting minutes should reflect community presence, choices of supports and services, health and safety, and goals and outcomes desired by the person.
8. **Support Intensity Scale (SIS) completed and support needs are addressed in the ISP**: SIS information should be noted throughout the entire ISP. Has the team reviewed the SIS data? Is there at least one sentence for each domain? Do the Exceptional Medical and Behavioral domains summarize the needs? Does the SIS support section identify needs that will be developed into Action Plans?
9. **Health and Safety Review Section completed accurately and thoroughly**: HRST information should be noted throughout the ISP. Is medication section complete? Are identified support needs included? Does the Help section list any needs for specialized personal items and if so who is responsible for the need? Does the Behavior section address whether a Positive Behavior Support Plan (PBSP) is needed or is in place.
10. **Goals are Person Centered**: Do new goals address and build on what is important to the person? Are the person's dreams and vision for home, family, and community involvement addressed? Do new goals address changes the person wants to make?
11. **Training Goal Action Plan**: Does the plan have the desired outcome of the person, discussion and rationale based on assessment information? Is the goal measureable and reflective of what is important to and for the person?
12. **Action Plans**: Are all objectives reflective of the Action Plan with a definition of how the person will know they are met? For each object are supports, frequency, and how progress will be documented/identified?

Information in Table 4 shows, for each of the 12 ISP expectations, the percent of ISPs that fall into each rating. For the 534 ISPs reviewed to date this year:

- On average, approximately 50.1 percent of ISP expectations were rated as 4, meaning all of the four requirements listed were present, and close to 80 percent with at least three present.
- Support Coordinators appeared to do well with rights, psychotropic medications and behavioral supports and completing all components of the health and safety review section, 89.3 percent and 78.5 percent respectively of ISPs with four requirements present in this area.
- Over 25 percent of ISPs reviewed to date had none or one of the standards present for person centered goals.
- Close to 17 percent of ISPs reviewed to date had none or one standard present in the Dreams and Vision section, which is the section of the ISP where most goals are generated for the Goals and Action Plan section.

- In six (6) of the 12 expectations, approximately 50 percent or more of the ISPs had all four criteria present.

Table 4: ISP QA Checklist Ratings by Expectation July 2013 – March 2014 (N=534)					
	Ratings				
ISP QA checklist description	0	1	2	3	4
Relationship Map (how to develop relationships)	1.7%	6.9%	17.8%	36.7%	36.9%
Communication Chart	1.5%	0.9%	6.9%	40.8%	49.8%
Person-centered Important to/For	0.6%	0.7%	10.3%	26.4%	62.0%
Dreams and Visions	8.2%	8.6%	10.5%	19.1%	53.6%
Service Summary	3.9%	8.6%	10.3%	28.3%	48.9%
Rights, Psychotropic Medications, Behavior Supports	0.9%	0.0%	1.1%	8.6%	89.3%
Meeting Minutes	4.3%	7.3%	17.8%	30.3%	40.3%
SIS completed; needs are addressed in the ISP	1.1%	0.4%	6.9%	37.6%	53.9%
Health and Safety Review Section completed	0.7%	0.0%	3.2%	17.6%	78.5%
Goals are Person Centered	10.1%	15.4%	19.3%	23.8%	31.5%
Training Goal Action Plan	1.1%	11.6%	10.7%	49.6%	27.0%
Action Plans	0.6%	11.4%	24.2%	34.1%	29.8%
Average	2.9%	6.0%	11.6%	29.4%	50.1%

Provider Record Review (PRR)

During the Provider Record Review, Delmarva QICs assess the provider's records on 16 different Expectations:

1. A Person Centered focus is supported in the documentation.
2. Human and civil rights are maintained.
3. The personal funds of the individual are managed by the individual and protected.
4. The provider clearly describes services, supports, care and treatment of the individual.
5. The provider maintains a central record for the individual.
6. The provider manages potential risk to the individual, staff and others.
7. The provider maintains a system for information management that protects individual information and that is secure, organized and confidential.
8. Providers with medication oversight or who administer medication follow Federal and State laws, rules, regulations, and best practice guidelines.
9. The individual is afforded choice of services and supports.
10. The provider has means to identify current health status, health/behavioral safety needs and is knowledgeable of individual's ability to self-preserve.
11. The provider has a means to evaluate the quality and satisfaction of services provided to the individual.
12. The provider meets NOW and COMP documentation requirements.
13. The individual is making progress and achieving desired goals.

14. The individual directs supports and services.
15. The individual chooses services and supports in the community.
16. Positive Behavior support plans are in place.

Figure 13 displays the percent present for each PRR Expectation for all providers working with the 534 individuals who participated in a PCR or QEPR between July 2013 and March 2014. A record review is completed for each service received by the individual. Therefore, a total of between 30 and 876 records were reviewed for each PRR Expectation to date this year. Results from the PPR (Figure 13) vary significantly across expectations, and are similar to previous years. Expectation 16, concerning positive behavior supports plans, was added to the review in February 2014. Findings from the records reviewed to date this year are similar to previous years and indicate:

- The average Provider Record Review score to date is approximately 63.2 percent.
- Three Expectations were met in over 90 percent of the records reviewed: most providers maintain a central record for individuals, meet NOW/COMP documentation requirements, and most have a means to evaluate the quality of and satisfaction with services.
- Most of the records reviewed did not document the provider's means to identify health status and safety needs (25.3% present); and most did not support a person centered focus (35.0% present).
- Approximately half of the records reviewed did not document how the person is afforded choice of services and supports, and fewer records documented how individuals are afforded choice of services and supports in the community (26.8% present).
- About one fourth of records reviewed indicated the individual directs supports and services received (26.5% present).

Figure 13: Provider Record Review (PRR)
Percent Present by Expectation
July 2013 – March 2014

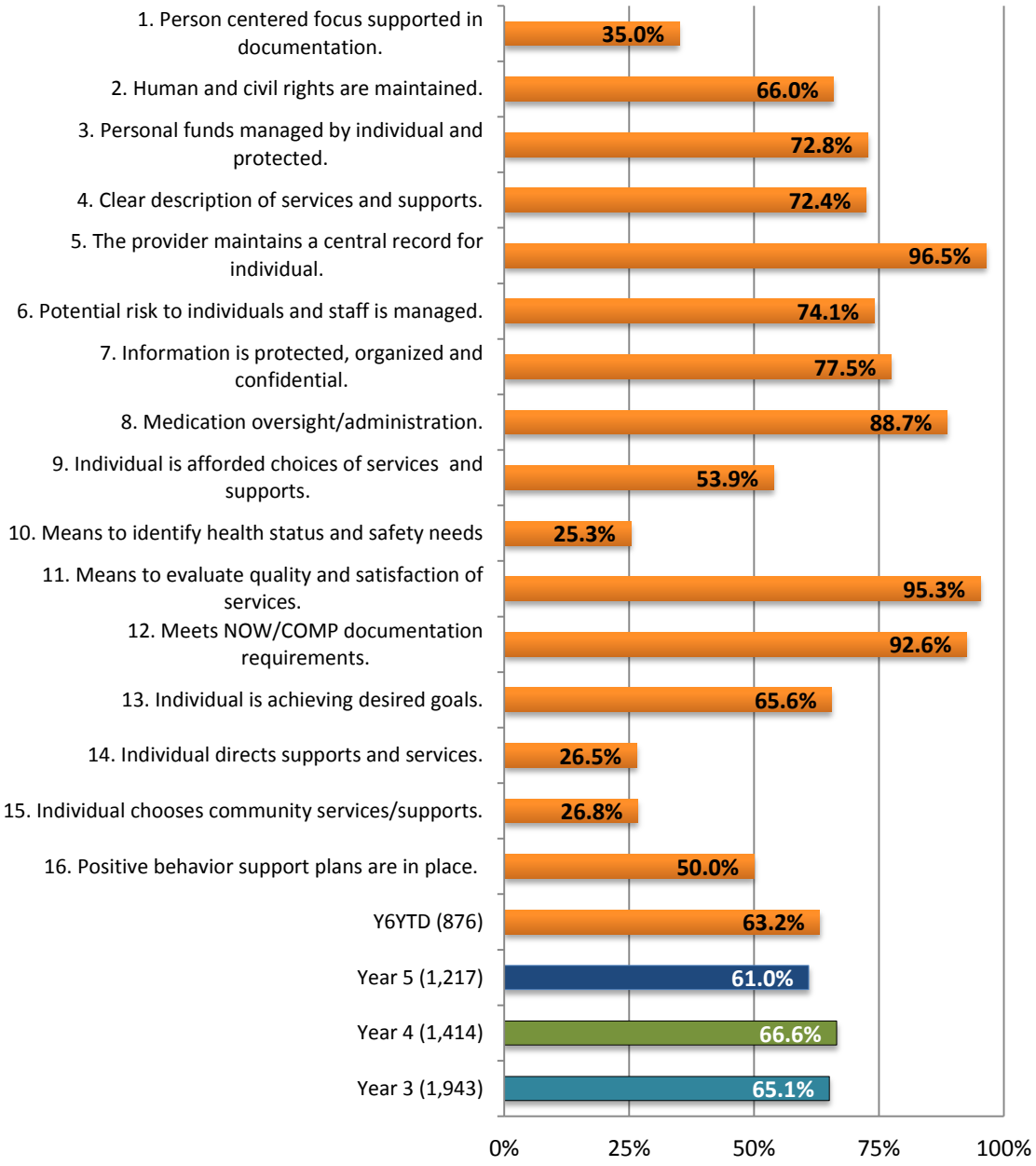
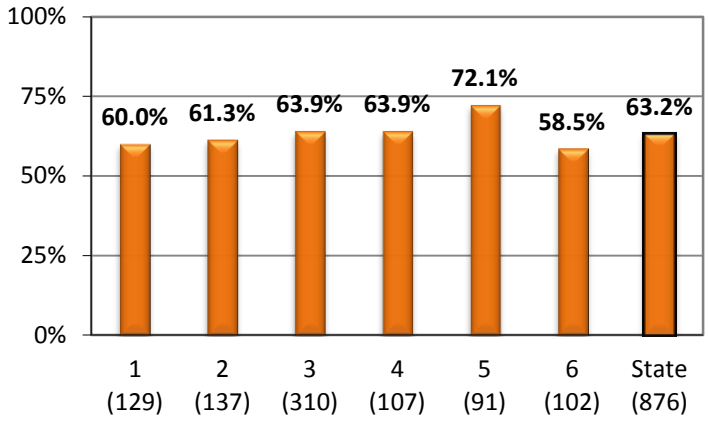


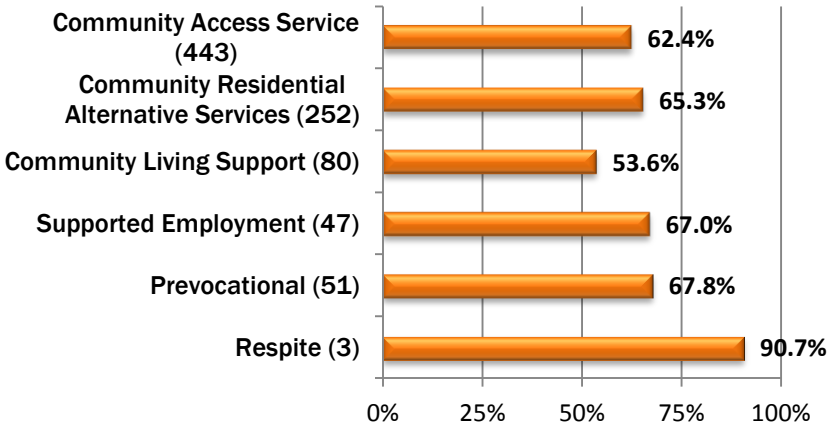
Figure 14 provides results for the Provider Record Reviews by region. The numbers in parentheses represent the total number of record reviews completed in each region. The number of elements scored in each region ranged from 1,248 (Region 5) to 4,303 (Region 3).

Figure 14: Provider Record Review (PRR)
Percent Present by Region
July 2013 – March 2014



Provider Record Review results are presented in Figure 15 for each service individuals were receiving at the time of the interview. The number of records reviewed is provided in parentheses. The percent present is based on the total number of expectations reviewed. For example, 615 expectations were scored for the 47 records reviewed for Supported Employment. Results to date this contract year show some variation across the different services for provider documentation in individuals' records, with Community Living Support provider records showing a somewhat lower compliance than other service records.

Figure 15: Provider Record Review (PRR)
Percent Present by Service
July 2013 – March 2014



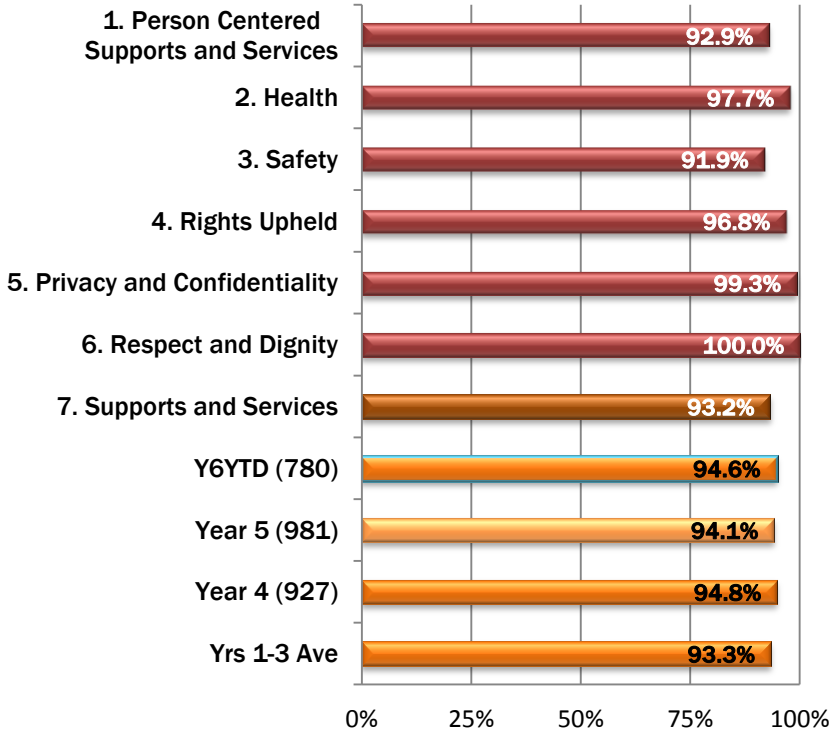
DD Staff/Provider Interviews

Staff and/or provider interviews are conducted with all providers and/or staff who provide a specific service for the individual participating in the PCR and for all services offered by the provider receiving a QEPR. A total of 780 interviews were completed through the third quarter of the year. Delmarva Consultants score the provider/staff on 23 indicators that measure seven different Expectations:[7]

1. Implementation of Person Centered/Directed Supports and Services (7 indicators)
2. Health (2 indicators)
3. Safety (3 indicators)
4. Rights Upheld (3 indicators)
5. Privacy and Confidentiality (2 indicators)
6. Respect and Dignity (1 indicator)
7. Implementation of the Plan's Identified Supports and Services (5 indicators)

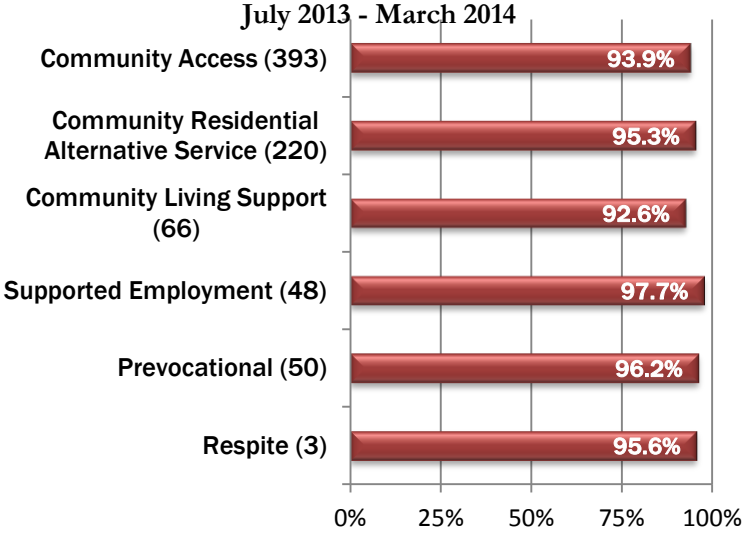
The percent present on each of the SPI Expectations is presented in Figure 16 and by service in Figure 17. The number of staff interviews for each service is provided in parentheses.

Figure 16: Staff/Provider Interview
Percent Present by Expectation (N=780)
July 2013 - March 2014



[7] See the Delmarva GQMS website to review the tool used during the staff interview and a description of each indicator used to measure the expectations. (http://www.dfmc-georgia.org/person_centered_reviews/index.html)

Figure 17: Staff/Provider Interview
Percent Presnet by Service
July 2013 - March 2014



Observations

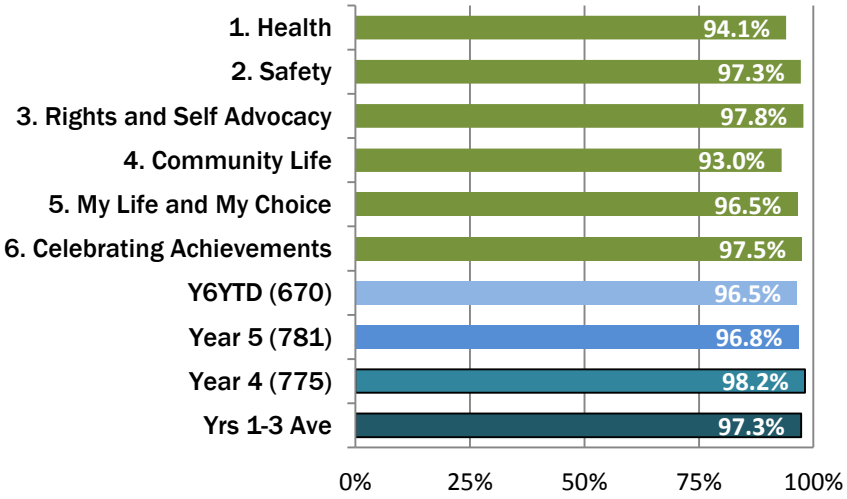
Onsite observations are completed for all individuals participating in the PCR who go to a day program or live in a paid residential setting such as a Personal Care Home or Host Home. During the QEPR, up to 20 residential and all day activity sites are visited per provider. Observations completed during the PCR are incorporated into the QEPR process and different sites are visited. Therefore, if the provider has 20 residential programs, four may be observed during the PCR process for individuals receiving services from the provider. An additional 16 will be observed during the QEPR process, for up to a total of 20 per provider.

Observations are made to determine how supports are being rendered to the person and how the person responds to those supports and services. Health and safety issues, including suspected or observed abuse, are included as part of this observation guide. Through the third quarter of Year 6, 670 Observations were completed. The Observation Guide, available on the Delmarva website (http://www.dfmc-georgia.org/person_centered_reviews/index.html), is used to assess the following Expectations for the individual in the facility.

1. **Health**: Observe the individual's physical well being, medication needs/effects, air quality and if any signs of illness are apparent.
2. **Safety**: Are there any safety issues, signs of abuse or neglect, and is the environment safe?
3. **Rights and Self-Advocacy**: Look for rights restrictions, access to personal possessions, any privacy issues.
4. **Community Life**: Individual decides where to go and when, helps make choices, and staff support helping individual develop different social roles.
5. **My Life, My Choice**: Individual has information to make informed choices, chooses own routine, and is able to expand opportunities as desired.
6. **Person Centered Practices**: Staff supports person by using a person centered approach and the person is acknowledged for accomplishments of self-described goals.

The following graph shows the Percent Present for the Observation Checklist by Expectation (Figure 18). A total of 670 Observation Checklists were completed but not every expectation is scored for each one. Results indicate providers perform very well on this portion of the reviews, with very little variation across expectations. Results by service are not displayed and reflect a compliance score of approximately 93 percent or higher for each service.

Figure 18: Onsite Observations (OBS)
Percent Present by Expectation
July 2013 – March 2014



DD Comparison by Focused Outcome Areas

Almost every indicator within the different components of the PCR and QEPR targets one of six quality improvement Focused Outcome Areas important to the success of any service delivery system:

- Health
- Safety
- Choices
- Community Life
- Person Centered Practices
- Rights

Each element from the various components has been categorized within one of the Focused Outcome Areas (FOA). The Percent Present for each FOA is presented in Table 4, for the 534 individuals who participated in a PCR or QEPR between July 2013 and March 2014. Results to date are preliminary but appear to be consistent with previous findings, indicating some variations across the different components:

- Providers and Support Coordinators continue to score relatively low in documenting Person Centered Practices, Choice, and particularly issues surrounding Community integration.
- Providers did not document health very well (PRR), with only 43.6 percent compliance.
- Provider documentation of Community integration was very low, 26.8 percent.
- Approximately 73 percent of individuals indicated (III) they are connected to the Community as they desire, the lowest score from the individual's perspective. However, provider and support coordination documentation was poor in this area.

Table 5. Comparison Across Focused Outcome Area
July 2013 – March 2014

Focused Outcome	III	SCRR	PRR	SPI	OBS
	N=534	N=409	N=876	N=780	N=670
Person Centered Practices	87.8%	52.3%	55.6%	95.2%	97.5%
Choices	93.6%	47.0%	53.9%	98.4%	96.5%
Health	93.4%	80.5%	43.6%	97.7%	94.1%
Safety	97.1%	80.5%	74.1%	91.9%	97.3%
Rights	94.0%	74.7%	77.7%	98.0%	97.8%
Community	73.5%	30.1%	26.8%	79.4%	93.0%

DD Person Centered Review Results

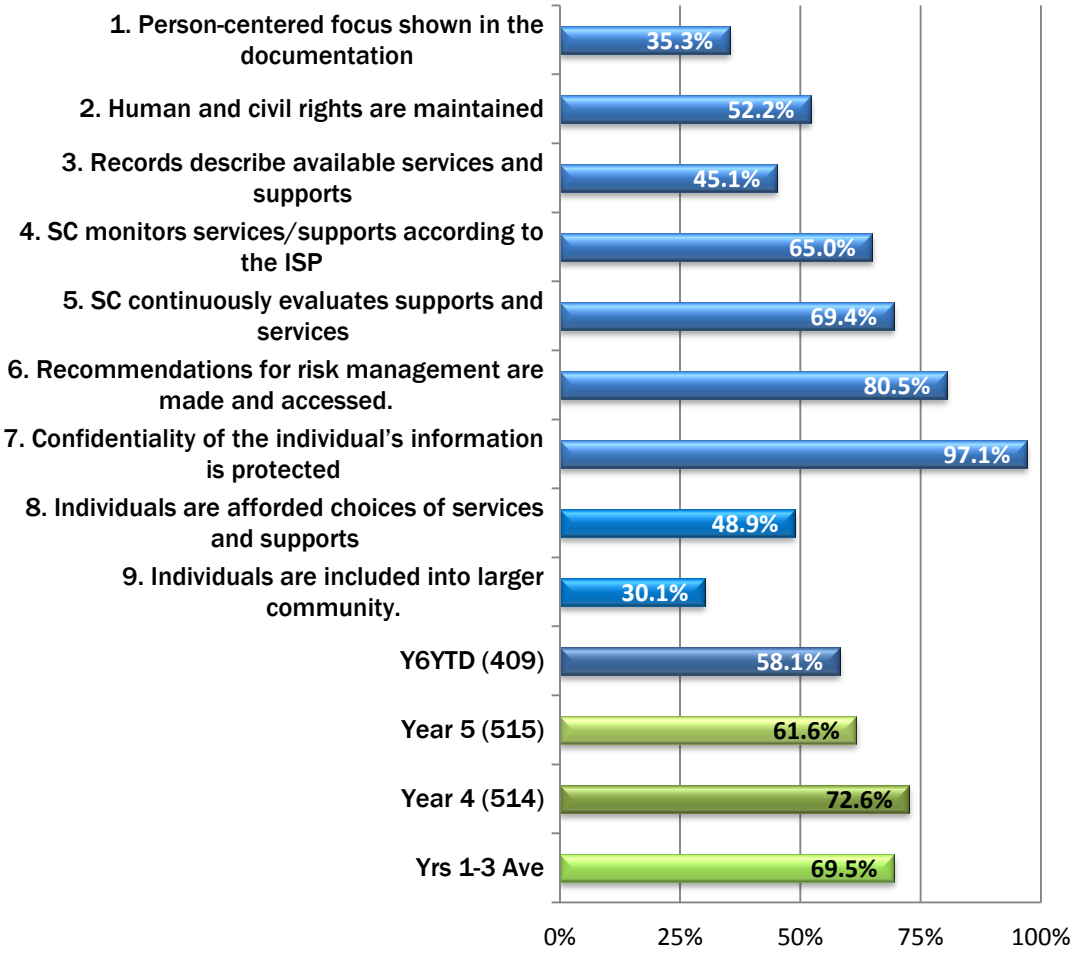
Support Coordinator Record Review (SCRR)
Each individual who is eligible for services through one of the waivers selects a support coordinator to act as an advocate and help identify, coordinate, and review the delivery of appropriate services, based on specific goals, needs and requirements of the individual. During each PCR, the QICs review the individual's record maintained by the individual's support coordinator. Information from the record is used to score the support coordinator on nine different Expectations (scored as Present or Not Present):[8]

1. A person centered focus is supported in the documentation.
2. Human and civil rights are maintained.
3. Documentation describes available services, supports, care, and treatment of the individual.
4. Support coordinator monitors services and supports according to the ISP.
5. Support coordinator continuously evaluates supports and services.
6. The support coordinator has an effective approach for assessing and making recommendations to the provider for improving supports and services related to risk management.

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

7. The support coordinator maintains a system of information management that protects the confidentiality of the individual's information.
8. Individuals are afforded choices of services and supports.
9. Individuals are included in the larger community.

Figure 19: Support Coordinator Record Review Results (SCRR)
Percent Present by Expectation
July 2013 – March 2014



Information in Figure 19 reflects Support Coordinator Record Review results for the 409 PCRs completed year to date in Year 6. Data reflect a wide variety of results by Expectation, from a low of 30.1 percent (inclusion in the community) to a high of 97.1 percent (confidentiality of personal information). The pattern is similar to previous years, with lower compliance showing a person centered focus in the documentation and for community inclusion. The average to date of 58.1 percent is lower in than previous years and reflects a continued decrease over the past several years.

SCRR results are shown by region, residential setting, and age group in Figures 20 – 22. Findings to date indicate some variation across these demographics, although the sample size within some groups is relatively small:

- Regional SCRR compliance ranges from 37.7 percent in Region 2 to 77.7 percent in Region 5
- Result for support coordinators supporting individuals who live in a Host Home appear to be higher than in other living situations
- Records for older adults, age 54 and greater, show lower support coordinator compliance

Figure 20: Support Coordinator Record Review Results Percent Present by Region July 2013 – March 2014

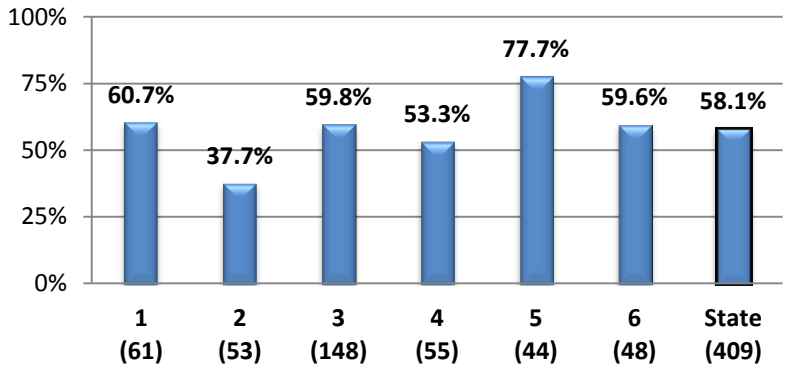


Figure 21: Support Coordinator Record Review Results Percent Present by Residential Status July 2013 – March 2014

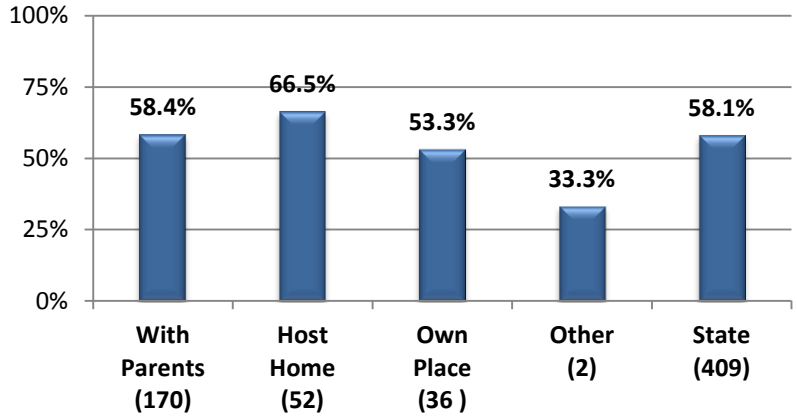
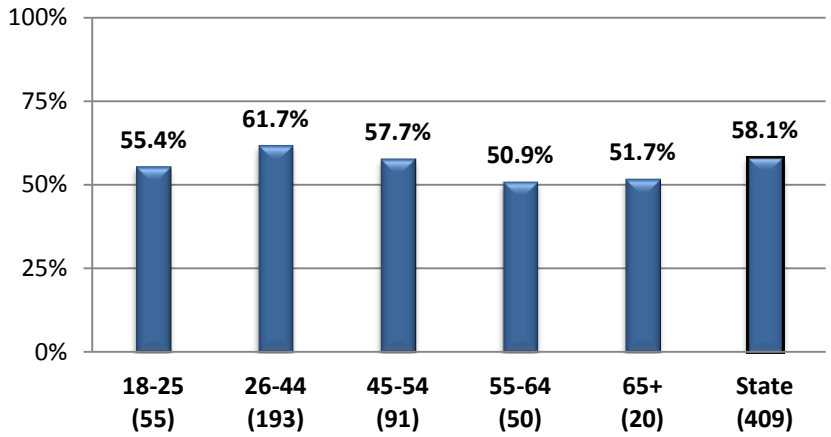


Figure 22: Support Coordinator Record Review
Percent Present by Age Group
July 2013 – March 2014



Quality Enhancement Provider Review

The Quality Enhancement Provider Review (QEPR) has been completed for 28 service providers randomly selected from the list of providers who have not received a QEPR since 2008. The QEPR is comprised of six distinct components and the number of cases for each component is dependent upon the number of individuals receiving services, number of services provided, and the number of residential and/or day programs the provider offered at the time of the review. Results have been reported for the III, ISP QA Checklist, Provider Record Reviews, Staff/Provider Interviews, and Onsite Observations. Provider demographic information and results from the Administrative Review are presented here.

QEPR Administrative Review

Each provider receives one Administrative Review to determine if providers have adequately documented Qualifications and Training (Q&T) for themselves and all relevant employees.[9] The Q&T component includes a review of a sample of personnel records to determine if staff has the necessary qualifications, specific to services rendered, and if the training was received within required timeframes. Due to the degree of revisions implemented in the Administrative tools, procedures, and the Standards for All Providers, comparisons to Years 1 through 3 are not appropriate. In addition, five Expectations were recently revised.

The Administrative Qualification and Training Checklist is used to score providers on 11 Expectations pertaining to service specific qualifications and receiving training within appropriate timeframes. Each Expectation, the number of elements/questions used to score each Expectation, and results for 28 providers reviewed this quarter are listed in Table 7. The number of records reviewed for each Q&T standard varies, depending upon the number of employees working for the organization. The average compliance score for the 28 providers reviewed to date this year was 61.4 percent. Records for 21 of 56 employees did not show evidence of a

[9] Beginning in Year 5 of the contract, Delmarva stopped reviewing the Administrative Policies and Procedures because licensure and certification reviews monitor these for all providers.

national criminal records check and compliance with annual training requirements appears to be relatively low.

Table 6: Administrative Qualifications and Training Elements
Average Percent Present
July 2013-March 2014 (N=28)

Number Questions	Expectations	Percent Met	Records Reviewed
4	The type and number of professional staff attached to the organization are properly Trained, Licensed, Credentialed, Experienced and Competent.	74.3%	109
2	The type and number of all other staff attached to the organization are properly Trained, Licensed, Credentialed, Experienced and Competent.	71.2%	52
6	Job descriptions are in place for all personnel.	56.5%	168
2	There is evidence that a national criminal records check (NCIC) is completed for all employees.	62.5%	56
4	Orientation requirements are specified for all staff. Prior to direct contact with consumers, all staff and volunteer staff shall be trained and show evidence of competence.	75.0%	92
15	Within the first sixty days, and annually thereafter, all staff having direct contact with consumers shall have all required annual training.	59.3%	329
7	Provider ensures that staff receives a minimum of 16 hours of annual training.	47.7%	174
1	Organizations having oversight for medication or that administer medication follow federal and state laws, rules, regulations and best practices.	68.0%	25
1	Provider has a current certification from MHDDAD Division (receives less than $250,000 waiver dollars per year).	71.4%	7
1	Provider has the required current accreditation if required (receives $250,000 or more waiver dollars per year).	76.2%	21
2	DD providers using Proxy Caregivers must receive training that includes knowledge and skills to perform any identified specialized health maintenance activity.	71.4%	14
45	**Average**	61.4%	1,047

Strengths and Barriers

During the QEPR, Delmarva works with each provider to identify strengths and best practices as well as barriers providers face in developing optimal service delivery systems. Quality Improvement Consultants have a list of strengths and barriers in a "drop down" menu. However, when "other" is listed, a comment is included in the data. The top strengths and barriers noted during the reviews are listed in Table 9, as well as the number of times each is noted and the percent this represents of the total number documented.[10]

A total of 360 strengths were identified, and a total of 261 barriers were documented during the reviews completed between July 2013 and March 2014. Providers may identify more than one strength or barrier, but each will be recorded only one time per provider.

Table 9: Provider Strengths and Barriers
Top Results, July 2013 – March 2014

Strengths (Top 8 Results)	Times Noted	Pct
Receptiveness to improving their quality of supports and services	21	5.8%
Respect for individuals served	17	4.7%
Customer's satisfaction with supports and services	16	4.4%
Provider is flexible	15	4.2%
Dependability	13	3.6%
Attitude of putting the persons served first	12	3.3%
People served have direct access to management and leadership staff	12	3.3%
Responsiveness to individuals' needs	11	3.1%
Total Number of Strengths Documented	360	
Barriers (Top 10 Results)		
Cost of doing business vs. reimbursement rates	14	5.4%
Support plan not driven by the person	10	3.8%
Lack of implementation of Person Centered Tools (i.e. Important To/For; Good Day/Bad Day)	9	3.4%
Documentation not reflective of person centered approach	9	3.4%
Excessive paperwork requirements	8	3.1%
Difficulty in accessing and obtaining individuals' medical information	7	2.7%
Process for obtaining exceptional rates is challenging	6	2.3%
Lack of Pre-ISP processes	6	2.3%
Lack of action plan review processes (i.e. Six Month ISP Reviews)	6	2.3%
Total Number of Barriers Documented	261	

Information in Table 9 indicates:

- Many of the strengths identified by most of the 28 providers reviewed to date in Year 6 reflect areas of respect, improving quality of supports and services, customer satisfaction, and flexibility.
- Barriers noted by many providers reflect issues that directly impact person centered planning-- a support plan that is not driven by the person, documentation that does not reflect a person centered approach to services, and a lack of implementation of Person Centered Tools
- The cost of doing business vs. reimbursement rates was noted by half of the providers.

DD Follow-Up Reviews

Follow-up with Technical Assistance

Delmarva conducts two types of Follow-up reviews: Follow up with Technical Assistance (FU w/ TA) and the FUTAC (Follow-up with Technical Assistance Consultations). The FU w/ TA is conducted 90 days after completion of the QEPR. Using findings from the QEPR, technical assistance is provided to support providers, including suggestions and guidance to help improve their service delivery systems. During the FU w/ TA consultants rescore Expectations on which providers were out of compliance during the QEPR.

Through the third quarter of the contract year, Delmarva completed 19 FU w/ TA reviews. Results are displayed in Table 10. The percent of Expectations scored as Met during the Follow-up is based on the number of Expectations scored as Not Met during the QEPR (the N in the table), and the number of these scored Met at the Follow-up. When all Expectations were Met during the QEPR, the FU w/ TA is not applicable with a dash (-) displayed. For example, BSA Blessings had all Expectations scored Met during the QEPR for the Qualifications and Training and therefore no Q&T Expectations were scored during the Follow-up review. However, for eight PRR Expectations that were Not Met during the QEPR, 13 percent (1 Expectation) was met during the Follow Up review.

Table 10. Follow Up with Technical Assistance
July 2013 – March 2014
% Met on items that were originally "Not Met"

Region	Q & T		PRR	
	% Met	(N)	% Met	(N)
6	100%	2	100%	24
3	0%	17	0%	90
3	25%	20	0%	8
3	100%	6	85%	20
3	89%	9	54%	13
3	-	-	0%	15
5	53%	19	46%	71
6	-	-	13%	8
3	100%	39	0%	21
4	-	-	100%	6

Table 10. Follow Up with Technical Assistance July 2013 – March 2014 % Met on items that were originally "Not Met"					
	Region	Q & T		PRR	
		% Met	(N)	% Met	(N)
	5	86%	7	86%	7
	2	12%	26	18%	88
	2	57%	14	36%	11
	2	33%	6	30%	47
	5	0%	14	33%	9
	2	93%	14	56%	16
	3	75%	4	8%	25
	3	23%	35	2%	107
	5	90%	10	29%	14

Follow Up with Technical Assistance Consultation (FUTAC)

Providers are tagged to receive a FUTAC through a referral system. The review uses a consultative approach to help providers increase the effectiveness of their service delivery systems. The focus is to help improve systems to better meet the health and safety needs, communicated choices, and preferences of individuals receiving services.

The FUTAC also supplements the PCR and QEPR processes by affording the State of Georgia and contracted providers the opportunity to solicit technical assistance for specific needs within the service delivery milieu. Through the third quarter of the contract year, 263 FUTAC were completed. Results are displayed in Tables 11-13 and include the following:

- Most FUTAC were completed onsite (96.2%), referred at the individual level (89.4%), and by one of the Regional Office Health Quality Managers (93.2%)
- Support Coordinator monthly scores of 3 or 4 were the primary referral reason (91.6%)
- Technical assistance most often included discussion with the provider and brainstorming

Table 11: Follow Up with Technical Assistance Consultation Number and Percent by Type and Referral Information July 2013 – March 2014		
Type	**Number**	**Percent**
Desk	10	3.8%
Onsite	253	96.2%
Referral Level	**Number**	**Percent**
Individual	235	89.4%
Provider	28	10.6%
Referral Source	**Number**	**Percent**
Division	1	0.4%
Health Quality Manager (HQM)	245	93.2%
Internal	4	1.5%
Other Regional Office Staff	3	1.1%

Provider	10	3.8%
Referral Reason	**Number**	**Percent**
SC Monthly Monitoring Scores of 3 & 4s	241	91.6%
Corrective Action Plan (CAP)/Critical Incident	4	1.5%
Provider Self Request	10	3.8%
Complaints/Grievance	6	2.3%
QEPR Alert	0	0.0%
PCR Alert	2	0.8%
Compliance Review	0	0.0%
Support Plan Needing Improvement	0	0.0%
Level of Care Registered Nurse (LOC RN) Review	0	0.0%
Region	**Number**	**Percent**
1	37	14.1%
2	61	23.2%
3	80	30.4%
4	27	10.3%
5	30	11.4%
6	28	10.6%
Total	263	

Table 12: Follow Up with Technical Assistance Consultation Number and Percent by Focused Outcome Area July 2013 – March 2014

Type	Number	Percent
Health	177	26.6%
Safety	128	19.2%
Rights	57	8.6%
Choice	10	1.5%
Community Life	11	1.7%
Person Centered	37	5.6%
Administrative Q&T	2	0.3%
Documentation SCRR	19	2.9%
Documentation PRR	1	0.2%
Documentation ISPQA	223	33.5%

Table 13: Follow Up with Technical Assistance Consultation Type of Technical Assistance Provided July 2013 – March 2014

Type	Number	Percent
1:1 Training	60	8.7%
Brainstorming	157	22.7%

Group Training	17	2.5%
Individual Discussion with Provider	211	30.4%
Strategic Planning	23	3.3%
CAP Development	6	0.9%
Resources-Hard Copy	45	6.5%
Group Discussion	40	5.8%
Resources-web-based	83	12.0%
Role Play	6	0.9%
Skill Building	45	6.5%

Focused Outcome Recommendations

As part of the QEPR and FUTAC, Delmarva captures specific recommendations for each Focused Outcome Area (FOA): Person Centered Practices, Community Life, Health, My Life My Choice, Rights, and Safety. Information is collected through drop down menus during the QEPR and the FUTAC, and is available to further analyze areas for which the service delivery system for the provider may need the most attention.

Recommendations help offer insight for providers to improve their organizational systems and practices. Recommendations are listed by Focused Outcome Area in Appendix 1, Exhibit 3 (QEPR) and Exhibit 4 (FUTAC). A total of 655 recommendations have been provided as part of a QEPR, with a range of 91 to 141 per FOA. For the 28 providers reviewed, 14 or more were provided the following recommendations:

- Assist the individuals to develop more person centered goals that matter most to the person.
- Connect individuals to resources that will help develop more natural and unpaid supports in the community.
- Use "real life" situations as teaching opportunities for learning about life choices.
- Conduct "what if" scenarios to determine an individual's skills in various safety situations.

A total of 1,445 recommendations were generated as part of a FUTAC. Health was most likely to be addressed, with 321 recommendations, 22 percent of the total. Recommendations most often indicated a need to keep health information or mediations current, and to offer health education to staff related to the person's specific health issues.

Individuals Recently Transitioned to the Community (IRTC)

A total of 49 individuals who transitioned from an institution to the community participated in a Person Centered Review using the III with a Delmarva consultant (See page 34 for details on the III tool). The following tables show Expectations from the Individual Interviews, PRR, ISP QA Checklist and the SCRR, comparing the current IRTC results to results from the PCR/QEPR interviews and to the IRTC results from Year 5. Because the current year is based on only 49 cases, results will be further analyzed in the annual report.

Table 15: Individual Interview Instrument July 2013-March 2014	PCR + QEPR (534)	IRTC (49)	IRTC Year 5 (177)
1. The person is afforded choice of services and supports.	94.0%	97.9%	89.3%
2. The person is involved in the design of the service plan.	82.0%	95.8%	79.7%
3. The service plan is reviewed with the person, who can make changes.	77.2%	77.6%	69.5%
4. The person's goals and dreams are reflected in supports and services.	88.0%	89.8%	91.0%
5. The person is achieving desired outcomes/goals	95.5%	93.9%	98.3%
6. The person actively participates in decisions concerning his or her life.	93.3%	83.7%	85.3%
7. The person is satisfied with the supports and services received.	96.3%	100.0%	96.6%
8. The person is free from abuse, neglect and exploitation.	97.0%	98.0%	96.0%
9. The person is healthy.	93.4%	98.0%	94.9%
10. The person is safe or has self-preservation skills.	97.2%	100.0%	96.0%
11. The person is educated and assisted to learn about and exercise rights.	85.0%	71.4%	82.5%
12. The person is treated with dignity/respect.	98.5%	100.0%	99.4%
13. The person's preferences related to privacy are upheld.	98.5%	100.0%	98.9%
14. The person has opportunities to access and participate in community activities.	83.7%	73.5%	88.1%
15. The person is developing desired social roles.	63.4%	36.7%	46.3%
Average III Score	89.5%	87.7%	87.5%

Tale 16: Provider Record Review Expectations	PCR+QEPR (876)	IRTC (142)	IRTC Y5 (387)
1. Person centered focus supported in documentation.	35.0%	20.4%	24.5%
2. Human and civil rights are maintained	66.0%	59.9%	63.0%
3. Personal funds managed by individual and protected.	72.8%	51.8%	66.2%
4. Clear description of services/supports/care/treatment.	72.4%	75.4%	69.3%
5. The provider maintains a central record for individual.	96.5%	97.2%	94.6%
6. Potential risk to individuals/staff/others is managed.	74.1%	77.5%	78.7%
7. Information is protected, organized and confidential.	77.5%	73.9%	76.4%
8. Medication oversight/administration.	88.7%	87.6%	87.8%
9. Individual is afforded choices of services &supports.	53.9%	47.2%	45.7%
10. Means to identify health status and safety needs	25.3%	33.8%	32.4%
11. Means to evaluate quality/satisfaction of services.	95.3%	90.0%	84.2%
12. Meets NOW/COMP documentation requirements.	92.6%	94.4%	86.3%

Tale 16: Provider Record Review Expectations	PCR+QEPR (876)	IRTC (142)	IRTC Y5 (387)
13. Individual is making progress/achieving desired goals.	65.6%	65.5%	55.0%
14. Individual directs supports and services.	26.5%	26.4%	19.2%
15. Individual chooses community services/supports.	26.8%	18.3%	15.4%
16. Positive behavior support plans are in place. (new in Feb 2014)	50.0%	79.1%	
Total	63.2%	61.4%	59.3%

Table 17: ISP QA Checklist			
ISP Written to Support:	PCR+QEPR (534)	IRTC (49)	IRTC Year 5 (177)
Service Life	20.2%	42.9%	41.8%
Good But Paid Life	75.8%	57.1%	56.5%
Community Life	3.9%	0.0%	1.7%
ISP Additional Criteria			
Provider info on demographic page match POC?	89.4%	87.8%	88.7%
Is the budget present?	100.0%	100.0%	98.9%
PA match the service(s) and unit rates on the budget?	97.4%	88.4%	90.4%
ISP contains a minimum of 3 goals.	99.6%	100.0%	99.4%
ISP contains at least one goal/objective per DD service?	100.0%	98.0%	98.9%
Are all goals person centered?	64.2%	63.3%	56.5%
At least one goal reflects the person's hopes and dreams?	70.9%	56.3%	70.6%
Signature page is signed by the individual?	99.2%	93.8%	89.8%
Annual informed consent for psychotropic medications is present?	29.6%	24.3%	43.1%
Behavior Support Plan/Crisis Plan and/Safety Plan is signed?	26.4%	44.4%	66.1%
Signature page of the ISP is in place, identifying that rights have been reviewed with the person?	97.5%	91.7%	89.2%
All required and applicable assessments are completed: Nursing assessment, Psychosocial review, and Physician summary?	63.9%	85.0%	85.8%
HRST is updated annually and within 90 days prior to the individual service plan expiration date?*	42.5%	41.0%	49.4%
The Health and Safety section includes discussion on HRST training consideration.	88.4%	89.8%	92.1%
Authorized medical support section is fully completed, including plans in an emergency.	65.2%	50.0%	50.6%

Table 18: Support Coordinator Record Review	PCR+QEPR (409)	IRTC (49)	IRTC Year 5 (306)

Table 18: Support Coordinator Record Review	PCR+QEPR (409)	IRTC (49)	IRTC Year 5 (306)
1. Person-centered focus shown in the documentation	35.3%	26.5%	43.5%
2. Human and civil rights are maintained	52.2%	30.6%	83.1%
3. Documentation describes available services, supports & care of individual	45.1%	40.8%	61.6%
4. Support coordinator monitors services/supports according to the ISP	65.0%	49.0%	84.7%
5. Support coordinator continuously evaluates supports and services	69.4%	61.2%	66.1%
6. Effective approach to assessing/making recommendations related to risk management	80.5%	77.6%	91.0%
7. Confidentiality of the individual's information is protected	97.1%	93.9%	99.4%
8. Individuals are afforded choices of services and supports	48.9%	34.7%	50.3%
9. Individuals are included into larger community.	30.1%	20.4%	19.5%
SCRR Average Score	58.1%	48.3%	66.7%

Longitudinal Study of IRTC Subgroup

Delmarva has completed 35 PCRs to date this year, for the IRTC group of individuals who have agreed to be interviewed in multiple years. To date, there are 33 individuals who were interviewed in all three years. Results for the study will be presented in the 2014 Annual Report

DD Discussion and Recommendations

The Division of DD strives to ensure quality assurance and quality improvement in the DD service delivery system. During the quarter, January – March 2014, the training schedule was revised to deliver two different training sessions by June 30: Valued Vision for My Life; and Quality Health and Safety Management for Nursing and Developmental Disabilities Professional. Delmarva Quality Review Consultants continue to be tested on and pass reliability to maintain consistency in the review processes. Delmarva facilitated the regional and statewide QI Councils, all working on their current QI projects. Feedback from providers and individuals, via the feedback surveys, continues to be very positive.

Through the third quarter, Delmarva Quality Improvement Consultants (QIC) completed 409 Person Centered Reviews (PCR) and 28 Quality Enhancement Provider Reviews (QEPR). As part of these reviews, Delmarva consultants completed 534 individual interviews, 409 Support Coordinator Record Reviews, 876 Provider Record Reviews, 780 Staff/Provider Interviews, and 670 observations. Because the total number of interviews and provider reviews in the sample will be completed during the final quarter, results through the third quarter may not yet reflect trends across regions or other demographic characteristics.

On average, individual interview findings show close to 90 percent of all outcomes were present, similar to Years 4 and 5. However, also consistent over the years is that individuals were least likely to be developing desired social roles or reviewing their services plans. Barriers most often identified during the QEPR reflect similar issues. Providers are often working with ISPs that are

not driven by the person, they lack implementation of person centered tools, and they often do not have a person centered focus in their documentation. Documentation that lacks a person centered focus was also noted for most records during the PRR and the SCRR, each reflecting approximately 35 percent compliance. All of these impact the degree to which person centered planning is incorporated into the entire service delivery system.

These findings are echoed in the current ISP QA Checklist results. Each year, ISPs appear to be more likely to be written to support a Service Life, with the current year to date showing over 20 percent of ISP supported a Service Life. This means many individuals have basic paid services and paid supports and there is no evidence of efforts made to address the person's expressed desires or to support community integration. The percent of Service Life ISPs appears to vary by region, age and where the person lives. Close to half of the ISPs reviewed in Region 5 and 27 percent of ISPs for individuals living in Group Home settings were written to support basic paid services. Only four percent of ISPs supported a Community Life. There appears to be a trend that after age 25 a person ages, ISPs are more likely to be written to support a service life.

From the person's perspective, health is fairly well supported, with III results showing 93.4 percent present. The ratings section of the ISP shows relatively good performance in some health –related areas, with all four components present for completing the health and safety review section and addressing issues surrounding rights, psychotropic medications and behavior supports. However, the annual informed consent form for psychotropic medication use is often not in the person's record, the behavior support plan/crisis plan/safety plan is often not appropriately signed, many individuals do not have needed assessments completed, and for many individuals the HRST is not updated within required timeframes. In addition, while providers have a means to evaluate the quality of their services they often do not have a means to identify health status and safety needs for individuals served.

DBHDD Quality Management Training Program

In May of 2014, the second in the series of QM web-based trainings was released to all DBHDD staff with the requirement for a June 2014 completion. The QM State Office plans to release one additional web-based training module in the Fall of 2014. Additionally, the DBHDD QM Learning Plan is in the process of being updated.

Data Reliability Process

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

Hospital System KPI Data Integrity

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

Community BH Key Performance Indicator Data Integrity

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

DD KPI Data Integrity

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

Summary

The sections above reference the multitude of quality related activities taking place across DBHDD. Key activities that have taken place between January 2014 and June 2014 include the annual DBHDD QM system review; the initiation of a major re-engineering of the I/DD service system, the release of the second DBHDD wide QM web-based training module, the satisfactory completion of the terms of the CRIPA settlement agreement, a review and updating of the hospital QM system, a review of DBHDD's KPIs using the PMET tool, the creation of recovery oriented KPIs, the prioritization of a PI project related to corrective action plans and the enforcement process, the expansion of the Community Mortality Review Committee to include an independent external reviewer, and significant communication with and training of providers on cognitive therapy (Beck Initiative) and suicide prevention.

During the upcoming six months, quality management activities will focus on the DD re-engineering project, finalizing the corrective action plan/enforcement process and developing a training plan, developing and implementing a new audit process designed to follow individuals with high service utilization throughout their community/hospital based services, incorporating independent subject matter expert review of settlement service consumer deaths, and analyzing & utilizing data trends/patterns to make program decisions and improvements.

Appendix A DBHDD Quality Management Work Plan

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

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

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

Tasks	Responsible Person	Target Completion Date	Status
Update the current QM Training Plan and ensure inclusion of training for hospitals, CBH and DD	Carol Zafiratos and Training Department	June 2013	Delayed until September 2014
Continue development of web based training materials – three additional modules	Carol Zafiratos and Training Department	December 2013	Completed
Develop and implement methodology to evaluate the effectiveness of the training	Carol Zafiratos and Training Department	December 2013	Completed

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

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

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

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

(EDS)			to updated QM Plan
Develop the DBHDD EDS	Director of IT	2015	Significantly revised refer to updated QM Plan
Evaluate the effectiveness and efficiency of the newly created system	Director of IT, Carol Zafiratos, Steve Holton and Eddie Towson	2016	Significantly revised refer to updated QM Plan

Appendix B Hospital System Quality Management Work Plan

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

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

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

Tasks	Responsible Person	Target Completion Date	Status
Update the current QM Training Plan and ensure inclusion of training for hospitals	Carol Zafiratos, Steve Holton and Training Department	June 2013	The scope and specificity of the training plan has been modified – refer to the Learning Plan contained within the QM Plan for specifics
Identify desired knowledge, skills, abilities and behaviors for Hospital Quality Managers	Director of Hospital System Quality Management	August 2013	The revised DBHDD Leaning Plan will include Hospital Quality Managers
Assess training needs of QMs	Director of Hospital System Quality Management	Sept 15, 2013	The revised DBHDD

			Leaning Plan will include Hospital Quality Managers
Develop training plans and methodology for QMs	Director of Hospital System Quality Management ,Carol Zafiratos and Training Department	Nov 1, 2013	Completed at the DBHDD level

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

Tasks	Responsible Person	Target Completion Date	Status
Set target values for Hospital System KPIs.	Dr. Emile Risby – Chair Hospital System Program Quality Council	June 2013	Completed
Each hospital creates their data definition/collection plans	Program Quality Council Chairpersons	March 2014	Revised to the Hospital System level and delayed due to current process of reviewing and modifying performance indicators with new Hospital System Director. Anticipated completion date November 2014

Each hospital identifies and submits their KPIs (hospital level) and PI goals to the HS PQC	Program Quality Council Chairpersons	March 2014	This has been changed to the Hospital System level. Anticipated completion date November 2014.
Hospitals update analyses and begin to prepare reports for Hospital System PQC (Quality Management effectiveness review meeting scheduled for March 2014).	Program Quality Council Chairpersons	March 2014	This has been changed to the Hospital System level. Anticipated completion date November 2014. The evaluation of progress on the new and revised indicators is scheduled for identified target date of March 2015.

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

Tasks	Responsible Person	Target Completion Date	Status
Organize a Hospital System information management committee	Director of Hospital System Quality Management	July 15, 2013	Completed
Develop methodology for performing IM needs assessment	Chair of Information Management Committee & Director of Hospital System Quality Management	September 1, 2013	The strategy for accomplishing this goal has been modified substantially. A consultant has been hired by OIT to perform a needs assessment and develop a subsequent action plan.

Perform needs assessment in hospitals and analyze results	Chair of Information Management Committee & Director of Hospital System Quality Management	November 1, 2013	Currently being performed by the OIT consultant.
Set priorities for IM needs and communicate priorities to OIT, as appropriate.	Chair of Information Management Committee & Director of Hospital System Quality Management	December 1, 2013	Revised target date to December 2014
Develop Hospital System IM plan	Chair of Information Management Committee & Director of Hospital System Quality Management	December 31, 2013	Revised target date to December 2014

Appendix C Community Behavioral Health Quality Management Work Plan

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

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

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

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

providers	Carol Zafiratos		target date March 2015
Develop a QM training plan for individuals served and families	CBH PQC, Chris Gault and Carol Zafiratos	March 2014	Delayed, new target date July 2015.

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

Tasks	Responsible Person	Target Completion Date	Status
Using the PMT, annually review all KPI's for efficiency and effectiveness	CBH PQC	January 2015	

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

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

Appendix D Developmental Disabilties Quality Management Work Plan

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

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

QM system with participation from DD Advisory Council	Management and Contractor		of Division of DD Re-Engineering Plan. Deadline will be adjusted to project timelines yet to be determined
Develop report describing the status of the "as is" system	Director of DD Quality Management and Contractor	08/01/13	Completed
Develop recommendations for improvements to Georgia's quality system	Director of DD Quality Management and Contractor	08/01/13	Completed and ongoing
As part of Goal 1 DD will establish accurate, effective, and meaningful performance indicators for DD Services and DD Providers	Director of DD Quality Management and Contractor	08/15/13	Ongoing and will be completed by January 2015
Finalize measurements	Director of DD Quality Management and Contractor	09/30/13	2015
Develop comprehensive description of redesign for statewide DD QM system	Director of DD Quality Management and Contractor	10/01/13	Deadline expanded due to DD Re-Engineering Project. Due date June 2015

Goal 2: Educate Stakeholders regarding QM (including staff, providers, and individuals and families)

Tasks	Responsible Person	Target Completion Date	Status
Identify core knowledge and skill requirements for each quality role identified.	Director of DD Quality Management and Department Director of QM	08/31/13	Completed
Review and analyze the instructional system/knowledge and basic skill topics with DBHDD Staff and quality councils.	Director of DD Quality Management and Department Director of QM	08/31/13	Ongoing
Develop materials and methods for learning	Director of DD Quality	09/30/13	Ongoing

management and curriculum development	Management and Department Director of QM		
Review drafts of each section with DBHDD staff and QI Councils and Advisory Council	Director of DD Quality Management	12/31/14	
Create DD training program draft and review with DBHDD Staff and Quality Councils	Director DD Quality Management	12/31/14	Ongoing
Finalize training program with input from Quality Councils and Advisory Council	Director DD Quality Management	12/31/14	March 2015
Train staff and stakeholders on new DD QM System	Director DD Quality Management and Contractor	12/31/14	June 2015

Goal 3: Ensure that individuals with DD transitioned out of state hospitals to receive high quality services and to achieve life goals in community via Re-Engineering of Division of DD Processes and Policies

Tasks	Responsible Person	Target Completion Date	Status
Implement Re-Engineering Project	Acting Assistant Commissioner of I/DD	07/01/14	
Completion of DD Re-Engineering Project	Acting Assistant Commissioner of I/DD	12/1/15	

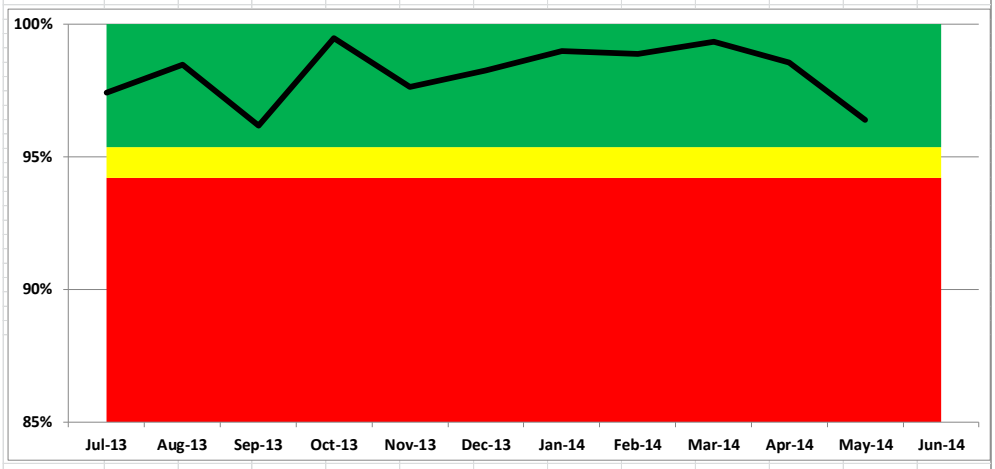
Goal 4: Integrate QM Data Systems in a matter which is compatible with Department data systems (Hospital, Community BH and Community DD) which will allow Division to follow an individual and their services across their lifetime. This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Develop Division DD information management committee	Director of DD Quality Management	08/01/13	Completed and a new data system will be developed through the ASO
Assessment current	Director of DD	08/01/13	Completed and findings

information management systems methods for collection and utilization	Quality Management and Division Data Manager		will be used in the implementation of the ASO
Set priorities for IM needs and work with OIT to address those needs as appropriate.	Director of DD Quality Management and Division Data Manager	10/01/13	Ongoing with work to be completed with ASO
Include development of new DD case management system in the Department's RFP for an Administrative Service Organization (ASO)	Director of DD Quality Management	10/01/13	RFP completed and ASO implementation set for April 2015
Work with ASO to develop and test new system	Director of DD Quality Management and Vendor	08/01/14	Ongoing
Train end users on new system	Director of DD Quality Management and Vendor	10/01/14	April 2015
Transition data from old case management system to new system	Director of DD Quality Management and Vendor	12/31/14	April 2015

Appendix E Hospital System KPI Dashboards

Continuing Care Plan Created (Overall)



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	413	385	351	379	288	282	293	261	301	339	320	
Denominator	424	391	365	381	295	287	296	264	303	344	332	
Rate	97%	98%	96%	99%	98%	98%	99%	99%	99%	99%	96%	
Quarterly Average	97%			99%			99%			Incomplete data		

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Changes in collection, Joint Commission, and CMS reporting requirements have temporarily disrupted the appropriate reporting of this measure. Reporting, retroactive to January 2014, is expected to resume in July 2014.

January-March 2014 Analysis

Data continues to trend towards 100%. Certain factors, such as clients discharged directly off of on long-term Conditional Release programs, will hinder reporting at 100%. In such cases, some semblance of a Continuing Care Plan was created at the time of release, but does not meet current The Joint Commission guidelines.

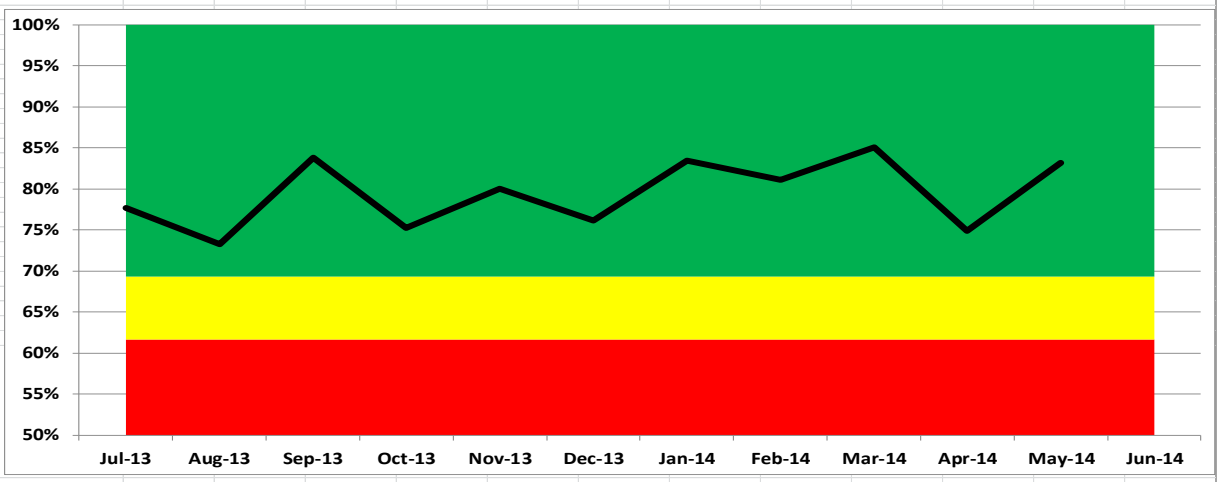
Oct-Nov 2013 Analysis

As expected, rate increased in October and November. Rates well above The Joint Comission target range. Changes expected in data collection will account for nuance in reporting concerning conditional release should increase rate of compliance to close to the goal of 100%.

July-September 2013 Analysis

In September, rate showed decline due to a nuance in reporting. Several clients were discharged directly off conditional realease, and Continuing Care Plan documentation is created at the time of conditional release. However, this measure asks if the paperwork was created at the time of discharge. Changes are being planned to allow our system to account for this issue in the future. Rate still well above The Joint Comission target range.

Client Perception of Outcome of Care



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	129	104	93	131	72	99	121	116	142	122	153	N/A
Denominator	166	142	111	174	90	130	145	143	167	163	184	N/A
Rate	78%	73%	84%	75%	80%	76%	83%	81%	85%	75%	83%	
Quarterly Average	78%			77%			83%					

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Data collection for this quarter is incomplete. It is inappropriate to provide analysis at this juncture.

January-March 2014 Analysis

The rate continues its established upward trend. National average of this data continues to display relatively large fluctuations, but DBHDD continues to score above the average this quarter.

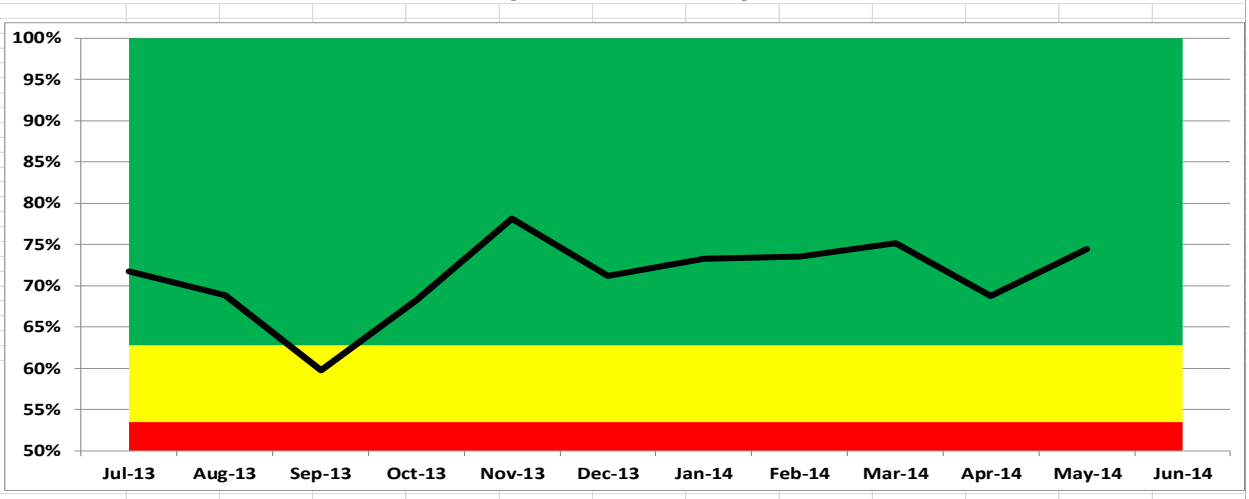
Oct-Nov 2013 Analysis

Although the rate is observed to vary from month-to-month, this is not abnormal when compared to national rate averages. DBHDD rates are consistently above the standard set forth. The linear trend line for January through November 2013 shows statistially positive trend. In addition, linear trends for the period of February 2012 through November 2013 further support the positive trend movement.

July-September 2013 Analysis

Although the rate is observed to vary from month-to-month, this is not abnormal when compared to national rate averages. DBHDD rates are consistently above the standard set forth.

Client Perception of Empowerment



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	99	64	43	114	68	84	96	100	124	110	137	N/A
Denominator	138	93	72	167	87	118	131	136	165	160	184	N/A
Rate	72%	69%	60%	68%	78%	71%	73%	74%	75%	69%	74%	
Quarterly Average	68%			72%			74%					

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Data collection for this quarter is incomplete. It is inappropriate to provide analysis at this juncture.

January-March 2014 Analysis

The rate continues its established upward trend. National average of this data continues to display relatively large fluctuations, but DBHDD continues to score above the average this quarter.

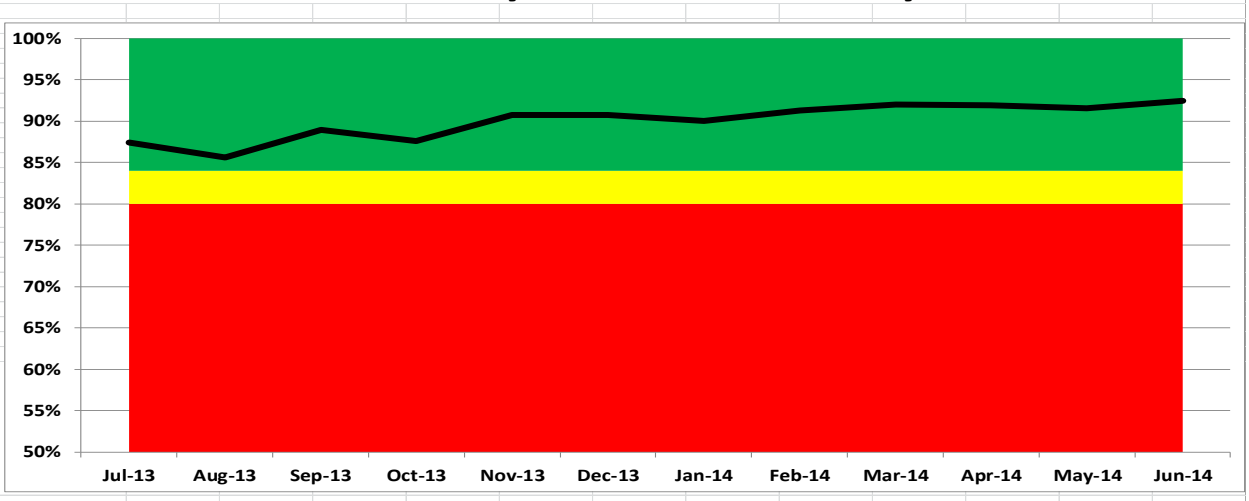
Oct-Nov 2013 Analysis

The four month downward trend ceased in October, as GRH-Atlanta pushed the overall rate in a positive direction. In November, rate for GRH-Atlanta continued to improve, and West Central RH rate increased. Overall trend for last 12 months, as well as last 21 months is slightly negative.

July-September 2013 Analysis

Statewide rates show a decided downturn in client perceptions, though still above guidelines. Data is gathered at the time of cliet discharge, so facilities with higher number of discharges influence the rate heavily. Both GRH-Atlanta and West Central RH experienced lower rates during this quarter.

Individual Recovery Plan Audit - Quality Measure



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	1697	1988	2220	2166	2091	1849	1892	1800	2007	1793	1975	1783
Denominator	1942	2323	2495	2473	2305	2038	2101	1971	2181	1950	2158	1929
Rate	87%	86%	89%	88%	91%	91%	90%	91%	92%	92%	92%	92%
Quarterly Average	87%			90%			91%			92%		

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

Denominator: Total number IRP audits conducted.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

The emphasis on IRP Quality continues to drive steady improvements on results. Continuing statistically significant upward trend in rate shows improving quality of the IRP is evidence of systematic processes.

January-March 2014 Analysis

The emphasis on IRP Quality continues to drive steady improvements on audit results. Continuing statistically significant upward trend in rate shows improving quality of the IRP is evidence of systematic processes.

Oct-Nov 2013 Analysis

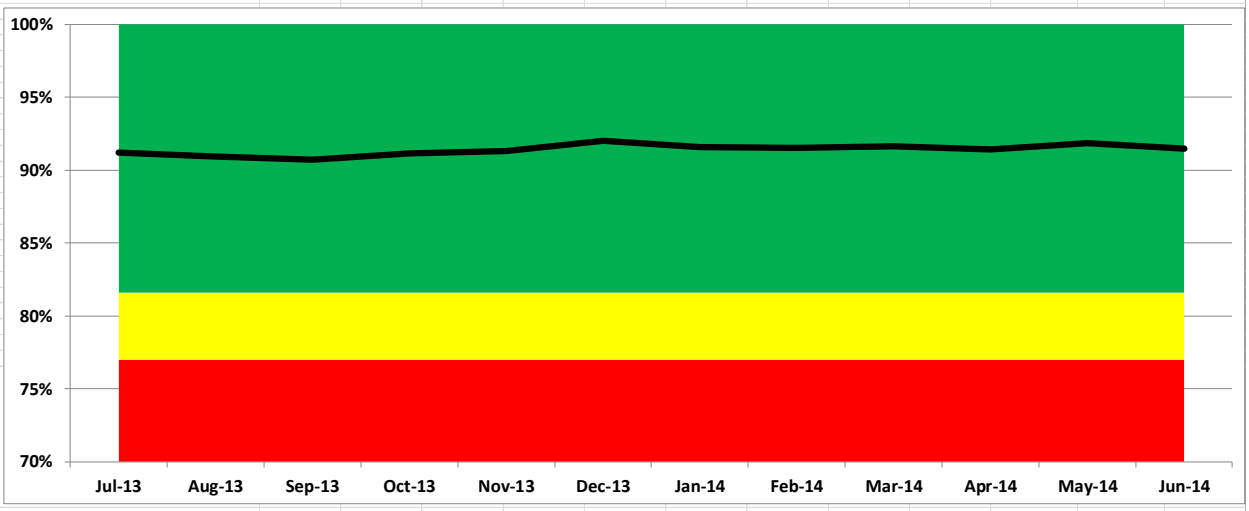
October rates dipped due to training issues at GRH-Atlanta (not in the same area as last quarter). Training was conducted during October, and November rates displayed a strong improvement. Year-to-date rates indicate that ongoing emphasis on auditing IRPs has contributed to improvements in the quality of the plans.

July-September 2013 Analysis

A slight decline in the statewide rate was due primarily to employee turnover and training issues at GRH-Atlanta. The issue was corrected during the quarter, with key employee positions filled and trained.

Appendix F CBH System KPI Dashboards

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	623	643	683	761	811	843	890	905	929	967	1026	1044
Denominator	683	707	753	835	888	916	972	989	1014	1058	1117	1141
Percent	91.2%	90.9%	90.7%	91.1%	91.3%	92.0%	91.6%	91.5%	91.6%	91.4%	91.9%	91.5%
Quarterly Average		90.9%			91.5%			91.6%			91.6%	

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

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

January-March 2014 Analysis

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

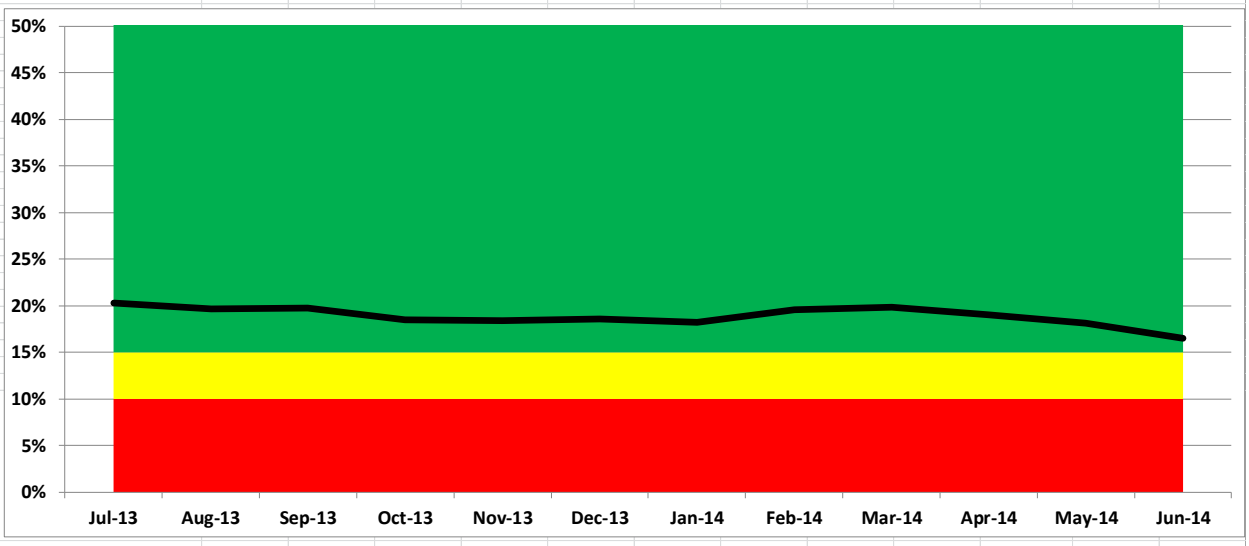
October-December 2013 Analysis

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

July-September 2013 Analysis

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

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	32	35	35	35	37	39	40	44	47	47	47	45
Denominator	158	178	177	189	201	210	220	225	237	247	259	273
Percent	20.3%	19.7%	19.8%	18.5%	18.4%	18.6%	18.2%	19.6%	19.8%	19.0%	18.1%	16.5%
Quarterly Average	19.9%			18.5%			19.2%			17.8%		

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Although lower than the historic rate of close to 20%, the target threshold of 10% has been exceeded by over 60%.

January-March 2014 Analysis

This measure continues to remain stable as 1 in 5 negative discharges are reengaged and reenter stable housing.

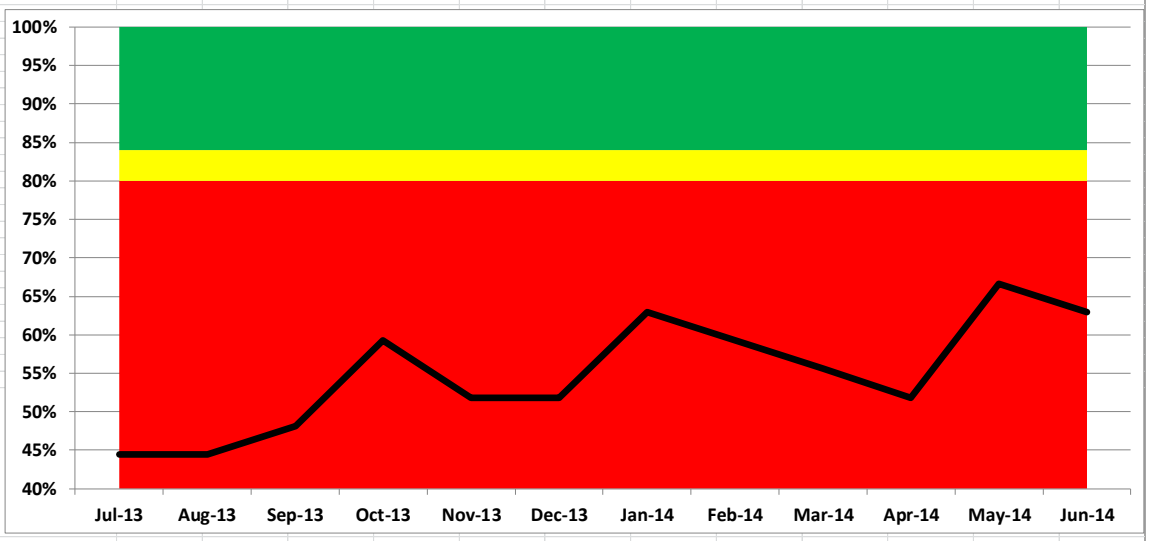
October-December 2013 Analysis

This measure continues to remain stable as 1 in 5 negative discharges are reengaged and reenter stable housing.

July-September 2013 Analysis

This measure continues to remain stable as 1 in 5 negative discharges are reengaged and reenter stable housing.

Percent of adult MH supported employment providers that meet a caseload on the last day of the month of employment specialist staff to consumer ratio (between 1:15 to 1:20)
Target (85%) or more
Key Performance Indicator activated July 2013



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	12	12	13	16	14	14	17	16	15	14	18	17
Denominator	27	27	27	27	27	27	27	27	27	27	27	27
Rate	44.4%	44.4%	48.1%	59.3%	51.9%	51.9%	63.0%	59.3%	55.6%	51.9%	66.7%	63.0%
Quarterly Rate	45.7%			54.3%			59.3%			60.5%		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of adult MH contracted supported employment providers that met a mental health caseload on the last day of the month average between 1 to 15 and 1 to 20 on the last day of the calendar month.

Measure explanation: To examine the proportion of mental health contracted Supported Employment agencies, that devote the appropriate staffing the Dartmouth model indicates is necessary for obtaining and maintaining

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of contracted providers with a consumer to staff ratio between 1:15 and 1:20 on the last day of the month.	**Denominator:** Number of contracts DBHDD Community Mental Health holds for Supported Employment.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Data collection and analysis not complete as of July 21, 2014.

January-March 2014 Analysis

There were a few providers who were over ratio during the quarter, however, there were more that were under ratio. This means that many providers had smallercaseloads per staff member.
Program Quality Council discussed this indicator and determined that if providers serve a smaller ratio, that it is not detrimental to the consumer, therefore thismeasure will end on 6/30/14 and be replaced with a measure that examines 20:1 and under starting on 7/1/14.

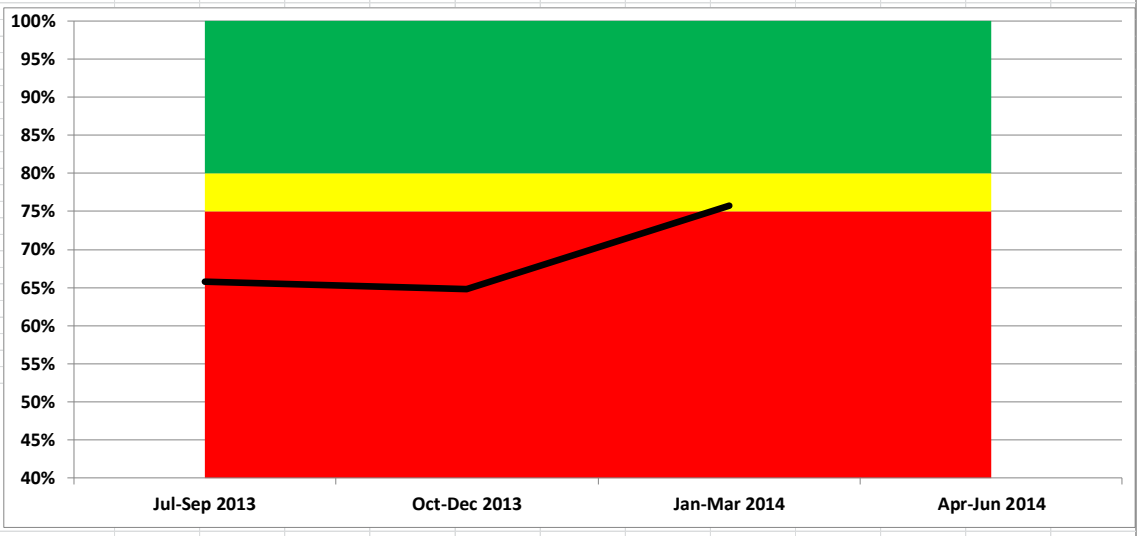
October-December 2013 Analysis

Average percentage trended upward in comparison to last quarter. Many of the providers who did not meet the target have ratios of 14:1 and under, meaning they had a larger number of staff dedicated to a smaller number of consumers.

July-September 2013 Analysis

The percentage of providers that met the target ratio remained low over the quarter. Many of the providers who did not meet the target had ratios of 14:1 and under, meaning they had a larger number of staff dedicated to a smaller number of

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



	Jul-Sep 2013	Oct-Dec 2013	Jan-Mar 2014	Apr-Jun 2014
Numerator	73	70	100	0
Denominator	111	108	132	0
Rate	66%	65%	76%	#N/A

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Data collection and analysis not complete as of July 21, 2014.

January-March 2014 Analysis

Despite the increase in the new enrollments during quarter three, the overall percentage of consumers who had first contact increased in comparison to quarter two.

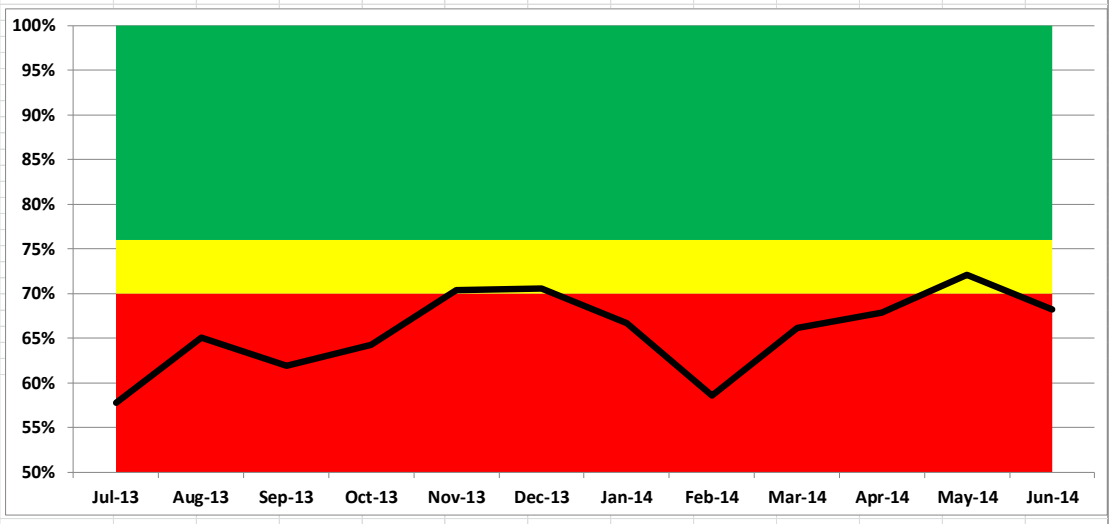
October-December 2013 Analysis

The target was not met this quarter. The percentage appears to be similar to last quarter. Two providers indicated that the Fidelity Reviews related to Supported Employment completed by DBHDD State Office has enhanced their understanding of this key performance indicator. Both indicated that they believe they will have better percentages moving forward.

July-September 2013 Analysis

The target was not met this quarter. Providers identified transportation as a barrier. To resolve this barrier, one agency has contracted with a taxi company to complete transportation for their consumers. Another agency is looking at viable job opportunities along existing bus routes. Yet another agency identified an existing program in their community that offers reduced bus fares. Other ideas included building relationship with local faith based entities that would be willing to assist in providing transportation.

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	78	80	78	99	76	84	92	82	80	76	75	58
Denominator	135	123	126	154	108	119	138	140	121	112	104	85
Rate	57.8%	65.0%	61.9%	64.3%	70.4%	70.6%	66.7%	58.6%	66.1%	67.9%	72.1%	68.2%
Quarterly Rate	61.5%			68.0%			63.7%			69.4%		

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Data collection and analysis not complete as of July 21, 2014.

January-March 2014 Analysis

Some barriers that the ACT Teams identified included: receiving incorrect contact information for the referred consumers which increases the amount of time it takes the team to locate and make contact with the consumer, receiving an increase of referrals for homeless consumers which increases the amount of time to locate the consumer, and consumers that move directly after the referral is made which increases the time it takes the team to identify new contact information.

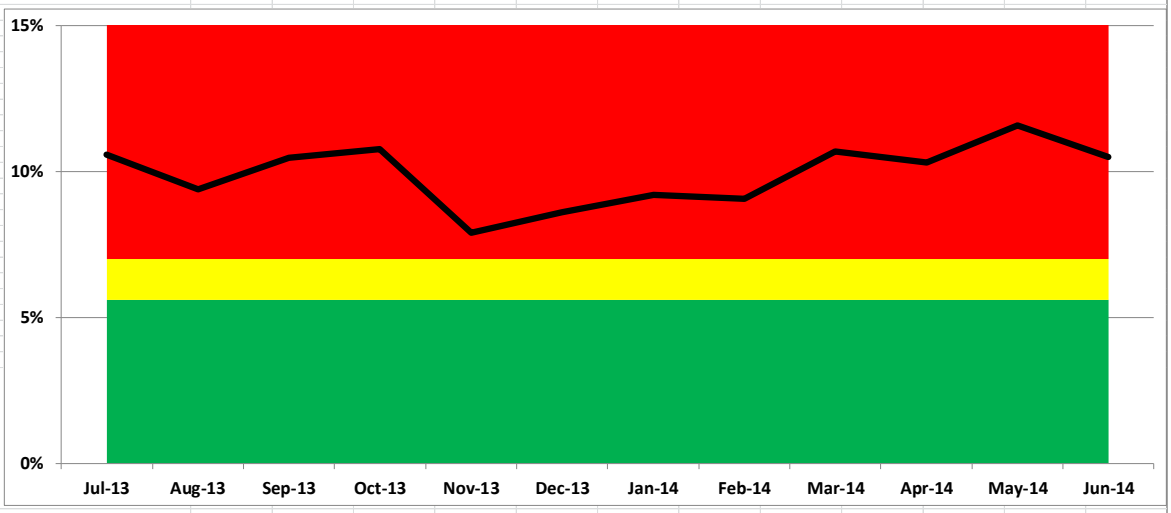
October-December 2013 Analysis

Slight upward trend through the quarter.

July-September 2013 Analysis

Throughout the quarter, ACT Teams were below the target. Several providers indicated that it was difficult to find and/or locate consumers after the referral was received, especially if the referral was received on a Friday. One provider indicated that they are now going to see the individual whereever they may be (egmedical hospital) once the referral comes in which has greatly assisted in ongoing engagement.

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	164	142	160	164	126	138	152	142	169	167	181	178
Denominator	1552	1515	1527	1523	1597	1603	1654	1568	1581	1621	1563	1696
Percent	10.6%	9.4%	10.5%	10.8%	7.9%	8.6%	9.2%	9.1%	10.7%	10.3%	11.6%	10.5%
Quarterly Average	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Data collection and analysis not complete as of July 21, 2014.

January-March 2014 Analysis

Some providers indicate that consumers are sometimes discharged from hospitals prior to achieving stability, which may lead to decompensation in the community and rehospitalization. Some ACT teams reported that sometimes consumers are discharged from the hospital withut their knowledge, preventing them from assisting with supportive discharge planning. Many teams indicated that their hospital days are typically from a small number of consumers with long length of stays in hospitals.

October-December 2013Analysis

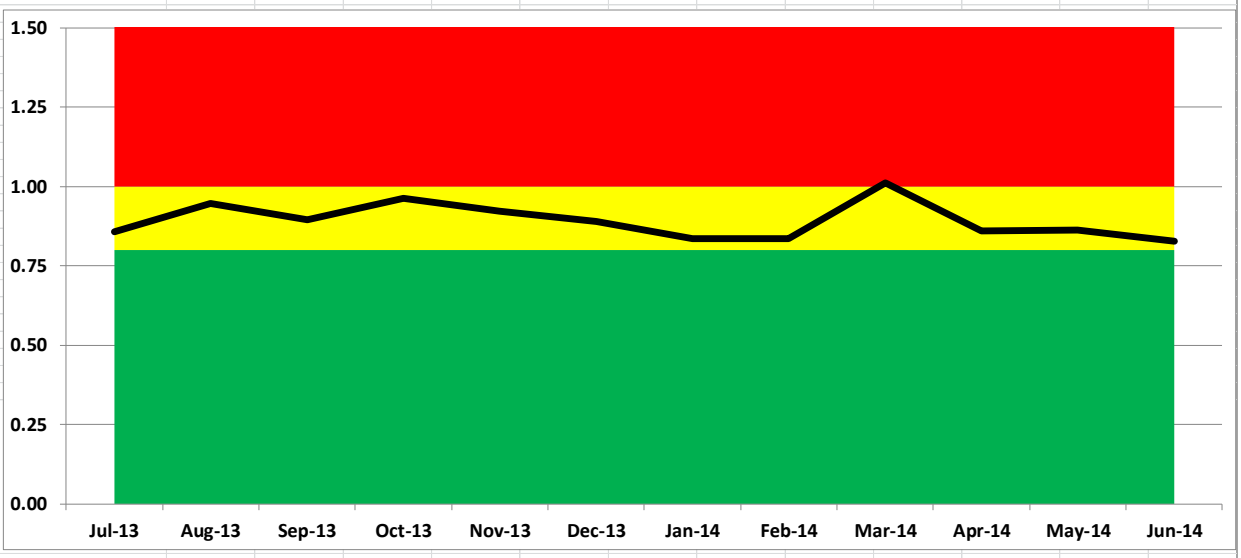
Slight upward trend through the quarter.

July-September 2013 Analysis

9.4% to 10.6% of consumers receiving ACT services each month had a psychiatric hospitalization, which is above the target amount. Many ACT providers are working on creating stronger relationships with any Personal Care Homes (PCHs) that house their consumers. Teams indicated that PCHs are more likely to call the police or send the consumer directly to the hospital than call the ACT Team when there is a minor crisis.

One provider indicated that the Statewide Beck Initiative has assisted the ACT Team and hospital build a common language. With this training they have worked with the hospitals to prevent premature discharges. It is possible that reduced recidivism rates to the hospital may occur if premature discharges can be avoided. Another provider indicated they help prevent premature discharges by being actively involved in the discharge process and become fully engaged with the consumer before discharge.

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	1481	1648	1542	1661	1641	1618	1525	1534	1873	1614	1574	1525
Denominator	1727	1742	1720	1725	1780	1820	1826	1833	1852	1875	1826	1841
Rate	0.858	0.946	0.897	0.963	0.922	0.889	0.835	0.837	1.011	0.861	0.862	0.828
Quarterly Rate	0.822			0.706			0.633			0.566		

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Analysis is not complete as of the date of this report.

January-March 2014 Analysis

Slight upward trend during the quarter. Some teams reported that some consumers where choosing to not take their prescribed medications which may have impacted this measure this quarter.

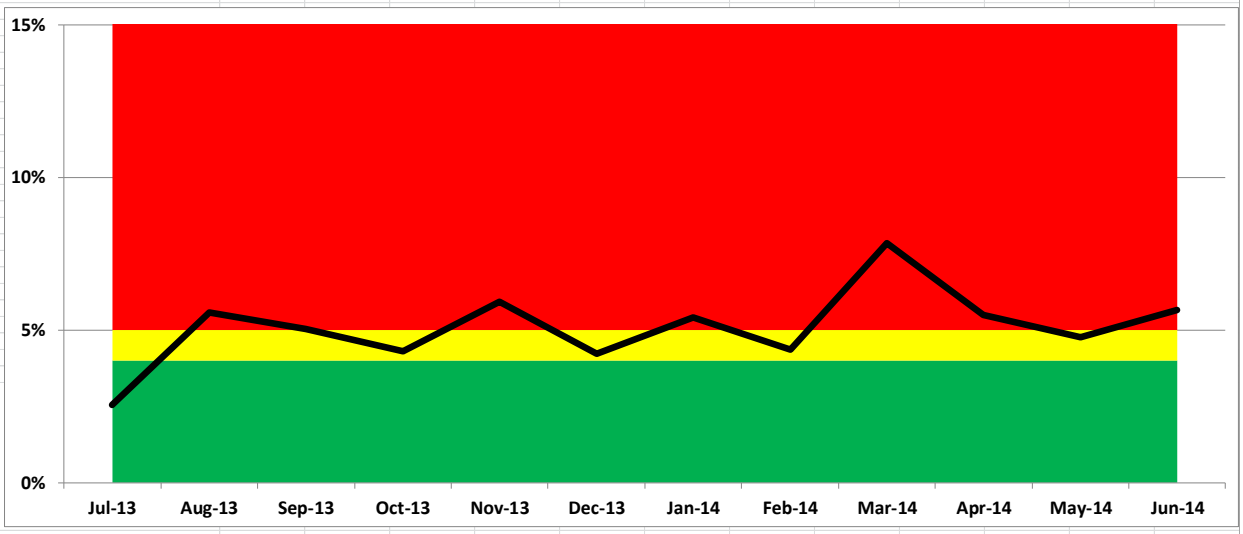
October-December 2013 Analysis

Previous quarter's trend continued into this month. Consumers receiving ACT services less than one day in jail per month.

July-September 2013 Analysis

Throughout the quarter, consumers receiving ACT Services averaged less than one day in jail per month.

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	7	21	22	21	34	25	34	28	52	40	37	39
Denominator	274	376	437	488	575	593	627	641	663	729	776	688
Percent	2.6%	5.6%	5.0%	4.3%	5.9%	4.2%	5.4%	4.4%	7.8%	5.5%	4.8%	5.7%
Quarterly Average	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Analysis is not complete as of the date of this report.

January-March 2014 Analysis

Percentage appeared to be consistent with previous quarters.

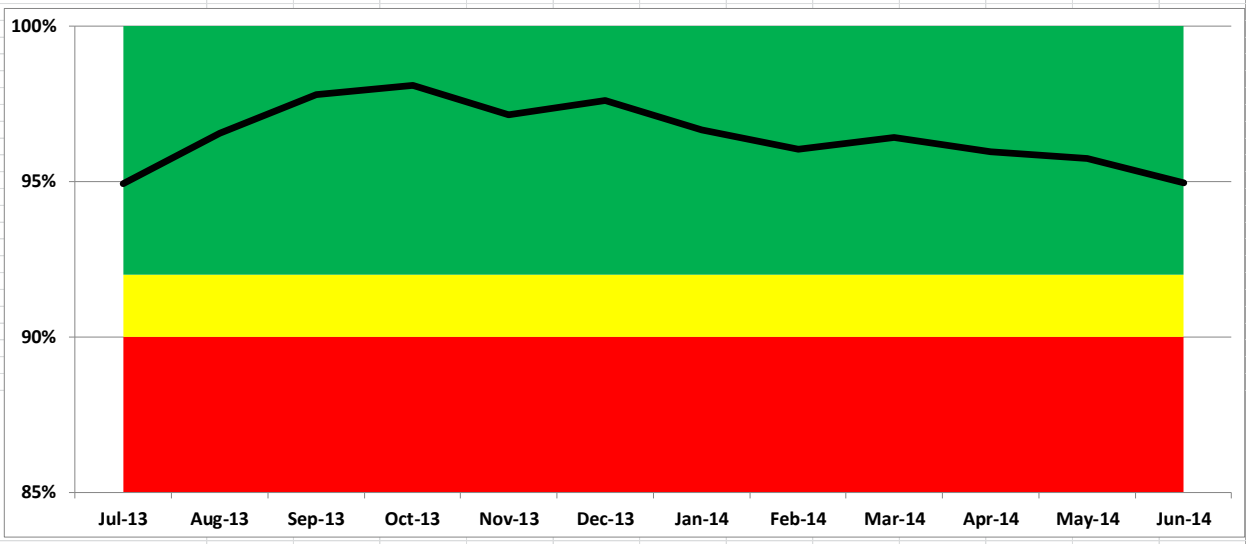
October-December 2013 Analysis

Percentages appeared to hover close to the target percentage.

July-September 2013 Analysis

There appeared to be a slight increase in percentage of consumers with a psychiatric inpatient admission over the quarter. This may have been impacted by the quick increase in the number of consumers that had been newly enrolled into the service. One provider had a Case Manager on medical leave during the quarter which impacted their consumers.

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	337	418	487	516	577	613	635	655	643	711	743	657
Denominator	355	433	498	526	594	628	657	682	667	741	776	692
Percent	94.9%	96.5%	97.8%	98.1%	97.1%	97.6%	96.7%	96.0%	96.4%	96.0%	95.7%	94.9%
Quarterly Average	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Analysis is not complete as of the date of this report.

January-March 2014 Analysis

Percentage remained above the target through the quarter. Providers did not report any barriers.

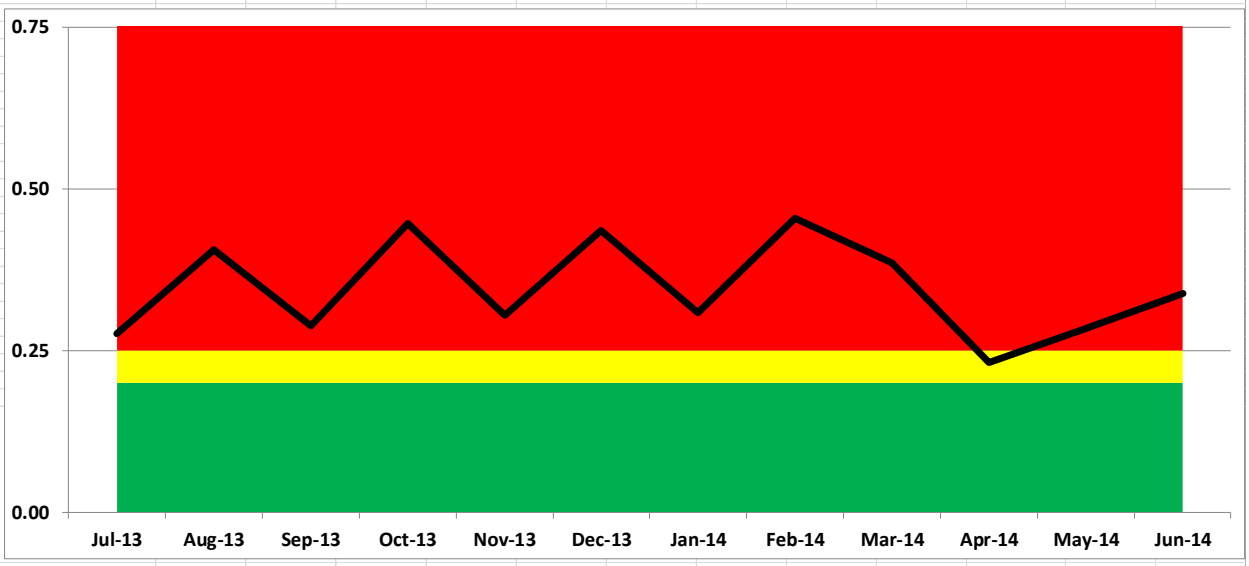
October-December 2013 Analysis

Percentage remained above the target through the quarter. Providers did not report any barriers.

July-September 2013 Analysis

There appears to be a slight increase in the percentage of consumers housed over the quarter.
Providers sited the availability of the GA Housing Vouchers as having a positive impact on this measure.

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	120	200	160	282	199	300	217	344	315	202	259	274
Denominator	435	493	554	632	655	689	705	756	816	872	911	811
Rate	0.276	0.406	0.289	0.446	0.304	0.435	0.308	0.455	0.386	0.232	0.284	0.338
Quarterly Rate	0.324			0.395			0.385			0.283		

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Analysis is not complete as of the date of this report.

January-March 2014 Analysis

Percentage appeared to be consistent with previous quarters.

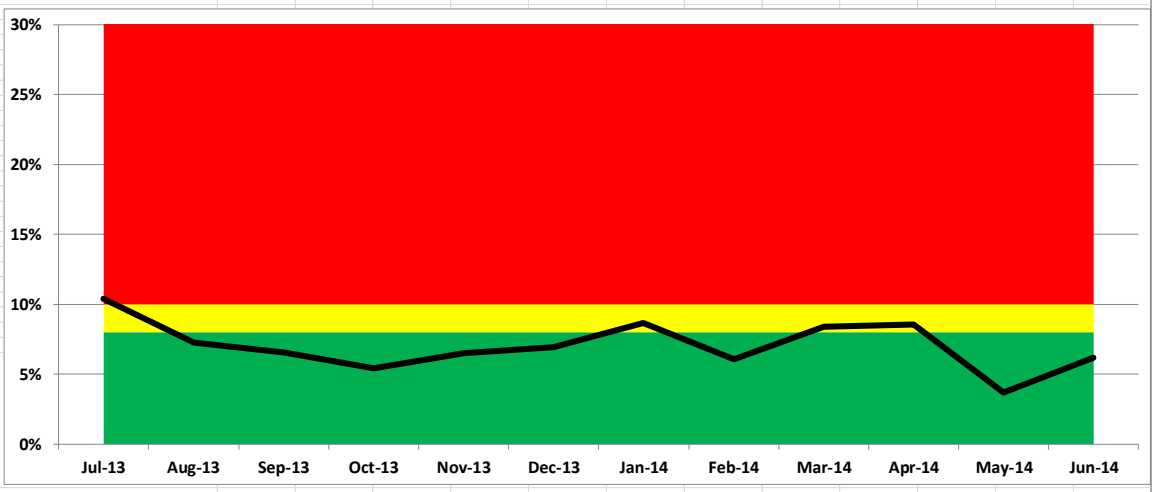
October-December 2013 Analysis

Percentage appeared to be consistent with previous quarters.

July-September 2013 Analysis

The target was not met during any month this quarter. One provider sited a specific court system was slow to process the releases of consumers that were in jail. Another provider sited there was increase utilization due to some consumers having to go to jail as a result of not meeting their individualized requirements set forth in the Mental Health Court.

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	13	11	11	10	13	15	19	14	20	21	9	15
Denominator	125	152	168	185	200	217	220	231	239	245	245	242
Percent	10.4%	7.2%	6.5%	5.4%	6.5%	6.9%	8.6%	6.1%	8.4%	8.6%	3.7%	6.2%
Quarterly Average	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Data collection and analysis not complete as of July 21, 2014.

January-March 2014 Analysis

The percentages appeared higher overall this quarter in comparison to previous quarters. Some teams indicated that the holiday season may have contributed to the increase in hospitalizations. One team reported that they were down a staff member, which may have not made their team as effective at preventing hospitalizations. Another team reported that they were able to proactively engage families during the second quarter but that family involvement waned in the third quarter, which may have impacted the increase in hospitalizations.

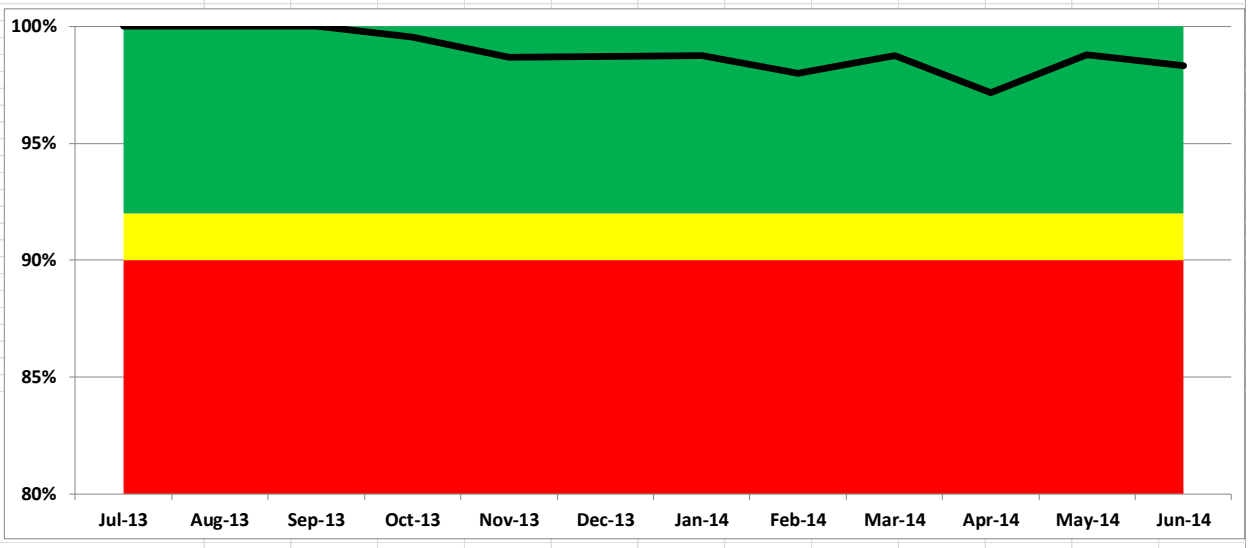
October-December 2013 Analysis

The percentages were below target through the quarter.

July-September 2013 Analysis

The percentage of consumers with psychiatric admissions appeared to decrease over the course of the quarter. However, the actual number of consumers with psychiatric admissions appeared to stay relatively consistent. Some of the strategies providers have used to reduce the proportion of individuals accessing psychiatric admissions have including building direct lines of communication with local emergency rooms and working with consumers and consumers' families to call the CST provider before 911 for urgent non-emergency mental health needs.

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	153	171	200	216	223	231	235	243	236	239	242	236
Denominator	153	171	200	217	226	234	238	248	239	246	245	240
Percent	100.0%	100.0%	100.0%	99.5%	98.7%	98.7%	98.7%	98.0%	98.7%	97.2%	98.8%	98.3%
Quarterly Average	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Data collection and analysis not complete as of July 21, 2014.

January-March 2014 Analysis

Consistent with previous quarters, the percentage appeared to remain consistent during the quarter. Teams did not report any barriers.

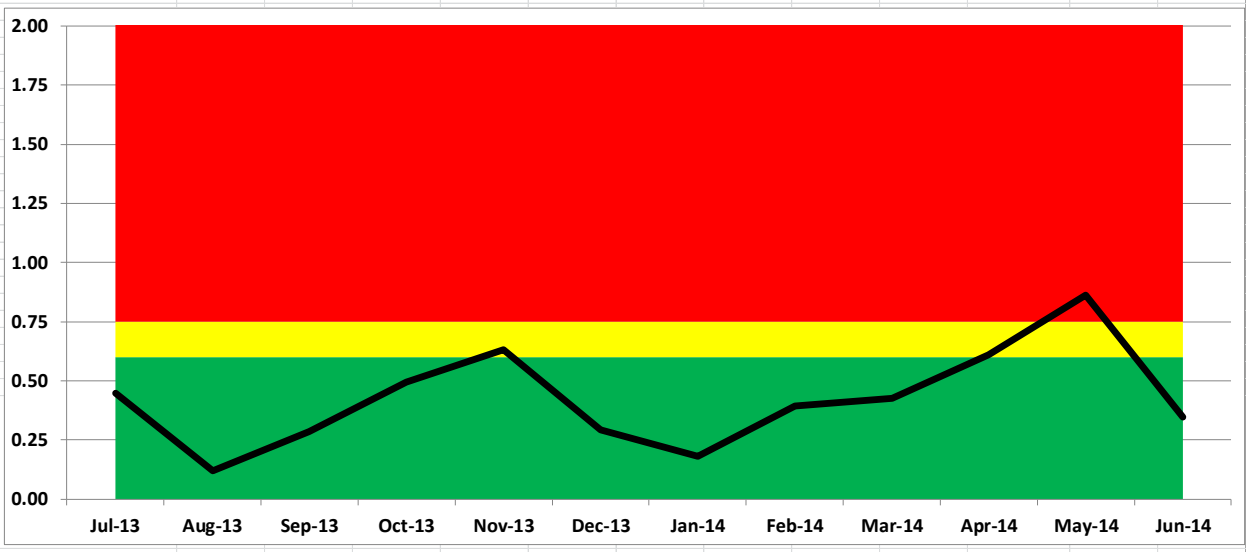
October-December 2013 Analysis

Percentages remained above target through the quarter.

July-September 2013 Analysis

Over the quarter all consumers were reported housed.

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	80	23	63	112	157	76	47	104	121	180	248	100
Denominator	179	194	222	227	248	259	262	265	285	295	288	287
Rate	0.447	0.119	0.284	0.493	0.633	0.293	0.179	0.392	0.425	0.610	0.861	0.348
Quarterly Rate	0.279			0.470			0.335			0.607		

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Data collection and analysis not complete as of July 21, 2014.

January-March 2014 Analysis

Slight upward trend through the quarter. One team reported that they were down a staff member, which may have not made their team as effective at preventing jail days or reducing length of stay in jail. Another team reported that they were able to proactively engage families during the second quarter but that family involvement waned in the third quarter, which may have impacted the jail utilization.

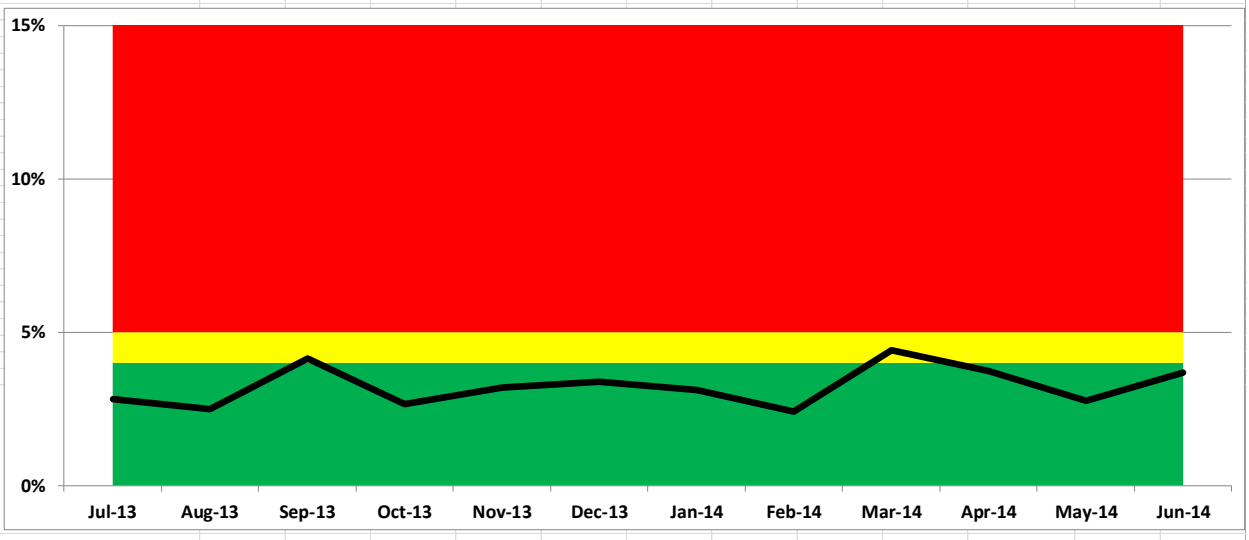
October-December 2013 Analysis

Downward trend through the quarter. Teams indicated that they were actively engaged with consumers when they were in jail.

July-September 2013 Analysis

Over the quarter there appeared to be variable amounts of jail days utilized. Providers sited
that a small number of consumers go to jail for small to long periods of time, which impacts the final average.

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	16	14	24	16	21	23	21	17	32	26	19	24
Denominator	568	563	580	604	655	681	673	703	727	695	688	653
Percent	2.8%	2.5%	4.1%	2.6%	3.2%	3.4%	3.1%	2.4%	4.4%	3.7%	2.8%	3.7%
Quarterly Average	3.2%			3.1%			3.3%			3.4%		

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Analysis is not complete as of the date of this report.

January-March 2014 Analysis

Percentage remained below the target through the quarter. Providers did not report any barriers.

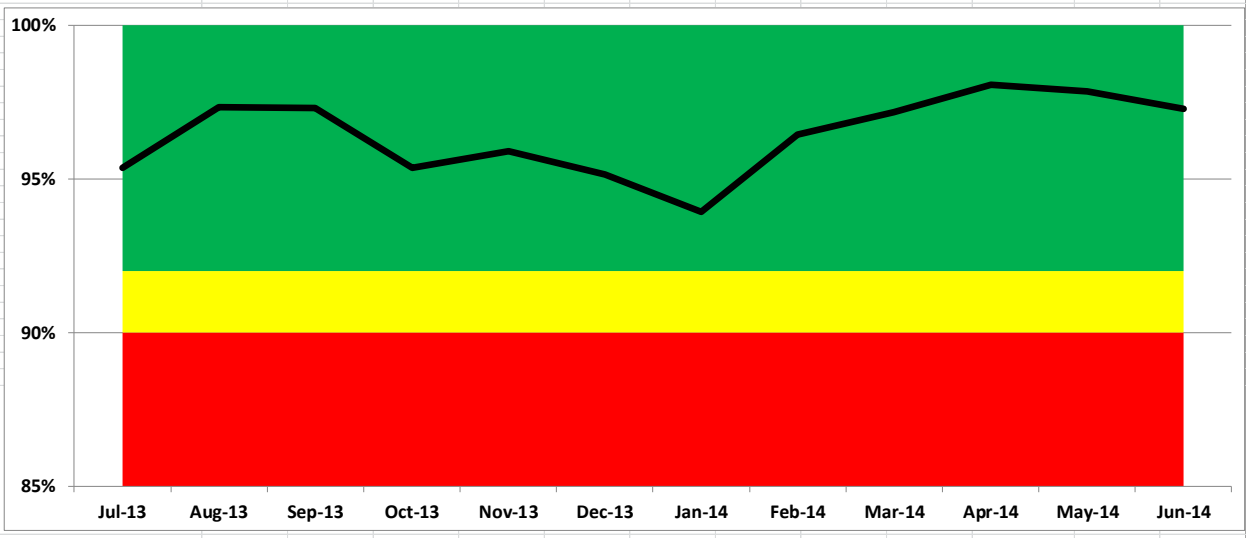
October-December 2013 Analysis

Percentage remained below the target through the quarter. Providers did not report any barriers.

July-September 2013 Analysis

It appeared that there was consistently low inpatient admission over the course of the quarter.

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	577	585	616	615	655	684	680	730	724	712	681	677
Denominator	605	601	633	645	683	719	724	757	745	726	696	696
Percent	95.4%	97.3%	97.3%	95.3%	95.9%	95.1%	93.9%	96.4%	97.2%	98.1%	97.8%	97.3%
Quarterly Average	N/A due to monthly unduplicated counts											

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Analysis is not complete as of the date of this report.

January-March 2014 Analysis

Percentage remained above the target through the quarter. Providers did not report any barriers.

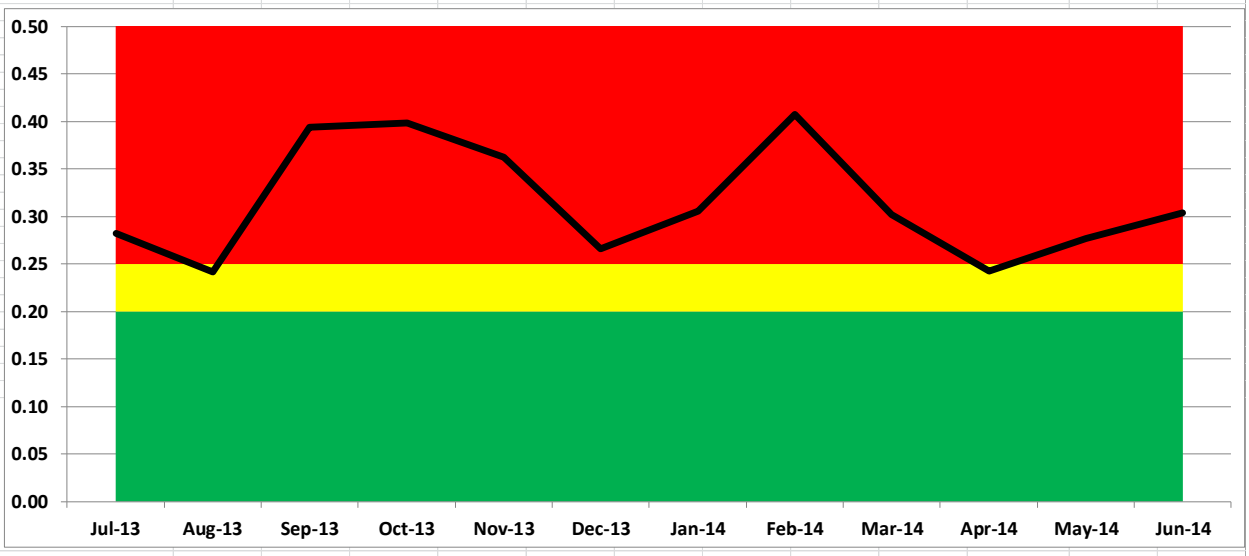
October-December 2013 Analysis

Percentage remained above the target through the quarter. Providers did not report any barriers.

July-September 2013 Analysis

It appeared that there was a consistently high percentage of consumers housed each month this quarter. CM providers sited the availability of the GA Housing Vouchers as having a positive impact on this measure. However, some of the providers in the more urban areas sited that they have seen an increase in the number of people moving into the area without housing.

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



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Numerator	183	166	282	297	279	211	246	336	253	204	234	248
Denominator	648	688	715	746	769	792	805	825	838	842	846	815
Rate	0.282	0.241	0.394	0.398	0.363	0.266	0.306	0.407	0.302	0.242	0.277	0.304
Quarterly Rate	0.308			0.341			0.338			0.274		

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Analysis is not complete as of the date of this report.

January-March 2014 Analysis

Percentage appeared to be consistent with previous quarters.

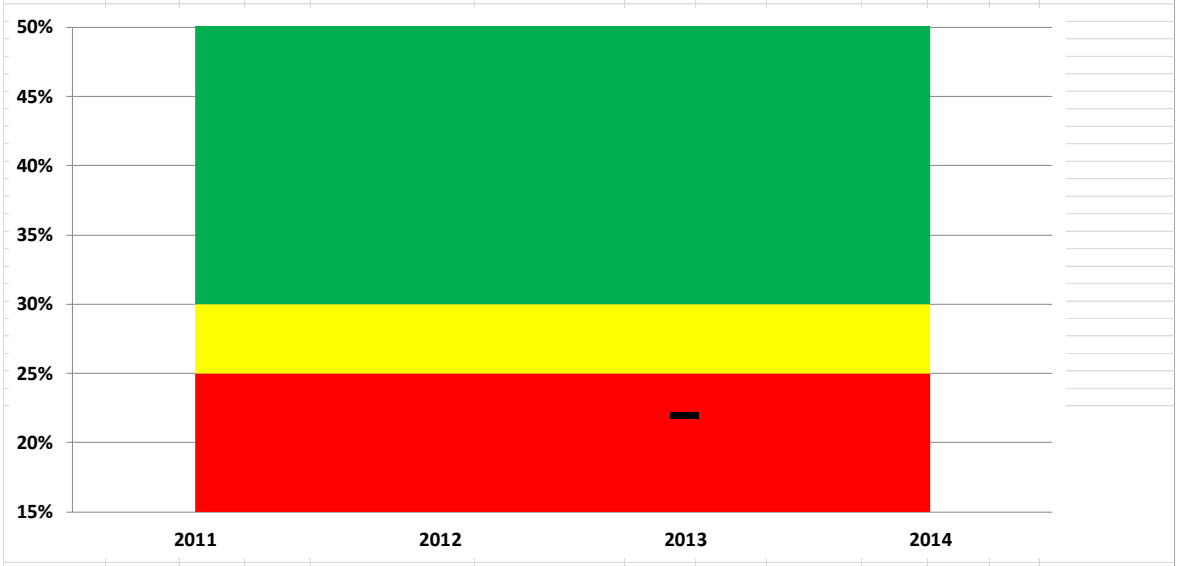
October-December 2013 Analysis

Numbers appeared to be consistent with previous quarters, however, there was a slight downward trend.

July-September 2013 Analysis

The target was not met during any month this quarter. One provider sited that they are having an increase in referrals from local jails. It was reported by providers that a small number of consumers are utilizing the majority of the jail days. One provider reported low jail utilization from their agency due to assisting consumers with their Mental Health Court requirements, therefore, eliminating the possibility of the consumers going to jail for not meeting their requirements.

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



	2011	2012	2013	2014
Numerator	0	0	22	0
Denominator	0	0	100	0
Percent	#N/A	#N/A	22.0%	#N/A

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER YEAR

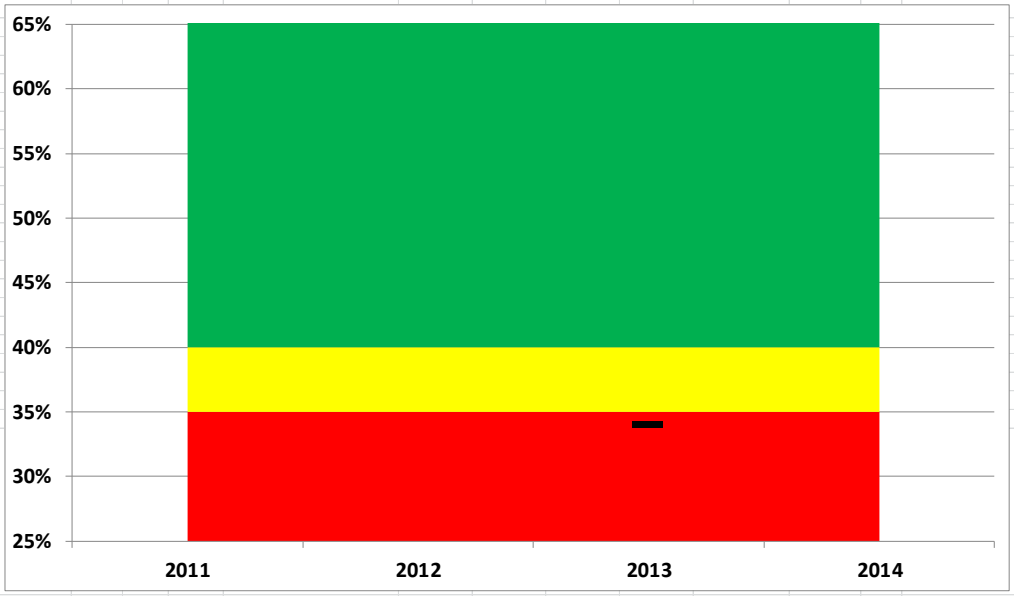
Annually 2014

This KPI became effective in July 2013, is collected on an annual basis and is considered a more critical quality issue. The target threshold of 25% was not met in 2013. It is anticipated that updated data will become available in October 2014.

Annually 2013

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

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



	2011	2012	2013	2014
Numerator	0	0	34	0
Denominator	0	0	100	0
Percent	#N/A	#N/A	34.0%	#N/A

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER YEAR

Annually 2014

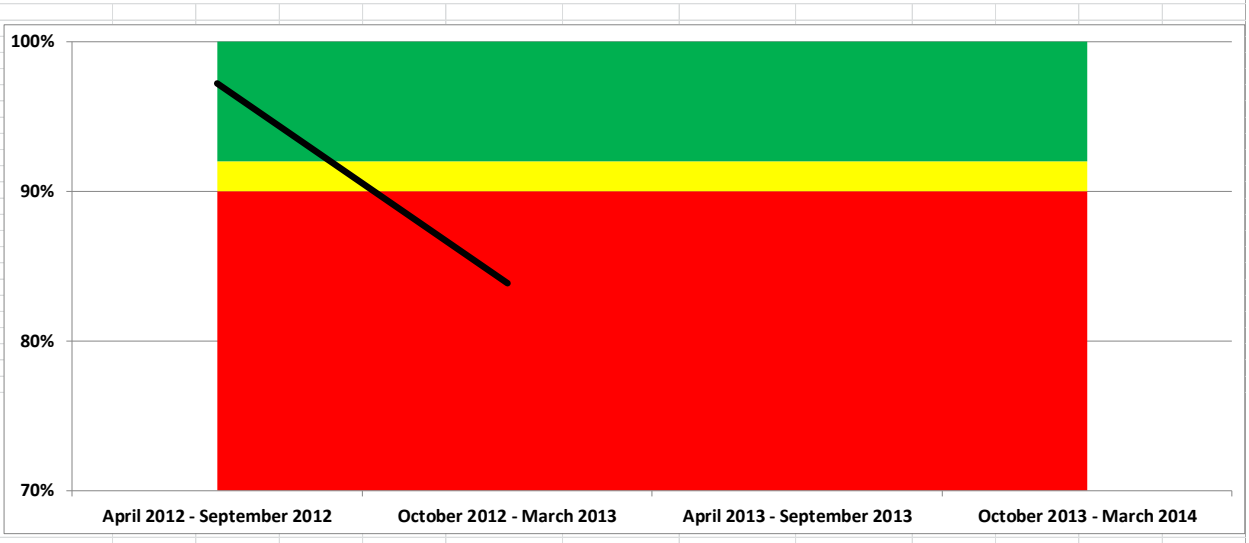
This KPI became effective in July 2013, is collected on an annual basis and is considered a more critical quality issue. It is anticipated that 2014 data will become available in October 2014.

Annually 2013

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

Percent of individuals meeting community settlement agreement criteria who are enrolled in settlement funded services who state they are satisfied with the services they are receiving

Target 90% or more



	April 2012 - September 2012	October 2012 - March 2013	April 2013 - September 2013	October 2013 - March 2014
Numerator	35	26	0	0
Denominator	36	31	0	0
Rate	97%	84%	#N/A	#N/A

MEASURE DEFINITION AND EXPLANATION

Measure definition: Those individuals who meet Settlement Agreement Criteria, were chosen by the QM Audit Team to receive an audit, and who agreed to be interviewed who stated they are satisfied with the ADA service they are receiving.

Measure explanation: The purpose of this measure is to provide the Department with a snapshot of the level of satisfaction of individuals involved in settlement agreement services.

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER PERIOD

October 2013 - March 2014

Data collection was put on hold between April 2013 – June 2014 secondary to the QM audit team performing a follow-up audit of inpatient hospital re-admissions.

April 2013 - September 2013

Data collection was put on hold between April 2013 – June 2014 secondary to the QM audit team performing a follow-up audit of inpatient hospital re-admissions.

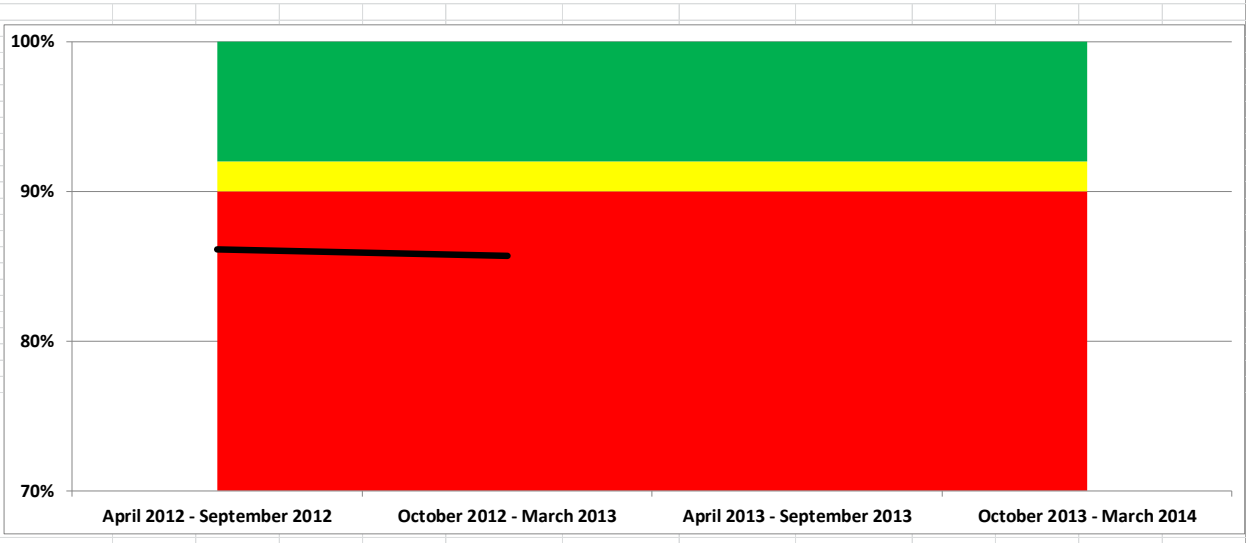
October 2012 - March 2013

ADA services have been in place for a longer period of time and providers have been improving their quality of service via agency specific PI indicators. It is hypothesized that these quality improvement processes may have impacted individuals' satisfaction with services.

April 2012 - September 2012

Many providers were still in the start up phase of service provision and many were in a learning curve regarding the state's standards and requirements during this time period. This may have impacted individuals' satisfaction with services.

Percent of individuals meeting community settlement agreement criteria who are enrolled in settlement funded services who feel their quality of life has improved as a result of receiving services
Target 90% or more



	April 2012 - September 2012	October 2012 - March 2013	April 2013 - September 2013	October 2013 - March 2014
Numerator	31	24	0	0
Denominator	36	28	0	0
Rate	86%	86%	#N/A	#N/A

MEASURE DEFINITION AND EXPLANATION

Measure definition: Those individuals who meet Settlement Agreement Criteria, were chosen by the QM Audit Team to receive an audit, and who agreed to be interviewed who stated their quality of life has improved since receiving ADA services.

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER PERIOD

October 2013 - March 2014

Data collection was put on hold between April 2013 – June 2014 secondary to the QM audit team performing a follow-up audit of inpatient hospital re-admissions.

April 2013 - September 2013

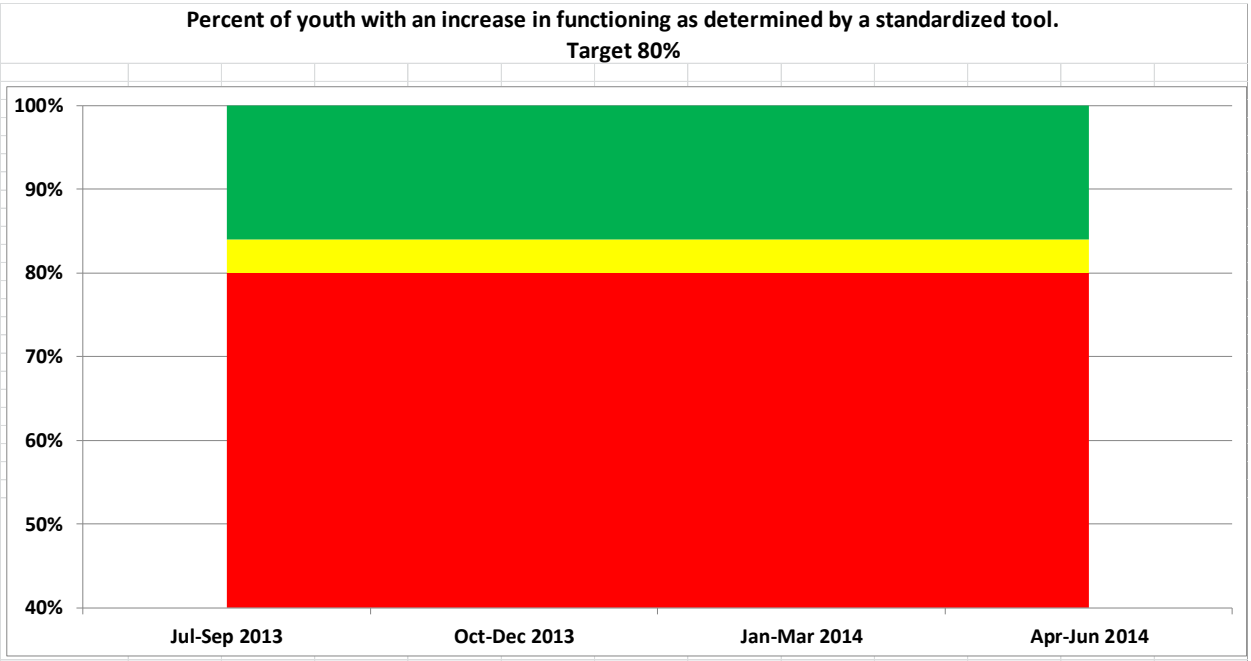
Data collection was put on hold between April 2013 – June 2014 secondary to the QM audit team performing a follow-up audit of inpatient hospital re-admissions.

October 2012 - March 2013

While there is an upward trend towards overall improvement in quality of life, the benchmark may be difficult to reach due to the nature of SPMI and its impact on the individual. Because individuals are continuously enrolled in services, there is a subset of individuals interviewed who may not have been enrolled in services for a sufficient amount of time to realize the impact on their quality of life. The trend should continue to improve as providers continue to improve their quality of service.

April 2012 - September 2012

ADA services had not been in place for a long period of time and it has been hypothesized that there was insufficient time for individuals to realize the impact on their quality of life.



	Jul-Sep 2013	Oct-Dec 2013	Jan-Mar 2014	Apr-Jun 2014
Numerator	0	0	0	0
Denominator	0	0	0	0
Rate	N/A	N/A	N/A	#N/A

MEASURE DEFINITION AND EXPLANATION

Measure definition: This measure captures if the services being provided assist the youth in their daily functioning from the providers perspective.

Measure explanation: To examine the perception of improvement in youths treatment from the providers perspective.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of youth who have increased functioning.	**Denominator:** Number of youth surveyed.

COMMENTS AND/OR ANALYSIS PER QUARTER

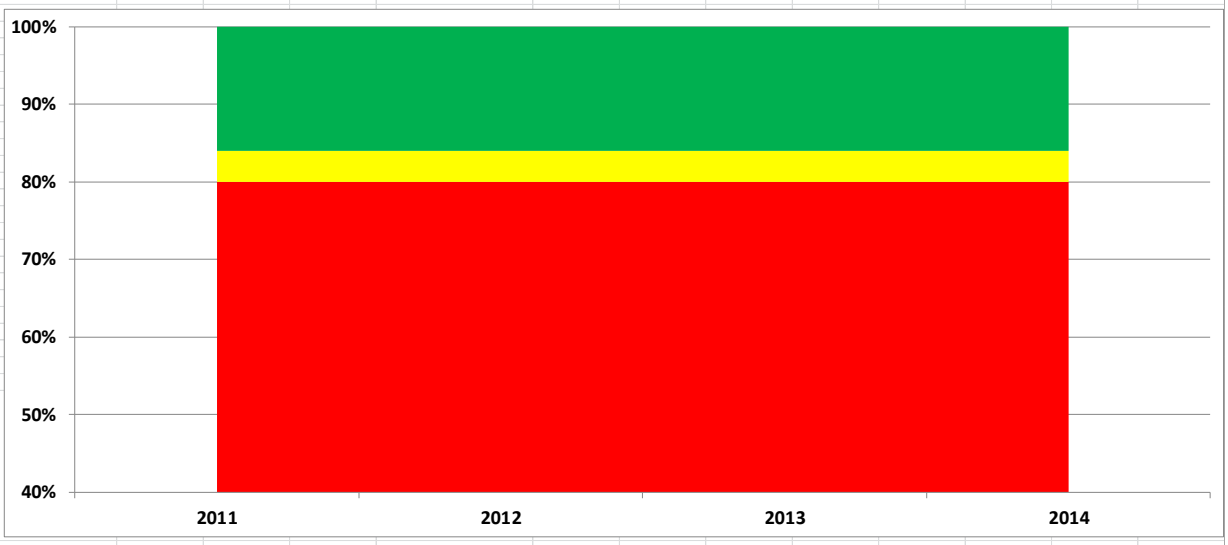
April-June 2014 Analysis

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

January-March 2014 Analysis

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

Percent of families of youth satisfied with services as determined by a standardized tool
Target 80%



	2011	2012	2013	2014
Numerator	0	0	0	0
Denominator	0	0	0	0
Rate	N/A	N/A	N/A	N/A

MEASURE DEFINITION AND EXPLANATION

Measure definition: This measure captures if the family is satisfied with the services being provided.

Measure explanation: To examine the perception of satisfaction with services from a family's perspective.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of families satisfied.

Denominator: Number of families served.

COMMENTS AND/OR ANALYSIS PER QUARTER

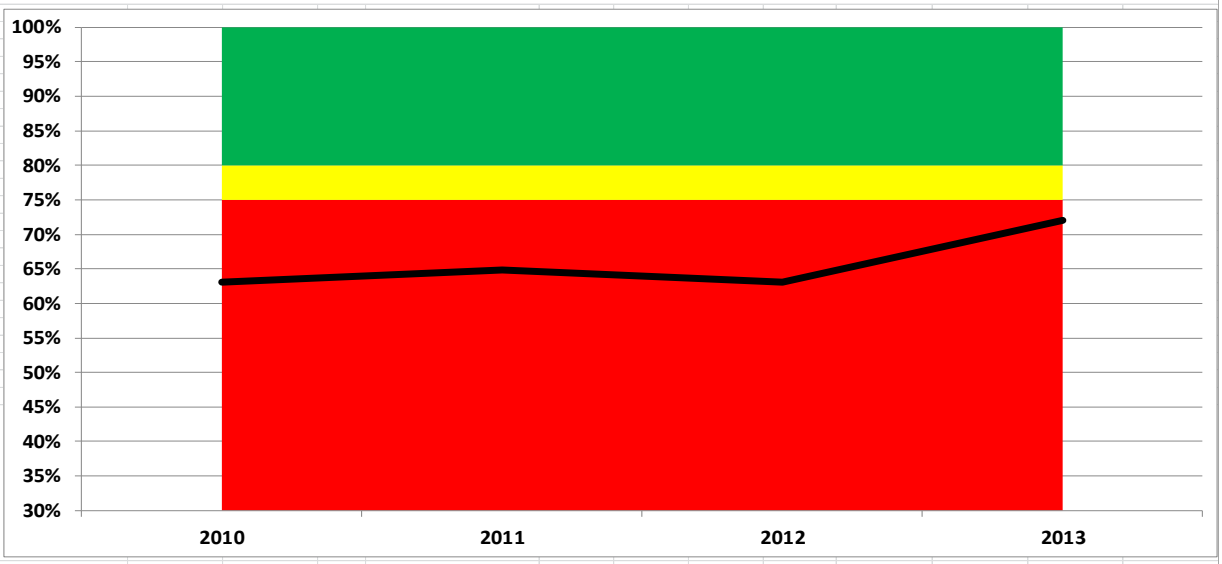
Annually 2014

This data is collected and analyzed on an annual basis. In 2013, 70.2% of families of youth were satisfied with the community mental health services they received. These results were based on a relatively small number of participants (n=346) so they should not be generalized to the general public. The Department is examining how the survey data is collected and will likely move to additional ways to gather more surveys. Also, in FY14, due to a transition in the children's mental health system where 95% of the youth will be receiving services through managed care organizations, DBHDD will expand the survey to cover all public mental health services recipients.

Annually 2013

Appendix G Developmental Disabilities KPI Dashboards

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



	2010	2011	2012	2013
Numerator	261	270	260	358
Denominator	414	416	412	497
Rate	63.0%	64.9%	63.1%	72.0%

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that they have had a flu shot in the last year. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered ata in ODESA which HSRI in turn downloaded for analysis.

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

COMMENTS AND/OR ANALYSIS PER YEAR

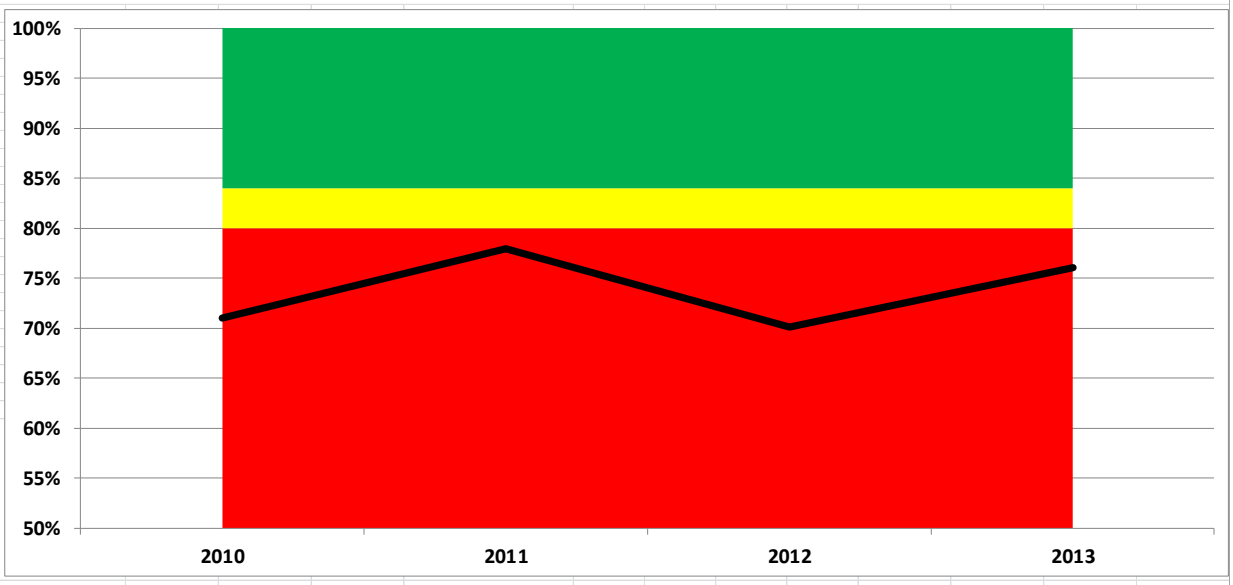
Annually 2013

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

Annually 2012

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

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



	2010	2011	2012	2013
Numerator	306	326	312	391
Denominator	431	418	445	514
Rate	71.0%	78.0%	70.1%	76.1%

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that they have had a dental examination in the last year. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI).
Most states entered ata in ODESA which HSRI in turn downloaded for analysis.

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

COMMENTS AND/OR ANALYSIS PER YEAR

Annually 2013

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

Annually 2012

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

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

	2010	2011	2012	2013
Numerator	414	373	466	448
Denominator	465	451	518	520
Rate	89%	83%	90%	86%

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that they have had an annual physical examination in the last year. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered ata in ODESA which HSRI in turn downloaded for analysis.	**Denominator:** The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or we aware is they had a physical exam or not. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered ata in ODESA which HSRI in turn downloaded for analysis.

COMMENTS AND/OR ANALYSIS PER YEAR

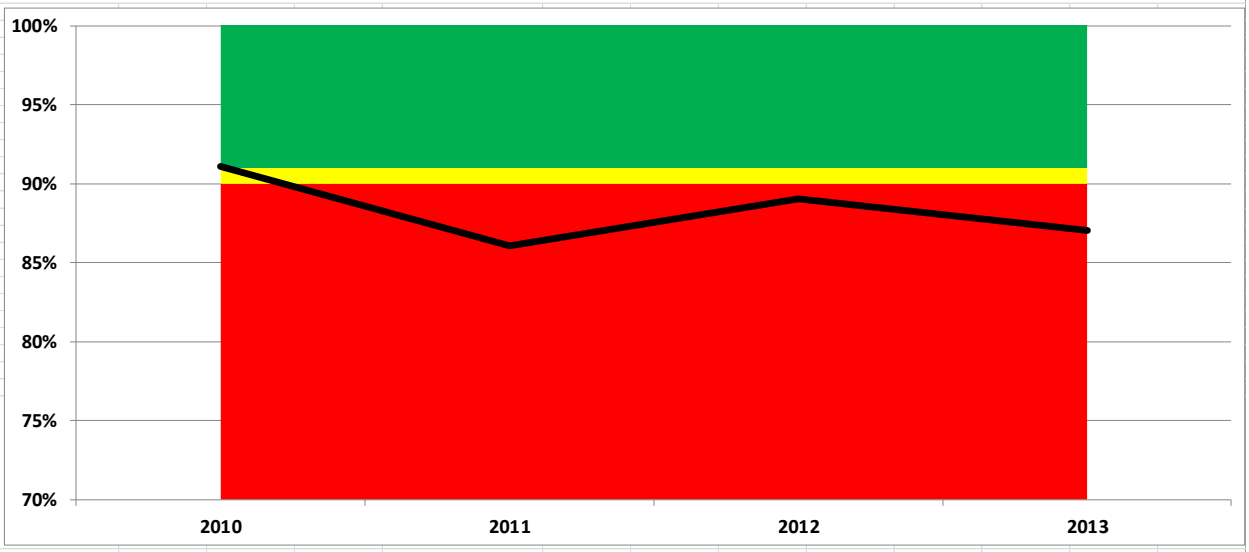
Annually 2013

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

Annually 2012

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

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



	2010	2011	2012	2013
Numerator	297	291	342	336
Denominator	326	338	384	386
Rate	91%	86%	89%	87%

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that they either feel safe in their home or never feel afraid in their home. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI).
Most states entered ata in ODESA which HSRI in turn downloaded for analysis.

Denominator: The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or were willing to answer this question. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI).
Most states entered ata in ODESA which HSRI in turn

COMMENTS AND/OR ANALYSIS PER YEAR

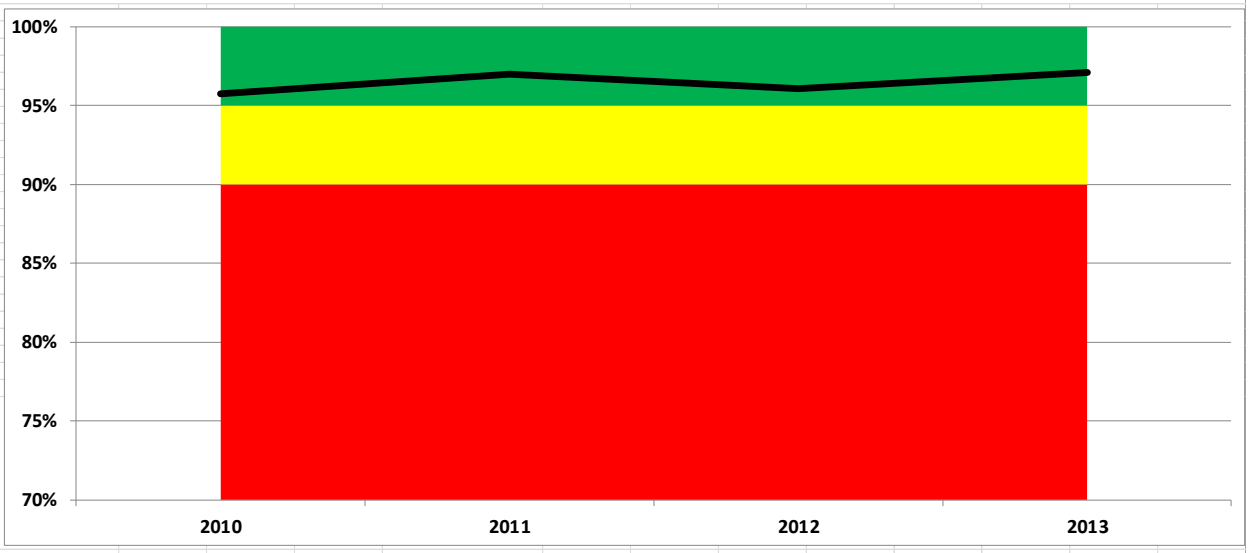
Annually 2013

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

Annually 2012

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

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



	2010	2011	2012	2013
Numerator	157	194	170	302
Denominator	164	200	177	311
Rate	96%	97%	96%	97%

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that their staff treat them with dignity and respect. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered ata in ODESA which HSRI in turn downloaded for analysis.

Denominator: The Denominator is the number of individuals who were able to answer this question. Not all individuals were capable or were willing to answer this question. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI).
Most states entered ata in ODESA which HSRI in turn

COMMENTS AND/OR ANALYSIS PER YEAR

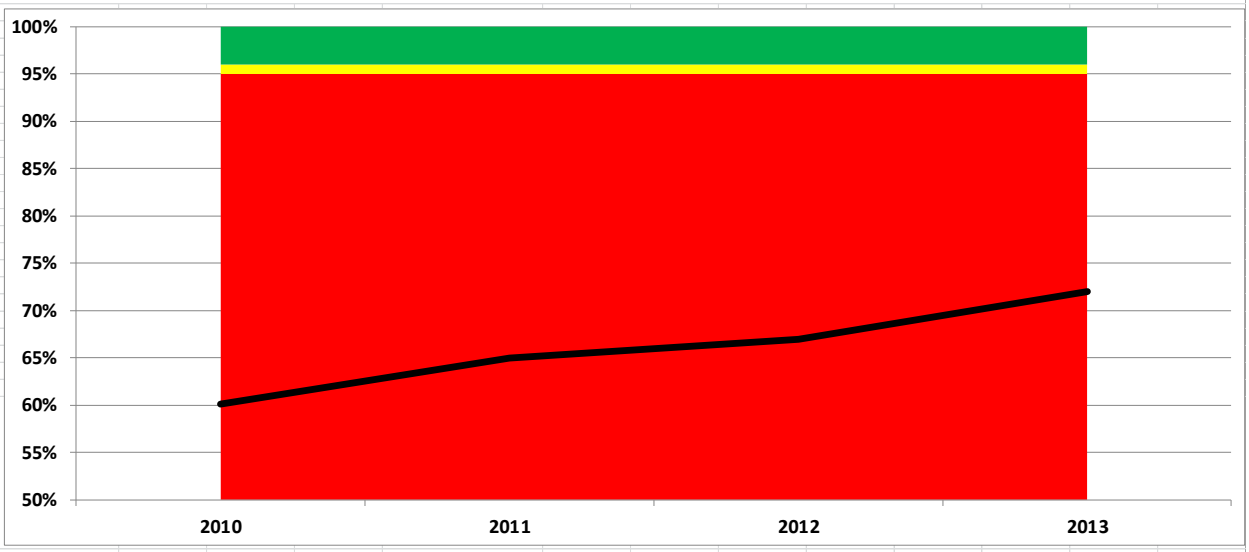
Annually 2013

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

Annually 2012

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

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



	2010	2011	2012	2013
Numerator	265	297	349	432
Denominator	441	457	521	600
Rate	60%	65%	67%	72%

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: The numerator is the number of individuals who reported that their staff treat them with dignity and respect. NCI data management and analysis is coordinated by Human Services Research Institute (HSRI). Most states entered in ODESA which HSRI in turn downloaded for analysis.

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

COMMENTS AND/OR ANALYSIS PER YEAR

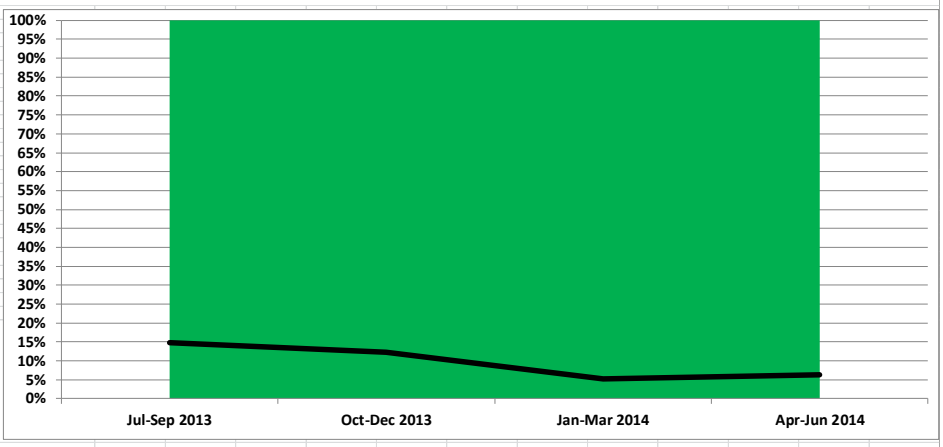
Annually 2013

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

Annually 2012

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

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



	Jul-Sep 2013	Oct-Dec 2013	Jan-Mar 2014	Apr-Jun 2014
Numerator	54	39	36	34
Denominator	364	318	683	542
Rate	14.8%	12.3%	5.3%	6.3%

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Data report includes only April and May data for the second quarter 2014. June data had not been collected fully by the time of this reports. June data will be added as part of the 2014 Year End Report. Utilization of intensive in-home supports increased slightly in April and May, but still is in line with last quarter's utilization. DBHDD continues to research appropriate respite alternatives to intensive in-home supports.

January-March 2014 Analysis

Utilization of intensive in-home supports dropped by slightly more than half during this quarter (5% as compared to 12% last quarter); however, the number of crisis call episodes doubled (682 compared to 318). Further investigation is needed into the cause for the rise in calls, and the main disposition categories. Receditivism and dually-diagnosed individuals continue to chanllenge DBHDD. DBHDD has been seeking possible providers of emergency respite and planned respite as alternatives to intensive in-home crisis sypports once the crisis has been stabilized.

October-December 2013 Analysis

Utilization of intensive in-home supports dropped by 2% this quarter. This is the lowest utilization of the year.

July-September 2013 Analysis

Utilization of intensive in-home supports remained stable during this time period, though provision of overall crisis services increased slightly

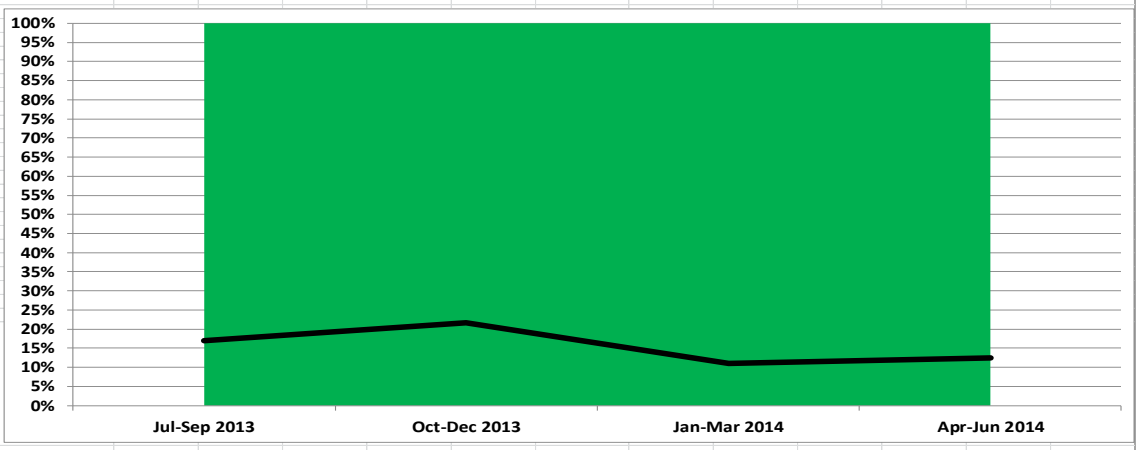
April-June 2013 Analysis

Utilization of intensive in-home supports dropped less than 1% during this quarter. This is in line with utilization for the previous year's timeframe

January-March 2013 Analysis

The DD Crisis Response System is was implemented in June 2011. It is new crisis system for Georgia, and goals have not been set at this time for the intensive in-home supports. It is the hope of the Department that most crisis episodes can be resolved with the least amount interruption in the individual's life. This quarter's result of 15% is in line with data from 3rd quarter last year which was 15%.

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



	Jul-Sep 2013	Oct-Dec 2013	Jan-Mar 2014	Apr-Jun 2014
Numerator	62	69	75	68
Denominator	364	318	683	542
Rate	17%	22%	11%	13%

MEASURE DEFINITION AND EXPLANATION

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

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

COMPONENTS OF NUMERATOR AND DENOMINATOR

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

Denominator: Total number of crisis episodes statewide.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2014 Analysis

Data report includes only April and May data for the second quarter 2014. June data had not been collected fully by the time of this reports. June data will be added as part of the 2014 Year End Report. Utilization of the crisis homes increased slightly in April and May, but still is in line with last quarter's utilization. DBHDD continues to research respite alternatives to out of home

January-March 2014 Analysis

Utilization of the crisis homes dropped by half during this quarter (11% as compared to 22% last quarter); however, the number of crisis call episodes doubled (682 compared to 318). Further investigation is needed into the cause for the rise in calls, and the main disposition categories. Receditivism and dually-diagnosed individuals continue to chanllenge DBHDD. DBHDD has been

October-December 2013 Analysis

Untilization jumped again (5% points), but not as much as 2nd quarter. Several placements this quarter were receditive dual diagnosis placements. Division of DD has implemented a dual diagnosis review committee to help address this issue.

July-September 2013 Analysis

Utilization dropped back to normal level as compared to last quarter. DD continues its evaluation of its emergency respite services. The emergency respite policy is being reviewed for possible updates.

April-June 2013 Analysis

Utilization of intensive out of home supports increase significantly (8% points) this quarter. Crisis providers report that a lack of community emergency respite services is still an issue that results in out of home placement. Division of DD will begin an analysis of its Emergency Respite system.

January-March 2013 Analysis

The DD Crisis Response System was implemented in June 2011. It is a new crisis system for Georgia, and goals have not been set at this time for the intensive out of home (crisis home) supports. It is the hope of the Department that most crisis episodes can be resolved with the least amount interruption in the individual's life. This quarter's result of 16% is up slightly from the time last year (14%). Many placements in a crisis home are the result of an individual being in crisis and the lack of appropriate emergency respite services in the community. The Department will be addressing this issue over the next few months.