Georgia Department of Behavioral Health & Developmental Disabilities

ANNUAL QUALITY MANAGEMENT REPORT
January 2013 – December 2013

Prepared by the DBHDD Office of Quality Management
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Contents

Introduction

The State of Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) is committed to developing and implementing policies, protocols, and fidelity assurance mechanisms to support generally accepted professional standards with regard to the care of individuals served within the DBHDD system.

The DBHDD Quality Management Program was established to support the Department's commitment to the continuous improvement of the quality of its services. The purpose of the Quality Management Program is to monitor and evaluate DBHDD programs/services in order to continuously improve the quality of care for all consumers served in the DBHDD system.

The Department's Quality Management Plan was revised in April 2013 and provides detailed information about the organizational structure of the Quality Management Program, a detailed description of the Executive and Program Quality Councils and the goals and objectives of each council. The revised QM plan can be found at: http://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/document/QM%20Plan-April%202013%20rev.pdf

This is the second year that DBHDD has completed an annual review of its Quality Management system. The purpose of this report is to provide a summary of the quality management activities that have taken place across DBHDD during 2013. Because there is a lag time associated with the availability of some data, the analysis and discussion contained within this report will vary by date range, but generally focuses on activities between January 2013 – December 2013.

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 oversight. It is the ultimate authority for all DBHDD QM activities including the QM plan, the DBHDD work plan, and the annual evaluation. During 2013 the EQC met in January, March, May, July, October and November.

During those meetings the EQC:

- Performed its annual review of the QM system including a review of the QM structure.
- Revised the membership of the Executive Quality Council and reviewed changes to the membership of the Community Behavioral Health (CBH) and Developmental Disabilities (DD) Program Quality Councils (PQCs).
- Approved the April 2013 revision of the DBHDD QM Plan.
- Discussed the feasibility of setting DBHDD-wide key performance indicators.
- Hosted a QM presentation by the Georgia Association of Community Service Boards (CSBs).
- Determined information that should be reported to the EQC.
- Received updates from the Hospital, CBH, and DD PQCs regarding the quality management-related work that each functional area has prioritized.

- Reviewed trends/patterns of their Key Performance Indicators (KPIs).
- Received updates regarding the transition of placements for DD consumers moving from institutions to the community.
- Supported the development of a DBHDD Enterprise Data Warehouse.
- Chartered a Performance Improvement Team, whose goal was to review and recommend changes to the community incident management and investigations process.
- Reviewed and provided recommendations in response to trends and patterns in data on incidents, complaints, and grievances.
- Provided guidance associated with assuring the receipt of dental services for DD consumers.
- Reviewed the results of the 2013 Developmental Disabilities Quality Improvement Study.
- Approved a Department wide CQI project related to a Corrective Action Plan (CAP) training project.
- Reviewed and provided recommendations to improve the DBHDD Suicide Prevention Program.
- Reviewed and provided input regarding compliance related to the ADA Settlement Agreement.

Hospital System Program Quality Council

The Hospital System PQC met quarterly during 2013, and held four meetings between January 2013 and December 2013. In addition to those quarterly meetings, the Hospital System held monthly Hospital System-wide quality management meetings to monitor and address patient safety performance measures. During those meetings this PQC:

- Reviewed PI initiatives focused on management of aggression, restraint and seclusion, polypharmacy, consumer satisfaction and other performance measures.
- 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.
- Work has also been done to improve related corrective action plans to assure better cause identification and descriptions of methodologies for improving the effectiveness of corrective actions.
- Collaborated with the Office of Incident Management and Investigations (OIMI) to improve investigations and reports so that there is more consistent consideration of root causes of incidents and to link any process or systemic issues identified into the Quality Management System.
- Improved the dissemination of information regarding the activities of the Executive Quality Council. In addition to distributing the EQC meeting minutes, a review of EQC activities has been added as a standing agenda item to the Hospital System PQC. The intent has been to assure effective two-way flow of information.

For 2014 the Hospital System PQC resumes a monthly schedule and, along with the monthly Quality Managers' meeting, will incorporate and integrate the monthly CRIPA compliance monitoring and improvement activities.

Community Behavioral Health Program Quality Council

The Community Behavioral Health PQC was scheduled to meet monthly and has held eleven meetings between January 2013 and December 2013. During those meetings the CBH PQC:

- Revised the membership of the Community Behavioral Health Program Quality Council to be more representative of its programs.
- Reviewed community-based data available from the Office of Incident Management and Investigations and selected five measures to monitor, reviewed sample reports that trend those measures, and determined the format to be used for reviews of trends.
- 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 needed to be developed and some of the current KPIs required revision
    - made suggestions/recommendations for program/service changes
- Developed a CBH Outcomes Framework to provide a foundation for its quality improvement system - see Appendix A.
- Discussed and established additional KPIs to provide a broader array of indicators of system-wide performance.
- Reviewed and approved an update/overview of the Child and Adolescent Program's quality management system.
- Received an update/overview of the Georgia Housing Voucher Program which included a discussion regarding trends/patterns and assessment of potential future challenges.
- Received periodic updates regarding the findings of the Fidelity reviews for Supported Employment and Assertive Community Treatment(SE & ACT)
- Received an update regarding the progress of the Suicide Prevention Program and discussed suicide trends.
- Participated in a QM brainstorming session with multiple Community Service Board (CSB) representatives in May 2013 in order to obtain stakeholder input.
- Developed a collaborative relationship with the Georgia Association of Community Service Boards (GACSB) and held a series of conference calls between a subgroup of the CBH PQC and the Chair of the Benchmarking subgroup for the GACSB in order to obtain stakeholder input.
- Reinforced the importance of whole heath and reviewed a list of suggested KPI physical health status indicators. Placed the issue of collecting physical health indicators on hold pending the outcome of the Department's Administrative Services Organization (ASO) planning in which analysis of Medicaid claims data is being discussed. Physical health indicator information for uninsured individuals remains a significant challenge.
- Implemented a review of its KPIs using the Performance Management Evaluation Tool.
- Reviewed information from the Office of Incident Management and Investigations (OIMI) regarding possible non-reporting of critical incidents (CIRs) from community providers for the past 12 months and recommended Central Office program

directors/managers follow-up with providers as appropriate. Additionally the PQC recommended a memo be sent from the Assistant Commissioners for BH and DD reminding providers of their requirement to report CIRs and requesting they review their processes and procedures to ensure they are consistent with DBHDD reporting requirements. This memo was sent to providers in October 2013.

- Received periodic updates about the work, priorities, and activities of the DBHDD Executive Quality Council.
- The Director of the Office of Recovery Transformation presented potential measures that could serve as a KPI reflective of the recovery orientation of the system of care, to the committee. These are in the process of review and will be finalized at the beginning of 2014.
- Reviewed and discussed trends from the 2012 Adult and Youth/Family Consumer Survey Reports.

Developmental Disabilities Program Quality Council

The Developmental Disabilities PQC met quarterly in 2013. Outcomes of those meetings include:

- A QI project between the Division of Developmental Disabilities and the Georgia Department of Public Health was discussed. This project has not been completed to fruition at the time of the writing of this report, but as an interim measure, the dental clinics at all DBHDD state hospitals remain open while the hospitals remain open and are available to individuals with DD who are supported by DBHDD.
- Received an evaluation of the current DD Quality Management System from an external contractor. See Attachment 1: Quality Management System Review - Summary of Current Status Report. Continued improvements will be made to the DD QM System in 2014.
- Helped to guide Division priorities for the Department's RFP for an Administrative Service Organization (ASO).
- Finalized the Statewide QI Council's Supported Employment Project.
- The Statewide Quality Improvement Council focused on re-defining their role in the State system. Along with completing its annual QI project, the Statewide Quality Improvement Council will provide additional guidance and external stakeholder input on the restructuring of the current DD QM system.

DD Quality Improvement Councils and DD Advisory Council

The Division of DD has six Regional and one Statewide Quality Improvement Council. The role of the Quality Improvement (QI) Councils is to review and analyze data for developing service improvement targets and tracking progress. Data sources that are available to the QI Councils include data collected by the DD ERO (Delmarva), such as, the National Core Indicator (NCI) surveys, Person Centered Reviews (PCR), Quality Enhancement Provider Reviews (QEPR), and other data sets. Because of their unique positions within the system, members of the QI Councils may identify gaps and problems with existing services and most importantly, then use this data, and what it identifies, to make system changes at local, regional and state levels. The QI Councils are an active partner in quality improvement efforts of the Division of DD.

The Regional and Statewide QI Councils met at least quarterly during 2013. All the Councils convened in October for their annual group conference. Data from the FY13 Quality Assurance Report was shared and discussed with the Councils. Each Council had a chance to begin developing their 2014 work plans based on their respective regional data. Additionally, each Council presented on the quality improvement projects that they completed in FY13. Examples of those presentations can be found at: http://www.dfmc-georgia.org/quality_improvement_council/project_plan_presentations/index.html.

The Division's Statewide QI Council met on March 12, 2013, to review the Supported Employment project and make final adjustments for the version to be vetted through the DD Advisory Council.

The Statewide Quality Council has chosen community integration as a Quality Improvement project for 2014. With the help of the Human Services Research Institute (HSRI) the Council will research how other states are supporting community integration for people with developmental disabilities. Best practices and effective methods of supporting people to develop social roles and connect with their community will be the focus. The QI Council has also set a goal of developing a definition of community integration that can be adopted by DBHDD. It is hoped that this will help to improve integration by giving stakeholders a clear picture of what supports and services are needed to help an individual become truly a part of their community. The Statewide Council will also play in important role in 2014 in the restructuring of the current DD Quality Management System

In 2013, the Division of DD also implemented the DD Advisory Council. The purpose of the DD Advisory Council is to advise the Department on matters related to the care and service of people with developmental disabilities served by the Department. The Council has been tasked:

- To assist the Division of DD in assuring the Department's services to people with developmental disabilities reflect adherence to the standard of "best practice."

- To assist the Division in assuring the Department's programs for people with developmental disabilities provide quality services in a cost effective manner.

- To recommend improvements to the Division for existing programs serving people with developmental disabilities.

- To recommend development and implementation of additional programs for people with developmental disabilities in Georgia.

- To review the Department's policy, policy revisions, and make recommendations regarding the adherence to the Department's mission and the cost of proposed policies and amendments.

- To facilitate communication among Department staff, providers of services, service recipients, parents/guardians/advocates of people with developmental disabilities, and

other public and private entities involved in delivering services to people with developmental disabilities.

The Advisory Council met monthly with Division staff and other stakeholders. Please see Attachment 2: DD Advisory Council Report for a summary of the Council's 2013 accomplishments. The DD Advisory Council continues to meet monthly.

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 oversees the development of 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 areas work plan and the progress toward achieving the work plan goals for each Quality Council:

DBHDD QM Work Plan

The DBHDD QM Work Plan (see Appendix C) outlines the key quality-related work prioritized by the Department. The first task of the first goal related to developing accurate, effective and meaningful performance measures was met via the development of KPI selection criteria, which are in a data definition/data collection plan document. Additionally, the criteria have been put into an electronic format for ease of use. The assessment of current PI measures for value and applicability was slightly behind schedule but has been completed. A comprehensive evaluation of the DD Quality Management System was completed by an external contractor in November 2013. Division of DD staff are reviewing the findings of that evaluation and the current DD KPIs will be updated after the review has been completed.

The second goal's first task related to modifying the QM Training Plan to include all the functional areas is in-process but its completion has been delayed until April 2014 due to competing priorities.

The first task of the third goal related to the development of a CBH outcomes frame work is slightly behind schedule. The draft framework is currently being assessed for applicability by the Division of DD.

The fourth goal related to IT data systems is progressing. A new Chief Information Officer was appointed during 2013 and has been assessing needs. A Request for Proposals is nearly completed for the procurement of an ASO that will address some of the Department's data integration, management and reporting challenges.

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:

Hospital System QM Work Plan

The Hospital System QM Work Plan (see Appendix D) represents a high level set of goals focused on the Quality Management infrastructure needed to maintain an effective quality management system. The overarching purpose of these goals is to refine the quality management system so that there is greater consistency, accuracy, data integrity and accountability. These goals reflect the Hospital System's dedication to developing and maintaining the capacity to improve quality and do so efficiently, effectively, and in a way that maximizes the utilization of its resources.

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 that they deserve. At the time of this report, the progress with regard to the identified goals was consistent with the plan with the exception of a delay related to integration of QM data due to the decision to hire a consultant expert.

CBH QM Work Plan

The Community BH QM Work Plan was discussed at the July 2013 PQC and was finalized at the August meeting. Although there were delays due to competing priorities, the majority of the tasks that were to be completed in 2013 have been completed. The first task of the second goal related to QM training for CBH State and Regional Office staff has been implemented with compliance monitoring taking place as of the publication of this report. The progress towards the remainder of the goals is consistent with the plan. See Appendix E for the CBH QM Work Plan.

DD QM Work Plan

Many tasks were accomplished by their initial completion dates; however, some timelines required adjustment. The adjustments allow additional time for more thorough planning and development of an updated DD quality management system. It is expected that that there will be significant changes to this work plan in 2014 to reflect increasing strategies regarding the transition of medically fragile individuals. See Appendix F for the DD work plan.

Key Performance Indicators and Outcomes

Data Collection Plan/Data Definition Document

A DBHDD data definition document was developed for the KPIs, for use by each of the three functional QM areas within the Department. The data definition document provides guidance on how each element and attribute should be used. It gives details about the structure of the elements and format of the data. Additionally this document was used as the basis to develop a tool (called the Performance Measure Evaluation Tool) which provides guidance on developing new and evaluating existing KPIs.

Dashboards

The KPI dashboard format was redesigned to incorporate the KPI data in table and graph form, measure definition & explanation, numerator & denominator explanation and an analysis of the KPI for the time period. The KPI dashboards can be found in Appendices G, H and I.

Hospital System Key Performance Indicators

The KPIs 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 Quality Management departments at each facility 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. 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. The linear trend line for January through November 2013 shows a positive trend. In addition, linear trends for the period of February 2012 through November 2013 further support the positive trend movement.
    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 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. The four month downward trend ceased in October, as GRH-Atlanta pushed the overall rate in a positive direction. In November, the rate for GRH-Atlanta continued to improve, and the rate for West Central RH increased. The overall trend for the last 12 months, as well as the last 21 months is slightly negative.
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. Summary comments and analysis: As expected, the rate increased in October and November and were well above The Joint Commission target range. Changes expected in data collection will account for the nuance in reporting concerning conditional release and should increase the rate of compliance closer to the goal of 100%.
3. The importance of supporting the recovery of individuals receiving hospital services.
    a. Individual Recovery Plan Audit - Quality Measure
        i. Summary comments and analysis: A gradual overall trend upwards (positive) has been achieved during the past year. 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 an ongoing emphasis on auditing IRPs has contributed to improvements in the quality of the plans. The hospital system will continue to work for additional improvements in this area.

Summary and Recommendations: Hospital System

The Hospital System has seen improvement in three out of four of its KPIs during calendar year 2013. The Hospital System plans to continue to monitor and improve the quality of care measured by these KPIs and will consider replacing those that have shown consistency and stability in their growth. The hospital system dashboard can be found in Appendix G.

Community Behavioral Health Program Key Performance Indicators

The KPIs utilized by the CBH Programs are a combination of quality measures that support the Department's vision and measure quality best practice for each program/service outlined below.

Summary and Recommendations for the current CBH KPIs:

1. Georgia Housing Voucher Program adult MH individuals who are 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 along with DBHDDs target of 77% for 2013, and appears to be stable at or above 90%. Further analysis over a longer time period is needed in order to pose a hypothesis of this measure's success.
2. Georgia Housing Voucher Program adult MH individuals who left stable housing under unfavorable circumstances and have been reengaged and reassigned vouchers
    - Summary comments and analysis: DBHDD has tracked Georgia Housing Voucher individuals who left stable housing under unfavorable circumstances and were reengaged in services for over a year. A baseline has been established at 17% and appears stable between 18-20%. This KPI will continue to be monitored.
3. Adult Mental Health Supported Employment providers that met a caseload average of employment specialist staff to consumer ratio between 1:15 to 1:20
    - Summary comments and analysis: The caseload average percent slowly increased between December 2012 and March 2013 as providers accommodated the July 1, 2012 funding increase. As of July 2013 the ratio was changed from 1:20 to a range of 1:15 to 1:20 in order to increase specificity. This is reflected in the dashboards with the retirement of the KPI with a threshold target of 1:20 and the activation of a new KPI with a threshold target range of 1:15 to 1:20. This indicator will continue to be monitored.
4. Adult Mental Health Supported Employment individuals who had a first contact with a competitive employer within 30 days of enrollment
    - Summary comments and analysis: This is an unduplicated measure which is calculated quarterly and whose target threshold was increased from 50% to 75% or greater in July 2013. For the time period January – June 2013 this KPI ranged between 60% – 67% and the previous target of 50% was met. The new threshold of 75% was not met for the July – September quarter and as of the date of this

report, data is not yet available for the October – December 2013 quarter. This indicator will continue to be monitored going forward with the revised threshold.

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 February but the data displayed varying percentages through June. As ACT providers indicated that there were different definitions of the term "enrollment" a revised KPI became effective in July 2013 and more clearly defined the intent of what needed to be measured. This is reflected in the dashboards with the retirement of the KPI utilizing the term "enrollment" and the activation of a new KPI using the phrase "received into services". For the remainder of 2013 the data is on an upward trend. This indicator will continue to be monitored.
6. Assertive Community Treatment consumers admitted to a Psychiatric Hospital within the past month
    - Summary comments and analysis: The data shows a slight upward trend in hospital utilization between April and October, peaking at just under 11%. The target of 7% or less was not met during this reporting period and providers indicated individuals were being admitted into hospitals for further stabilization. This measure is also known to increase when providers admit individuals with patterns of high utilization and there is a cohort of new patients that are experiencing the early engagement and stabilization period.
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 this reporting period. There is a slight upward trend in days utilized and this indicator will continue to be monitored. A similar effect in jail utilization is known to occur when there is an increase in admissions and a cohort of individuals relatively early in their tenure in the program.
8. Intensive Case Management consumers with a Psychiatric Inpatient Admission within the past month
    - Summary comments and analysis: This target was decreased from 10% to 5% in July 2013 due to the target being consistently met at the lower threshold. Overall the target of 5% or less was met for all months except August and November which were respectively 5.6% and 5.9%.
9. Intensive Case Management consumers housed (non homeless) within the past month
    - Summary comments and analysis: Overall the target of 90% or more was met during this reporting period.
10. Average number of jail/prison days utilized per enrolled Intensive Case Management consumer
    - Summary comments and analysis: The target of 0.50 days or less was decreased to 0.25 days or less effective July 2013 due to consistently meeting the lower threshold. The new target of 0.25 days has not been met since the threshold was changed and 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 for all periods except July 2013.

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 2013.
14. Case Management consumers with a Psychiatric Inpatient admission within the past month
    - Summary comments and analysis: The target for this measure decreased from 10% to 5% in July 2013 due to consistently meeting the threshold. 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 was some variability in the average number of jail/prison days utilized during this time period. Providers attributed this to a small number of individuals with longer incarcerations.
17. Adult Addictive Disease (AD) clients active in AD treatment 90 days after beginning non-crisis stabilization
    - Summary comments and analysis: The Division of Addictive Diseases has chosen to replace an existing KPI with this KPI for 2013. The Division of AD will use this data to establish a baseline in order to anchor future evaluation of the data and how it relates to the quality/effectiveness of the services being delivered**.**
18. Clients discharged from crisis or detoxification programs who receive follow up behavioral services within 14 days.
    - Summary comments and analysis: The Division of Addictive Diseases has chosen to replace an existing KPI with this KPI for 2013. The Division of AD will use this data to establish a baseline in order to anchor future evaluation of the data and how it relates to the quality/effectiveness of the services being delivered**.**
19. Individuals meeting Community 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 has been in place for approximately sixteen months for this semiannual KPI. Overall there is a downward trend for the May – October period with three of five responses related to dissatisfaction with aspects of the service that did not meet their needs such as frequency of contact or assistance with obtaining resources.
20. 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
    - Summary comments and analysis: Data collection has been in place for approximately sixteen months for this semiannual KPI. Overall the satisfaction percent has been holding steady at 86% which is just short of the 90% target. This KPI will continue to be monitored.

21. Percent of youth with an increase in functioning as determined by a standardized tool
    - Summary comments and analysis: This is a new KPI and as of the date of this report, 2013 data was not yet available and is not included in Appendix H.
22. Percent of families of youth satisfied with services as determined by a standardized tool.
    - Summary comments and analysis: This is a new KPI and as of the date of this report, 2013 data was not yet available and is not included in Appendix H.

Summary and Recommendations: Community Behavioral Health

During 2013 there were major strides in the development and refinement of the quality management program for the community behavioral health programs. This included review and modification of existing KPIs, development of new KPI's, discussion around developing KPIs for suicide prevention and recovery, didactic communication with providers through the coalition meetings regarding KPIs & quality, and the development of a collaborative relationship with the Georgia Association of Community Service Boards. Also the KPIs were used by community behavioral health leadership to systemically review the services being provided by the behavioral health provider network and identify opportunities for change and modification. The Community Behavioral Health dashboard can be found in Appendix H.

Developmental Disability Programs Key Performance Indicators

In 2013, The Division of Developmental Disabilities completed an evaluation of its Quality Management System via an external consultant. See Attachment 1: Quality Management System Review Executive Summary. An outcome of the evaluation will likely be a change in the current key performance indicators. Possible changes will be determined during the Division's Quality Management System Update planning which will occur during the second quarter of 2014. (See Appendix I for the DD Programs dashboards). The time period for data collection and analysis presented below was January 1, 2013 through November 30, 2013. Data collected in December 2013 was not available at the time of the writing of this report; but will be included in the 2014 Interim Report.

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

- The level at which individuals are receiving person centered supports and services;
- The quality of transitions from State Hospitals to the Community
- Whether individuals are healthy and safe
- The efficiency of specific DD services

Person Centered Supports

Please refer to the Section entitled: "DD Reviews of Individuals Served" for additional information on Person Centered Supports, Individual Support Plan Quality Assurance, and DD Transitions of Individuals into the Community.

Implementation of New Individual Support Plan Process and Template

In September 2013, the Division convened a stakeholder workgroup to develop a training and implementation plan for the new ISP process and electronic template. The new ISP will assure a more person-centered approach to developing supports for an individual, and should lead to increased community integration. A training curriculum and ISP Guide is being developed.

Please see Attachment 3: New ISP Training Plan. Training will take place during the first and second quarters of 2014. Implementation will begin July 1, 2014.

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 the those individuals. Additional health and safety information is gathered from the independent reviewer as well as reviews performed by the Regional Offices. In 2014 this information will be incorporated into the 2014 work plan.

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

The latest Georgia NCI data (2011-2012) was reported in the DBHDD 2013 Interim Report. 2012-2013 data is scheduled to be released in May of 2014 and will be reported on in the 2014 Interim Report. Georgia's 2011-2012 State Report can be found at: http://www.nationalcoreindicators.org/resources/reports/2013/#reports-state-reports

As stated in the 2013 Interim Quality Management System Report, Georgia has regularly scored low on dental services compared to other NCI states. These low scores were brought to the attention of the DBHDD Medical Director and the Executive Quality Council in 2012. As a result of the high prioritization by the EQC, a possible performance improvement project between the Division of Developmental Disabilities and the Georgia Department of Public Health was discussed. Due to circumstances beyond DBHDD's control, the project is moving slower than DBHDD would have hoped. As an interim measure to support individuals in need of dental services, the dental clinics at all DBHDD state hospitals will remain open and available to individuals with DD who are supported by DBHDD.

Efficiency of Services (Georgia Crisis Response System for Developmental Disabilities)

In 2011, 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).

Two main components of the Georgia Crisis Response System (GCRS) 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. In 2013, 15% of crisis incidents resulted in the need for intensive in-home supports.

The intent of Intensive Out-of-Home Supports is to stabilize the individual through nursing and behavioral supports, on a time-limited basis. Intensive Out-of-Home Supports are to be provided in one of 11 Crisis Support Homes strategically located across the state. Individuals under the

age of 18 years must not be served in a Crisis Support Home. Those individuals are served in the Division's Temporary and Immediate Support Home. In 2013, 20% of crisis incidents resulted in the need for intensive out-of-home supports.

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 implemented its own Mobile Crisis Response System, and the Division of DD is partnering with Behavioral Health to address this shared population. An example of this partnership is the establishment of a Co-Occurring Case Review Committee. The Committee reviews cases that have presented challenges for community providers to a team of clinical leaders in DBHDD and from Georgia Regents University. The Committee conducts focused discussions to identify possible gaps/barriers in care, practice issues (e.g. medication regimens, polypharmacy), workforce training issues, and any other circumstances that will assist in developing strategies to assure that individuals are receiving high quality care. An additional goal of the Committee is to define a process and a group of individuals with expertise who can be consulted with when problems arise and how we can use what is learned there to improve the transition and discharge planning process for individuals leaving our institutions.

In 2013, DD began to take a more focused look at individuals who were repeatedly accessing the Crisis System. Efforts to address this issue included increased behavioral supports for the individual, increased technical assistance and training of provider staff, and increased access to waiver services for those individual not already supported by DBHDD. The Co-Occurring Case Review Committee will also review specific cases where individuals have repeatedly accessed the Crisis System.

Summary and Recommendations: Division of Developmental Disabilities

In 2013 the Division of DD increased its efforts to improve the quality of supports and services through the use of its key performance indicators and system evaluation. The Division is using this data as a driver for an improved transition process. National Core Indicator data showed that Georgia has areas of improvement around its health indicators, and steps have been taken to address access to dental services. DBHDD also recognizes the need for a more comprehensive, robust and systematic analysis (gathered from multiple sources such as the independent reviewer and the ROs) of consumer transitions. The Crisis Response System for DD has provided quality behavioral crisis service to individuals with DD which has resulted in less involvement of law enforcement and hospitalization. Though dual diagnosed individual still present a challenge to not only the Crisis Response System, but the DD/BH community as whole, the Division has and continues to take steps to evaluate how to better serve these individuals.

Quality Monitoring Activities

Complaints and Grievances

In 2013 the DBHDD Office of Public Relations (OPR) received 271 complaints/grievances and inquires requiring the attention of State Office, Regional Office and/or regional hospital staff. Cases were triaged and tracked for review, response and/or depending on the nature of the

concern, cases were assigned to either the State Office, a Regional Office or to a regional hospital for review.

As illustrated in the table below, the State Office was assigned 19.9% of the 271 cases. Seventy one percent (71.6%) were addressed by the Regional Offices, 8.5% were handled by the regional hospitals and 19% were handled by State Office staff. In comparison to 2012 data, there is a slight decrease in the total number of cases received, from 280 to 271.

Assignment Location	**Disabilities**				**Percentages**	
					Facilities Offices	**All Complaints**
Regional Hospitals						
	AD	**DD**	**MH**			
GRH- Atlanta	0	0	13	13	56.5%	4.8%
ECRH- Augusta	0	1	1	2	8.7%	0.7%
WCRH- Columbus	0	0	3	3	13.0%	1.1%
CSH- Milledgeville	0	0	2	2	8.7%	0.7%
GRH- Savannah	0	0	1	1	4.3%	0.4%
SWSH- Thomasville	0	0	2	2	8.7%	0.7%
Total	**0**	**1**	**22**	**23**	**100.0%**	**8.5%**
Regional Offices	**AD**	**DD**	**MH**			
Region 1	0	19	17	36	18.6%	13.3%
Region 2	1	14	5	20	10.3%	7.4%
Region 3	3	49	21	73	37.6%	26.9%
Region 4	0	9	3	12	6.2%	4.4%
Region 5	0	8	7	15	7.7%	5.5%
Region 6	3	19	16	38	19.6%	14.0%
Total	**7**	**118**	**69**	**194**	**100.0%**	**71.6%**
State Office						
2 Peachtree – Data Information				1	1.9%	0.4%
2 Peachtree -Public Relations				8	14.8%	3.0%
2 P Peachtree – Human Resources				5	9.3%	1.8%
2 Peachtree - Legal				1	1.9%	0.4%
2 Peachtree – Provider Network Management				10	18.5%	**3.7%**
2 Peachtree – Addictive Diseases				6	11.1%	2.2%
2 Peachtree Developmental Disabilities				2	3.7%	0.74%
2 Peachtree- Mental Health				1	1.9%	0.37%
DCH				2	3.7%	0.74%

Other Non State Agency				18	33.3%	6.64%
Total				**54**	**100.0%**	**19.9%**

Total Cases	**271**	**100.0%**

There were fifty-two issue categories that included adult addictive disease services; DUI intervention services; child and adolescent addictive disease services; developmental disabilities exceptional rate, developmental disabilities planning list; mental health PRTF; mental health residential; mental health housing; general information about DBHDD programs; inpatient treatment and evaluation; provider application, certification and enrollment; investigations; medical records request; host homes; personnel; and issues that were referred to other agencies.

After reviewing the complaints and grievances received, there were approximately fifty-two (52) issue categories. The five (5) most frequent issues received between January 1, 2013 and December 1, 2013 were:

1. Developmental Disabilities eligibility for the New Options Waiver (NOW) and the Comprehensive Supports (COMP) Wavier *(Approved for a waiver but funding is limited)*
2. Mental Health Complaint *(Inpatient Treatment, Discharge, Evaluation; Provider Issue)*
3. Mental Health Residential Complaint *(Housing, Provider Issue, Abuse or Neglect)*
4. Mental Health Service Need *(Long-Term Treatment, Placement)*
5. Developmental Disabilities Services Access (*Services, Waiver Budget Provider Issue, Funding)*

Approximately, 45% of the constituent concerns pertained to developmental disabilities. This is a minimal increase from 44% in 2012. A review of the data also showed Region 3 as having the highest number of inquiries. This is attributed to Region 3 having the highest population density of all regions. Also, the review showed individuals were receiving some community services while waiting for waiver funding. While most complaints and grievances received were addressed by the hospital or Regional Offices, many clients and families continued to inquire with the Office of the Governor or with members of the Georgia General Assembly.

OPR received 34% of complaints and grievances concerning mental health services. This is a decrease of 5% from 2012. This is likely due to the development of increased community services leading to the public becoming more informed about how to locate services locally.

Twenty percent (20%) of complaints and grievances were forwarded to OPR by the Office of the Governor. Requests initiated by members of the Georgia General Assembly accounted for 16% of the cases. The majority of cases received were concerning a request for additional funding for the New Options Waiver (NOW) and the Comprehensive Supports (COMP) Wavier.

Approximately, 50% of the reported concerns were initiated by families, consumers, friends, advocates or providers. Although a great percentage of cases were triaged to the regions and hospitals, the State Office addressed 20% of the 271 complaints and grievances.

The Office of Public Relations will continue to monitor the volume of inquiries as well as any trends that occur and continue to periodically provide that information to the Executive Quality Council.

Hospital and Community Incident Data

The following incident review covers death reports and critical incident reports received in the Office of Incident Management and Investigations from January 1, 2013, through December 31, 2013. 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 (CY 2013) with the prior calendar year (January 1, 2012 – December 31, 2012).

Hospital Incident Data

As Table 1 indicates, the total number of hospital incidents for Calendar Year (CY) 2012 was 8,979 compared to the current report period of 8,038. Overall a 10.5% reduction occurred. However, when the rate is analyzed, the rate for CY 2012 is 97.29 and for CY 2013 is 95.43 which is consistent when comparing the two years. (Note: Rate is calculated by Total Incidents/Occupied Bed Days x 1000.) Quarters are based on calendar years.

Table 1: Total Incidents by Month

Hospital

CY-2012	Qtr1	Qtr2	Qtr3	Qtr4	Total
	2362	2367	2155	2095	8979
CY-2013	2075	2027	2149	1787	8038

The five most frequent hospital incidents reported during this review period (CY 2013) are listed below in Table 2. Incident types A03 and A04, Aggressive act to another individual-Physical and Aggressive act to staff-Physical, occurred more often than all others and account for 51% of the total number of incidents reported. This number did not change significantly from the prior 12 months. However, Aggressive act to another individual-Physical decreased 4.17% and Aggressive act to staff-Physical Increased 3%. 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% of the total number of incidents reported.

Table 2: Most Frequently Reported Hospital Incidents (CY 13)

Hospital Incident Type	Total
A03-Aggressive act to another individual-Physical	2090
A04-Aggressive act to staff-Physical	2002
A01-Accidental Injury	677
A30-Property Damage	670
A2-Aggressive act to self	644
Total	6083

Community Incident Data

The total community incidents for the report period (CY 12) were 3,408 compared to the current report period of 3,377 reflecting a slight increase of 1%, which is not considered to be significant.

Table 3: Total Incidents by Month

Community					
CY-2012	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr4**	**Total**
	798	928	856	795	**3377**
CY-2013	847	979	828	754	**3408**

The most frequently reported community incident type is Hospitalization of an Individual in a community residential program. See Table 4 below for the five most frequently reported community incidents.

Table 4: Most Frequent Occurring Community Incidents (CY 13)

Community Incident Type	Total
C-Hospitalization of an Individual in a community residential program	1200
C-Individual injury requiring treatment beyond first aid	344
C-Incident occurring in the presence of staff which requires intervention of law enforcement services	318
C-Individual who is unexpectedly absent from a community residential program or day program	305
C-Alleged Individual Abuse-Physical	210

Hospitalization of an individual in a community residential program occurred more frequently than all other community incident types combined and increased 9.1% from the prior 12 month period. This incident type includes hospitalizations for any reason. Individual injury requiring treatment beyond first aid decreased 4.4%; Incident occurring in the presence of staff which required intervention of law enforcement services decreased 2.4%; Individual who is unexpectedly absent from a community residential program or day program increased 15.1%, and Alleged Individual Abuse-Physical remained the same. Additional analysis will be performed on community incidents related to individuals who are unexpectedly absent from a community residential program or day program and the results will be reported to the CBH PQC in early 2014.

Community Incident Data – Behavioral Health Services

Community Incident Data can be further categorized by disability type. Community behavioral health providers reported 952 critical incidents during this report period or 28% 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, Individual who is unexpectedly absent from a community residential or day program, Incident occurring in the presence of staff which requires intervention of law enforcement services, Criminal Conduct by Individual and Individual, injury requiring treatment beyond first aid.

Community Incident Data – Developmental Disability Services

Community developmental disability providers reported 2,456 critical incidents or 72% of all incidents during this report period. The incident types requiring an investigation and reported most frequently for developmental disabilities were Hospitalization of an Individual in a

community residential program, Individual injury requiring treatment beyond first aid, Incident occurring in the presence of staff which requires intervention of law enforcement services, Alleged Neglect and Individual who is unexpectedly absent from a community residential or day program.

Community Mortality Reviews

During this review period the Community Mortality Review Committee met five times to review the unexpected deaths of individuals receiving DBHDD services. *(Note: Category III deaths that require no investigation per policy were not reviewed unless the death was also investigated.)* A total of 82 unexpected deaths were reviewed during this period with 21 reviewed in the 1st quarter, 43 in the 2nd quarter, 9 in 3rd Quarter, and 9 in 4th Quarter of 2013. As a result of these additional reviews, several questions were asked and additional information obtained from the investigator and/or provider; recommendations were made for additional corrective action; and changes in investigative processes have been identified and will be incorporated into policy and practice as appropriate.

Additional analysis of cases involving suicide was initiated in 2013 and the DBHDD Suicide Prevention Coordinator presented national trends and additional information regarding suicidality to the CBH PQC.

Patterns and Trends

During this report period the Office of Incident Management and Investigation compiled, analyzed and provided information regarding incident patterns and trends to the Community Behavioral Health Program Quality Council (CBH PQC), the DBHDD Executive Quality Council (EQC), 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 trended information has been used for quality improvement purposes to identify providers who may require technical assistance and/or training. OIMI also noted that a significant number of providers had not reported any critical incidents in FY 12. As a result, the Assistant Commissioner for Behavioral Health and the Assistant Commissioner for Developmental Disabilities Services notified all community BH and DD providers, via letter, of their obligation to report deaths and critical incidents under the Community Incident Management Policy. Additionally, they were asked to review their processes and procedures to ensure compliance with the reporting policy. Providers were offered technical assistance and training if needed, in order to assist them in reporting all critical incidents.

Hospital Peer Review and Credentialing

During this reporting period the Medical Staff Bylaws have been updated and the Hospital System leadership has improved its management of credentialing of contracted services to address the need for primary source verification of credentials and to include performance indicators in contracts that are integrated into the Quality Management and peer review structures. Recent work has also been done on improving the primary source verification processes for psychologists.

Hospital Utilization Review

Utilization review data were used to help determine the implications of, and to inform the planning for the closure of Southwestern State Hospital. It has helped to estimate the capacity of community-based programs to accommodate the needs resulting from that closure. 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.

Adult Mental Health Fidelity Reviews

Assertive Community Treatment

Assertive Community Treatment Fidelity Reviews are conducted annually for all twenty two state contracted ACT teams. Between January-June 2013 fourteen Fidelity Reviews were completed using the 28-item Dartmouth Assertive Community Treatment Scale (DACTS) model for Fidelity. The 22nd team became operational in April 2013 and in accordance with best practice after the team had been operational for 6 months a fidelity review was conducted in October 2013. The remaining 7 teams were reviewed during the second half of 2013.

Once the DBHDD ACT Fidelity Review Team completed the review, results of the Fidelity Review were given to the ACT team, the regional office in which the team operates the DBHDD Adult Mental Health Director, and other Departmental leadership. The results were also provided to the ACT Subject Matter expert hired as part of the DOJ Settlement and posted on our DBHDD website. Reviews are followed by an exit interview inclusive of provider and Regional and State staff for detailed discussion of the review outcome and report. Outcomes were also discussed with the Community Behavioral Health Program Quality Council. Review items that were found to be below the acceptable scoring range; a score of 1 or 2, resulted in a Corrective Action Plan (CAP) which each team developed and submitted for acceptance to the regional and state office. ACT teams are contractually expected to minimally obtain a DACTS mean score of 4.0 and total DACTS score of 112.

Of the twenty one teams that have received a Fidelity Review, sixteen achieved a score within the acceptable range of fidelity, indicating that they were serving the appropriate population, maintaining an acceptable caseload, delivering the service with the intended frequency and intensity, providing crisis response, conducting effective daily team meeting discussions of consumers, engaging formal and informal supports, being involved in hospital admission and/or discharges and consistently delivering 80% of the teams services in the community.

Six teams scored below the acceptable range of fidelity. Some of those areas of needed attention were, 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 submitted Corrective Action Plans to the regional office and the state office. The state review team reviewed the plans to ensure that the CAP was inclusive of all scales that received a rating below fidelity. The regional office then continues to oversee and monitors the progress of the CAP. The state review team conducted additional technical assistance to these six teams and all have demonstrated improvements in most areas.

Supported Employment

Supported Employment (SE) Fidelity Reviews are conducted annually for all twenty-two state contracted SE providers. In FY13 from January-June 2103 a total of twenty Fidelity Reviews were completed using the 25-item Individual Placement and Support (IPS) model for supported employment, the 21st and 22nd SE providers became operational in late Spring of 2013 and are scheduled to receive a review in early 2014. Once the SE Fidelity Review was complete, results were given to the SE provider, the Regional office in which the team operates, the DBHDD Adult Mental Health Director, and other Departmental leadership. Results were also provided to the SE Subject Matter expert hired as part of the Settlement and were posted on DBHDDs website. This was followed by an exit interview inclusive of the provider and, Regional and State staff with a detailed discussion of the review outcome and report. Outcomes were also discussed with the CBH PQC. Review items that were found to be below the acceptable scoring range a score of 1 or 2, resulted in a Quality Improvement Plan (QIP) which each team developed and submitted for acceptance to the Regional and State office. SE providers are contractually expected to minimally obtain an IPS total score of 74.

Of the twenty providers who have received a Fidelity Review, 15 achieved a score within the acceptable range of fidelity, indicating that they were effectively integrating SE and mental health, maintaining collaboration with 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, 5 providers scored below the acceptable range of fidelity.

Some of the areas of needed attention were, increasing collaboration with GVRA (11 of 20 providers did not meet fidelity), connecting consumers with competitive job options (8 of 20 providers did not meet fidelity), integration of SE and mental health treatment team (8 of 20 providers did not meet fidelity), engaging in sufficient employer contacts (12 of 20 providers did not meet fidelity), and having executive leadership support (9 of 20 providers did not meet fidelity). In the area of individualized job search 8 of 20 providers did not meet fidelity, and 8 of 20 providers did not meet fidelity in the area of assertive engagement and outreach by an integrated treatment team. These providers have submitted or are in the process of submitting QIP's and are receiving technical assistance in order to improve operation in areas of deficiency. During FY14 July-June there have been 5 SE IPS Fidelity Reviews conducted in the State with 17 Reviews tentatively scheduled through June 30, 2014.

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 is scheduled to be statewide on July 1, 2014.

Two vendors 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 monthly by a State MCRS committee, as well as 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.

QM Audits: Quality Service Reviews of Adult Behavioral Health Community Providers

As a component of DBHDD's quality management system and the Settlement Agreement, a quality audit/service review of a sample of individuals meeting Settlement Agreement criteria and who were enrolled in Settlement funded services was created and implemented beginning October 2011. The audit was designed to follow the care of an individual throughout the system of care as they transitioned between services and as they received multiple ongoing services. In an effort to further align the audits/service reviews with the Department's consumer centric focus on consumer choice, satisfaction, and how services impact an individual's quality of life, the audits were redesigned in November 2012. The redesigned audits focused on the perceptions of the individuals served, their level of satisfaction with services, and how a service improved their quality of life. It also identified whether an individual's needs were not met by the design, implementation, or availability of the particular service. The audit process continued to include interviews with individuals served, interviews with provider leadership and direct care staff, on-site observations, and a review of medical records. Policies, procedures and relevant documents related to the performance improvement and risk management processes were also reviewed where applicable.

The new audit criteria, developed between November 2012 and January 2013, addressed an identified pattern previously found where individuals admitted repeatedly to Crisis Stabilization units were not subsequently being enrolled in more intense Settlement Agreement services such as Assertive Community Treatment. The revised audits were designed to include a review of the discharge planning processes of a sample of these individuals at each Crisis Stabilization Unit reviewed. After a pilot, the third cycle of audits commenced using the revised audit tool on March 4, 2013 with reviews in Region 4.

Eleven organizations providing seventeen services in two regions participated in the audit/service review process between March 4, 2013 and October 3, 2013. Individuals were enrolled in the following services: Assertive Community Treatment (ACT), Community Support Team (CST), Case Management (CM), Supported Employment (SE), Crisis Stabilization Units (CSU), and Peer Mentor or Peer Wellness and Respite Services. Ninety-three individuals were chosen for the audit. Of those, sixteen received multiple services. Seventy-one percent (71%) of individuals chosen for the review consented to and were interviewed. The numbers below reflect reviews conducted within each service:

Services	Providers	Teams/Sites	Charts Reviewed	Individuals Interviewed	Staff Interviewed
ACT	6	8	48	38	36
Community Support Team	1	1	6	4	3
Case Management	1	1	4	3	1
Peer Mentoring and Peer Wellness	1	3	NA	16	7
Supported Employment	5	5	23	20	13
Crisis Stabilization Unit	3	3	13	NA	4
Totals	17	21	94	81	64

Total unduplicated	11	21	94	66	63

An exit interview was conducted on the last day of each provider audit where the preliminary findings were discussed. Data was then collected, reviewed and compiled. Citations were written when deficits below 90% were noted within a service. A final report, including the citations and consumer based feedback were forwarded to each provider's leadership, the respective regional office, and to the DBHDD central office staff to include the ADA Settlement Agreement Director, Adult Mental Health Director, Director of the Office of Recovery Transformation, and Assistant Commissioner.

Throughout the course of the last audit cycle, providers voluntarily described specific barriers they experienced in being successful. They also described barriers individuals experienced in their efforts to be successful within the community. As a result, the audit team initiated additional criteria in August 2013. Two criteria were added to gather data on barriers to success for both the provider and individuals served.

At the time of this report, nine of the eleven organizations audited provided feedback about their perceptions of barriers. Within these organizations, services that included ACT, Community Support Team, Supported Employment, Crisis Stabilization Units, Peer Wellness and Respite and Peer Mentoring responded. The following were identified as common themes among the respondents:

- Provider Barriers: Limited housing, staff recruitment and retention, service area size for rural areas and gaps in the service continuum of care especially post crisis and pre-employment were the most identified.
- Individual Barriers: Limited transportation, limited housing, limited and appropriate substance abuse treatment, limited employment opportunities and supports, stigmas about mental illness (held by the individual, family and/or community) that limit access to opportunities for success and limited array of services to meet the individual's need (in both urban and rural areas) were the most common identified.

A review of the audits identified some common issues. Some of the same concerns listed by providers as a barrier for success were similar to the audit findings. The following concerns were identified consistently within particular services regardless of the Region or provider:

- Peer Mentoring acknowledged inconsistent communication with hospital staff when needing referrals, attending discharge planning sessions and knowing a person's placement post discharge.
- Case Management services to include (ACT, CST and CM) acknowledged difficulty obtaining adequate community resources for individuals especially in rural areas.
- All services that developed treatment plans had difficulty individualizing the plan and keeping it relevant to the individual's needs as conditions changed.
- All services routinely had staff vacancies and acknowledged staff recruitment and retention as an ongoing issue.

Currently, this information is reported to DBHDD CBH Leadership as a source of information for ongoing planning and program improvement.

In October 2013, the DBHDD Executive Leadership redirected the focus of the QM Department's audit work as a result of findings provided by Dr. Nancy Ray regarding data collected and reported from quality audits for repeat admissions. The QM Department is in the process of designing an audit tool and process to address high risk individuals who are 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. These audits will be implemented in 2014 and provide data to the Department in order to continue assessing the quality of services an individual receives and to identify gaps in services for this high risk population.

Child and Adolescent Community Mental Health Programs (CAMH)

Monthly or quarterly reports related to Quality Improvement data were produced for all programs (PRTF's, CMEs/CBAY, CSUs and Clubhouses) by the Georgia State University Center of Excellence for Child and Adolescent Behavioral Health. The data and formats of the reports were reviewed by the applicable program quality consortium. All quality improvement consortiums agreed to move toward a provider report card instead of the extensive report and have finalized data collection measures. All quality improvement consortiums also reviewed their respective quality improvement plans and made the necessary changes to match the standardized data collection measures for CY2014. These standardized processes will increase the reliability and validity of the data being entered into the data tool by the providers and will therefore produce better data reports in the future, allowing for accurate review and process improvement activities. All quality consortiums have also standardized their agendas allowing a large amount of time to be spent on reviewing data and looking for opportunities to improve programming. It is anticipated that the standardized quality improvement processes will improve the services being delivered to children and adolescents.

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/improve the quality of the service(s) they provide. Topics were varied and included, but were not limited to: data informed decision making, trauma-informed systems, cultural competence, and improving clinical competence. Approximately 350 people participated in this training. The next symposium will be held in the summer 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 below is a graph that provides 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
RFW Residential Residential treatment for women (ASAM 3.5-3.1).	Site visits are currently conducted by Women's Treatment Coordinator. APS does not audit these programs. Staff use tool to review 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	Of the 20 RFW Residential programs, two were provided a site review beginning July 2013 and met fidelity/program requirements (10%). Reviews are scheduled ongoing until 2016 and being tracked/measured as part of the Dept's strategic plan.
RFW Outpatient Programs	Site visits are currently conducted by Women's Treatment Coordinator. APS does not audit these programs. Staff use tool to review 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.
RFW 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.
Clubhouses Recovery Support Services for youth	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 Recovery Support Services for adults	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 EIS HIV testing and education	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 Opioid maintenance treatment in OP setting	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 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;

Making the Connection: Engaging At-Risk Populations and Persons Living with HIV
Therapeutic Childcare Meeting and Training
Lunch and Learn : Motivational Interviewing and Relapse Prevention
STAR BH Military Culture Training (offered three different times/locations)
Lunch and Learn : Criminal Addictive thinking & Conflict Resolution
Ready For Work Quarterly Meeting
Motivational Interviewing as the Foundation of SBIRT (offered two different times/locations)
Compassion Fatigue
Motivational Interviewing Core Training (offered two different times/locations)

Mental Health Coalition Meetings

Adult Mental Health specialty service providers meet either monthly or bi-monthly, these include individual Coalition meetings for all Supported Employment providers, a Coalition meeting for all Assertive Community Treatment providers, a Coalition meeting for all

Community Support Team providers, a combined Coalition meeting for all Case Management and Intensive Case Management providers, and a Coalition meeting for all providers of Crisis Stabilization Unit services.

These Coalition 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 several ACT policy adjustments, including: increasing number of allowable monthly enrollment, increasing initial authorization period, CTP units increase, group therapy units increase, group therapy staff ratio adjustment, and billing for collateral contacts and for increased usage of transportation funds in SE.

In person service specific coalition meetings for ACT are held in Macon for ease of access, and there is a call in number for those unable to be present. Between January and June 2013 three coalition meetings were conducted with representation from all ACT teams, DBHDD state office and regional offices and APS. The meeting locations alternated between Macon and Atlanta and were conducted on a bi-monthly basis. On July 3rd the fourth coalition meeting was held in Atlanta followed by an ACT Roundtable discussion with all State contracted ACT providers. Since January 2013, there have been 6 SE Coalition Meetings held for State contracted providers between February 20th - November 20th. Also on July 3rd AMH SE held a SE Roundtable discussion with all State SE contracted providers. Over the course of January 2013 - December 2013 there have been monthly CM/ ICM Coalition meeting. Between March 2013 - December 2013 there have also been monthly CST Coalition meetings.

Behavioral Health Contracted External Review Organization (ERO)

APS Healthcare is the External Review Organization (ERO) for DBHDD's behavioral health service. Many of the functions and products provided by this vendor contribute to the Department's quality management of the Provider Network. These elements include training, technical assistance, prior authorization for services, provider audits, and provider billing and service provision data. Several notable outcomes occurred during the time period of this report regarding provider network management, training opportunities, and authorization processes.

Audits:

The ERO conducted 335 audits in 2013. In an effort to develop a systematic review and response to audit findings, DBHDD implemented *Policy 01-113, Noncompliance with Audit Performance, Staffing, and Accreditation Requirements for Community Behavioral Health Providers,* in September 2012. This policy provides a protocol for DBHDD to respond to providers who receive failing audit scores, do not meet minimum staffing requirements, or fail to achieve or maintain accreditation. DHBDD made improvements to tracking and communicating audit scores both internally and with the Department of Community Health (DCH). Staff at DBHDD has worked to collaborate with DCH to develop procedures regarding consistent management of providers which fail to achieve compliance with DBHDD standards as evidenced by failing audits. As a result of this collaboration, protocols and

dialogue have been strengthened between the two Departments to ensure a consistent and efficient process of responding to provider deficiencies via corrective or adverse action. In 2013, DBHDD executed Policy 01-113 for 10 providers who had failing audit scores. This implementation has resulted in a refinement of the network based on provider performance.

DBHDD and the ERO completed the annual evaluation of the ERO audit tool. Adjustments were made to the Programmatic Audit Tool for Psychosocial Rehabilitation Individual, Case Management, Intensive Case Management, and Assertive Community Treatment to align with current service definitions and fidelity models. The current audit tools can be found on the APS Knowledgebase page at www.apsero.com.

Training

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

- Expanded prior authorization reviews to include private psychiatric hospitals in Regions 4 and 6 to support least restrictive and appropriate treatment and service for those in need of acute services options. ERO outreach and training to Region 4 and 6 private hospitals emphasized that successful admission, treatment delivery, and discharge planning are best accomplished when both the hospital and community-based providers are actively engaged in the process to improve the quality of life post discharge through facilitation of stable housing, identification of chronic medical conditions and referrals for coordinated care through Assertive Community Treatment (ACT), Intensive Case Management (ICM) and other community-based programs.
- Sponsorship of a Statewide Provider Training Forum in Macon, GA in January 2013. This event included training regarding evidenced based practices, use of ERO tools for quality improvement (e.g. audit scores, utilization reports), and responding to needs of specific populations (i.e. deaf services & homeless populations).
- Participation and training as an element of the Georgia Certified Peer Specialist training, including CPS-Parenting Documentation Training, the first of its kind.
- Provided on-site regional training in Region 4 as requested by the providers. This training focused on ACT, Psychosocial Rehabilitation, and general ERO practices. The result of this meeting resulted in improved communication and collaboration between the ERO and Providers.
- Continued offering of the Ambassador Program for new providers and providers' new staff members.
- In coordination with DBHDD and to support the roll out of Task Oriented Recovery Services (TORS), the ERO provided training to agencies that deliver this service.
- Participated in the development, rollout, and subsequent provider training of the Case Management/Intensive Case Management Toolkit as these services were made available to providers across the state.

In addition, the ERO has been instrumental in assisting the Department with additional training opportunities related to ACT. Following feedback received from providers, DBHDD and the ERO partnered to provide training regarding ACT services in multiple

venues. In addition to the ERO's regular attendance at ACT Coalition Meetings, the ERO provided technical assistance specific to ACT via:

- Targeted feedback to DBHDD regarding ACT authorization and audit processes and evaluation of inter-rater reliability. One of several outcomes of this discussion was the development of an extended initial authorization period of 1 year.
- In preparation for the transition to a 1-year initial authorization, APS provided two webinars to providers to outline the new process. These meetings also provided ongoing technical assistance regarding Documentation Requirements, Admission and Continuing Stay Criteria, and Transitioning to-and-from intensive services.

Service Utilization & Authorization:
During the report period, licensed clinicians at the ERO manually reviewed 79,140 authorization requests for community services. Of those, 3,978 authorization requests were specific to ACT services. As identified above, the ERO and DBHDD modified the authorization for ACT services to extend the initial authorization from 6 months to one year.

Claims information provided by the ERO also informed key decisions related to the content of service authorization packages. In the spring of 2013, DBHDD used utilization data to perform a review of units authorized for several service packages and to identify trends. This review was conducted by a panel of experienced clinicians and operational experts using a zero-based methodology that examined each service individually and in the context of other services available. The review resulted in a recommendation and subsequent changes to selected authorization packages. While there was some reduction in the number of units authorized in each package, the changes did not equate to a reduction or limit to services.

The primary aim of the initiative was to support services at levels sufficient to treat and support individuals at all levels of care. The changes to the authorization array promoted recovery and resiliency through the use of a comprehensive and robust array of case management/skills development services combined with appropriate psychiatric treatment, individual, group, and family therapy services rather than relying heavily on one or two isolated service modalities for individuals with complex needs. DBHDD continues to monitor utilization trends for continuous quality improvement activities.

Provider Network Analysis

The Department engages in community behavioral health and developmental disability service planning that encompasses an array of services that will assist individuals in living a life in the community. This service array provides levels of care for individuals who are identified as the target population as well as those who meet eligibility criteria for state supported services. Service planning is unique to the needs of each community and includes significant input from community members and service recipients.

An annual network analysis is conducted through DBHDDs Regional Offices and seeks to identify the impact of state and federal resources on the consumers who received services from State contracted treatment providers. The Regional Network Analysis (RNA) concluded in 2013 looked at services for the SFY 12 and the first quarter of SFY 13. The next RNA will capture the remaining quarters of SFY 13 and the first quarter of SFY 14.

Regional Offices also conduct a Regional Annual Plan which seeks to identify gaps in services and describe priorities for service in the upcoming fiscal year. The DBHDD will evaluate the feasibility of integrating these two reports into one document in 2014 and is considering whether this document may also incorporate indicators of the effectiveness of new services added to a region during the fiscal year. Because service planning is unique to each region, provider and consumer input will be solicited to both better understand the needs as well as to receive input regarding satisfaction with existing and new services.

The RNA was reviewed by DBHDD State and Regional leadership and is used as a consolidated resource to better understand where the gaps in services are and what resources are needed to close the gap(s). An example from last year's analysis of Region 1 showed a need for an increase of residential addictive disease services. The Region utilized this information and developed a service design that included a full continuum of addictive disease services including residential services. Funding for these services has not been identified, but if an opportunity existed to request additional allocations or redirect funds, the Region is well-prepared to act.

Georgia currently has several inter-departmental initiatives involving services provided to sub-populations of Georgians who may have special needs related to disability services. Examples of these sub-populations include veterans and service members; individuals with criminal justice involvement including those returning to the community from correctional institutions; children in foster care or involved with the juvenile justice system; and individuals with co-occurring behavioral health and physical healthcare needs. The RNA serves as a resource to state and regional office staff who participate on these local and statewide task forces as a comprehensive source of information about existing partnerships between community providers, other state agencies' local county and regional offices, and court systems. This not only assists in identifying what is available but also assists in providing information that can be useful in searching for opportunities for replication and partnership in areas where such coordination may be needed.

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 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 a 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 lives 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 a roadmap for delivering recovery-oriented care; and
- To serve as a model for other large mental health systems.

FY: 14 - Project Plan
Providers in Region 6 received this training between August and December 2013. Regions 1 and 3 will be trained and receive consultation/supervision between February 2014 - August 2014. 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 (ACT teams, Community Support Teams and Community Service Boards), and supervisors.

Project Plan progress for Region 6 providers:

- Supervisor Training
  - 10 professionals trained

- Hospital Training
  - August 8: 53 professionals trained
  - August 9: 32 professionals trained
  - August 15: 37 professionals trained
  - August 16: 34 professionals trained

- Week one of community providers training: August 19-23
  - 17 professionals trained

- Week two of community providers training: August 26-30
  - 37 professionals trained

Trainings for Regions 1 & 3 are slated to begin in February (Hospital Trainings) and March 2014 (Community Providers). Region 4 was completed in June 2013.

Suicide Prevention Program

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

- preventing suicide deaths,
- reducing other suicidal behaviors including attempts,
- reducing the harmful after-effects associated with suicidal behaviors, and

- improving the mental health of Georgians through primary prevention activities, access to care, early intervention, crisis treatment and continuing care.

A foundation of suicide prevention is providing awareness to communities and groups about the crisis of suicide and engaging citizens to work in their communities. In 2013 over 30 awareness events were held in Georgia throughout the entire state with group sizes ranging from 20 to 200 and serving at least 3,000 people. In 2013 there were 9 active suicide prevention coalitions and at least 12 new communities interested in forming coalitions. In September 2013 the second annual Suicide Prevention Coalitions' Conference, *Joining Hands Across Georgia* was held in Rome, GA with an attendance of about 100 people from active and developing coalitions.

The Georgia Suicide Prevention Information Network (GSPIN) website www.gspin.org supports awareness, coalitions, survivors groups and the interested public. During 2013 the traffic to the GSPIN website constantly grew. The beginning of the year had a daily average of 1,160 hits and a monthly average of 35,969 hits on the GSPIN website. By September 2013 the number more than quadrupled with a daily average of 5,123 hits and a monthly average of 153,719 hits on the GSPIN website. September was Suicide Prevention Awareness Month as well as the Coalitions Conference which resulted on a lot of activities and much more marketing of the site. By the end of the year the number remained more than triple from the beginning of the year with an average 117,300 monthly hits.

With a more aware general public, there is a need to identify people at high risk of suicide in the general public and assist them in accessing care. In order to address the access to care issue, the Suicide Prevention Program supported two evidence based gatekeeper trainings. Gatekeepers act as outreach liaisons who provide their community with information about how to identify someone at high risk of suicide, how to encourage the person to get help, and how to access behavioral health and crisis services. The programs are called: *Question, Persuade, and Refer (QPR)* and *Mental Health First Aid (MHFA)* and are for both adults and youth. These programs teach community members to recognize the signs of suicidal behavior and direct individuals to assistance. Between January 1, 2013 and December 31, 2013, DBHDD trained at least 500 Georgia citizens in QPR and 500 citizens in mental health first aid. The training was provided throughout the State and included 25 QPR trainings, 20 adult Mental Health First Aid trainings and 42 Youth Mental Health First Aid trainings in DeKalb, Henry, Gordon, Fulton, Newton, Haralson, Gwinnett, Walker, Bartow, Douglas, Rockdale, Chatham, Walker and Dougherty counties to community members in churches, schools, libraries and other community settings.

To help to expand the use of QPR in Georgia communities and support its sustainability, the Suicide Prevention Program supported two QPR Train the Trainer events in Albany, GA and Macon, GA and added 28 new certified trainers to the existing group of 189 certified QPR trainers throughout the state. In October 2012 the Suicide Prevention Program and the federal CHIPRA program collaborated to sponsor a Train the Trainer for Youth Mental Health First Aid and 17 individuals were certified. Fourteen of these individuals provided three trainings each during 2013 and continue to be in the trainer pool for Georgia.

The Suicide Prevention Program, through its contractor, The Suicide Prevention Action Network of Georgia (SPAN-G), revised the suicide prevention training segments in the Crisis Intervention

Team (CIT) trainings coordinated by the National Alliance on Mental Illness (NAMI) that is given to law enforcement and first responders throughout Georgia. In addition to identification of suicide, the program now contains information about supporting and managing suicide survivors at the scene of a death and on self-care. This module has been expanded into two modules, the first on suicide and the second on self-help and peer to peer support. During 2013 SPAN-GA gave 39 trainings in the revised Suicide module during CIT trainings to over 1,000 personnel from The Georgia Bureau of Investigation (GBI), Sheriff's Offices, Police Departments, High School Security, Pardons and Parole, Emergency Medical Service (EMS) and Fire Departments. In May, the new Suicide curriculum module was delivered to be included in the national revision of the entire CIT curriculum due to be published in 2014. The new self-help and peer to peer support module is in development by SPAN-G and will be delivered in the coming months to be included in the revised curriculum.

Once there is awareness and training to the general public and agencies that deal with individuals at high risk of suicide that referral for care is needed, the behavioral health network needs to be trained to further screen, assess and treat individuals at risk of suicide. The program staff worked with experts from the New York State Psychiatric Institute consisting of Dr. Barbara Stanley from the Suicide Intervention Center and Dr. Kelly Posner from the Center for Suicide Risk Assessment in order to address provider needs for screening, intervention and follow up which were identified as a result of death reviews. Additionally the program staff worked with Dr. Doreen Marshall, Associate Dean of Counseling at Argosy University, to design an evidence-based program for the Department's providers. By the end of 2012 the Suicide Prevention Evidence-Based Practice Initiative (SPEBP) had begun. Level 1 of the SPEBP Initiative involves:

- Using the CDC's (Center for Disease Control) Self-Directed Violence Surveillance: Uniform Definitions and Data Elements to address lack of common definitions in reporting suicidal behavior,
- Using The Columbia Suicide Severity Rating Scale (C-SSRS) to address lack of an effective process to identify people at risk of suicide,
- Using Drs. Barbara Stanley and Greg Brown's Safety Planning and Follow-up Tool (brief interventions) to address lack of immediate interventions for those at risk of suicide but who don't need to be hospitalized.
- Providing training to our provider leadership in the current best practices in Assessing and Managing Suicide Risk with a focus on basic competencies.

Taken together, the elements above form DBHDD's Suicide Prevention Evidence Based Practice (SPEBP) Initiative called A.I.M. (Assessment, Intervention, and Monitoring) with the outcome of identification, brief intervention and monitoring of consumers who are at high risk of suicide move toward the goal of helping them become securely situated in services and more empowered to act in their own self-interest.

During 2013 the Suicide Prevention Program staff provided a variety of A.I.M process training activities. Monthly one hour "Introduction to A.I.M." webinars began in February 2013 and are ongoing. Over 500 individuals participated in these introductory webinars during 2013. Trainings on the individual tools (C-SSRS, Safety Plan and Monitoring) were also developed and presented four times between January and May around the state serving, approximately another

200 attendees. An A.I.M. skill building day for DBHDD providers was held on May 3, 2013 in Macon, GA attracting 160 attendees.

To further address the need for information about assessment skills, a series of two *Assessing and Managing Suicide Risk for Mental Health Professionals* trainings provided by the SAMHSA funded Suicide Prevention Resource Center were taught by Dr. Doreen Marshall to clinical leadership in DBHDD provider organizations (140 attendees) on March 18 and April 17, 2013 and received very positive feedback.

Postvention, intervening when there has been a suicide death, is becoming more and more a focus of the Suicide Prevention Program. *Working with Those Bereaved by Suicide for Mental Health Providers* was developed by Dr. Doreen Marshall to help behavioral health providers understand how to help those bereaved by suicide in behavioral health settings, including how to help professionals bereaved by suicide. In 2013, Dr. Marshall taught 4 workshops in *Working with the Bereaved*, one in four of DBHDD's six regions to over 100 mental health providers.

The Suicide Prevention Program also provided ongoing postvention suicide training to the schools through its LIFELINES: Postvention and LIFELINES: Intervention Programs. Between January and March 2013, four LIFELINES: Postvention trainings and two LIFELINES Intervention trainings were provided to teams of school personnel and community professionals who work with school staff after a suicide death of a young person. Combined, these programs trained over 350 school and behavioral health personnel to respond effectively to suicide deaths in the schools.

Additionally, DBHDD provides training to teams of survivors of suicide and other committed individuals and technical assistance to these teams in developing and running groups. During 2013 there were 27 Survivors of Suicide Groups (SOS) groups operating in Georgia covering all 6 DBHDD regions. Two trainings were held to prepare new SOS group leaders in February and August of 2013 and 31 new group leaders were trained. New groups were established in Fayetteville, Gwinnett, Villa Rica, Valdosta, and Kennesaw and groups are developing in Newnan, Albany, and Rabun and Cobb Counties. Leaders were also trained to join current teams for sustainability in Cumming, Habersham, Houston, Gordon, Augusta, Athens, and Dublin. Two family events were created this year. Camp SOS was a weekend camp for families that was held for five families of children, parents, and grandparents ages 7 to 78 and the Starfish Program was, an innovative SOS program for families including children, where 22 leaders were trained in four teams and piloted one six-week program in Adairsville, GA.

Educational and outreach materials (purple packets) were designed that included materials from the Link Counseling Center, the American Association of Suicidology, identification of crisis service providers and crisis telephone numbers. Purple packets are disseminated to survivors of suicide by first responders, mental health professionals, funeral directors, clergy and others who encounter survivors of suicide death. Purple packets were provided to all DBHDD providers who attended provider meetings from December 2012 through May 2013 in Regions 1, 4, and 6. In 2013 over 9,000 purple packets were disseminated throughout the state to DBHDD providers, EMS personnel, school personnel, coalitions and survivors of suicide.

The DBHDDs Suicide Prevention staff continue to provide on-site and telephone consultation with providers who have experienced the death of a consumer by suicide, participate in meetings of the EQC, the CBH PQC, the DD PQC and the Community Mortality Review Committee. Consultation to providers included introduction to the EBP Initiative and A.I.M program. As part of its consultation to other agencies in Georgia there were five on-site visits with school systems experiencing a large number of deaths, including suicide deaths.

There have been coordinated efforts with the Georgia Department of Human Services and Georgia Divisions of Aging and Family & Children's Services in order to assist with planning for future suicide prevention initiatives. Suicide Safer Communities was developed for state agency personnel and other community members to introduce the core principles of providing prevention, identification, intervention, and postvention. These trainings disseminated the core principles to over 500 people who work with the elderly as well as those who work in the schools and higher education settings.

Additionally, DBHDD and the Garrett Lee Smith Youth Suicide Prevention Program contracted with the University of Rochester's with Dr. Peter Wyman to provide resources and technical assistance for selected communities in Georgia to implement the Sources of Strength Youth Suicide Prevention Program with a high degree of fidelity in middle and high schools in the project's target communities from 2010 through 2013. The overall project objectives are: (a) to increase healthy coping practices to reduce the numbers of youth who become suicidal. (b) to connect potentially suicidal youth with capable adults. Currently DBHDD has contracts with two local agencies (CETPA which serves the Latino community and The Southern Jewish Resource Network) and six school systems.

During 2014, the Suicide Prevention Program staff anticipate researching, developing the infrastructure and implementing KPIs for the Suicide Prevention Program.

Division of Developmental Disability 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 ERO (Delmarva) used interviews, observations and record reviews to compile a well-rounded picture of the individual's circle of supports and how involved the person was in the decisions and plans laid out for that person. The time period for DD data reported here was January 1, 2013 through November 30, 2013. December 2013 data was not available at the time of the writing of this report, but will be included in the 2014 Interim QM Report.

A total of 165 individuals who transitioned from an institution to the community participated in a Person Centered Review (PCR) with a Delmarva consultant. The following table shows the demographic distribution of Intensive Residential Treatment Center (IRTC) individuals, and the distribution of the random sample of individuals (N=430) who received waiver services during the same time period, participated in a PCR, and were already established in the community.

While individuals in both groups, IRTC and Established, were more likely to be male, there are some large demographic differences between the groups. Individuals who had recently transitioned to the community were:

- More likely to be older, age 45 and over (68% v 46%);

- Much more likely to live in a group home (90% v 37%);
- More likely to have a profound intellectual disability (56% v 10%);
- More likely to receive services through the COMP waiver (99% v 63%).

Table 1. Demographic Characteristics Jan - Nov 2013				
Region	**IRTC**		**Established**	
1	26	15.8%	42	9.8%
2	43	26.1%	80	18.6%
3	34	20.6%	194	45.1%
4	24	14.5%	57	13.3%
5	18	10.9%	27	6.3%
6	20	12.1%	30	7.0%
Gender				
Female	62	37.6%	182	42.3%
Male	103	62.4%	248	57.7%
Age Group				
18-25	10	6.1%	46	10.7%
26-44	43	26.1%	188	43.7%
45-54	52	31.5%	102	23.7%
55-64	33	20.0%	74	17.2%
65+	27	16.4%	20	4.7%
Home Type				
Group home	148	89.7%	158	36.7%
Host home	9	5.5%	46	10.7%
Other	4	2.4%	1	0.2%
Own place	3	1.8%	38	8.8%
With parent	1	0.6%	187	43.5%
Disability				
Autism	0	0.0%	7	1.6%
Cerebral Palsy and Other	0	0.0%	2	0.5%
Intellectual Disability	72	43.6%	378	87.9%
Profound Intellectual Disability	93	56.4%	41	9.5%
Waiver				
GIA	0	0.0%	28	6.5%
NOW	1	0.6%	133	30.9%
COMP	164	99.4%	269	62.6%
Total	**165**		**430**	

Table 2 displays information from the face to face interviews with individuals (Individual Interview Instrument or III), providing their perspective on the outcomes measured. Results were positive, with most standards scored close to 90 percent present or better and an average rate of 86 percent of outcomes present. The two lowest scoring standards were: 78.8 percent of the individuals were involved in the design of the service plan and only 67.9 percent of the service plans were reviewed with the person who can then make changes as desired/needed.

Compared to the Established population, IRTC results were similar except on the following Standards:

- Person actively participated in decisions concerning his or her life (IRTC group is 12.7 percentage points lower)
- Person was developing desired social roles (IRTC group is 29.6 points lower)
- Service plan was reviewed with the person, who can make changes (IRTC group is 11.6 points lower)

Compared to last year's IRTC results, seven out of the fifteen standards have had various degrees of improvements, and the other eight standards had slight declines. On average, this year's results are similar to last year's.

Table 2: Individual Interview Instrument Results by Standard

Standard	Jan - Nov 2013 IRTC (165)	Jan - Nov 2013 Established (430)	CY 2012 IRTC (187)
1. The person is afforded choice of services and supports.	89.1%	94.7%	82.3%
2. The person is involved in the design of the service plan.	78.8%	86.5%	74.7%
3. The service plan is reviewed with the person, who can make changes.	67.9%	79.5%	75.3%
4. The person's goals and dreams are reflected in supports and services.	90.3%	90.9%	88.2%
5. The person is achieving desired outcomes/goals	97.0%	94.0%	92.5%
6. The person actively participates in decisions concerning his or her life.	82.4%	95.1%	91.4%
7. The person is satisfied with the supports and services received.	96.4%	97.2%	97.8%
8. The person is free from abuse, neglect and exploitation.	95.8%	98.6%	98.9%
9. The person is healthy.	94.5%	94.9%	94.1%
10. The person is safe or has self-preservation skills.	95.8%	97.9%	93.5%
11. The person is educated and assisted to learn about and exercise rights.	78.8%	85.6%	82.2%

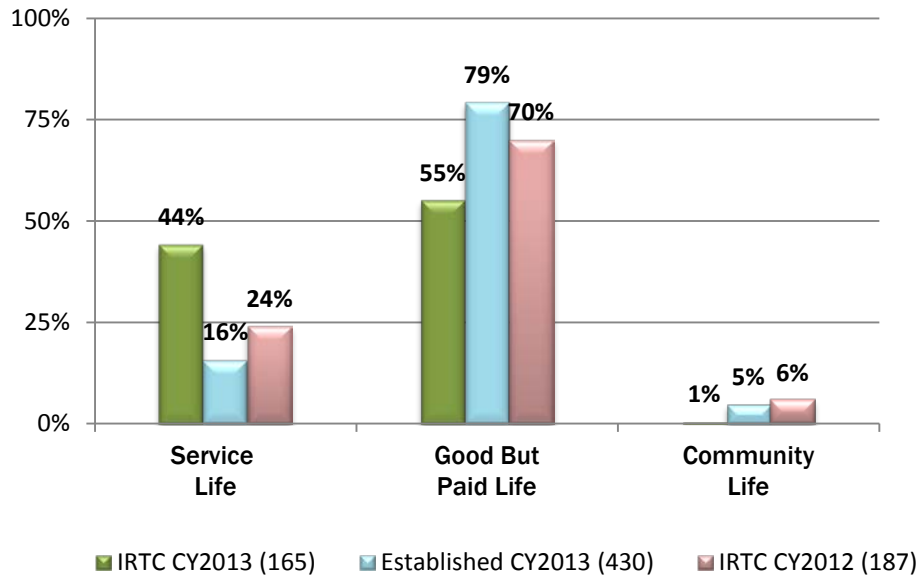
12. The person is treated with dignity/respect.	99.4%	98.8%	99.5%
13. The person's preferences related to privacy are upheld.	98.8%	98.8%	99.5%
14. The person has opportunities to access and participate in community activities.	85.5%	87.2%	89.2%
15. The person is developing desired social roles.	39.9%	69.5%	48.9%
Average	86.0%	91.3%	87.2%

Delmarva Quality Improvement Consultants (QIC) reviewed each person's Individual Support Plan with a Quality Checklist (ISP QA) to determine an overall rating for each individual reviewed, based upon the degree to which the ISP was written to provide a meaningful life for the individual receiving services. There are three different categories for each ISP.

1. 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.
2. 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.
3. 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 from this year and last year is presented in Figure 1. For individuals who transitioned from an institution in 2013, 44 percent of the ISPs were written to support a Service Life, which is greater than the established population (16%) and greater than last year's IRTC results (24%). Only one percent of ISPs in this year's IRTC group were written to support a Community Life, which is lower than the established population and last year's IRTC results.

Figure 1: ISP QA Checklist
Results by How ISP is Written



During the Person Centered Review process, a record review was completed for all providers offering services to the individual at the time of the review. Therefore, provider documentation was examined for each service the individual received. For the 165 individuals who transitioned from an institution, 281 provider records were reviewed. Results for each standard reviewed are presented in Table 3. On average, IRTC results were slightly lower than for individuals established in the community (58.6% v 62.5%), particularly on the following standards, where IRTC results were approximately 10 percentage points lower:

- Personal funds are managed by individual and protected (13.5 points lower)
- Individual chooses community services and supports (12.9 points lower)

The other low scoring standards for the IRTC group were: person centered focus is supported in the documentation (24.2% met); and documenting how the individual directs supports and services (18.5% met). These two standards were also among the lowest scoring standards for the Established group. However, the IRTC group had better results indicating providers have a means to identify health status and safety needs (IRTC: 33.2% versus Established: 23.8%). When comparing this year's results with last year's, both the IRTC and the Established groups have shown some declines.

Table 3: Provider Record Review Results by Standard			
	Jan – Nov 2013		CY 2012
Standard	IRTC (281)	Established (760)	IRTC (324)
1. Person centered focus supported in documentation.	24.2%	29.7%	30.2%
2. Human and civil rights are maintained	62.1%	65.9%	76.4%
3. Personal funds managed by individual and protected.	64.9%	78.4%	90.9%
4. Clear description of services/supports/care/treatment.	63.7%	72.3%	91.4%
5. The provider maintains a central record for individual.	94.7%	96.1%	95.4%
6. Potential risk to individuals/staff/others is managed.	78.9%	77.0%	83.3%
7. Information is protected, organized and confidential.	72.9%	76.8%	79.9%
8. Medication oversight/administration.	85.1%	89.1%	94.2%
9. Individual is afforded choices of services &supports.	46.6%	54.3%	51.9%
10. Means to identify health status and safety needs	33.2%	23.8%	36.5%
11. Means to evaluate quality/satisfaction of services.	85.7%	90.8%	87.5%
12. Meets NOW/COMP documentation requirements.	87.1%	92.5%	90.1%
13. Individual is making progress/achieving desired goals.	56.2%	64.0%	43.5%
14. Individual directs supports and services.	18.5%	25.2%	43.5%
15. Individual chooses community services/supports.	14.6%	27.5%	16.6%
Average	58.6%	62.5%	66.3%

Every individual has a Support Coordinator who helps ensure the person receives needed services, delivered as prescribed in the ISP. Documentation maintained by the Support Coordinator for the person was reviewed during the Person Centered Review process. Results for the Support Coordinator Record Review (SCRR) are shown in Table 4. Overall, this year's results were lower than last year (2012). The average results for IRTC were somewhat higher than for individuals already established in the community (64.4% and 58.5% respectively). On the standard indicating the person is included in the larger community, IRTC results were 10 percentage points lower than for individuals already established in the community. However, IRTC results were much better than the Established group on the following standards:

- Human and civil rights are maintained (22.6 points higher);
- Monitors services and supports according to ISP (14.8 points higher)

Table 4. Support Coordinator Record Review Results by Standard			
	Jan – Nov 2013		CY 2012
Standard	IRTC (165)	Established (430)	IRTC (187)
1. Person-centered focus shown in the documentation	41.8%	33.7%	48.1%
2. Human and civil rights are maintained	80.6%	58.4%	80.7%
3. Documentation describes available services, supports & care of individual	60.0%	52.3%	71.0%
4. Support coordinator monitors services/supports according to the ISP	78.8%	64.0%	82.9%
5. Support coordinator continuously evaluates supports and services	65.5%	63.7%	79.1%
6. Effective approach to assessing/making recommendations related to risk management	87.9%	80.4%	92.0%
7. Confidentiality of the individual's information is protected	98.2%	96.7%	95.7%
8. Individuals are afforded choices of services and supports	47.9%	49.4%	60.4%
9. Individuals are included into larger community.	17.9%	28.6%	31.6%
Average	64.4%	58.5%	71.3%

To help complete a well-rounded description of provider services, relevant providers/staff were interviewed. Results for the Staff Provider Interview are presented in Table 5. Findings were generally quite positive. IRTC results are slightly lower than for individuals already established in the community.

Table 5: Staff Provider Interview Results by Standard			
	Jan – Nov 2013		CY 2012
Standard	IRTC (281)	Established (760)	IRTC (324)
1. Implementation of individual centered/directed supports and services.	87.3%	92.5%	90.2%
2. Health	96.1%	96.3%	91.4%
3. Safety	84.0%	90.3%	88.6%
4. Rights Upheld	93.3%	97.4%	90.7%
5. Privacy and Confidentiality	99.5%	99.6%	98.9%
6. Respect and Dignity	99.6%	99.9%	100.0%
7. Implementation of the plan's identified supports and services	94.2%	94.2%	94.0%
Average	91.5%	94.5%	92.2%

Observations were conducted for residential services (if not a family or individual's home) and day services programs. This year's results are similar to previous years on the standards measuring Health, Safety, Rights and Self Advocacy. However, IRTC results for the current year were much lower than last year, and lower than the Established group on the standards measuring Community Life, Choice, and Celebrating Achievements.

Table 6: Observation Results by Standard

Standard	Jan – Nov 2013 IRTC (275)	Jan – Nov 2013 Established (633)	CY 2012 IRTC (316)
1. Health	97.4%	96.6%	98.1%
2. Safety	97.0%	98.7%	98.7%
3. Rights and Self Advocacy	97.3%	98.5%	98.4%
4. Community Life	56.8%	91.8%	92.5%
5. My Life and My Choice	89.6%	97.2%	97.6%
6. Celebrating Achievements	89.2%	96.6%	97.4%
Average	93.5%	97.5%	97.9%

DD Transition Quality Review Analysis

It was reported in the 2013 Interim QM Report that as a result of reviews conducted by the ADA Independent Reviewer and the Division of DD, a 45 day suspension on community transitions was put in place in May 2013. During the suspension period, the Division implemented a process to review the quality of placements for the 79 individuals who had transitioned to the community since July 2012.

The reviews were conducted by the Regional Quality Review staff who received specific training on how to conduct the reviews. The review tool utilized was the "Monitoring Questionnaire" that has five Sections, 163 questions and 10 supplemental questions. The five Sections are:

- Demographics/Observations
- Individual Interview
- Environment
- Health Care
- Behavior Interventions

There were 74 Monitoring Questionnaires completed. The Questionnaires were sent to Georgia State University for compilation and analysis.

Transition Quality Indicators were established based on the Vision of DBHDD, the Olmstead decision, the Settlement Agreement, and the community service standards. These indicators were used to guide the trend analysis of the transitions. The Indicators include:

- Individual Rights & Community Integration
- Environmental Safety & Individual Needs
- Health Care; and
- Behavior Supports

Examples of trends that were identified:

- There was a high percentage of engagement of community activities (91.9%), but a lack of individualized, integrated, and self-choice activities.
- Homes were relatively clean and safe, some improvements were needed.
- Most of the clinical assessments were completed if they were ordered by physician.
- Many needed clinical services were not provided, as ordered by physicians.
- Documentation of following health care protocols was lacking.
- Many providers did not have dining plans in place for individuals; or if in place, the dining plan was not followed by staff.
- 59.5% of all individuals received psychotropic medications; however, only about half (57%) of the individuals had confirmed Axis I psychiatric diagnosis.

A summary of the findings can be found in Attachment 4: DD Transition Quality Review Analysis.

Additionally during 2013 a Fidelity Review Team (joint effort between Support Coordination, the Regional Offices and the DBHDD State Office) was developed to review and approve all consumer transitions to the community prior to the transition. The goal of the Fidelity Review was to ensure individuals with DD who transitioned from state hospitals received adequate services and supports in a safe environment.

In an effort to address the issues found in the Georgia State analysis, DBHDD is re-evaluating the current transition process, is developing CAPS, and will be taking additional steps to increase the quality of those transitions. The outcome of DBHDD's transition quality improvement efforts will be reported in the 2014 Interim Report.

DD QM Reviews of Providers

Quality Enhancement Provider Reviews

The purpose of the Quality Enhancement Provider Reviews is to monitor providers to ensure they meet requirements set forth by the Medicaid waiver and Division of DD and to evaluate the effectiveness of their service delivery system. Between January 1 and September 30, 2013, the Quality Enhancement Provider Review (QEPR) was completed for 26 service providers.

- The average compliance score for the 26 providers reviewed was 69.0%, 1 point lower than the previous reporting period (Jul 2012-Jun 2013). The Division of DD has not set a target for the compliance scores; however an increase in compliance is desired from one year to the next.
- Providers performed better than in the previous reporting period in terms of having internal structures to support good business practices (increased from 86% to 93%), and with medication oversight (68% to 71%).
- Providers continue to score relatively low in the area of completing a minimum of 16 hours of annual training (60.3%), and receiving annual training within 60 days after hiring (61.3%).

To address these documentation issues, DD will continue providing documentation training to providers (see above). Providers failing to complete their annual required training present an

ongoing challenge. The Department is developing policies and procedures that will address provider quality improvement strategies. The annual training issue will be a part of that project. Additionally, by March 1, 2014, the Division will develop a workgroup including provider representation to develop a training curriculum providers can use to ensure staff receive the annual training as required by the Division. To address training needs around medication administration, law and regulations, the Division of DD implemented in May and June 2013 the training series, "Quality Medication Management and Healthcare Oversight". The series was held statewide and was well received.

During the QEPR, Delmarva worked with each provider to identify strengths and best practices as well as barriers providers face in developing optimal service delivery systems. A total of 492 strengths were identified, and a total of 303 barriers were documented during the reviews completed between January and September 2013. Providers may have identified more than one strength or barrier, but were recorded only one time per provider.

- Many of the strengths identified reflected areas of satisfaction with supports and services, receptiveness to improving quality, accessibility, flexibility and respect.
- Barriers noted by many of the providers include excessive paperwork and lack of financial resources (cost of doing business vs. reimbursement rates), conflicting messages (regulation versus person centered approach) and problems surrounding not having the support plan driven by the person.

Using findings from the QEPR, technical assistance was offered to support providers, including suggestions and guidance to help improve their service delivery systems. The Division of DD implemented two technical assistance processes: the Follow up with Technical Assistance (FU w/TA) and the Follow Up with Technical Assistance Consultation (FUTAC). The FU w/ TA is conducted ninety days after completion of the QEPR. From January 1 through September 30, 2013, 24 FU w/ TA reviews and 247 FUTAC were completed.

Providers are identified to receive a FUTAC through a referral system. The review process utilizes a consultative approach to assist providers in their efforts to increase the effectiveness of their service delivery systems. The focus is to improve systems that meet the needs, communicated choices, and preferences of the individuals receiving services. The FUTAC also supplements the PCR and QEPR processes by affording the Division of DD and contracted providers the opportunity to solicit technical assistance for specific needs within the service delivery milieu.

- FUTACs were completed in each of the six Regions
- Most of the reviews were onsite (88.3%), referred at the individual level (84.6%), the source of the referral was from one of the Regional Office HQMs (85%), with the Support Coordinator monthly score of a 3 or 4 as the primary reason for the referral (81.8%).
- Health, Safety and Provider Record Review documentation were most often the Focused Outcome Area addressed.
- Technical assistance most often included discussion with the provider and brainstorming.

The Regional Offices are taking advantage of the FUTAC process to support the providers. Documentation is an ongoing challenge for providers. The Division of DD will monitor the degree to which its efforts in providing documentation technical assistance and training will increase the quality of documentation.

2013 Specialized DD Quality Improvement Study

A study was designed to assess the prevalence of psychotropic and anticonvulsant medication use in adults with intellectual and developmental disabilities (I/DD). The primary focus of the study were individuals identified as meeting the Settlement Criteria and those who recently transitioned to the Community (IRTC) from one of the State hospitals. As identified in the Settlement Agreement, individuals must be provided with the least restrictive living environment, utilizing supports and services as appropriate in order to thrive in their communities.

Data from the National Core Indicators collected in Georgia demonstrated an increase in the proportion of individuals with I/DD who use of psychotropic medications; from 36.2 percent in fiscal year 2005-2006 to 51.0 percent in fiscal year 2010-2011.[1] [5] These results sparked discussion between the Division of Developmental Disabilities and the Delmarva Foundation about possible reasons for this marked increase. One possibility identified was the population of individuals transitioning into the community from institutions as they presented with significant and complex medical and behavioral challenges. The transition process may be challenging for them and also for the community providers.

The Division of DD, in an ongoing effort to assess the appropriateness and effectiveness of the transition process and the health of individuals, requested a closer analysis of medication use for this group: before, during and after transition from the state hospital system. The research questions include the following:

- Has there been an increase in the percent of individuals prescribed psychotropic or anticonvulsant medication, particularly after transition?
- Do the IRTC individuals have a higher prevalence than the I/DD population that is already established in the community (the comparison group)?
- How many people were prescribed a psychotropic/anticonvulsant medication for the first time after transitioning?
- Does the prevalence vary based on: residential setting, gender, ethnicity or disability type?

Please See Attachment 5: Quality Improvement Study for the results of the study and next steps.

DBHDD Quality Management Training Program

During July 2013, the first QM web based training module (Building a Customer-Focused Quality Management Program) was approved for Department-wide use. A memo to Departmental senior leadership was distributed to assist in communicating the importance of the

[1] Go to www.nationalcoreindicators.org for more information.

training. In August, a Department-wide training announcement was sent to all staff notifying them of the requirement to participate in this mandatory training. The target date for completion of the first module was September 1, 2013. Compliance with completion of this module is currently taking place. Two additional QM web-based training modules have been developed, will be reviewed for continued applicability, and will be released using a similar process in 2014.

Data Reliability Process

Accurate and reliable data is imperative 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.

A report tool was developed that allowed hospitals to be able to drill down directly to reported data failures and make needed corrections to data that is reported to The Joint Commission (commonly known as the HBIPs measures). Use of that tool resulted in several data-collection methodology changes, which improved both reported scores as well as the reliability of the data. Beginning in December 2013, DBHDD's EMR system was improved to capture needed data directly from the physician electronic record. This improved data collection by eliminating interpretation and data re-entry of the reported data.

Community BH Key Performance Indicator Data Integrity

The majority of the data that comprises the CBH KPIs is received from providers via a monthly programmatic report. Over the previous year, these reports have transitioned from being received by program staff via e-mail to an online database where providers enter the data directly into a web portal. The online database went live for Case Management, Intensive Case Management, and Community Support Teams in SFY2013. It went live for ACT and SE in July 2013. 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 and regional DBHDD office staff before it is accepted. 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 the ERO (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

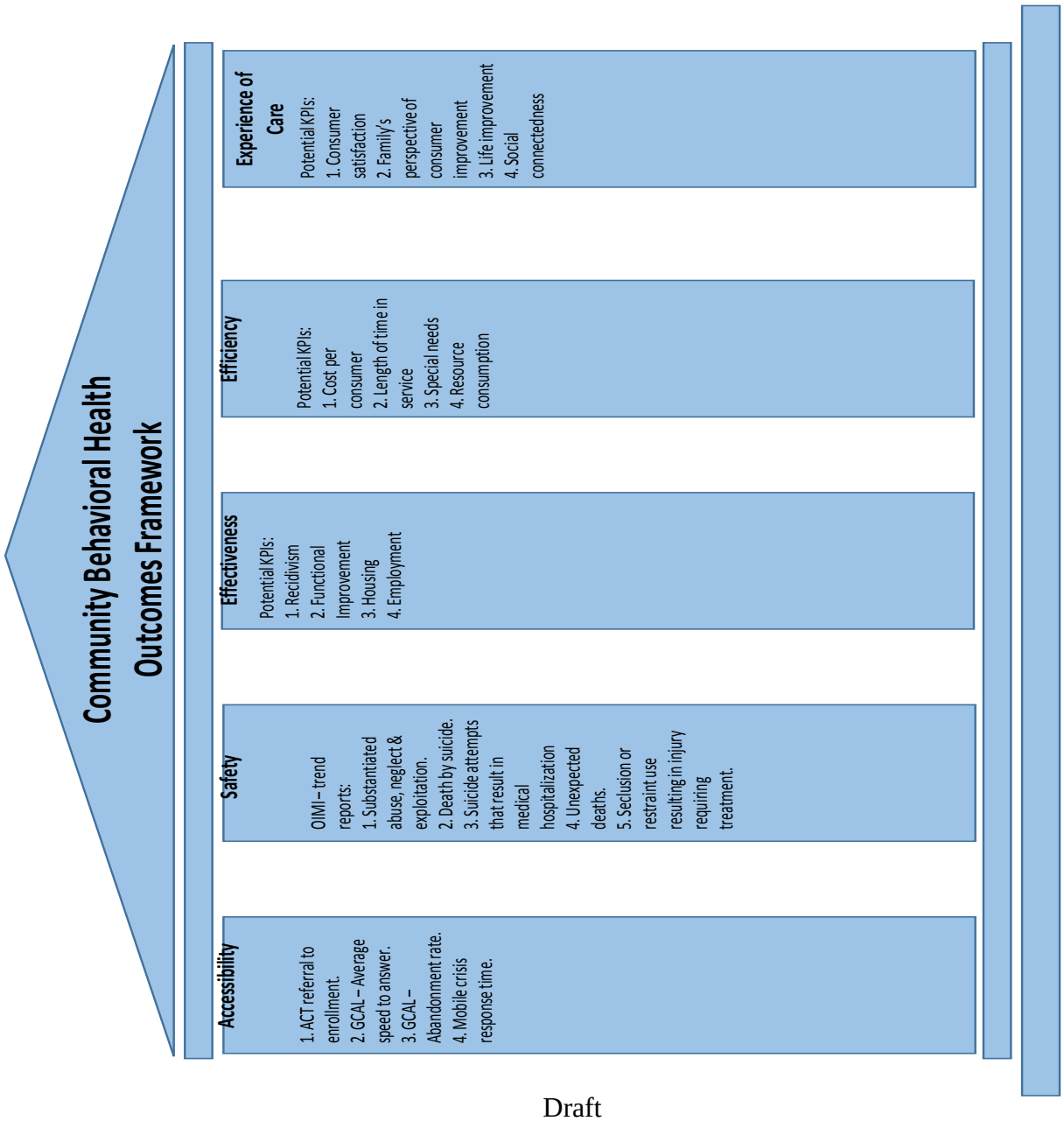
for possible trends. After the data in the report have been corrected, a new report is generated and distributed as necessary.

Summary

The sections above reference the multitude of quality related activities taking place across DBHDD. Key activities that have taken place between January 2013 and December 2013 include the inaugural DBHDD QM system review; a revision of the DBHDD QM Plan; the revision, standardization and reconfiguration of the KPI dashboard format; the development of a data definition/data collection plan document; the development and implementation of a Performance Measure Evaluation Tool (PMET); the development of a report which focuses on incident trends and patterns; the initiation of a comprehensive system wide review of the DD QM system by an external contractor; the development of an ongoing collaborative relationship with the Georgia Association of Community Services Boards, the implementation of web-based DBHDD QM training for staff, and significant communication with and training of providers on cognitive therapy (Beck Initiative) and suicide prevention. Additionally a review of KPIs has been completed in the hospital and community systems and is in process in the Division of DD.

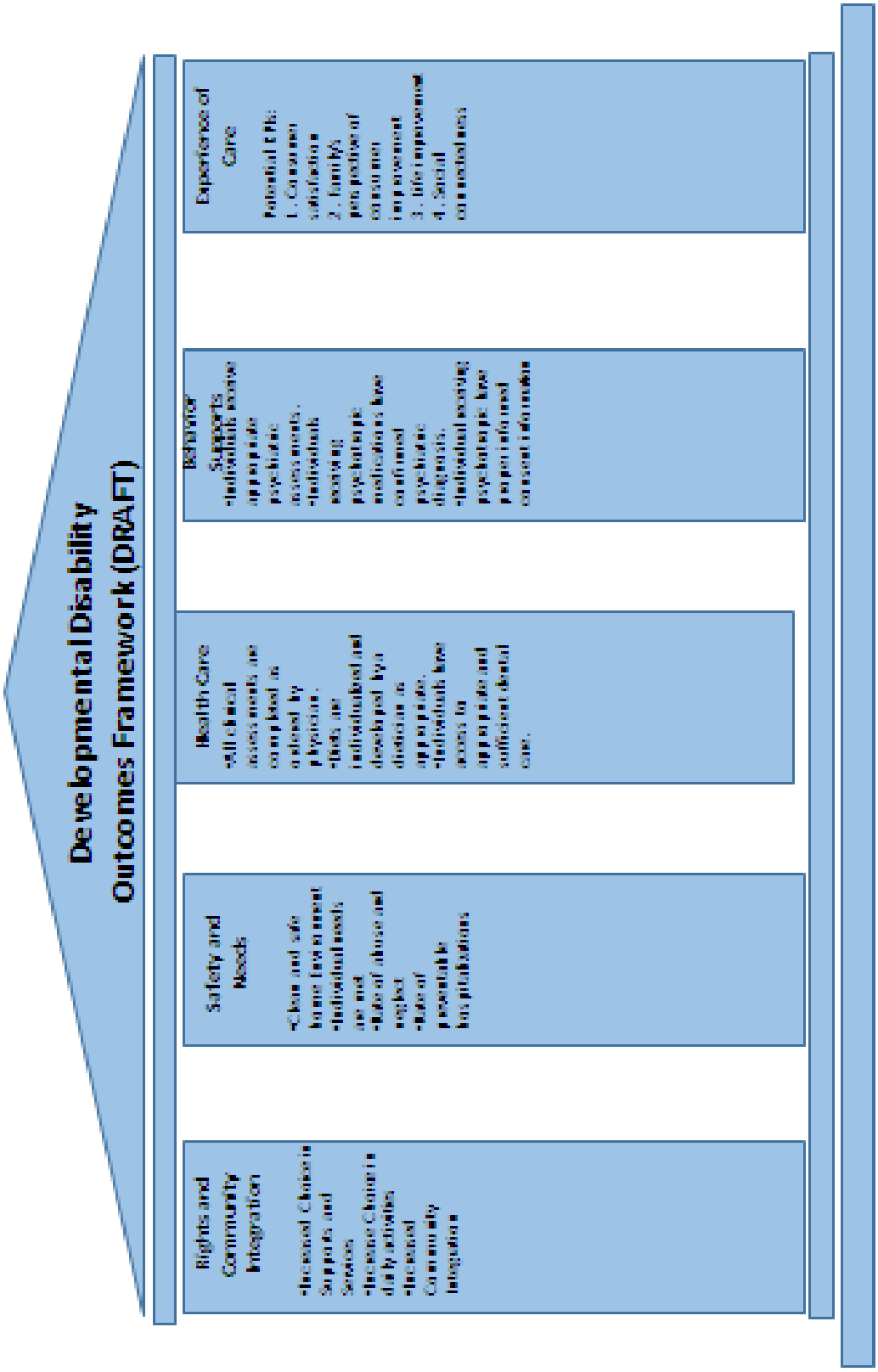
During 2014 the DBHDD QM Plan and QM work plans will be reviewed. It is anticipated that there will be minor changes to the Hospital and Community Behavioral System work plans but recognize the need for a more significant overhaul of the DD QM work plan. Additionally, community based recovery KPIs will be identified as will KPIs for the Suicide Prevention program: the KPI dashboard format will continue to be refined and the data used to analyze trends and patterns for program decisions: and the Division of DD will complete its review of the consultant's report related to its QM system and make program modifications.

Appendix A Community Behavioral Health Outcomes Framework



Draft

Appendix B Developmental Disabilities Outcomes Framework



Appendix C 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 – delayed but completed in December 2013	Completed
Collaborate with stakeholders using the identified criteria to develop key performance indicators	Program Quality Councils	July 2013 – delayed but completed in November 2013.	Completed and will become an ongoing task
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 – delayed to November 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 – see Appendix L for current plan	Carol Zafiratos and Training Department	June 2013 – revised completion date April 2014	Delayed - awaiting results of DD QM system review
Continue development of web based training materials – three additional modules	Carol Zafiratos and Training Department	December 2013 – revised completion date April 2014	Delayed due to competing priorities
Develop and implement methodology to evaluate the effectiveness of the training	Carol Zafiratos and Training Department	December 2013 – delayed until January 2014	

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	Program Quality Council Chairpersons	June 2013 – delayed until February 2014.	Draft outcomes framework =

applicable, develop a data definition/collection plan for each measure and implement data collection).			completed for CBH and is under review by the Division of DD
Assess achievement levels of quality goals	Program Quality Council Chairpersons	March 2014	
Assess performance indicator achievement against target thresholds	Program Quality Council Chairpersons	March 2014	
Modify QM system and/or components as needed	Program Quality Council Chairpersons	March 2014	

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 - delayed to April 2014	Delayed due to IT Senior level personnel changed
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	
Create a QM information management plan (i.e.: policy and procedure development)	Director of IT	July 2014	
Develop a RFP to build a DBHDD Enterprise Data Systems (EDS)	Director of IT	July 2014	
Develop the DBHDD EDS	Director of IT	2015	
Evaluate the effectiveness and efficiency of the newly created system	Director of IT, Carol Zafiratos, Steve Holton and Eddie Towson	2016	

Appendix D 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 – see Appendix J for current plan	Carol Zafiratos, Steve Holton and Training Department	June 2013 - Delayed until January 2014	
Identify desired knowledge, skills, abilities and behaviors for Hospital Quality Managers	Director of Hospital System Quality Management	August 2013 – Delayed to December 2013	Completed
Assess training needs of QMs.	Director of Hospital System Quality Management	Sept 15, 2013 – Delayed to February 2014	
Develop training plans and methodology for QMs.	Director of Hospital System Quality Management ,Carol Zafiratos and Training Department	Nov 1, 2013 - Delayed to March 2014	

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	
Each hospital identifies and submits their KPIs (hospital level) and PI goals to the HSPQC	Program Quality Council Chairpersons	March 2014	
Hospitals update analyses and begin to prepare reports for Hospital System QC (Quality Management effectiveness review meeting scheduled for March 2014).	Program Quality Council Chairpersons	March 2014	

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 – a committee has been selected. Will initiate activities when the consultant has been hired.
Develop methodology for performing IM needs assessment	Chair of Information Management Committee & Director of Hospital System Quality Management	September 1, 2013 Revised: will depend on timeframes developed by consultant. Estimate: April 2014	

		Projected hire date for consultant has been moved to after January 2014	
Perform needs assessment in hospitals and analyze results	Chair of Information Management Committee & Director of Hospital System Quality Management	November 1, 2013 – delayed pending consultant. Anticipate April 2014	
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 – delayed. Anticipate July 2014	
Develop Hospital System IM plan	Chair of Information Management Committee & Director of Hospital System Quality Management	November 2014	

Appendix E 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 delayed but completed in December 2013	Completed
Use PMET and develop new KPI's as indicated	Chris Gault and CBH Program Staff	October 2013	Completed
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 – delayed but completed in December 2013	Completed
Collaborate with stakeholders to review and provide feedback on new KPI's	Chris Gault and CBH Program Staff	October 2013	Completed
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	
Initiate provider based data integrity reviews	Resources need to be identified	March 2014	

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	Completed
Once approved implement the training recommendations and monitor compliance for state staff	CBH Program Managers	Start Date = October 2013. Target completion February 2014	In process

Develop a QM training plan for providers	CBH PQC, Chris Gault and Carol Zafiratos	January 2014	
Develop a QM training plan for individuals served and families	CBH PQC, Chris Gault and Carol Zafiratos	March 2014	

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 delayed until March 2014	In process

Appendix F 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. See Attachment 1- Quality Management System Review - Summary of Current Status Report
Assessment of current data utilization	Director of DD Quality Management and Contractor	07/31/13	Completed. See Attachment 1- Quality Management System Review - Summary of Current Status Report
Interview Central and Regional Office staff to identify capabilities of quality practitioners	Director of DD Quality Management and Contractor	07/31/13	Completed. See Attachment 1- Quality Management System Review - Summary of Current Status Report
Conduct Stakeholder interviews to determine capabilities of quality practitioners	Director of DD Quality Management and Contractor	07/31/13	Completed. See Attachment 1- Quality Management System Review - Summary of Current Status Report

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. See Attachment 1-Quality Management System Review - Summary of Current Status Report
Conduct Interviews with service provider and service coordination staff	Director of DD Quality Management and Contractor	07/31/13	Completed. See Attachment 1-Quality Management System Review - Summary of Current Status Report
Conduct comparison of requirements generated by DBHDD to CMS and DOJ requirements	Director of DD Quality Management and Contractor	07/31/13	Completed.
Establish QI Council workgroup to design new QM system with participation from DD Advisory Council	Director of DD Quality Management and Contractor	07/31/13 – Revised to 02/01/14	Planning timeline for design of new system has been extended to allow for more thorough planning and development
Develop report describing the status of the "as is" system	Director of DD Quality Management and Contractor	08/01/13	Completed. See Attachment 1-Quality Management System Review - Summary of Current Status Report
Develop recommendations for improvements to Georgia's quality system	Director of DD Quality Management and Contractor	08/01/13 – Revised to 02/01/14	In process See Attachment 1-Quality Management System Review - Summary of Current Status Report
As part of Goal 1 DD will establish accurate, effective, and meaningful performance indicators for DD Services and DD Providers	Director of DD Quality Management and Contractor	08/15/13 – Revised to 03/01/14	Planning timeline for design of new system has been extended to allow for more thorough planning and development
Finalize measurements	Director of DD	09/15/30/13 –	Planning timeline for

	Quality Management and Contractor	Revised to 03/01/14	design of new system has been extended to allow for more thorough planning and development
Develop comprehensive description of redesign for statewide DD QM system	Director of DD Quality Management and Contractor	10/01/13 – Revised to 03/01/14	Planning timeline for design of new system has been extended to allow for more thorough planning and development

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

Tasks	Responsible Person	Target Completion Date	Status
Identify core knowledge and skill requirements for each quality role identified.	Director of DD Quality Management and Dept Director of QM	08/31/13	Completed. See Attachment 1- Quality Management System Review - Summary of Current Status Report
Review and analyze the instructional system/knowledge and basic skill topics with DBHDD Staff and quality councils.	Director of DD Quality Management and Dept Director of QM	08/31/13 – Revised to 03/01/14	Planning timeline for design of new system has been extended to allow for more thorough planning and development
Develop materials and methods for learning management and curriculum development	Director of DD Quality Management and Dept Director of QM	09/30/13 – Revised to 03/01/14	Development timeline has been extended to allow for more thorough planning and development
Create DD training program draft and review with DBHDD Staff and Quality Councils	Director DD Quality Management	10/31/13 – Revised to 04/01/14	Timeline has been adjusted as a result of extended planning and development period
Finalize training program with input from Quality Councils and Advisory Council	Director DD Quality Management	11/15/13 – Revised to 05/01/14	Timeline has been adjusted as a result of extended planning and development period
Train staff and stakeholders	Director DD	12/15/13 –	Timeline has been

on new DD QM System	Quality Management and Contractor	Revised to 08/01/14	adjusted as a result of extended planning and development period
Draft a manual which includes the following sections:	Director of DD Quality Management and Contractor	12/15/13 – Revised to 03/01/14	Timeline has been adjusted as a result of extended planning and development period
• QM and improvement requirements section			
• Roles and responsibilities section			
• Guidance on joint agency collaboration			
• Reporting requirements			
• Tools for data collection and analysis			
Review drafts of each section with DBHDD staff and QI Councils and Advisory Council	Director of DD Quality Management	12/31/13 – Revised to 04/01/14	Timeline has been adjusted as a result of extended planning and development period

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

Tasks	Responsible Person	Target Completion Date	Status
Develop the follow-up and monitoring process	Joseph Coleman, Director of Transitions DD	04/01/13 6/5/13	Completed Revisions completed to incorporate full review of findings/reports by Central Office
Finalize the audit tool	Joseph Coleman, Director of Transitions DD	04/01/13 6/5/13	Completed Revisions completed to utilize full monitoring tool developed by DOJ
Identify the reviewers/auditors	Joseph Coleman, Director of Transitions DD	04/01/13	Completed
Create, hire, train Regional DD Transition Quality Review Team	Joseph Coleman, Director of Transitions DD,	7/1/13	Completed

	and Rose Wilcox. Director of Training and Education DD		
Decide the process of data collection, reporting, and correcting problems identified	Joseph Coleman, Director of Transitions DD	6/10/13	Completed
Review quality of transition for 79 individuals who have transitioned out of state hospitals as of July 1, 2012	Joseph Coleman, Director of Transitions DD	06/20/13	Completed. Results sent to GSU for analysis Provider CAPs generated by reviews submitted by Providers and reviewed/approved by Region Office and Transition Fidelity Committee
Pre-transition review of Provider capacity to ensure quality care for 40 individuals whose planned May/June transitions were postponed until after July 1, 2013	Joseph Coleman, Director of Transitions DD	06/25/13	Completed Provider CAPs generated by reviews submitted by Providers and reviewed/approved by Region Office and Transition Fidelity Committee
Review and revise the current transition process to develop a comprehensive process / plan	Joseph Coleman, Director of Transitions DD	7/1/13	Work ongoing. Final revisions to transition process to be completed February, 2014

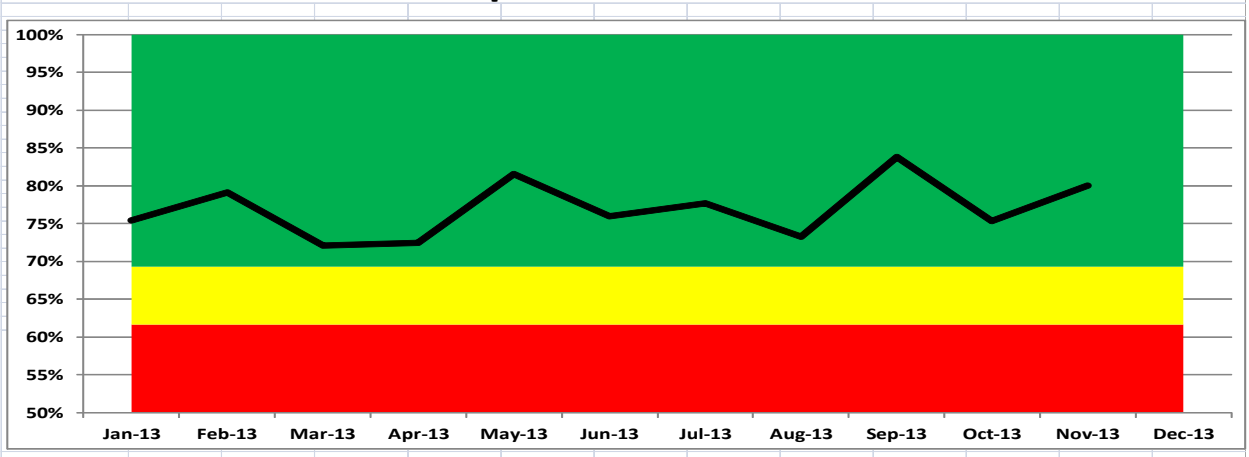
Goal 5: Integrate QM Data Systems in a matter which is compatible with Department data systems (Hospital, Community BH and Community DD) which will allow Division to follow an individual and their services across their lifetime. This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Develop Division DD information management committee	Director of DD Quality Management	08/01/13	In the first quarter of 2014, DBHDD will be releasing an RFP for an Administrative Services Organization (ASO). A Core Group is developing the RFP and a subgroup is acting as the information management committee

Assessment current information management systems methods for collection and utilization	Director of DD Quality Management and Division Data Manager	08/01/13	Completed. See Attachment 1- Quality Management System Review - Summary of Current Status Report
Set priorities for IM needs and work with OIT to address those needs as appropriate.	Director of DD Quality Management and Division Data Manager	10/01/13	Completed as part of the DBHDD ASO RFP.
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	Completed
Work with ASO to develop and test new system	Director of DD Quality Management and Vendor	08/01/14 – Revised to 07/2015	Timeline adjusted to match ASO implementation timeline.
Train end users on new system	Director of DD Quality Management and Vendor	10/01/14 – Revised to 07/2015	Timeline adjusted to match ASO implementation timeline.
Transition data from old case management system to new system	Director of DD Quality Management and Vendor	12/31/14 - Revised to 07/2015	Timeline adjusted to match ASO implementation timeline.

Appendix G Hospital System KPI Dashboards

Client Perception of Outcome of Care



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	123	140	168	158	159	133	129	104	93	131	72	N/A
Denominator	163	177	233	218	195	175	166	142	111	174	90	N/A
Rate	75%	79%	72%	72%	82%	76%	78%	73%	84%	75%	80%	
Quarterly Average		75%			77%			78%				

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

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.

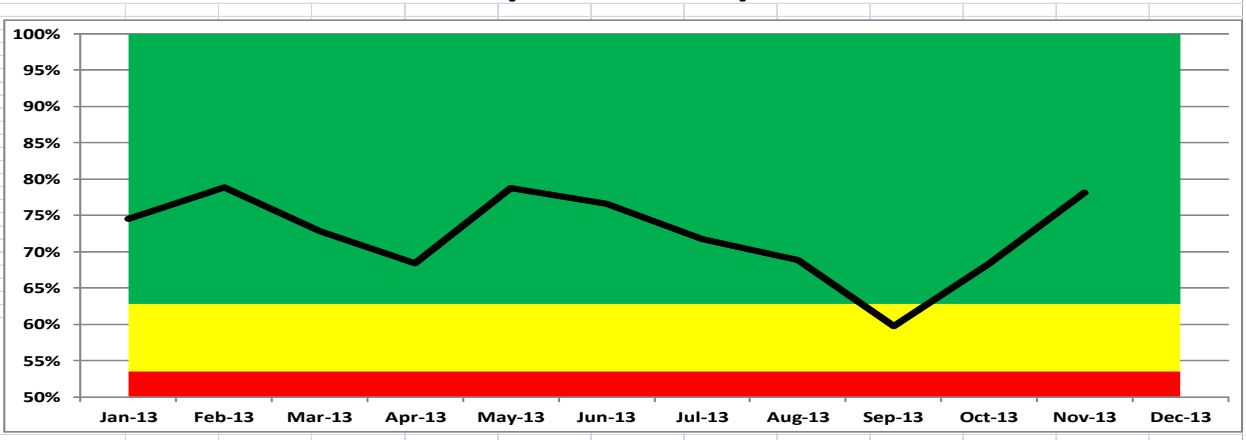
April-June 2013 Analysis

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.

January-March 2013 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 Quality Management departments are looking at ways to improve the consistence and timeliness of reporting and the consistency and quality of the methods of administration of the survey

Client Perception of Empowerment



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	120	134	166	13	37	131	99	64	43	114	68	N/A
Denominator	161	170	228	19	47	171	138	93	72	167	87	N/A
Rate	75%	79%	73%	68%	79%	77%	72%	69%	60%	68%	78%	
Quarterly Average		75%			76%			68%				

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

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.

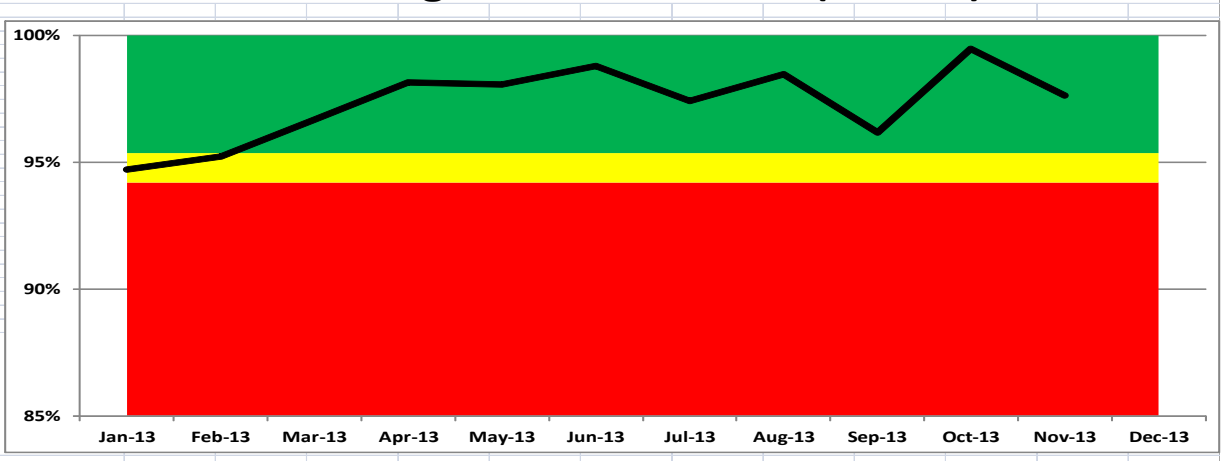
April-June 2013 Analysis

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.

January-March 2013 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 Quality Management departments are looking at ways to improve the consistence and timeliness of reporting and the consistency and quality of the methods of administration of the survey

Continuing Care Plan Created (Overall)



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	502	497	526	525	555	487	413	385	351	379	288	N/A
Denominator	530	522	544	535	566	493	424	391	365	381	295	N/A
Rate	95%	95%	97%	98%	98%	99%	97%	98%	96%	99%	98%	
Quarterly Average		96%			98%			97%				

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

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.

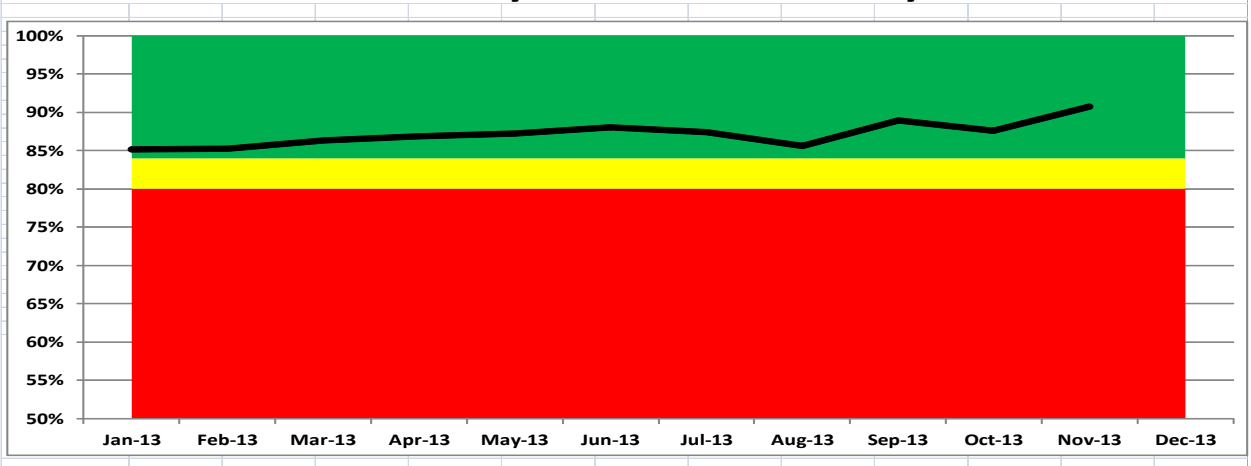
April-June 2013 Analysis

The gradual inprovements reflected in these data indicate that the current strategy has been effective.

January-March 2013 Analysis

Issues that led to the decline reflected in December 2012's 94% (which was just below the lower target of 94.4%) were identified and corrected in January 2013. The result is represented in this quarter's reporting of compliance steadily increasing for all three months.

Individual Recovery Plan Audit - Quality Measure



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	2247	1996	2322	2125	2237	2023	1697	1988	2220	2166	2091	N/A
Denominator	2640	2342	2689	2447	2566	2299	1942	2323	2495	2473	2305	N/A
Rate	85%	85%	86%	87%	87%	88%	87%	86%	89%	88%	91%	
Quarterly Average		86%			87%			87%				

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

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.

April-June 2013 Analysis

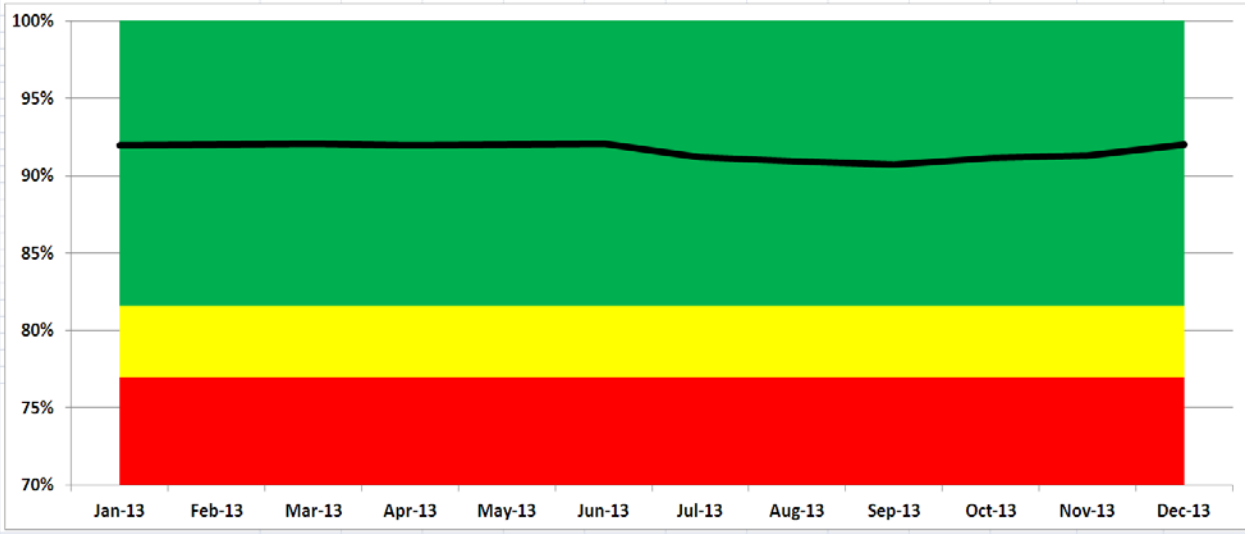
The gradual inprovements reflected in these data indicate that the current strategy has been effective.

January-March 2013 Analysis

A gradual overall trend upwards (positive) is being achieved, even though the timeframe of January-March appears to be relatively flat. It appears the training and emphasis placed on the measure had an overall positive affect on the averages.

Appendix H CBH System KPI Dashboards

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	536	574	579	582	599	613	623	643	683	761	811	843
Denominator	583	624	629	633	651	666	683	707	753	835	888	916
Percent	91.9%	92.0%	92.1%	91.9%	92.0%	92.0%	91.2%	90.9%	90.7%	91.1%	91.3%	92.0%
Quarterly Average		92.0%			92.0%			90.9%			91.5%	

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

October-December 2013 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

July-September 2013 Analysis

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

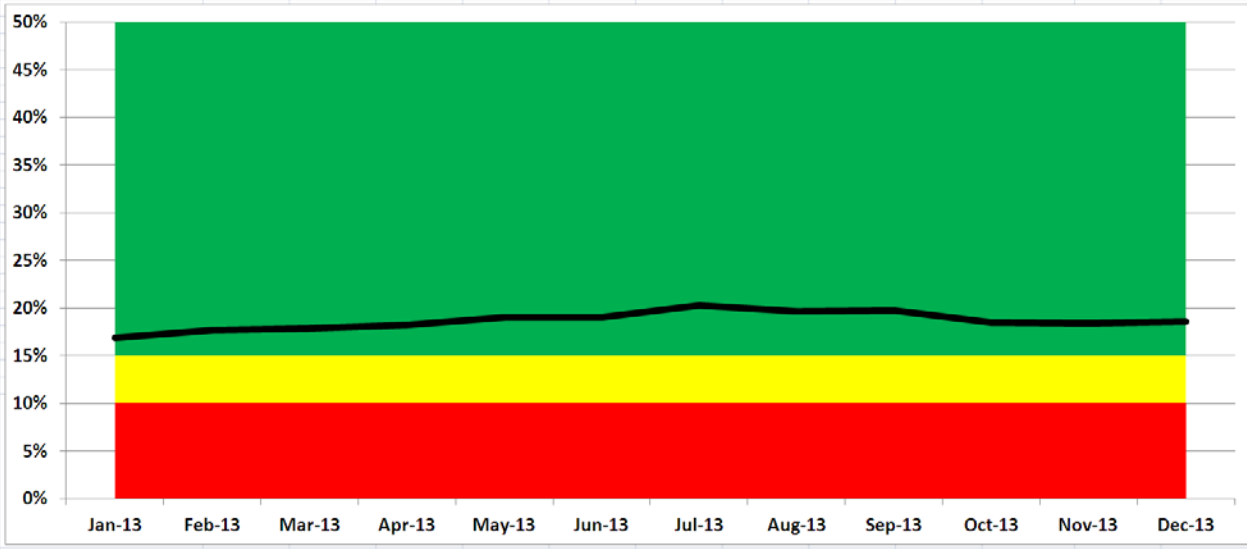
April-June 2013 Analysis

The quarter saw a rapid increase in the number of individuals placed in the program but will not show up in the data until next two quarters. The quarter stability rate is pulling the rolling average up as it has for the previous two quarters. The target is being met.

January-March 2013 Analysis

The rate of new enrollees remained stable and at a low level. With 9 months of a slow increase in new enrollees the stability rate for the quarter remains high. The target is being met.

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%



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	16	18	20	22	27	27	32	35	35	35	37	39
Denominator	95	102	112	121	142	142	158	178	177	189	201	210
Percent	16.8%	17.6%	17.9%	18.2%	19.0%	19.0%	20.3%	19.7%	19.8%	18.5%	18.4%	18.6%
Quarterly Average	17.5%			18.8%			19.9%			18.5%		

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

October-December 2013 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

July-September 2013 Analysis

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

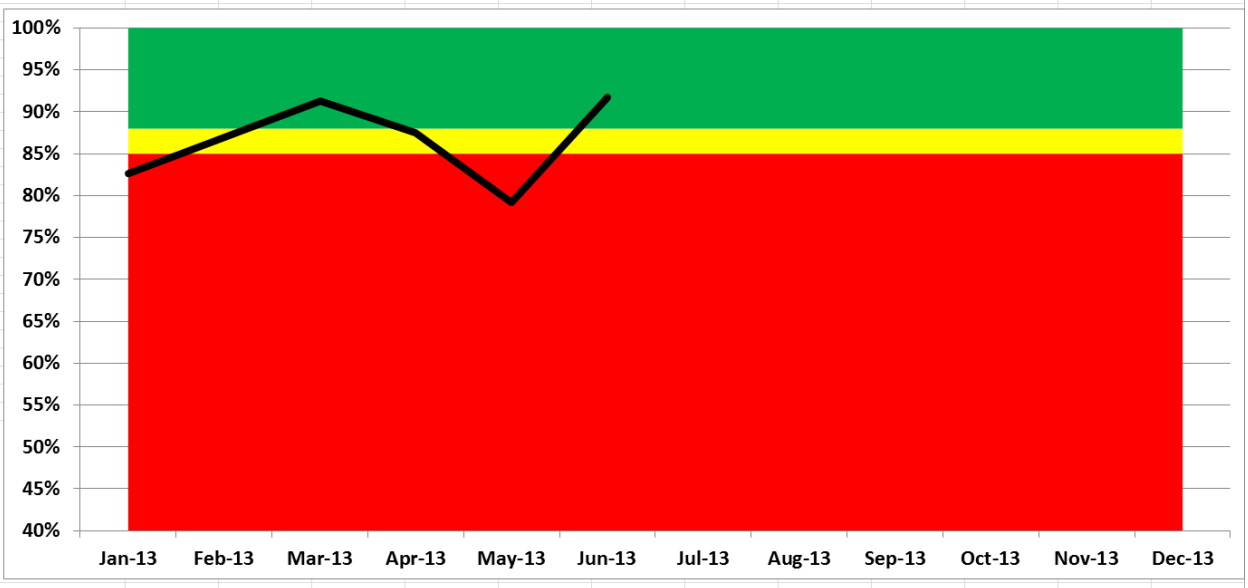
April-June 2013 Analysis

There is a slight upward trend in the reengagement rate unless variability as the portfolio ages with more opportunities for providers to work with their clients knowing the program has the ability to continue the support.

January-March 2013 Analysis

A floor seems to be established with some consistency in the rate of reengagement.

Percent of adult MH supported employment providers that meet a caseload average of employment specialist staff to consumer (ratio 1:20)
Target (85%) or more
Key Performance Indicator retired June 2013



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	19	20	21	21	19	22	0	0	0	0	0	0
Denominator	23	23	23	24	24	24	0	0	0	0	0	0
Rate	82.6%	87.0%	91.3%	87.5%	79.2%	91.7%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
Quarterly Rate	87.0%			86.1%			Data collection change see revised KPI			Data collection change see revised KPI		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of adult MH contracted supported employment providers that met a mental health caseload average of 1 to 20 or less 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 employment.

COMPONENTS OF NUMERATOR AND DENOMINATOR

Numerator: Number of contracted providers with a consumer to staff ratio of 1:20 or below 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

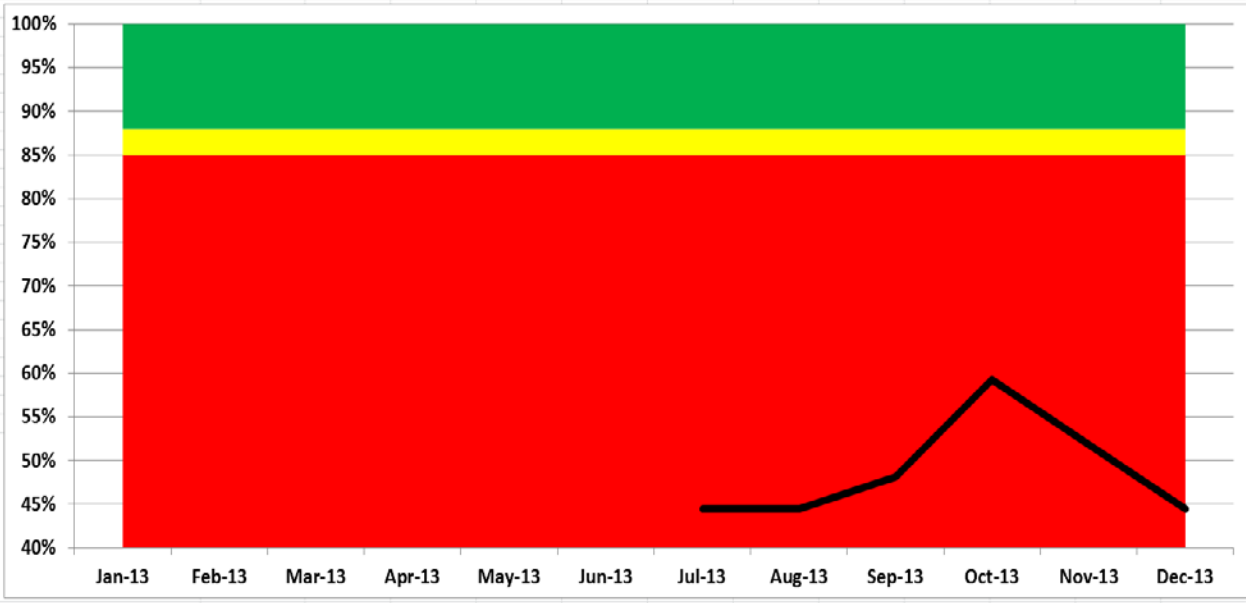
April-June 2013 Analysis

Over the course of the past four quarters, there appears to be an upward trend in the percentages of providers meeting the ratio. Two providers indicated that the demand in the community for these services has kept the number of consumers enrolled high. Two other providers indicated the amount of time it takes their Supported Employment Specialists to support individuals meeting ADA criteria in the workplace has created smaller overall caseloads.

January-March 2013 Analysis

Per the January 9, 2013 Quality Council meeting, starting July 1, 2013, this measure will end and a new one will start. The new measure will be to examine a 1:15 to 1:20 ratio, rather than 1:0 to 1:20. During this quarter, providers received training and communication in regards to how important this measure is and how it relates to Fidelity in the IPS Fidelity Model.

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	0	0	0	0	0	0	12	12	13	16	14	12
Denominator	0	0	0	0	0	0	27	27	27	27	27	27
Percent	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	44.4%	44.4%	48.1%	59.3%	51.9%	44.4%
Quarterly Average	KPI not active			KPI not active			45.7%			51.9%		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of adult MH contracted supported employment providers that met a mental health caseload 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 employment.

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

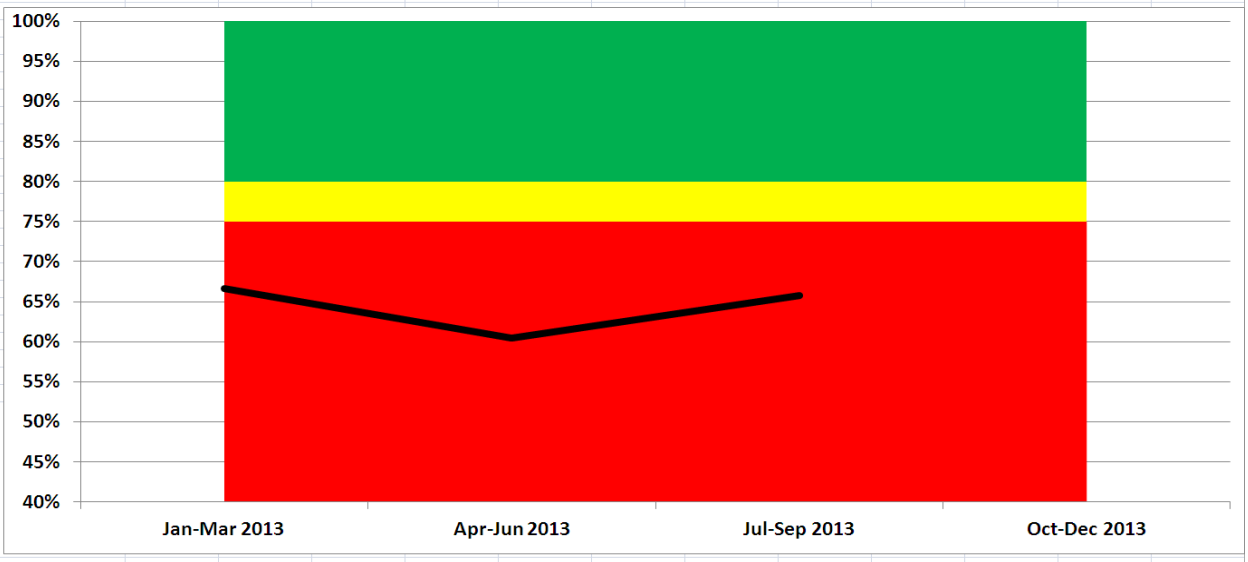
October-December 2013 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

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 consumers.

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



	Jan-Mar 2013	Apr-Jun 2013	Jul-Sep 2013	Oct-Dec 2013
Numerator	56	98	73	0
Denominator	84	162	111	0
Rate	67%	60%	66%	#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.

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

October-December 2013 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

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 a faith based entities that would be willing to assist in providing transportation.

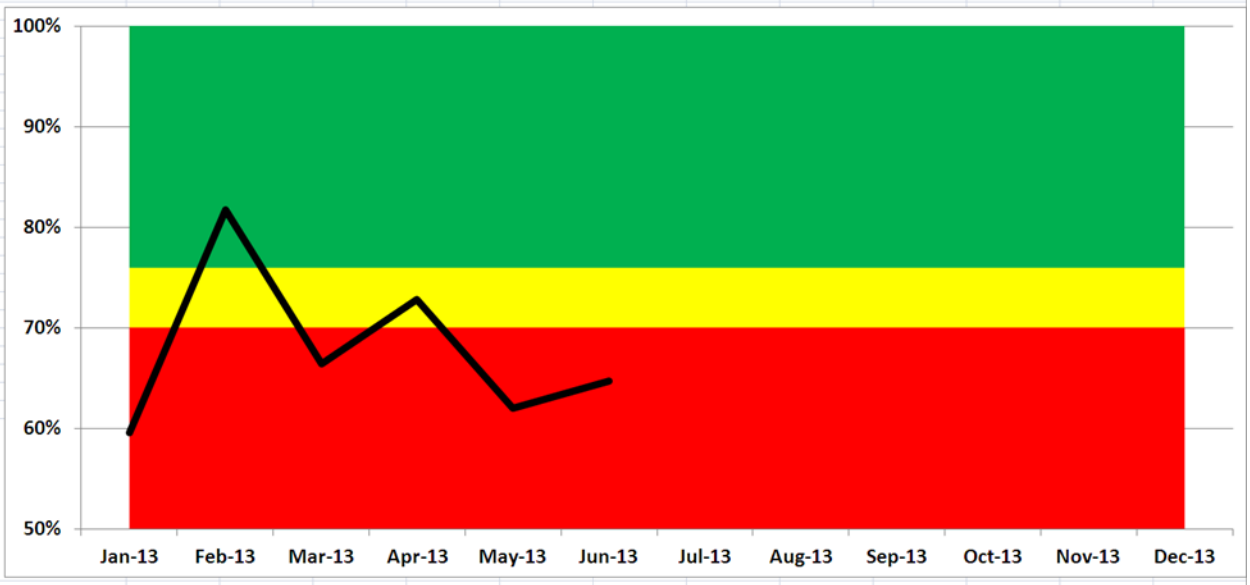
April-June 2013 Analysis

Over the past four quarters, this percentage has trended downward. Two providers indicated that staff turnover of the Supported Employment Specialist position has impacted their numbers. Once the new Supported Employment Specialists build rapport in the community, the providers believe that their consumers will have more opportunities in their communities. One provider noted that the consumers meeting ADA criteria are slow to trust the Supported Employment Specialist, making first contact with employers difficult.

January-March 2013 Analysis

Per 1/9/13's Quality Council Meeting, starting 7/1/13, the target for this measure will be 75%.

Percent of Assertive Community Treatment consumers who are enrolled within three days of referral
Target (70%) or more
Key Performance Indicator retired June 2013



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	84	94	101	83	80	88	0	0	0	0	0	0
Denominator	141	115	152	114	129	136	0	0	0	0	0	0
Rate	59.6%	81.7%	66.4%	72.8%	62.0%	64.7%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
Quarterly Rate	68.4%			66.2%			Data collection change see revised KPI			Data collection change see revised KPI		

MEASURE DEFINITION AND EXPLANATION

Measure definition: The percent of ACT consumers enrolled 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 enrolled within 24 hours of referral date plus number of consumers enrolled within 3 days of referral date.	**Denominator:** Total number of consumer enrollments.

COMMENTS AND/OR ANALYSIS PER QUARTER

April-June 2013 Analysis

Providers were given further clarity regarding the definition of enrollment during the previous quarter which may have influences reporting percentages this quarter.

This key performance indicator ends June 2013 and is replaced with a new indicator: "Percent of consumers who are received into ACT services within three days."

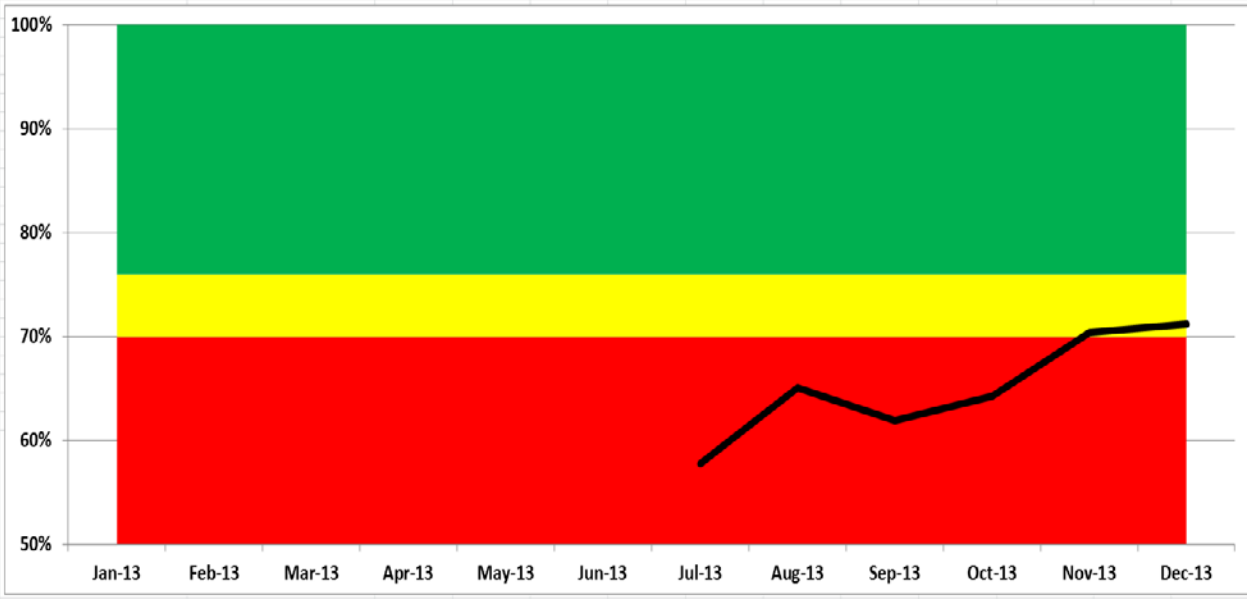
January-March 2013 Analysis

Although there has been an overall increase in percentage over the past one and a half years, this quarter displayed varying numbers. Providers of ACT services indicated varying definitions of "enrollment." Therefore, a determination was made to end this indicator and create a new indicator starting in July 2013 that more clearly defines the intent of the measure (ensuring ACT teams are responsive to consumers referred to the service).

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	0	0	0	0	0	0	78	80	78	99	76	84
Denominator	0	0	0	0	0	0	135	123	126	154	108	118
Percent	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	57.8%	65.0%	61.9%	64.3%	70.4%	71.2%
Quarterly Average	KPI not active			KPI not active			61.5%			68.2%		

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 referral date.	**Denominator:** Total number of consumers received into services.

COMMENTS AND/OR ANALYSIS PER QUARTER

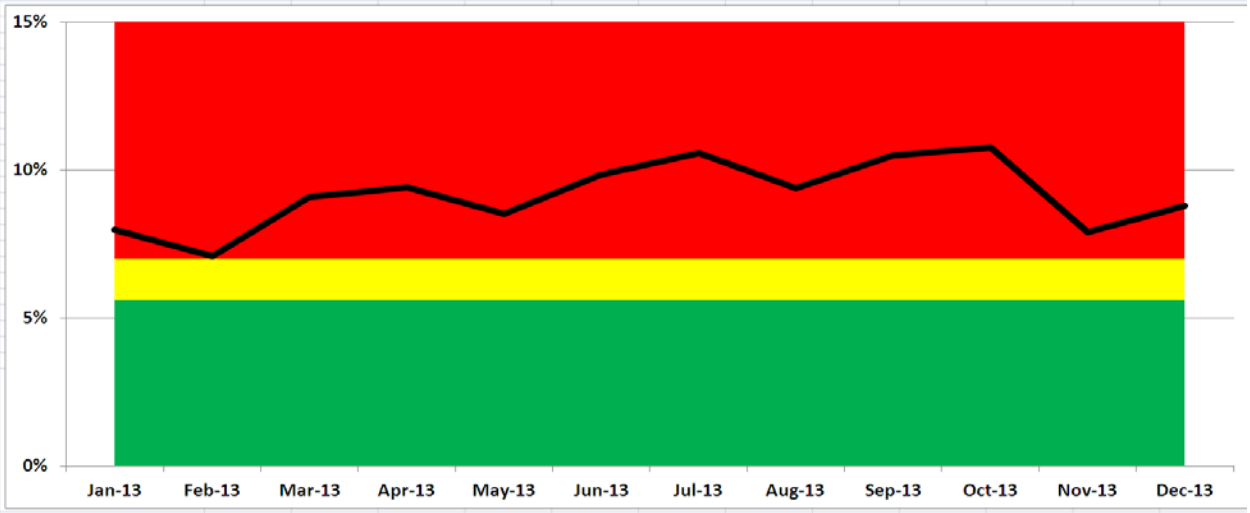
October-December 2013 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

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 wherever they may be (e.g.-medical 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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	113	100	121	138	127	151	164	142	160	164	126	135
Denominator	1418	1410	1333	1468	1489	1535	1552	1515	1527	1523	1597	1535
Percent	8.0%	7.1%	9.1%	9.4%	8.5%	9.8%	10.6%	9.4%	10.5%	10.8%	7.9%	8.8%
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

October-December 2013Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

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.

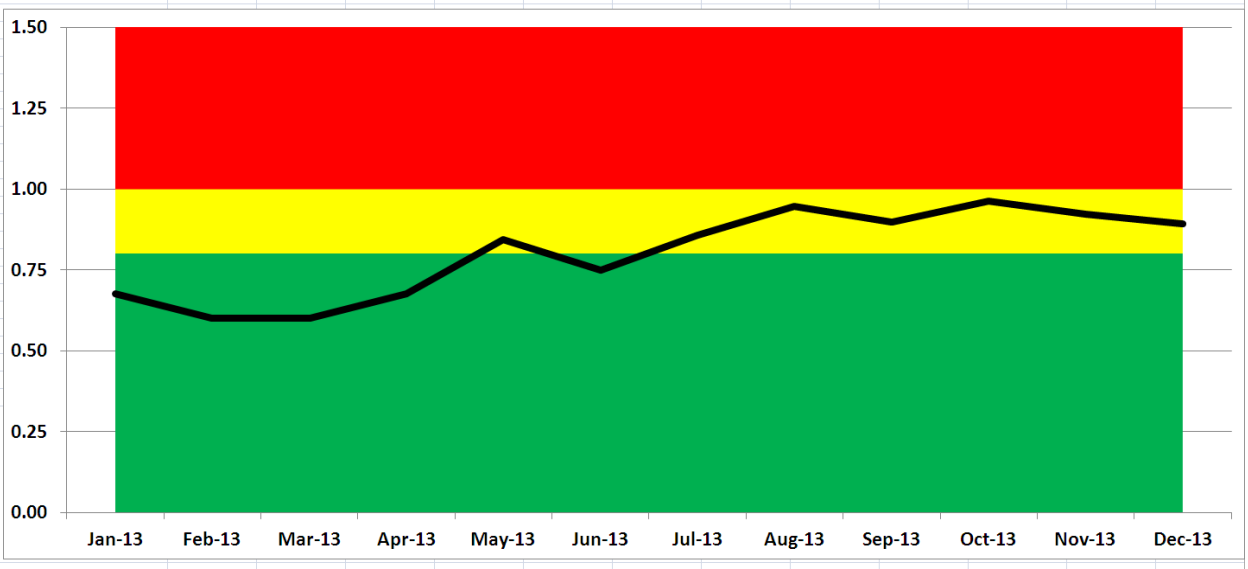
April-June 2013 Analysis

Trend noted last quarter was maintained this quarter. ACT teams report that consumers are more mobile in summer months which can decrease the teams' contact while increasing the opportunity for decompensation.

January-March 2013 Analysis

A slight upward trend in utilization was identified in this quarter. ACT teams indicated that many of their newer individuals in services were being admitted into the hospital for further stabilization.

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	1104	975	940	1137	1457	1310	1481	1648	1542	1661	1641	1558
Denominator	1635	1621	1569	1679	1729	1751	1727	1742	1720	1725	1780	1747
Rate	0.675	0.601	0.599	0.677	0.843	0.748	0.858	0.946	0.897	0.963	0.922	0.892
Quarterly Rate	0.578			0.663			0.822			0.852		

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

October-December 2013 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

July-September 2013 Analysis

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

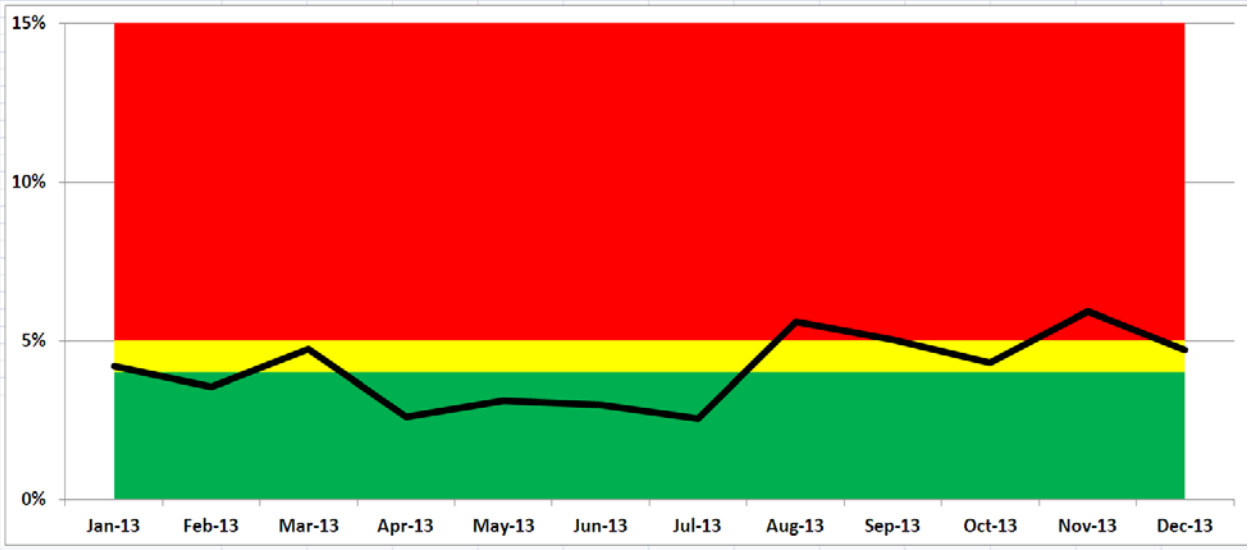
April-June 2013 Analysis

A slight higher trend was noted in Quarter 4. ACT teams report that consumers are more mobile in summer months which can decrease the teams' contact while increasing the opportunity for incarceration. (Please note comments from previous quarter.)

January-March 2013 Analysis

A slight downward trend in jail utilization was noted in this quarter. Some ACT teams reported that some incarcerations were related to probation and parole violations of conditional release orders. Looking at data from the same time period for last year, it appears that there is a higher utilization in the summer months. Some ACT teams hypothesized that the warmer weather brought individuals outside more and small crimes like loitering, panhandling, etc. occur more often in the summer months.

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	9	8	11	6	8	7	7	21	22	21	34	23
Denominator	215	225	233	232	257	235	274	376	437	488	575	489
Percent	4.2%	3.6%	4.7%	2.6%	3.1%	3.0%	2.6%	5.6%	5.0%	4.3%	5.9%	4.7%
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

October-December 2012 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

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.

April-June 2013 Analysis

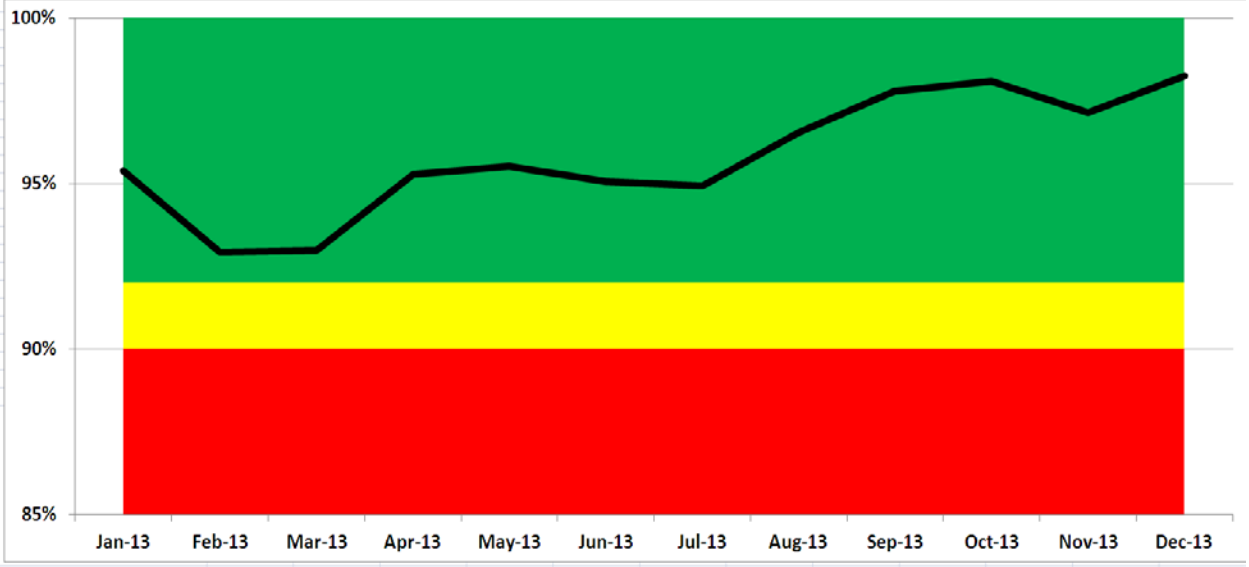
The target was met every month this quarter.

January-March 2013 Analysis

March data indicated an increased number of individuals with psychiatric admissions. Providers attributed this spike to an increased number of persons served.

Per the January 9, 2013 Quality Council meeting, starting July 1, 2013, the target for this measure will be decreased to 5%. This target is currently being met.

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	206	210	225	222	255	270	337	418	487	516	577	508
Denominator	216	226	242	233	267	284	355	433	498	526	594	517
Percent	95.4%	92.9%	93.0%	95.3%	95.5%	95.1%	94.9%	96.5%	97.8%	98.1%	97.1%	98.3%
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

October-December 2013 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

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.

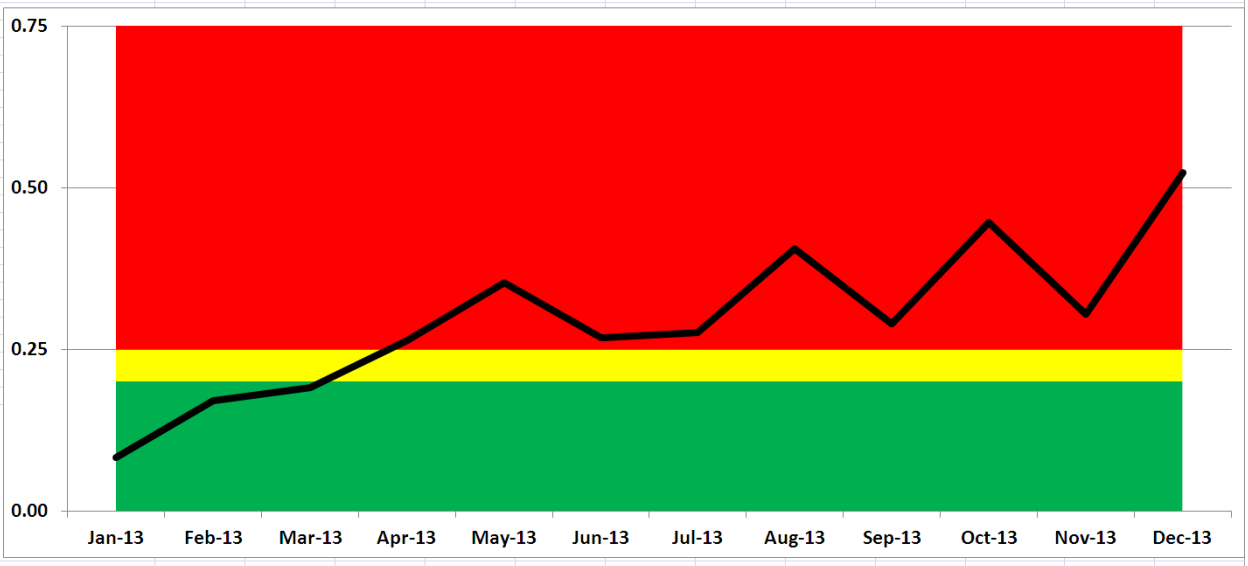
April-June 2013 Analysis

The target was met every month this quarter.

January-March 2013 Analysis

Although data shows consistently high percentages throughout the quarter, Coalition meetings focused on resources available for individuals without income or with limited income. Target currently being met.

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	22	45	54	78	102	97	120	200	160	282	199	300
Denominator	268	265	284	296	289	363	435	493	554	632	655	574
Rate	0.082	0.170	0.190	0.264	0.353	0.267	0.276	0.406	0.289	0.446	0.304	0.523
Quarterly Rate	0.370			0.687			0.324			0.420		

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

October-December 2013 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

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.

April-June 2013 Analysis

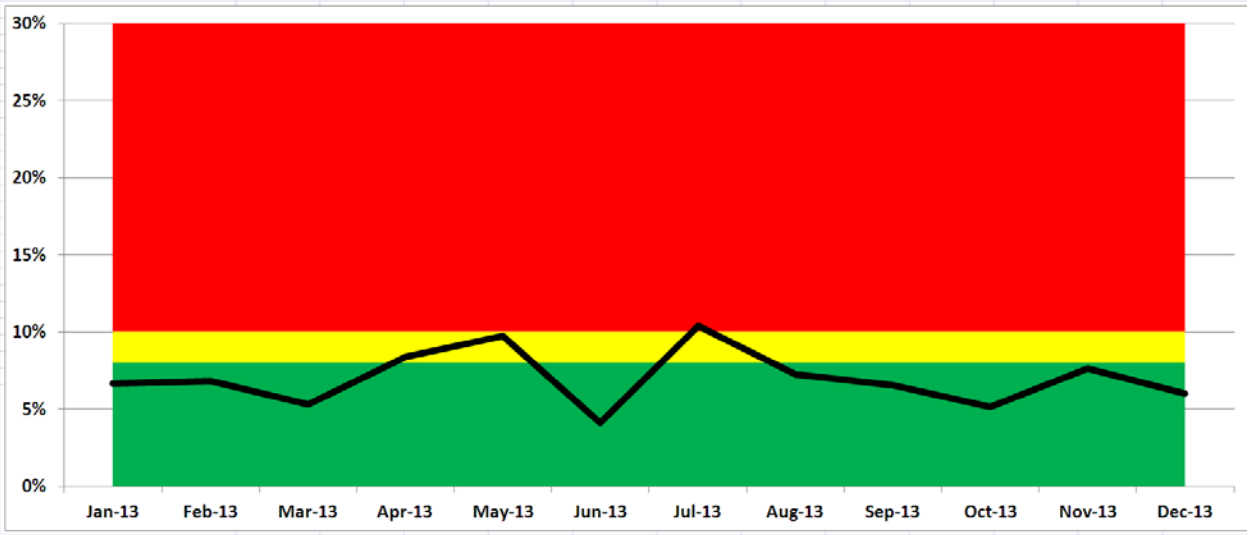
The target was met every month this quarter.

January-March 2013 Analysis

Some variability in this quarter was attributed to one consumer who cycled in and out of jail.

Per the January 9, 2013 Quality Council meeting, starting July 1, 2013, the target for this measure will be decreased to 0.250 days or less. The target is currently being met.

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	6	7	6	10	12	5	13	11	11	10	16	12
Denominator	90	103	113	119	123	122	125	152	168	195	210	199
Percent	6.7%	6.8%	5.3%	8.4%	9.8%	4.1%	10.4%	7.2%	6.5%	5.1%	7.6%	6.0%
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

October-December 2013Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

July-September 2013Analysis

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.

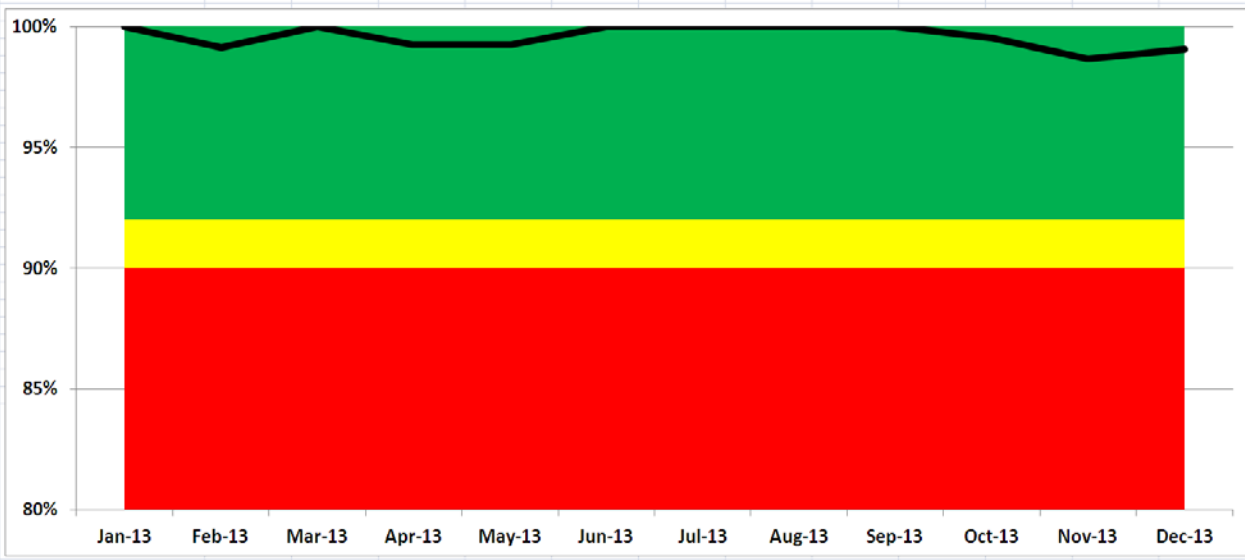
April-June 2013 Analysis

One provider indicated that the same individuals are hospitalizing and that their families are typically not as active in their lives. However, the target was met every month this quarter.

January-March 2013 Analysis

The number of consumers served has steadily increased through the fiscal year. The percentages have reduced this quarter even though the number of individuals who have required psychiatric hospitalizations has remained steady. This is due to an increase in the number of individuals served.

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	98	116	133	131	133	136	153	171	200	216	223	211
Denominator	98	117	133	132	134	136	153	171	200	217	226	213
Percent	100.0%	99.1%	100.0%	99.2%	99.3%	100.0%	100.0%	100.0%	100.0%	99.5%	98.7%	99.1%
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

October-December 2013 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

July-September 2013 Analysis

Over the quarter all consumers were reported housed.

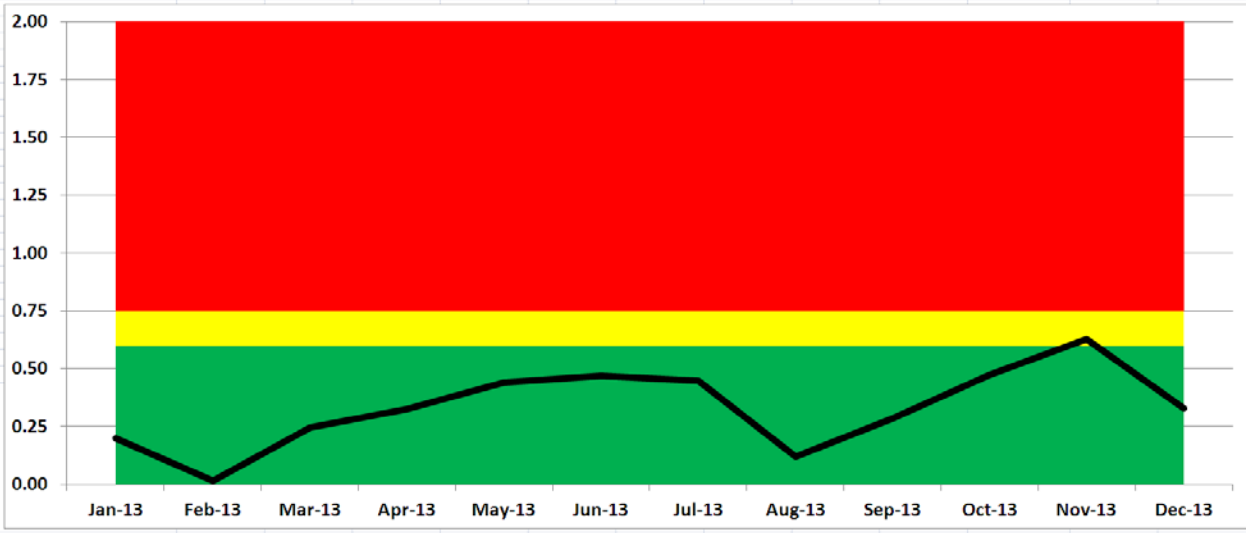
April-June 2013 Analysis

CST Providers indicate that utilizing the Georgia Housing Voucher Program has been helpful in keeping these percentages high. Another provider indicated that their consumers are living with families and they are utilizing CST to help support the family to support the individual.

January-March 2013 Analysis

During provider Coalition meetings, providers stated that many individuals live with family members and the need for housing is not an issue. Target currently being met.

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	22	2	35	50	67	72	80	23	63	112	157	76
Denominator	110	125	142	154	152	154	179	194	222	237	250	232
Rate	0.200	0.016	0.246	0.325	0.441	0.468	0.447	0.119	0.284	0.473	0.628	0.328
Quarterly Rate	0.396			1.022			0.279			0.480		

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

October-December 2012 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

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.

April-June 2013 Analysis

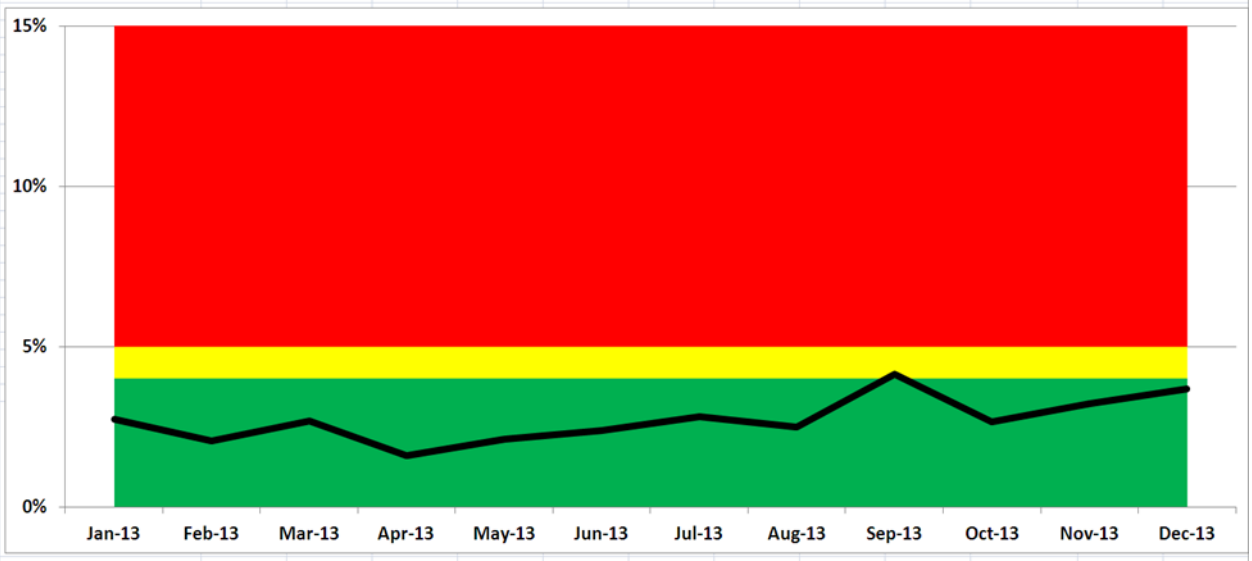
One provider indicated that individuals who were referred to CST from the Mental Health Drug Court impact these percentages. (When ca consumer has a first offence they will automatically spend 1-2 days in jail, for a send offence 30 days). For this particular provider they have a small number of consumers that end up in jail a long time due to non-compliance of treatment. Statewide, however, the target was met every month.

January-March 2013 Analysis

Utilization this month was impacted due to a small number of individuals spending many days in jail. This data element can be significantly affected when one or two individuals are incarcerated. Typically, a single person incarcerated many days versus several individuals incarcerated only a few days cannot be determined from this data alone.

Per the January 9, 2013 Quality Council meeting, starting July 1, 2013, the target for this measure will be decreased to 0.250 days. The target is currently being met.

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	12	10	14	9	11	14	16	14	24	16	21	22
Denominator	441	483	525	566	518	587	568	563	580	604	655	598
Percent	2.7%	2.1%	2.7%	1.6%	2.1%	2.4%	2.8%	2.5%	4.1%	2.6%	3.2%	3.7%
Quarterly Average	2.5%			2.0%			3.2%			3.2%		

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

October-December 2013 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

July-September 2013 Analysis

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

April-June 2013 Analysis

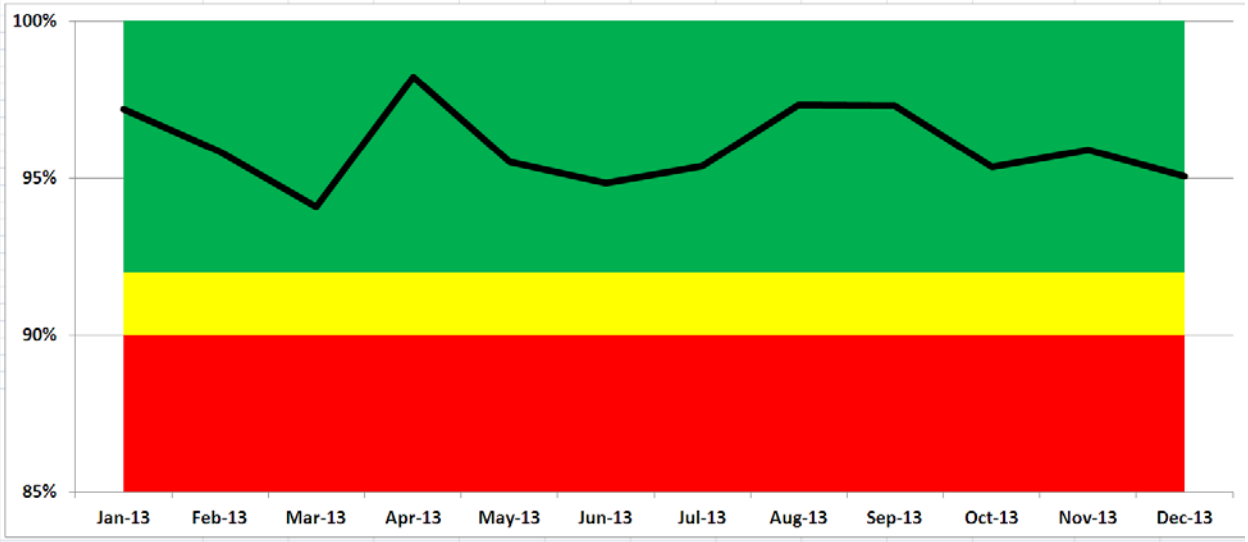
Throughout the quarter, the target was met.

January-March 2013 Analysis

The number of consumers with a psychiatric admission increased in March, however, due to a disproportionate increase in the numbers served, the percentage remained consistently low.

Per the January 9, 2013 Quality Council meeting, starting July 1, 2013, the target for this measure will be decreased to 5%. Target currently being met.

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	487	529	574	604	577	587	577	585	616	615	655	598
Denominator	501	552	610	615	604	619	605	601	633	645	683	629
Percent	97.2%	95.8%	94.1%	98.2%	95.5%	94.8%	95.4%	97.3%	97.3%	95.3%	95.9%	95.1%
Quarterly Average	95.6%			96.2%			96.7%			95.5%		

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

October-December 2013 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

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.

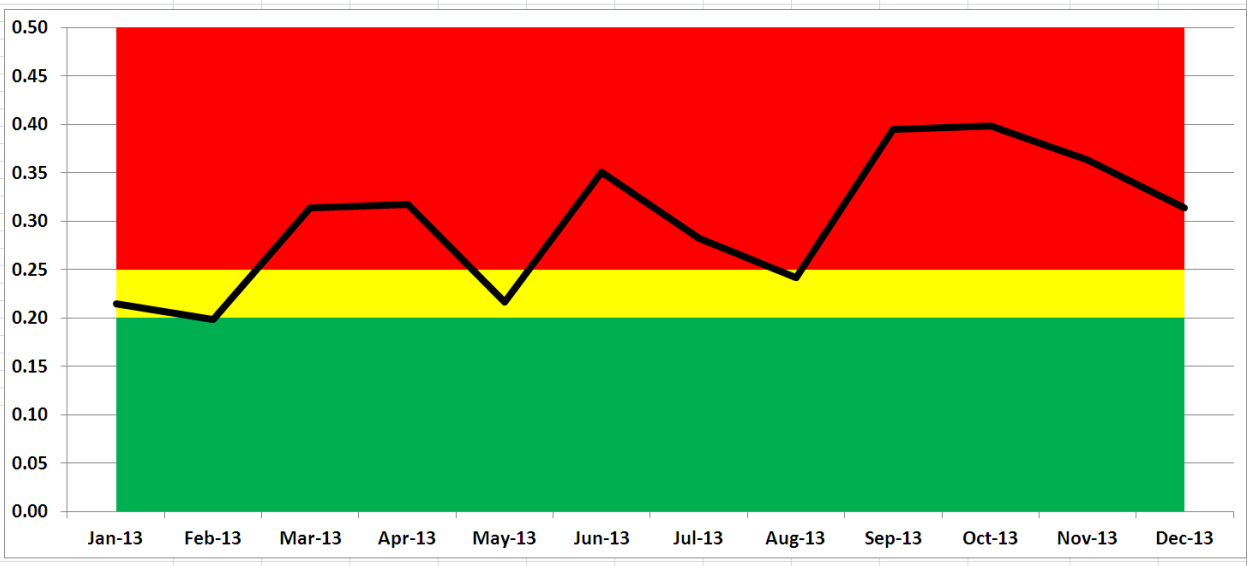
April-June 2013 Analysis

One provider reported being successful at locating homes for individuals during the month of enrollment, resulting in their percentages remaining high. Overall, the target was met every month.

January-March 2013 Analysis

Although data shows consistently high percentages throughout the quarter, Coalition meetings focused on resources available for individuals without income or with limited income. Target currently being met.

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



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Numerator	123	121	201	208	144	233	183	166	282	297	279	211
Denominator	574	609	641	656	667	665	648	688	715	746	769	672
Rate	0.214	0.199	0.314	0.317	0.216	0.350	0.282	0.241	0.394	0.398	0.363	0.314
Quarterly Rate	0.609			0.778			0.308			0.360		

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

October-December 2013 Analysis

Data collection is in progress with only a percent of data submitted for December and the analysis is not complete as of the date of this report.

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.

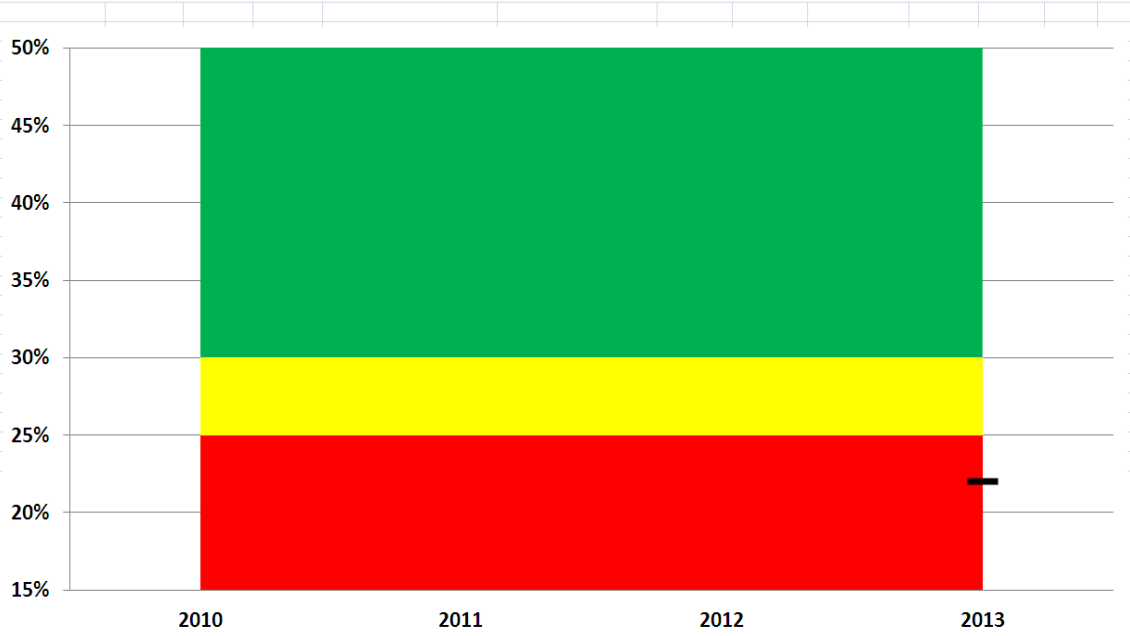
April-June 2013 Analysis

The target was met one month during the quarter.

January-March 2013 Analysis

Case Management providers attributed the increase to a small number of individuals with longer incarcerations.

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



	2010	2011	2012	2013
Numerator	0	0	0	22
Denominator	0	0	0	100
Percent	#N/A	#N/A	#N/A	22.0%

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

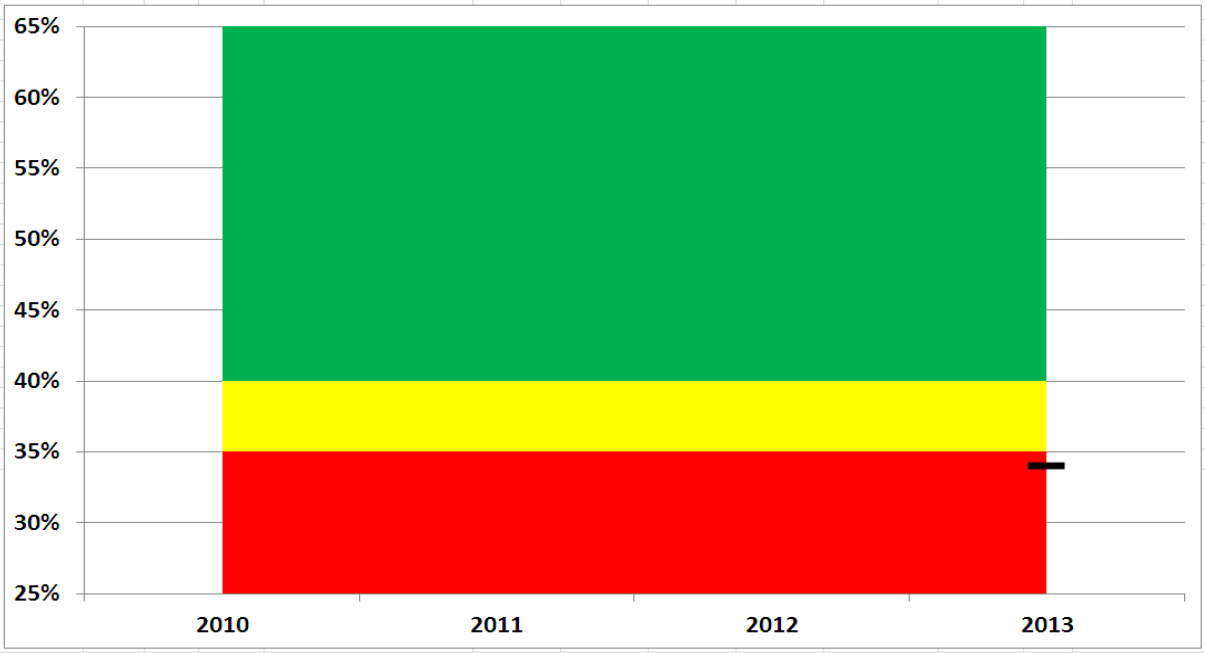
Numerator	Denominator
Numerator: The percentage of individuals entering non-crisis stabilization services identified by having a Registration or New Episode MICP who had Medicaid claims or State Encounters for community Based Treatment services, excluding Crisis Stabilization and Detoxification (Residential 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 2013

The Division of Addictive Diseases has chosen to replace an existing KPI with this KPI for 2013. The Division of AD will use this data to establish a baseline in order to anchor future evaluation of the data and how it relates to the quality/effectiveness of the services being delivered.

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



	2010	2011	2012	2013
Numerator	0	0	0	34
Denominator	0	0	0	100
Percent	#N/A	#N/A	#N/A	34.0%

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

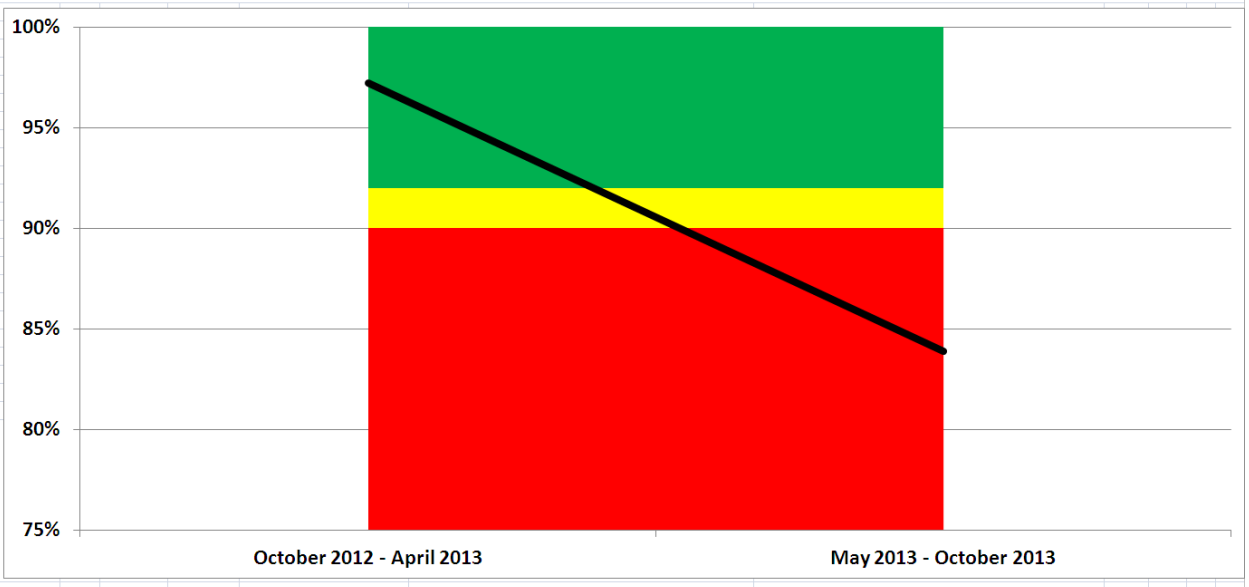
Numerator: The unduplicated count of individuals who had Medicaid Claims or State Encounters for any Community Based Treatment service excluding Crisis Stabilization and Detoxification (Residential and Ambulatory) within 14 days of the last Crisis encounter.	**Denominator:** The unduplicated count of 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 2013

The Division of Addictive Diseases has chosen to replace an existing KPI with this KPI for 2013. The division of AD will use this data to establish a baseline in order to anchor future evaluation of the data and how it relates to the quality/effectiveness of the services being delivered.

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



	October 2012 - April 2013	May 2013 - October 2013
Numerator	35	26
Denominator	36	31
Percent	97%	84%

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 TIME PERIOD

May-October 2013 Analysis

Three of five responses were related to dissatisfaction with aspects of the service that did not meet their needs such as frequency of contacts or assistance with resources. The trend will continue to be monitored and if it continues it will be flagged for review by the state office staff.

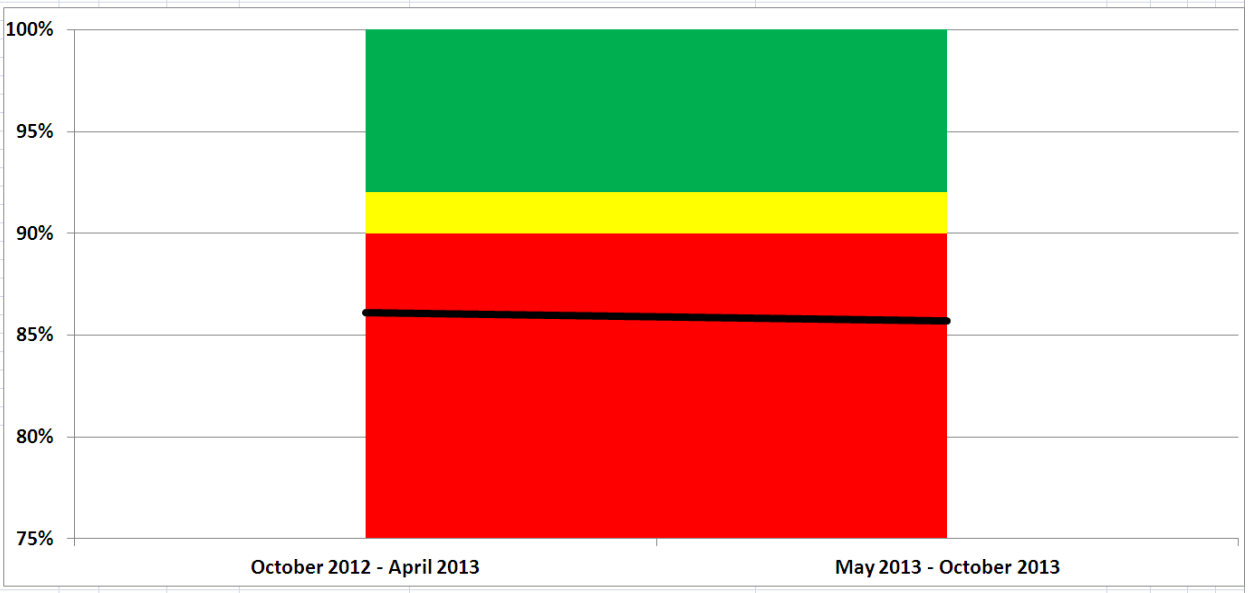
October 2012-April 2013 Analysis

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 Analysis

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



	October 2012 - April 2013	May 2013 - October 2013
Numerator	31	24
Denominator	36	28
Percent	86%	86%

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 TIME PERIOD

May-October 2013 Analysis

There was no significant change in the trend during this time period, although two of the four responders indicated that they had not experienced a change in their status and two of four responders indicated that they continued to have issues with symptom management.

October 2012-April 2013 Analysis

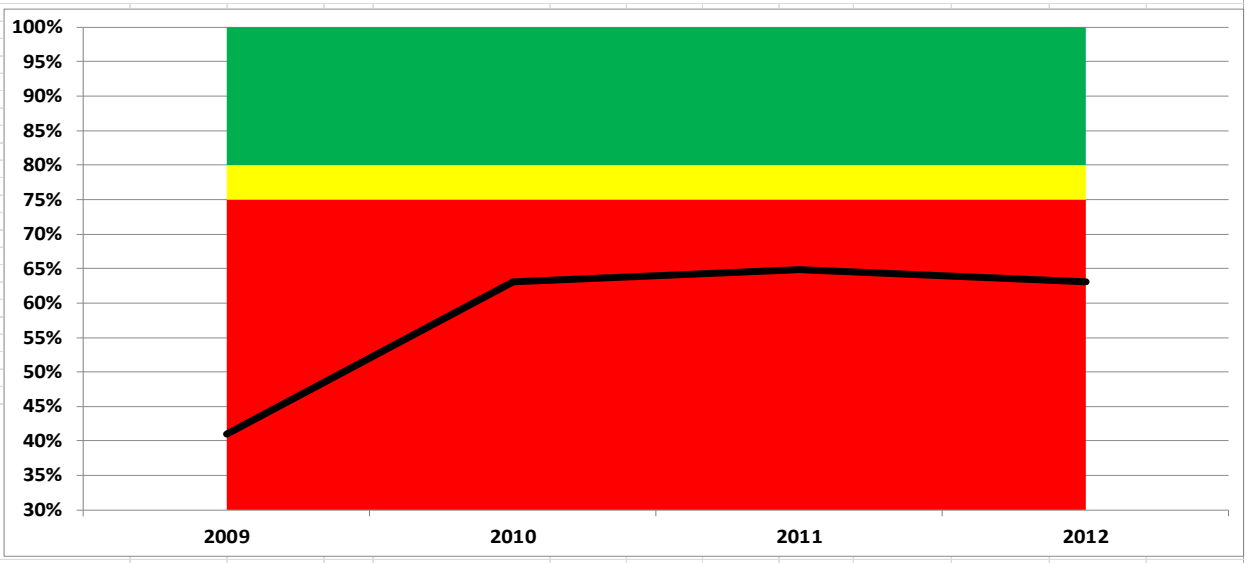
While there is an upward trend towards overall improvement in quality of life, the benchmark may be difficult to reach due to the nature of SPMI and its impact on the individual. Because individuals are continuously enrolled in services, there is a subset of individuals interviewed who may not have been 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 Analysis

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.

Appendix I Developmental Disabilities KPI Dashboards

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



	2009	2010	2011	2012
Numerator	193	261	270	260
Denominator	470	414	416	412
Rate	41.1%	63.0%	64.9%	63.1%

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

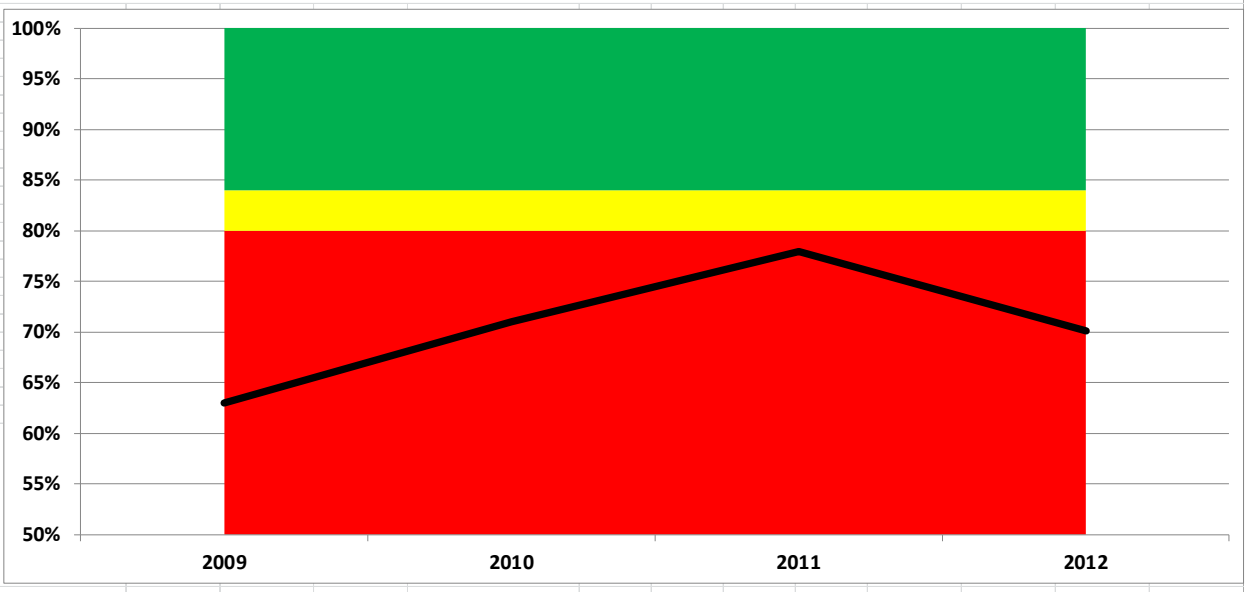
Annually 2013

2013 Annual data will not be available until May 2014. This dashboard will be updated in the 2014 Interim Report. The winter of 2013 proved to have a particularly high number of flu cases within the DD community. The Division will be researching partnerships with Public Health in an attempt to increase the rate of vaccinations prior to the 2014 flu season.

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%



	2009	2010	2011	2012
Numerator	301	306	326	312
Denominator	478	431	418	445
Rate	63.0%	71.0%	78.0%	70.1%

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.

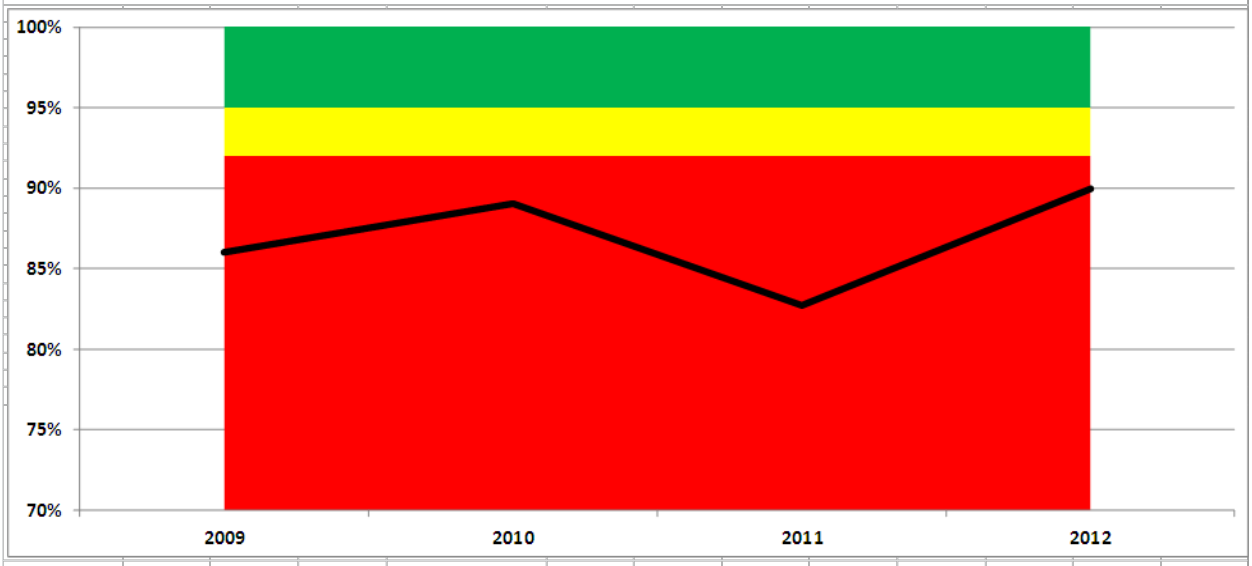
COMMENTS AND/OR ANALYSIS PER YEAR

Annually 2013

2013 Annual data will not be available until May 2014. This dashboard will be updated in the 2014 Interim Report. Increasing access to dental services has become a priority for the Division. While state hospitals are being closed as a result of the ADA Settlement, DBHDD will keep the hospital dental clinics open in order to serve DD individual who are being supported through the NOW and COMP Waivers.

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%



	2009	2010	2011	2012
Numerator	412	414	373	466
Denominator	479	465	451	518
Rate	86%	89%	83%	90%

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

COMMENTS AND/OR ANALYSIS PER YEAR

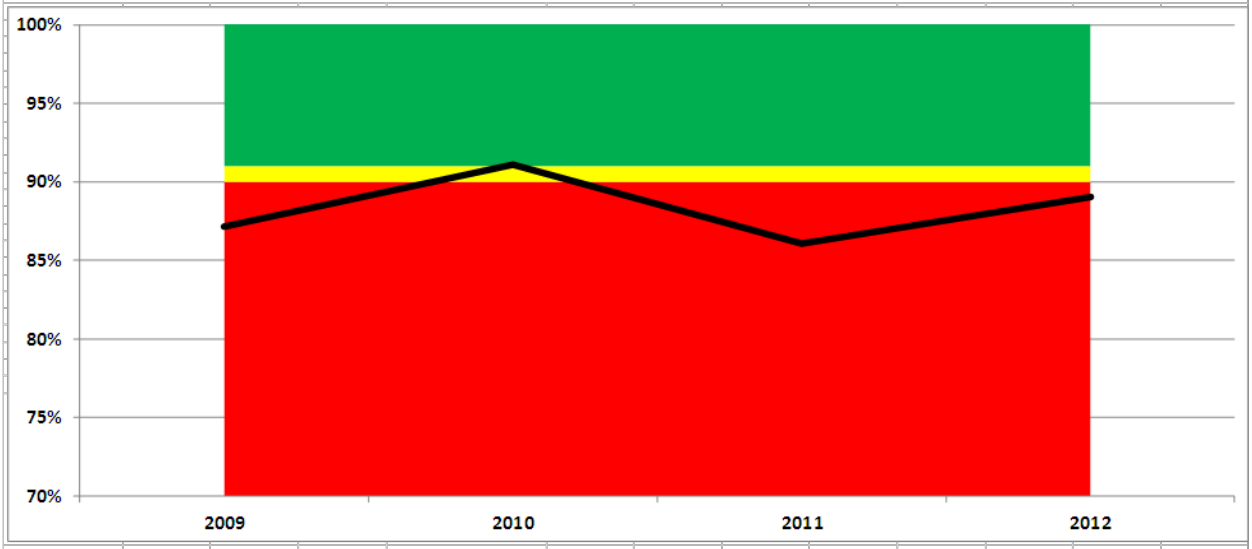
Annually 2013

2013 Annual data will not be available until May 2014. This dashboard will be updated in the 2014 Interim Report.

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%



	2009	2010	2011	2012
Numerator	264	297	291	342
Denominator	303	326	338	384
Rate	87%	91%	86%	89%

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

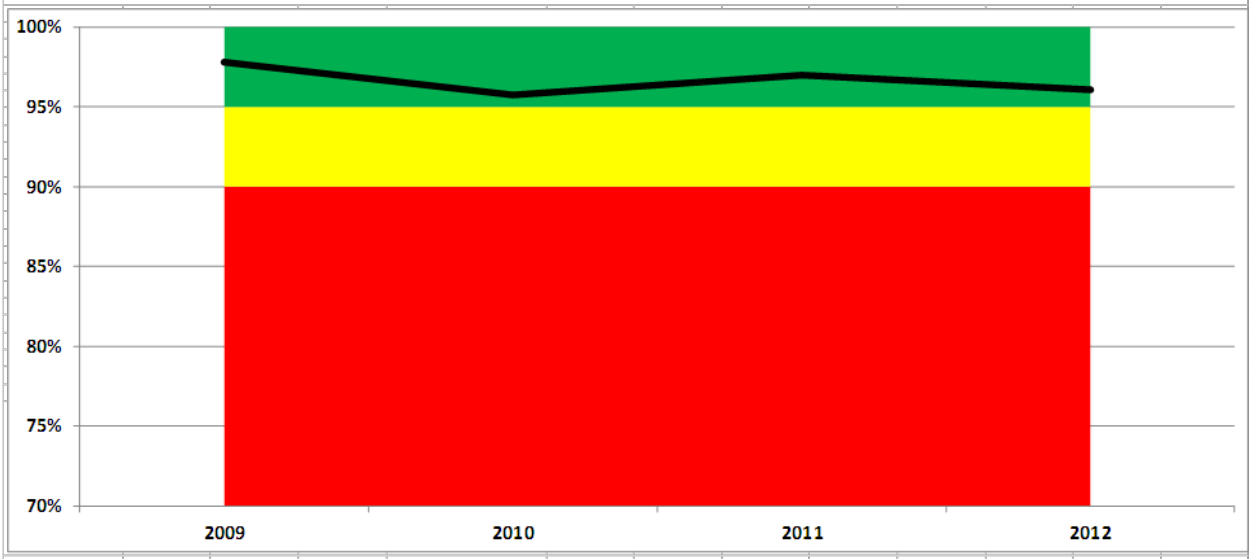
Annually 2013

2013 Annual data will not be available until May 2014. This dashboard will be updated in the 2014 Interim Report.

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%



	2009	2010	2011	2012
Numerator	133	157	194	170
Denominator	136	164	200	177
Rate	98%	96%	97%	96%

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

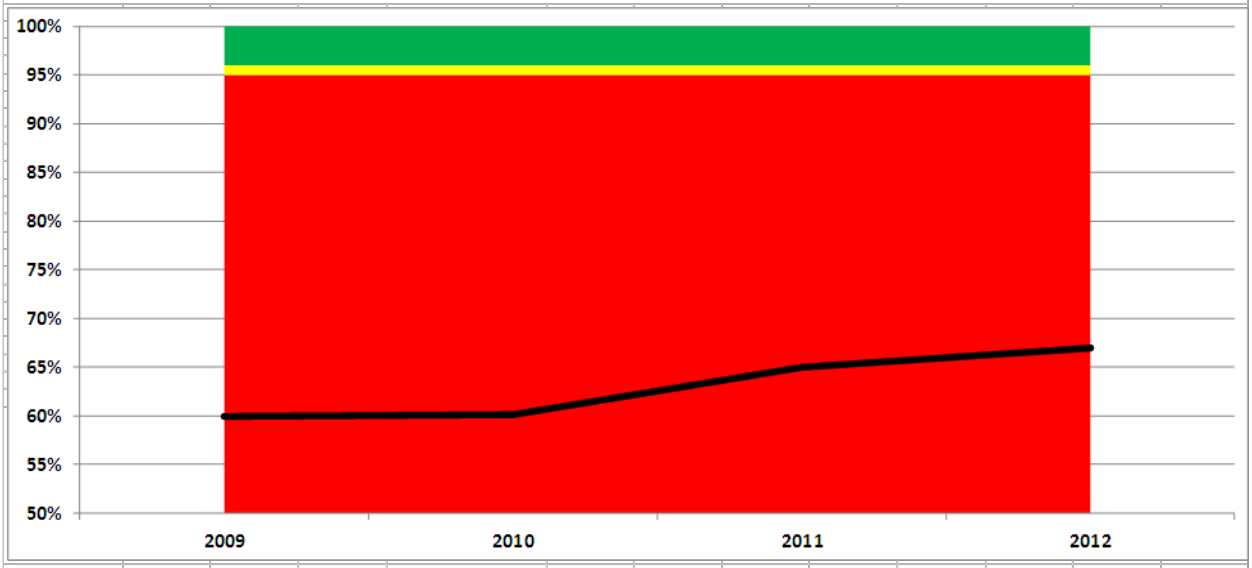
Annually 2013

2013 Annual data will not be available until May 2014. This dashboard will be updated in the 2014 Interim Report.

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%



	2009	2010	2011	2012
Numerator	281	265	297	349
Denominator	469	441	457	521
Rate	60%	60%	65%	67%

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

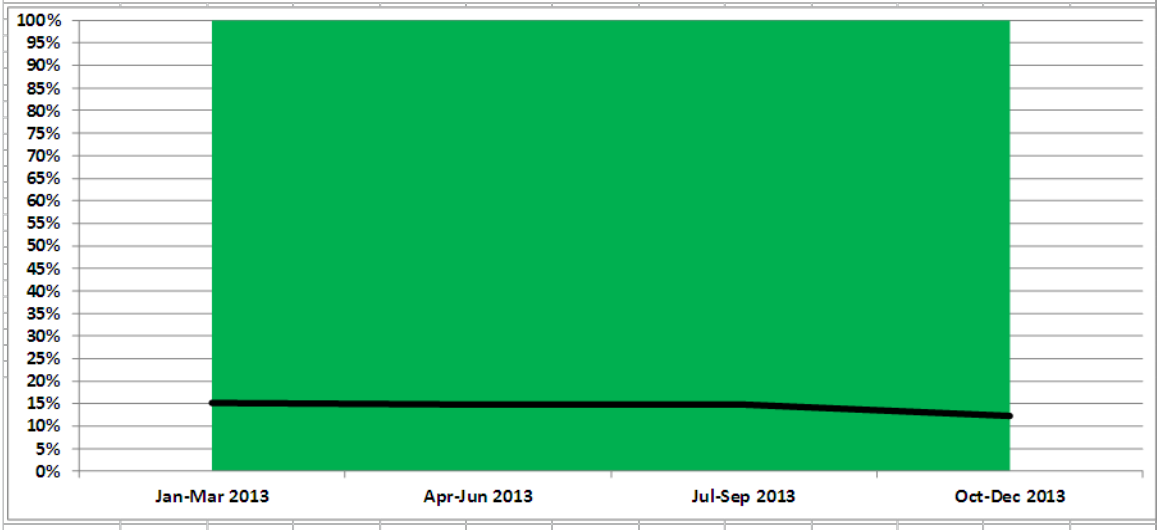
Annually 2013

2013 Annual data will not be available until May 2014. This dashboard will be updated in the 2014 Interim Report.

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



	Jan-Mar 2013	Apr-Jun 2013	Jul-Sep 2013	Oct-Dec 2013
Numerator	35	43	54	39
Denominator	231	291	364	318
Rate	15.2%	14.8%	14.8%	12.3%

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

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

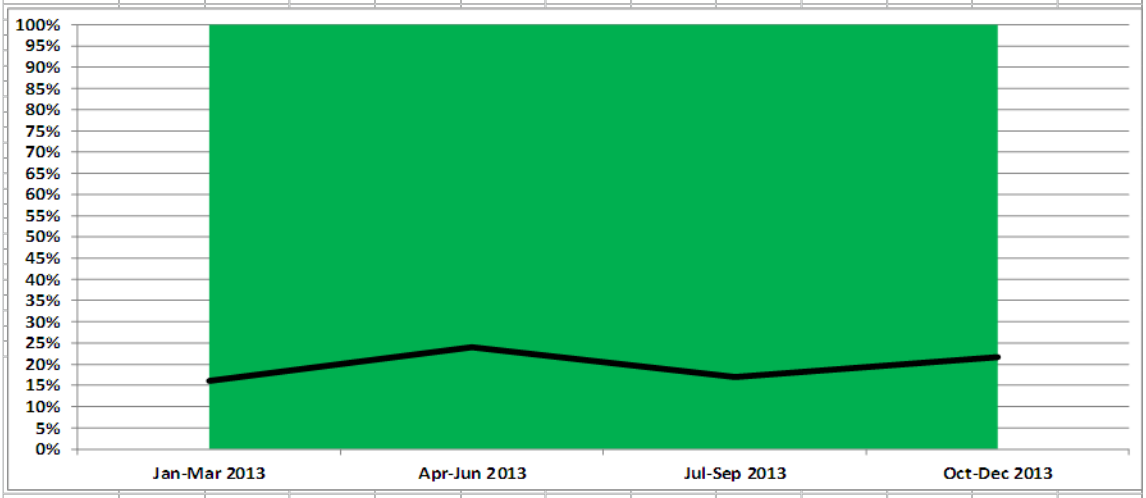
April-June 2013 Analysis

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



	Jan-Mar 2013	Apr-Jun 2013	Jul-Sep 2013	Oct-Dec 2013
Numerator	37	70	62	69
Denominator	231	291	364	318
Rate	16%	24%	17%	22%

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

October-December 2013 Analysis

Untilization jump 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.