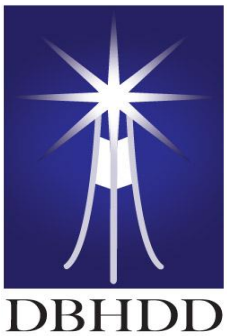
Georgia Department of Behavioral Health & Developmental Disabilities



ANNUAL QUALITY MANAGEMENT REPORT
January 2012 – December 2012

Prepared by the DBHDD Office of Quality Management
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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 in response to 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 DBHDD Office of Quality Management was formally established in August of 2011. The Department's Quality Management Plan was developed and implemented in December 2011 and was updated in June of 2012. This plan established guidelines for the structure of a DBHDD system-wide quality management program encompassing hospital and community based services.

Readers are encouraged to refer to the Quality Management Plan for detailed information about the organizational structure of the Quality Management Program and a detailed description of the Executive and Program Quality Councils and the goals and objectives of each council.

This report provides a summary of pertinent and significant modifications that have been made to the Quality Management Plan and the Quality Councils along with detailed information about the quality management activities that have taken place between January 2012 and December 2012.

ACTIVITIES OF THE QUALITY COUNCILS

Executive Quality Council

A Quality Council, made up of Departmental leadership, created the organizational structure necessary for the Department's quality management system operations. The Department's first Quality Council meeting was held in January 2012. In April of 2012, a Department-wide DBHDD Executive Quality Council (EQC) was created, which replaced the DBHDD Quality Management Council.

The EQC was tasked with providing leadership for the consistent, systematic review and improvement of the DBHDD services provided within the service system. Council membership is based upon strategic position and expertise within the organization. Executive Quality Council membership is composed of the Department's Commissioner, key Department leaders and key Program Quality Council (PQC) members. It is the responsibility of the Executive Quality Council co-chairs to review the annual DBHDD QM report and present the findings and recommendations to the Program Quality Councils and the DBHDD Board of Directors.

During 2012, the EQC met quarterly and the council's activities and actions included:

- Supporting and guiding implementation of the quality management plan such as:
  - reviewing and approving the DBHDD QM goals, objectives and plan.
- Creating and defining three Program Quality Councils:
  - the Hospital System, Community Behavioral Health, and Developmental Disabilities (originally formed in November 2008).
- Establishing and supporting specific quality improvement initiatives such as:
  - encouraging a partnership between the Division of DD with the Georgia Department of Public Health to increase access to dental services for individuals with DD.
- Receiving and reviewing reports of data/performance improvement activities such as;
  - reviewing Program Quality Council key performance indicator data and making recommendations to the Program Quality Councils regarding areas of concern and setting priorities for performance improvement initiatives
- Addressing systemic issues that affect quality such as:
  - Identifying the need for QM training and directing the development of a QM training program,
  - reviewing and making recommendations regarding the analysis of community based incidents and premature mortality trending.
- Setting priorities such as:
  - receiving information about and discussing challenges related to quality data/information management storage, retrieval and analysis resulting in the allocation of money for data system development.

A new DBHDD Commissioner was appointed in August 2012 and a number of changes were made in the executive management team. As a result, the membership of the EQC will be updated in the January 2013 meeting. The EQC membership roster can be found in Appendix A. In 2013, the EQC meeting frequency will increase to six times per year.

Program Quality Councils

The scope and content of the quality management program is comprehensive, involving evaluating and improving quality of care and services in all settings and for individuals receiving services for behavioral health issues and/or developmental disabilities. To provide adequate infrastructure to support the Department's quality management program, a less centralized and more focused structure was deemed necessary and the three Program Quality Councils were defined in April 2012 (See Appendix B). These supporting Program Quality Councils (PQCs) report to the EQC and they function as the systems to continuously screen and review information about quality issues and to identify potential quality improvement projects and system improvement needs.

Each of the Program Quality Councils is responsible for identifying, analyzing and periodically reviewing key performance indicators and other information relevant to quality in the program area (See Appendix C). Additionally each of the Program Quality Councils is responsible for presenting systems problems and solutions, trends and patterns and other issues requiring senior leadership guidance and direction to the EQC.

Program Quality Council (PQC) membership is composed of key program level leaders and staff and is detailed in Appendix A. The Hospital System PQC and Community Behavioral Health (mental health and addictive diseases) PQC meet monthly. The DD PQC meets quarterly with specific workgroups meeting more often, as needed.

All Program Quality Council meetings follow an agenda designed to encourage discussion, provide feedback, make recommendations and assignments, and ensure appropriate follow-through. The Council Chair (or his/her designee) has responsibility for presiding at meetings, assisting with agenda preparation, reviewing meeting minutes, and assisting with preparation of required documents. Meeting minutes are taken during every quality council meeting and distributed to its membership.

Examples of information provided to and actions taken by the PQCs include the following:

Community BH Program Quality Council

- In December 2011, identified the key performance indicators (KPI) for 2012 and reviewed data for these indicators during the year.
- In December of 2012, the CBH PQC initiated the annual review of the KPI and the target thresholds established in the previous year, made adjustments to the target thresholds and discussed retention or replacement of KPI indicators for the following year.

Hospital Program Quality Council

- Reviewed data on KPI throughout the year and made recommendations for performance improvement initiatives to address areas where targets were not achieved identified the need to perform root cause analysis training to hospital leadership and hospital QM staff; this was completed in August of 2012.

DD Program Quality Council

- Determined that statewide data obtained during FY 2011 - 2012 demonstrated that access to supported employment services and community connections as areas needing improvement. As a result, the DD Program Quality Council developed a Supported Employment brochure, the intent of which was to reach individuals who were currently receiving waiver/state-funded services but not supported employment services. The brochure has been given to support coordinators to review with those individuals and their families (if necessary).
- Created a Supported Employment Guide to: explain why employment is important; to illustrate through real life examples the difference work makes in people's lives; answer common questions about pay and health benefits when you work and have an intellectual and/or developmental disability; provide employment resources for people with or without services; and provide information and resources on Supported Employment programs in Georgia.

In November 2012 an Assistant Commissioner was hired whose responsibilities will include assisting DBHDD in advancing its quality management framework. The committee membership of the PCQs will be reviewed and updated at the January 2013 EQC meeting.

STAKEHOLDER INVOLVEMENT IN QUALITY MANAGEMENT

An important component of our quality management program is to focus attention on the needs of our customers. Customer feedback and stakeholder input is essential. Opportunities for stakeholder and customer input/feedback during the year were varied and include, but are not limited to:

1. A community-based needs assessment that was distributed by DBHDD service region. Target stakeholders included:
    a. Individuals receiving services
    b. Family members of individuals receiving services
    c. Advocates
2. A discussion regarding the DBHDD Quality Management System with:
    a. The Behavioral Health Advisory Committee on December 12, 2011
    b. Regional Planning Board Leadership on January 27, 2012
    c. Advocacy groups on April 11, 2012
    d. Statewide provider meeting on May 24, 2012
3. Community-based consumer satisfaction surveys through the Georgia Mental Health Consumer Network (GMHCN). This is a review of thousands of individuals who receive DBHDD behavioral health services.
4. Consumer satisfaction feedback from individuals receiving community-based behavioral health services received through quality management audits which follows the treatment and assesses satisfaction of individuals in service.
5. Consumer satisfaction from individuals in DBHDD hospitals - The hospitals have historically used a variety of surveys and measures of consumer satisfaction. Effective February 2012, all the hospitals began participating in a nationally recognized system of survey methodology for consumers of mental health services with the NASMHPD (National Association of State Mental Health Program Directors) Research Institute. The Hospital System PQC receives reports from each of the hospitals on their efforts to improve consumer satisfaction. The strategies of the hospitals vary and information about those strategies is shared in the PQC meetings, for the purpose of contributing to other hospitals' strategies. Hospitals have encouraged the increased use of peer specialists, offering additional food choices and utilization of committees whose purpose is to support a "recovery-oriented" culture in their hospitals.
6. Consumer satisfaction feedback from consumers with DD and their families/guardians – The Division of Developmental Disabilities gathers feedback on the quality of and satisfaction with services through the Person-Centered Review process and participation in the National Core Indicator Survey (NCIS). The NCIS gathers satisfaction data from both the individual receiving services and their family members or guardians. Annually, 480 individuals who are receiving services participate in the Consumer Survey of the NCIS. The Consumer Survey is conducted face to face with the individual receiving services. Additionally, 1600 Family and Guardian Surveys are mailed to family members or guardians of individuals receiving services. The response rate to the mail out survey is approximately 32 percent annually. The response rate allows for statistically significant data analysis.
7. The DDD also incorporates individual and family participation in various councils and workgroups such as the six regional and one statewide quality improvement councils, the

Individual Service Plan (ISP) restructuring workgroup, and the community inclusion planning workgroup.

a. The Regional and Programmatic Quality Councils developed various quality improvement projects such as training programs to help educate individuals and providers on the various aspects of community inclusion
b. The ISP restructuring group developed an entirely new ISP which:
    i. is a meaningful person centered service plan that visually, and in words, tells the person's story**;**
    ii. includes opportunities for self advocacy and long term goals. Reflects the past but focuses on the present and future;
    iii. is an electronic document that can be accessed by individuals, family members and authorized Division staff and readily updated, changed, and amended.

8. The Division of Developmental Disabilities regularly communicates with the Georgia Service Providers Association for Developmental Disabilities (SPADD) and the Georgia Association of Community Care Providers (GACCP) as a way of sharing current information on the Division and to garner provider input on policies, procedures, etc.
9. The Division of Developmental Disabilities has created the DD Advisory Council which consists of representatives from the provide community, support coordination agencies, self advocates, and family members. The Advisory Council will take a pivotal role in providing input and guidance in all areas of DD operations.
10. The Divisions of Behavioral Health and Developmental Disabilities meets monthly with Georgia's Medicaid authority, the Department of Community Health (DCH), to discuss issues concerning the NOW and COMP waivers and community behavioral health care services. Standing agenda items include:
    a. Policy Changes
    b. Provider issues
    c. Program Integrity
11. The DDD participates in quarterly meetings with DCH to discuss quality assurance and improvement efforts related to the waivers. Standing agenda items include:
    a. Support Coordination Reports
    b. Mortality Reports
    c. Remediation Reports
    d. Letter of Agreement Deliverables
    e. Waiver Performance Measures

STATUS OF QUALITY MANAGEMENT WORK PLAN GOALS

Each Quality Council develops a work plan to guide the quality management activities within its area of responsibility. The EQC defines the work plan for the Department and 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 progress toward achieving the work plan goals for each Quality Council:

DBHDD QM Work Plan –The foundation structure for the DBHDD QM program was identified and implemented and includes an Executive Quality Council with DBHDD wide decision making authority as well as three Program Quality Councils. The work plan goal of improving access to data relevant for QM initiatives and reporting via the development of a data warehouse is progressing but at a pace slower than anticipated. A centralized method of data collection is being developed and will be piloted in 2013. The goal of increasing DBHDD employee knowledge about performance improvement is an ongoing project and pilot testing of the first three training modules of the QM training program will began in January 2013.

Hospital System Work Plan – All goals that were created for the 2012 work plan have been achieved with the exception of the data analysis training goal, which has been partially accomplished. Continued training will be done in order to bring staff up to the desired level of competence. Much of the training is being conducted on a "just-in-time" basis and is measure specific. Training is targeted to those staff who have responsibilities associated with each respective measure (QMs, Mentors, Incident Managers, etc.).

Community BH Work Plan – All goals created have been met or are on target with the exception of tracking health status indicators which is on hold as the Department works to identify a way of capturing and analyzing such information. In 2012, a community behavioral health quality management infrastructure and system was set up via the leadership of the Community Behavioral Health Program Quality Council. A reduction in the number of readmissions for consumers who have been admitted more than three times to a State Psychiatric Hospital is ongoing and data systems should be modified by 3/31/2013 to allow collection and trending of data that is currently being tracked. Suicide prevention activities and Cognitive Therapy best practice implementation was started in 2012 and will continue into 2013. KPI have been identified and will continue to be analyzed going forward.

Developmental Disabilities (DD) QM Work Plan - The DD Quality Work plan is based on the state's fiscal year (July 1, 2012 through June 30, 2013). All goals for the period of July 1, 2012 through December 31st) have been met or are ongoing. An example of an ongoing goal would be the Mortality Review Committee meetings which take place quarterly. All other goals in the plan are on target for completion by June 30, 2013.

KEY PERFORMANCE INDICATORS AND OUTCOMES

Key performance indicators (KPI) are used to assist in defining and measuring progress towards organizational goals. KPI are quantifiable measurements that reflect the critical success factors of the Department and vary depending upon the program or service. The 2012 key performance indicators are program-specific but in 2013 the setting of DBHDD wide key performance indicators will be discussed.

In 2012 KPIs were selected and tracked along with their associated outcomes to cumulatively provide a picture of service delivery in each of the identified areas. The following subsections discuss those key indicators.

Each of the three program areas (hospitals, community behavioral health and developmental disabilities) are in different phases of data collection and analysis. The hospital system has had a

quality management system for many years. Since the formation of the new Department, DBHDD has built upon the individual quality management programs that have existed for years in all the State hospitals and moved towards a better integrated quality program that has enjoyed the benefits of economies of scale and has developed improved system wide information and communication systems. These developments have enabled the hospital system to develop improved performance measurements and reporting capabilities and used them to improve important areas of patient care and safety such as increasing consumer participation in the planning of their own treatment.

The Community BH quality system was developed in 2011 and implemented in 2012. As Community Behavioral Health program data collection was initiated in January 2012, DBHDD recognizes that performance patterns must be established over time to effectively make recommendations for program changes and indicators must be evaluated for their effectiveness in accurately portraying the intended outcome. When adverse or deleterious aggregate data is identified, the findings are referred for immediate review, discussion, and/or correction (as appropriate) at the program and/or executive levels.

The Department's Division of DD quality system was created in 2008 in response to the Centers for Medicare and Medicaid (CMS) requirement that all waiver programs have a quality assurance plan. The DDD Georgia Quality Management System (GQMS) was developed in order to assist in the evaluation of the quality of supports and services rendered to individuals with developmental disabilities. The Division of DD uses this system to evaluate the quality of supports and services, create initiatives, and identify areas needing improvement for the State's service delivery system.

The DD QM plan addresses all of the outcomes identified in the CMS Quality Framework for the Home and Community Based Services. To ensure this occurs, stakeholder workgroups, along with the guidance of the Division's External Quality Review Organization (EQRO), participated in the development of the Person Centered Review (PCR) and Quality Enhancement Provider Review (QEPR) processes. Since its inception, the GQMS has released four Annual Quality Assurance Reports, four Quality Improvement Studies, and various ad hoc quality reports.

A. Hospital Quality System

The DBHDD Hospital System maintains a quality management program chaired by the Director of Hospital Operations. The Hospital PQC is responsible for implementing the provisions of the DBHDD Quality Management Plan within the six (6) hospital system.

In addition, each of the six hospitals in the DBHDD hospital system has its own quality management plan and Quality Council that is responsible for overseeing the quality improvement activities within their respective hospitals and who report to the Hospital System Program Quality Council. Quality management activities and results are communicated to the members of the Hospital System PQC during the monthly meetings. Reports are captured in meeting minutes and recordings. In addition to the four key performance measures identified in this report, the Hospital System has a number of other measures that it uses to monitor its overall performance. Those measures are focused in three main areas: safety, consumer satisfaction and recovery orientation.

One of the major focus areas for the hospital quality management program is a performance dashboard that is comprised of a number of performance measures that are intended to reflect

the priority areas of concern within the hospital system. Performance measures are changed as new priorities are determined. The Hospital System also sets evaluation thresholds that are used as aids in determining progress towards meeting performance expectations. Key hospital performance indicator data is collected and reviewed monthly by the Hospital PQC where hospitals report on improvement activities, and identify any issues or obstacles they have encountered. See Appendix D for the hospital system dashboard.

The four performance measures are currently being monitored for the DBHHDD Hospital System are:

1. Continuing Care Plan Created Overall

Definition: Percent of adult mental health 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. (NASMHPD Research Institute)

Results Summary and Analysis: The Hospital System has averaged 96% on this measure for calendar year 2012. The target threshold of 95% has been met or exceeded in 4 out of the 12 months, with 3 of those in the first 6 months and 1 in the last six months.

2. Individualized Recovery Plan - Quality

Definition: Percent of criteria that were met on quality audits performed on chart reviews of adult mental health patients.

Results Summary and Analysis: The Hospital System has achieved consistent improvement from January (52%) through December (87%). The target percentage is 95%. These improvements reflect the results of a substantial amount of training resources committed to improving the performance of Individual Recovery Teams in developing care plans.

3. Consumer Satisfaction/Outcome of Care Domain

Definition: Percent of adult mental health clients at discharge or at annual review who respond positively to the outcome of care domain on the Inpatient Consumer Survey.

Results Summary and Analysis: The last two months for which data is currently available (Oct. & Nov. 2012), show a significant improvement in this area compared to the previous eight months. While the Department's eight-month average score prior to October was 75%, this score is similar to the national average for similar facilities. The Department's goal of 95 % has not yet been achieved. Improvement efforts are being focused on more effective utilization of treatment mall programming and improving the methodology utilized in obtaining valid feedback from consumers.

4. Consumer Satisfaction/Empowerment Domain

Definition: Percent of adult mental health clients at discharge or at annual review who respond positively to the empowerment domain on the Inpatient Consumer Survey.

Results Summary and Analysis: The last two months for which data is currently available (Oct. & Nov. 2012), show a slight improvement (82% & 80%) in this area compared to the previous 8 months (77% average). While the scores fall within the average of similar facilities nationally, the goal of 95 % has not yet been achieved.

Improvement efforts are being focused on “Respect” training for staff and on improvements in the involvement of consumers in the recovery planning process .

B. Community Behavioral Health (CBH) Programs

The CBH key performance indicators were vetted with nationally recognized subject matter experts prior to implementation in 2012. Twenty-three indicators were chosen. Data are collected monthly or quarterly, depending on the indicator, and reviewed quarterly by the Community Behavioral Health PQC (see Appendix E for the CBH dashboard):

1. The Georgia Housing Voucher Program (GHVP) (2 indicators)

a. Definition: Percent of individuals with vouchers who remain in stable housing for greater than 6 months.

Results Summary and Analysis: A review of the data currently indicates that the supports provided to voucher recipients is effective at assisting those individuals in maintaining stable housing. The Department’s results (92%) exceeded the HUD standard for the Shelter Plus Care Program (77%) for a similar population profile by an average of 15%. Additionally, it confirms the referral application process of describing the individuals community support needs and how they will be met. This information is broken out by Region and provided to Regional Office staff, who then review it down to the provider level in order to determine provider effectiveness in monitoring housing stability.

b. Definition: The percent of individuals who have left stable housing under unfavorable circumstances and have been re-engaged and reassigned vouchers as indicated.

Results Summary and Analysis: There are reasons for leaving the program, such as reunification with family or moving out of state, that would not call for re-engagement efforts. This measure focuses only on those who left the program due to an unfavorable outcome and the effectiveness of re-engagement efforts by service providers. The target for the indicator was set at 10% based on consensus of the council membership. There is no local or national benchmark for this indicator. A review of the data suggests that re-entry into the voucher program, even after eviction or termination of a voucher, is possible and the percentage who were re-engaged ranged from 17% to 30% in 2012. This information is reviewed by the Regional Office staff that are charged with oversight responsibility and follow up with providers who update the status of those individuals that can be re-engaged.

Baseline data was obtained during 2012 and as a result of the annual review by the CBH program quality council these key PI indicators will continue to be tracked during 2013.

2. Supported Employment (SE) (2 Indicators)

a. Definition: The percent of providers that meet an average staff to consumer caseload ratio of 1:20.

Results Summary and Analysis: A low staff to consumer ratio of no more the 1:20 is desired for this service to ensure that each participant has the opportunity to receive the service at the intensity needed to produce good outcomes.. During 2012, the target threshold was met six out of the twelve months. From January to June, only data from the three settlement funded SE providers was collected for this indicator. Starting in July, all Adult Mental Health contracted SE providers supplied data for this indicator. The increase

in providers may have influenced the overall percentage because those newly added providers were still in a data submission and fidelity learning curve.

Each month this indicator is reviewed with the providers during the Supported Employment Coalition Meeting. Barriers that keep providers from meeting this indicator are discussed and shared. Barriers that providers have cited include difficultly retaining qualified staff and obtaining referrals from external sources. Coalition Meetings also included program highlights from providers that were successful in creating relationships with other agencies to increase the number of referrals to Supported Employment. DBHDD brought in a consultant to provide a session related to staff burn-out at the Community Mental Health Training and Technical Assistance Event in January 2013 in Macon, GA.

DBHDD also noted a selection of providers whose ratios are much smaller than expected and therefore were not counted as meeting this measure. The Community Behavioral Health PQC discussed this during its annual review of key performance indicators and it was agreed that the indicator needed refinement during 2013 since a lower ratio would not be expected to be associated with low service intensity for individual consumers and therefore, unrelated to the purpose of the indicator. This indicator will be changed to capture the percentage of providers whose staff to consumer ratio falls in between 1:15 and 1:20.

b. Definition: The percent of unduplicated individuals who had first contact with a competitive employer within 30 days of enrollment.

Results Summary and Analysis: Engagement in rapid job search is desired for persons enrolled in this service. During 2012, the target threshold 50% was met each quarter it was evaluated. From January to June, only data from the three settlement-funded SE providers was collected for this indicator. Starting in July, all Adult Mental Health contracted SE providers supplied data for this indicator. Data from July to September 2012 demonstrated that 70.4% of settlement consumers enrolled during that time frame were able to have first contact with potential employers within 30 days.

From July to September 2012, several providers new to the data collection had difficulty calculating the number of full-time employees (FTEs) that were devoted solely to consumers with mental illnesses. This impacted DBHDD's ability to calculate an accurate consumer to staff ratio. In response to this difficulty, DBHDD provided ongoing individual technical assistance to these providers to ensure that accurate data collection methods were in place.

This indicator is discussed at every Supported Employment Coalition meeting. Providers have cited barriers related to the economy/poor job market, difficulty finding employers that are receptive to hiring individuals with mental health diagnoses, and transportation barriers. Coalition Meetings have provided the opportunity for sharing successful experiences in building positive partnerships and relationships with employers.

As this data must be collected with a one month delay, data from second quarter of FY13 (October 2012 to December 2012) was unavailable at the time of this report.

As a result of the annual review by the CBH program quality council, these key PI indicators for Supported Employment will continue to be tracked during 2013.

3. Assertive Community Treatment (ACT) (3 indicators)

Note: In July 2012 DBHDD began to collect this data from all ACT Teams regardless of funding source. Initially, only teams under contract to receive state funds were included but Medicaid-funded teams were added in July 2012 to provide a better overall picture of ACT service outcomes. This changed the population by including more consumers that otherwise would not have been included in this indicator.

a. Definition: The percent of consumers who are enrolled within three days of referral.
Results Summary and Analysis: Rapid enrollment of referred consumers is desired for this service. The target for this measure is 70% and the 2012 results ranged from 28.9% to 71.9%. The increased percentages during October and November may be related to DBHDD's transition of individuals from terminating State Funded ACT teams to newly established teams that were ready to enroll individuals.

Data is discussed with providers during ACT Coalition meetings. Providers are engaged in discussions of the barriers to meeting targets, solutions are strategized. Technical assistance is provided. Providers that consistently score high on this indicator are invited to shared what positively impacts rapid enrollment. Barriers have included newly added providers being in a data submission learning curve. DBHDD has been providing ongoing technical assistance to these new providers to ensure accurate data reporting. DBHDD will also be investigating the effect of high volume of referrals on this measure. It is possible that differences between providers' results may be more related to differences in volume rather than provider-controlled factors.

b. Definition: The percent of ACT consumers admitted to psychiatric hospitals within the past month.
Results Summary and Analysis: Lower utilization of psychiatric hospitals by persons participating in this service is desired. The target for this measure is no more than 7% per month and the 2012 results ranged from 6.3% to 9.9%.

Data is discussed with providers during ACT Coalition meetings. Providers are engaged in discussions of the barriers to meeting targets and solutions are strategized. Technical assistance is provided. Providers have not cited any barriers that they are experiencing related to this indicator. However, conversations at Coalition meetings have focused on the needs of high level of care consumers and ways to reduce length of stay when a hospitalization is necessary. Many teams noted that building relationships with area law enforcement entities as a way to help educate the community on alternative mental health interventions and reduce the utilization of psychiatric hospitalizations.

c. Definition: The average number of jail/prison days utilized per enrolled consumer.
Results Summary and Analysis: Decreased incarceration for persons participating in this service is desired. The target for this measure is less than 1.0 days per month and the 2012 results ranged from .559 to1.032 days.

As with the other ACT indicators, data is discussed with providers during ACT Coalition meetings. The slight decrease in November and December 2012 was discussed at the ACT Coalition Meeting in January 2013. Several teams cited that the colder weather has kept many of their consumers from loitering in public areas. The teams also state that

loitering increases police contacts which impacts jail utilization. Conversation at the meeting was then focused on other ways for teams to impact the amount of time their consumers loiter (e.g. assisting consumers in finding other meaningful daily activities by teams building relationships with local Supported Employment providers, building consumer's informal networks, locating community recreational programs). DBHDD will be monitoring this indicator in the future to determine if there is a correlation between seasonal changes and jail utilization.

Baseline data was obtained during 2012 and as a result of the review by the CBH program quality council these KPIs will continue to be tracked during 2013.

4. Intensive Case Management (ICM) (3 indicators)

a. Definition: The percent of ICM consumers with a Psychiatric inpatient admission within the past month.

Results Summary and Analysis: Decreased psychiatric re-admission for persons participating in this service is desired. A review of the 2012 data indicates that the target threshold of not exceeding 10% was met every month.

Data is discussed with providers during Coalition meetings similar to the method used during the ACT Coalition meetings described above.

Since 2012 was designed to collect baseline data and the target was met every month, the target for this indicator will be lowered to 5% during 2013.

b. Definition: The percent of individuals housed (non-homeless as defined in the programmatic report) within the past month.

Results Summary and Analysis: Increased housing stability for persons participating in this service is desired. A review of 2012 data indicates that the target of 90% was met nine out of the twelve months. It is hypothesized that the decrease in percentages may have been impacted by the increase in the number of new consumers served and an associated higher number who entered without housing.

Data is discussed with providers during Coalition meetings. Providers are engaged in discussions of the barriers to meeting targets and solutions are strategized.

c. Definition: The average number of jail/prison days utilized per enrolled consumer.

Results Summary and Analysis: Decreased incarceration for persons participating in this service is desired. A review of 2012 data indicates that the target of 0.5 days was met every month.

Data is discussed with providers during Coalition meetings using the same method as the other indicators in this section.

Since 2012 was designed to collect baseline data and the target was met every month, the target for this indicator will be lowered to 0.25 days during 2013.

5. Community Support Teams (CST) (3 indicators)

a. Definition: The percent of CST consumers with a Psychiatric inpatient admission within the past month.

Results Summary and Analysis: Decreased psychiatric re-admission for persons participating in this service is desired. A review of 2012 data indicates CST providers met this target of 10% eight months out of the year. The increase in percentages in June and September 2012 were greatly influenced by the number of new consumers that received services during those months.

Data is discussed with providers during Coalition meetings. Providers are engaged in discussions of the barriers to meeting targets and solutions are strategized.

b. Definition: The percent of individuals housed (non-homeless as defined in the programmatic report) within the past month.
Results Summary and Analysis: Increased housing stability for persons participating in this service is desired. A review of 2012 data indicates the target of 90% was met every month. Data is discussed with providers during Coalition meetings.

Definition: The average number of jail/prison days utilized per enrolled consumer.
Results Summary and Analysis: Decreased incarceration for persons participating in this service is desired. A review of 2012 data indicates CST providers met this target of 0.75 days nine months out of the year. The increase in utilization in July 2012 was likely impacted by the number of consumers utilizing the service during the month. The discussion regarding this measure during a Coalition Meeting revealed that the 21 days were primarily utilized by one consumer due to a specific personal event.

Data is discussed with providers during Coalition meetings. Providers are engaged in discussions of barriers to meeting target, solutions are strategized.

Baseline data was obtained during 2012 and as a result of the review by the CBH PQC these key PI indicators will continue to be tracked during 2013.

6. Case Management (CM) (3 indicators)

a. Definition: The percent of CM consumers with a Psychiatric inpatient admission within the past month.
Results Summary and Analysis: Decreased psychiatric re-admission for persons participating in this service is desired. A review of 2012 data indicates Case Management providers met the target of 10% every month. Data is discussed with providers during Coalition meetings as described above.

Since 2012 was designed to collect baseline data and the target was met every month, the target threshold for this indicator will be revised to 5% during 2013.

b. Definition: The percent of individuals housed (non-homeless as defined in the programmatic report) within the past month.
Results Summary and Analysis: Increased housing stability for persons participating in this service is desired. A review of 2012 data indicates Case Management providers met this target of 90% every month. Data is discussed with providers during Coalition meetings as described above.

c. Definition: The average number of jail/prison days utilized per enrolled consumer.

Results Summary and Analysis: Decreased incarceration for persons participating in this service is desired. Jail utilization data was not collected and tracked during State FY12 (July 2011-June 2012) for consumers receiving CM services. Data collection processes were implemented in July 2012. A review of 2012 data indicates CM providers met the target of 0.25 days twice out of the six months data was collected.

Data is discussed with providers during Coalition meetings as described above. Discussions during Coalition Meetings have focused on the relatively higher jail utilization by CM consumers compared to higher intensity community services such as ICM and CST. One theory is that the intensity of service of ICM and CST services has a greater impact on jail utilization but these services are not always available in the same region as CM . A possible implication of this for CM providers is that they may be serving consumers that are in need of higher intensity services. DBHDD and providers have discussed the option of referring those consumers to other higher level services in their areas for which the consumers may be eligible, such as ACT services, until such time that ICM and CST services are available statewide. Another option that will be considered is to lower the caseload expectations for case managers in these areas to allow for higher frequency of contact.

Baseline data was obtained during 2012 and as a result of the review by the CBH PQC these key PI indicators will continue to be tracked during 2013.

7. Addictive Disease Services (2 Indicators)

a. Definition: Percent of Adult Addictive Disease consumers who abstain from use or experience a reduction in use while in treatment.

Results Summary and Analysis: This measure is self reported but assists providers in understanding the behaviors of those in services as it relates to reducing the harmful consequences of their substance use while engaging in clinical care. This indicator is a required NOMS (National Outcome Measures) for SAMHSA and has not been used to drill down to the provider level

A review of the most recent available statewide data for (FY 2012) suggests that 45% of adult participants in treatment report a reduction in use or abstinence from alcohol and drugs, which is slightly higher than data from previous years. Over the four year period of data collection, we were able to see providers meet the targets set for the coming year demonstrating an incremental improvement in the performance indicator each year from a statewide perspective.

Although reduction in use and abstinence is important for programs to measure, during this last year of QM development and implementation, our evaluation of this indicator determined the need to adopt new indicators that will measure engagement and retention, which are critical quality components of a successful substance abuse treatment program. These PIs will be discussed in further detail below.

b. Definition: Percent of Youth Addictive Disease consumers who abstain from use or experience a reduction in use while in treatment.

Results Summary and Analysis: This measure is self reported but assists providers in understanding the behaviors of those in services as it relates to reducing the harmful consequences of their substance use while engaging in clinical care.

A review of the most recent available statewide data (FY 2012) suggests that 58% of youth participants in treatment report a reduction in use or abstinence from alcohol and drugs. Over the four year period the state has collected data on this indicator, we were able to see providers meet the targets set for the coming year which demonstrated an incremental improvement in the performance indicator from a statewide perspective.

Although reduction in use and abstinence is important for programs to measure, during this last year of QM development and implementation, our evaluation of this indicator determined the need to adopt new indicators that will measure engagement and retention, which are critical quality components of a successful substance abuse treatment program.

These key PI indicators will be replaced with new indicators in 2013. The new key Addictive Disease (AD) Service performance indicators will focus on consumers discharged from crisis/detoxification who receive follow-up services and clients remaining active in treatment for 90 days after beginning non-crisis stabilization services. The new PI indicators will be drafted by the AD program staff and will be presented to the CBH PQC for review and approval.

8. Customer Satisfaction from the Quality Management Audits, Community Behavioral Health Programs. Face-to-face interviews were conducted with adult consumers who were in the target population. Target thresholds for each of the satisfaction indicators were set at 90%.

Definitions:

- Percent of individuals that are satisfied with services they are receiving. (80.4%)
- Percent of individuals which feel their quality of life has improved as a result of services. (80%)
- Percent of individuals which feel the location of services is convenient for them. (84.6%)
- Percent of individuals which feel staff treats them with respect. (86.5%)
- Percent of individuals which state they regularly discuss goals with staff. (78%)

Results Summary and Analysis: Currently, the available data for these KPIs is limited to 6 months worth of data collection and will continue to be collected in order to establish baseline information. Results ranged from a low of 78% (consumers state they regularly discuss their goals with their service provider staff) to a high of 86.5% (consumers who state service provider staff treat them with respect). The Department will continue to collect customer satisfaction data through the Quality Management audits/reviews and will summarize patterns over time, as applicable.

Adult Mental Health Fidelity Reviews

Assertive Community Treatment (ACT) Fidelity Reviews are conducted annually for all 22 state contracted ACT teams. In the current fiscal year a total of 8 Fidelity Reviews have been completed using the 28-item DACTS model for Fidelity. Once the DBHDD ACT Fidelity Review Team completes the review, results of the Fidelity Review are given to the ACT team, the regional office in which the team operates, the DBHDD Adult Mental Health Director and other departmental leadership, and results are provided to the ACT Subject Matter expert hired as part of the DOJ Settlement.

Review items that are found to be outside of the acceptable scoring range result in a Corrective Action Plan (CAP) which each team develops and submits for acceptance to the regional and state office. Of the 8 teams that have received a Fidelity Review, all are operating within a good to very good range of Fidelity with evidence of serving the appropriate population, maintaining an acceptable caseload, delivery of the service with intended frequency and intensity, provision of crisis response, effective daily team meeting discussion of consumers and consistent delivery of 80% of the teams services in the community. Some of the areas of needed attention are, increasing team involvement in hospital admissions and discharges, strengthening delivery and documentation of contacts with consumer's informal support system, and more out-of-clinic delivery of services by the psychiatrist on

Supported Employment (SE) Fidelity Reviews are conducted annually for all 21 state contracted SE providers. Fidelity Reviews were completed in late 2011 for the 3 state contracted SE providers and as a result of the FY'2013 expansion from 3 funded providers to 21 funded providers, SE reviews will resume within the next month.

All teams will receive a Fidelity Review using the 25-item IPS model supported employment scale. Once the SE Fidelity Review is complete, results will be given to the SE provider, the regional office in which the team operates, the DBHDD Adult Mental Health Director and other departmental leadership and results will be provided to the SE Subject Matter expert hired as part of the DOJ Settlement. Review items that are found to be outside of the acceptable scoring range will result in a Corrective Action Plan (CAP) which each team develops and submits for acceptance to the regional and state office.

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

As a component of DBHDD's quality management system, a quality audit of a sample of individuals meeting settlement agreement criteria and who were enrolled in settlement funded services was created and implemented. 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.

The audits included interviews with individuals served and with provider leadership and staff, direct observation, reviews of treatment records, and reviews of provider's performance improvement systems. By following individuals through the system of care, a more holistic picture of the functioning of the overall system could be identified while allowing for site-specific feedback towards improving services for individuals served. Audits were performed October 2011 through October 2012 in all six regions. From April 2012 through October 2012, individuals interviewed were also asked about their overall satisfaction with services and their quality of life. Consumer satisfaction continues to be an identified key performance indicator.

Each of the following ADA related services were included in the sampling of ADA individuals as outlined below:

Services	**Cycle 1- Reviews Completed**	**Cycle 2- Reviews Completed**
Assertive Community Treatment	4 Providers / 9 Teams	4 Providers / 8 Teams
Intensive Case Management	1Provider / 1 Team	1 Provider / 1 Team
Supported Employment	3 Providers / 5 Teams	3 Providers / 4 Teams
Peer Support/Peer Mentoring	1 Provider / 1 Team	1 Provider / 5 Teams

Community Hospital Beds	4 Providers	7 Providers
Crisis Stabilization Units	7 Providers	13 Providers / 15 CSUs
Single Point of Entry	1 Provider	1 Provider
Bridge Funding	7 Providers / 8 Locations	*N/A
MH Supported Housing	4 Providers / 6 Locations	N/A
DD Support Coordination	4 Providers / 9 Teams	N/A
DD Mobile Crisis Teams	4 Providers / 6 Teams	N/A
DD Crisis Respite	1 Provider	N/A
DD Congregate Living Homes	9 Providers	N/A
DD Host Homes	4 Providers	N/A

Cycle One= Number of Providers/Teams reviewed October 2011 – December 2011
Cycle Two= Number of Providers/Teams reviewed January 2012 – December 2012
*N/A = No Review this cycle

Sample Selection:
Individuals were considered for selection when they utilized any Settlement Agreement services within the six months prior to the audit of a region. Individuals were selected for the audits based on the following: enrollment in multiple services, random selection and clinical reasons that included length of stay, time of enrollment, or inclusion in a previous audit.

Reviews/Audits Completed
Between October 2011 and the end of October 2012, the Quality Management audit team completed a total of 142 provider/site audits of ADA Settlement Agreement providers. The services individuals were enrolled in included: Assertive Community Treatment, Intensive Case Management, Supported Employment, Peer Support, Peer Mentoring, Community Hospital Beds, Crisis Stabilization Units, Bridge Funding, Georgia Housing Voucher Program, Support Coordination, DD Mobile Crisis Teams, DD Crisis Respite Homes, DD Congregate Living Homes, and DD Host Homes. The Single Point of Entry and Georgia Crisis Access Line services were also included in the continuity of care review. During those audits, 842 charts were reviewed, 150 consumers received face-to-face interviews, and 347 provider staff were interviewed. Providers were given copies of their audit results and expected to utilize that information in their internal QM/QI processes to correct any concerns or issues identified. Individuals placed in Mental Health Supportive Housing and individuals with Developmental Disabilities were included only in the first set of reviews which occurred between October 2011 and December 2011.

Trends Identified:
At the end of each quality management audit cycle, a summary report was developed and shared with DBHDD senior leadership, the Regional Coordinators, and key Central Office program leadership. The leadership in the areas that have been identified in the report as having possible deficient practices or which require further analysis/review were expected to follow up and or correct and modify program and procedures as deemed necessary and appropriate. The top two recurring themes identified in these review reports include:

- An absence of a master DBHDD database which easily and accurately identifies and tracks consumers across their continuum of care.
- That individualized Recovery Plans (IRP) did not consistently include the individual's input or involvement, nor were they always individualized or comprehensive (i.e. medical needs missing, substance abuse issues not addressed, etc).

Summary and Recommendations for Community Behavioral Health

The sections above reference the current status of the KPIs as well as the Department's other quality management activities. The past year, 2012, provided a base line for these indicators. The BHQC has made modifications as well as changes to the targets and indicators to improve the sensitivity of the indicators to more accurately reflect the program outcomes. The Department will continue through 2013 to evaluate the quality of these indicators, improve our performance and continue to search for measures that have objective or national benchmarks that might guide this process. In addition to the Department's review, input will be utilized from consultants to evaluate our KPIs and include indicators that would provide us with outcome information for our entire population.

DBHDD has begun a collaboration with the Department of Community Health to better coordinate activities of our respective External Review Organizations. This will provide a more systemic and comprehensive view of the community and behavioral health provider network. A significant goal is to reduce duplication and reallocate resources to gather information not currently available.

Health Status Indicators, Community Behavioral Health Programs

Physical health is often neglected when dealing with psychiatric or addictive disease concerns and individuals with behavioral health issues are known to be more likely to have other chronic diseases as well as poorer health outcomes compared to those without behavioral health problems. Identifying and analyzing specific key health performance indicators has been discussed at length by the CBH PQC and the current challenges related to capturing, sending and storage prohibit its collection and analysis at this time. This issue will be included in discussions related to data systems and potential Administrative Service Organizations (ASO) or External Review Organizations (ERO).

C. DBHDD Division of Developmental Disabilities

The DDD utilizes an external Quality Improvement Organization (QIO) to carry out much of its data collection and analysis. The population for the DDD indicators (except for the crisis indicators) is adults with intellectual or developmental disabilities (IDD)who are currently receiving waiver services. Crisis services are available to adults and children age 5 -18 years of age with I/DD regardless if they are currently receiving DD services. Therefore the PI indicators for crisis services are inclusive of this population. The QIO creates an annual quality report which contains data on key performance and quality indicators. The full report for FY12 can be found in GQMS Annual Report (Attachment 1). KPIs include (see Appendix F for Community DD dashboard):

1. **Individual Support Plans (ISP):** The data for these key quality indicators is collected on an ongoing basis and is reported quarterly to the Director of Quality Assurance for the Division of Developmental Disabilities. The data is either collected using the ISP Quality Assurance (QA) checklist or through a Person-Centered Review. The ISP QA Checklist was developed by the State to ensure the ISP includes all necessary requirements as required by the State, to ensure what is "important to" and "important for" the individual is captured in the overall plan for that year, as well as to ensure the individual has a healthy, safe, and meaningful life. The purpose of the Person-Centered Review is to assess the effectiveness of and the satisfaction individuals have with the service delivery system.

   1.a The percent of ISPs written to support either a Service Life, Good but Paid Life, or Community Life.

- Service Life means the individuals uses paid supports and services and has little to no connection with the community.
- Good but Paid Life means the plan supports life in the community, but real community connections are lacking. The individual has both paid and unpaid supports.
- Community Life means the ISP is written to move people toward a community life as the person chooses.

1.b Percentage of individuals reporting they are involved in the development of their annual ISP.

Results Summary and Analysis:

1.A ISP QA Checklist results indicate the proportion of ISPs written to support a Community Life saw a steady decline over the last four years of the contract, with a small increase in FY 12. The decline may be related to the faltering economy which resulted in a decrease in available community supports and funding. Additionally, the numbers of DD community providers increased a great deal in 2009. The capacity of these new providers to support a Community Life, may need to be increased through training and technical assistance.

1.B In FY12, 88% of individuals reporting being involved in developing their annual ISP which is an increase from 83% in FY11. This positive increase may be a result of increased training and emphasis on the importance of individuals and families being included in the planning of their services.

2. **Crisis Response System:** The Georgia Crisis Response System for Developmental Disabilities provides crisis supports to children ages 5 – 18 and adults regardless of receipt of waiver services. The data for the crisis response system is collected monthly and are reviewed by the Director of Quality Assurance for the Division of Developmental Disabilities:

2.a The percent of Mobile Crisis Team (MCT) dispatches.
2.b Average Mobile Crisis Team response time.
2.c The percent of crisis incidents that resulted in intensive in-home supports.
2.d The percent of crisis incidents that resulted in placement of the individual in a crisis home.

Results Summary and Analysis:

2. A. A review of the data for indicator 2.a currently suggests that 48% of crisis calls result in the Mobile Crisis Team being dispatched. This number will probably increase over the next year, as the Division takes steps to reduce telephonic resolution of crisis episodes.

2. B. The data for indicator 2.b suggests MCT are on average meeting the required response time of 1.5 hours. The average for FY12 was 93 minutes. FY13 data is showing a decrease in response time to 60 minutes on average. The most likely reason for the positive result is that crisis providers are becoming more familiar with their service area and the crisis system as a whole.

2. C. The data for indicator 2.c suggests that 18% of mobile crisis team dispatches result in the individual needing additional intensive in-home support beyond the initial crisis resolution. It is a goal for the crisis system to keep in the individual in their home environment through the provision of in-home crisis supports rather than remove them to an unfamiliar setting. The Division has provided

additional technical assistance and training to crisis providers in order to increase the use of in-home crisis supports.

2. D. The data for indicator 2.d suggests that 14% of mobile crisis team dispatches result in the individual needing to be moved to a crisis home.

The DDD continues to work closely with its crisis providers to evaluate and strengthen the crisis system. Mobile Crisis Teams are now able to be dispatched to state hospitals and jails in order to assess individuals in these locations for possible DD crisis supports. The Mobile Crisis Teams do not transport individuals to jails, but may transport individuals to a State hospital if it is determined an individual needs Behavioral Health supports. The Division is also developing protocols for Mobile Crisis Team dispatch to Crisis Stabilization Units.

3. **Health and Safety:** This data is collected annually and reported bi-annually through the National Core Indicator Survey**.**

3.a Percentage of individuals who had a routine dental examine in the past year.
3.b Percentage of individuals who had a flu vaccine in the past year.
3.c Percentage of individuals who had a Pap Test in the past 3 years.
3.d Percentage of Individuals who has a PSA test in the past 5 years.
3.e Percentage of Individuals who feel safe in their home.
3.f Percentage of Individuals who feel safe in their neighborhood.
3.g Percentage of Individuals who feel safe at work or day program.

Results Summary and Analysis

3.A 2009-2010 data shows that 72% of individuals reported having a routine dental screening which was well below the nation average of 83%. 2010-2011 data shows an increase in examinations to 78% but Georgia still remains below the nation average of 80%. Many dental procedures are not covered by either Georgia's State Medicaid plan or the Medicaid waivers. Efforts are underway to partner with the Georgia Department of Public Health to increase access to dental services.

3.B 2009-2010 data shows that 63% of individuals reported having flu vaccine which was below the national average of 77%. 2010-2011 data shows a slight increase in vaccinations to 65% but Georgia still remains significantly below the nation average of 75%. Standard vaccinations are covered under the State Medicaid plan. Discussions with providers and families have suggested that transportation to and from a physician's office is an issue. The Division will investigate possible partnerships with the Department of Public Health to address this issue.

3.C 2009-2010 data shows that 77% of individuals reported having Pap Test in the past 3 years which was within the national average of 76 %. 2010-2011 data shows a slight decrease in testing to 74% but Georgia remains within the national average of 71%.

3.D 2009-2010 data shows that 50% of individuals reported having a PSA test in the past year which was lower than the national average of 57 %. 2010-2011 data shows a decrease in testing to 45% but Georgia remains below the national average of 56%. The Division will survey families and providers in an attempt to determine why Georgia is consistently below the national average.

3.E 2009-2010 data shows that 91% of individuals reported feeling safe in their homes which was higher than the national average of 84%. 2010-2011 data shows a decrease to 86% but Georgia remains above the national average of 83% reporting they feel safe in their homes.

3.F 2009-2010 data shows that 92% of individuals reported feeling safe in their neighborhood which was higher than the national average of 86%. 2010-2011 data shows a slight decrease to 89% but Georgia remains within the national average of 86% reporting they feel safe in their neighborhood.

3.G 2009-2010 data shows that 96% of individuals reported feeling safe at work or in their day program which was higher than the national average of 85%. 2010-2011 data shows no change but Georgia remains above the national average of 89% reporting they feel safe at work on in their day program.

4. **Rights and Choice:** This data is collect annually either through the National Core Indicator Survey or the Person-Centered Review**.**

4.a Percentage of Individuals reporting that they are educated and assisted to learn about and fully exercise their rights.

4.b Percentage of Individuals reporting their home was entered without their permission.

4.c Percentage of individuals reporting they are allowed to use the phone or internet when they want to.

4.d Percentage of individuals reporting that their mail is opened without permission.

4.e Percentage of individuals reporting that they are treated with respect and dignity.

4.f Percentage of individuals reporting they have a choice of support and services.

4.g Percentage of individuals reporting that they decide how to spend free time.

Results Summary and Analysis:

4.A In FY12, 83% of individuals reporting being educated on and able to fully exercise their rights. This is slight increase from 81% in FY11.

4.B 2009-2010 data shows that 6% of individuals reported that their home had been entered without their permission, which is below the national average of 10%. 2010-2011 data shows only a slight increase to 7% with Georgia still remaining below the nation average of 10%.

4.C 2009-2010 data shows that 96% of individuals reported being able to use the phone or internet when they wanted to. This was within the national average of 92%. 2010-2011 data shows a slight decrease to 95% but Georgia ranks top in all the states participating in the National Core Indicator Survey, with the national average being 91%.

4.D 2009-2010 data shows that 6% of individuals reported their mail was opened without their permission which was lower than the national average of 10 %. 2010-2011 data shows a significant increase, 13%, with Georgia slightly above the national average of 12%. The Division regularly trains individuals/families and providers on individual rights. In future trainings, the Division will stress the importance that an individual be allowed to open their own mail if they are physically able to do so.

4.E In FY12, 97% of individuals reported that they are treated with respect and dignity. This is slight increase from 96% in FY11.

4.F In FY12, 95% of individuals reported that they have a choice in supports and services. This is increase from 91% in FY11.

4.G 2009-2010 data shows that 98% of individuals reported they decide how to spend their free time, which was higher than the national average of 91%. 2010-2011 data shows a decrease to 94%, however Georgia remains above the national average of 92%.

The Division of Developmental Disabilities continues to focus its efforts on transitioning individuals from the State hospitals to the community. The Division will continue to rigorously monitor its key quality data to ensure the health, safety, and success of all individuals receiving DDD services and supports in the community.

DBHDD QUALITY MANAGEMENT TRAINING PROGRAM

The need for training in quality management principles was identified for the Department's staff as a whole and the DBHDD Quality Management Training Program has been initiated. The training program is a collaborative effort between the Quality Management team and the DBHDD University staff. It incorporates webinars, an e-learning modular structure, and/or classroom style trainings as appropriate.

The first three e-learning modules (see list below) have been completed and converted into an e-learning format by DBHDD University. These first three modules started pilot testing during January 2013. The target audience for the e-training modules is all DBHDD staff. Participation in the training program content will vary depending upon role, responsibility, and program or service within the Department. In the future, training modules will be developed and made available to community providers.

It is currently anticipated that the QM trainings will include but will not be limited to:

- Customer Focus
- Introduction to Quality
- DBHDD Quality Management Program
- Introduction to Project Selection
- Introduction to Quick Wins & Rapid Improvement Events
- Project Documentation
- Voice of the Customer & Stakeholder Analysis
- Introduction to Establishing Measures
- Root Cause Analysis
- Data Analysis and Interpretation
- How to Complete a PI Project
- Case Management
- Health Status Indicators

On August 1, 2012 the first classroom style training session on performing a Root Cause Analysis was completed for hospital based quality management staff and senior leadership who work in the inpatient setting. Additional training will take place in 2013 based on identified need.

OTHER QUALITY MANAGEMENT ACTIVITIES

1. Community and Hospital Incident Data – Summary Review for 2012

Background**:** It is the policy of DBHDD to ensure that individuals who receive services in state hospitals and in a variety of community settings do so in a safe and humane environment and

that they are protected from abuse, neglect and exploitation. To accomplish this, DBHDD's Office of Incident Management and Investigations (OIMI) is responsible for receiving reports of deaths and critical incidents, reviewing the reports, and ensuring that investigations are conducted according to DBHDD policies.

Hospital and Community Incidents: The number and types of incidents required to be reported to OIMI differ for community settings and state hospitals; however, providers in both settings are required to self report critical incidents as defined by policy. Incidents may be investigated by the provider or by OIMI Investigators.

The following incident review covers death reports and critical incident reports received during 2012. The information is reported in numbers of incidents for state hospitals and community settings. Community settings are further categorized by incidents in behavioral health services and developmental disabilities services.

Hospital Incident Data

State Hospitals reported almost 9,000 critical incident types for CY 2012. (Note: A single critical incident report may include multiple incident types.) The incident types reported most frequently were (1) aggressive acts to another individual-physical, (2) aggressive act to staff-physical, (3) accidental injuries, (4) falls, and (5) aggressive acts to self.

These five incident types account for almost 75% of the total hospital incident types. The aggressive acts and falls are tracked monthly through the Hospital System's aggregated Triggers and Thresholds Report for trending and intervention, as indicated. Additionally, each hospital maintains a Triggers and Thresholds report for their respective hospitals. Each month they analyze their data, address those areas for which interventions are appropriate, and report on those analyses and associated activities during each Hospital's QC meeting and also in the Hospital System Quality Council meetings. The aggregated version of the Triggers and Thresholds report also offers comparative analyses of data and opportunities for the hospitals to benchmark with one another. Strategies for critical incident reduction are also discussed and developed within the DBHDD Medical Executive Committee meetings during the quality management portion of those meetings.

Community Incident Data – Behavioral Health Services

Community behavioral health providers reported almost 1,300 critical incident types for 2012. The incident types requiring an investigation and reported most frequently were (1) hospitalization of an individual in a community residential program, (2) individual who is unexpectedly absent from a community residential program or day program, and (3) incident occurring in the presence of staff which required the intervention of law enforcement services. The Program and Executive Quality Councils began reviewing and analyzing this data in October 2012 and will regularly review this data going forward.

Community Incident Data – Developmental Disabilities Services

Community developmental disabilities providers reported almost 2,350 critical incident types for CY 2012. The types of incidents reported most frequently were (1) hospitalization of an individual in a community residential program, (2) individual injury requiring treatment beyond first aid, (3) incident occurring in the presence of staff which required intervention of law enforcement services, (4) alleged individual abuse-physical, and (5) alleged neglect. The Executive Quality Council began reviewing and analyzing this data in October 2012 and will regularly review this

data going forward.

For both behavioral health services and developmental disabilities, the Department is implementing an additional level of review of premature mortality of individuals receiving community services. The review includes suicides and unexpected deaths. The review team is comprised of the Medical Director, a DBHDD Hospital Physician, the Director of Quality Management, the DD Director of Quality Assurance, the Director of Incident Management and Investigations, the Addictive Disease Services Assistant Executive Director, and a registered nurse. This review process was developed and implemented in October of 2012. Results of reviews will be reviewed by the CBH and DD Program Quality Councils starting in 2013.

2. Complaints and Grievances

In 2012, the Office of Public Relations (OPR) (formerly the Office of External and Legislative Affairs changed its) received 280 complaints/grievances requiring the attention of state office, regional office and/or regional hospital staff. The cases were triaged and tracked for review, response and/or resolution.

Depending on the nature of the concern, a case is assigned to either the state office, a regional office or to a regional hospital. The state office was assigned 20% of the 280 cases. Sixty-four percent (64%) were addressed by the regional offices and 16% were handled by the regional hospitals.

Complaints and grievances received by OPR were initiated by a variety of stakeholders. Nineteen percent (19%) were forwarded to OPR by the Governor and Lt. Governor's Offices. Requests initiated by members of the Georgia General Assembly accounted for 16% of the cases. Approximately, 38% of the reported concerns were initiated by families, consumers, friends, advocates or providers.

Of the 280 complaints received in 2012, there were 59 issues categories that included addictive diseases; administration; community care; developmental disabilities; financial services; fraud and abuse; health care-personal care; general information about DBHDD programs; investigations; mental health; DBHDD contracts; medical records request; personal care homes; personnel; provider services; transportation and issues that were referred to another agency.

Complaints and grievances included issues related to access to behavioral treatment and habilitation services; problems related to service delivery and supports; eligibility; abuse and neglect; self direction; prior authorization; exceptional rate funding; forensic services; inpatient treatment and evaluation; provider application, certification and enrollment. Approximately, 44% of the constituent concerns pertained to developmental disability services and 41% to mental health services. Seventeen percent (17%) were categorized as other (e.g. provider network management and other state offices).

The top three primary issues of concern were related to developmental disabilities and mental health. The first category of concerns was related to eligibility for the New Options Waiver (NOW) and the Comprehensive Supports (COMP) Wavier. Fifty-five percent (55%) were received from family members, friends and legislators inquiring about waiver services for their loved one or constituent. The second category of concern was developmental disabilities self-directed services. Nineteen percent (19%) of 280 cases attributed to family members experiencing difficulty understanding and managing their loved ones waiver budgets. These cases were triaged

to state office disability staff as well as regional staff to address each individuals concern. The third category of concern was in the mental health area and accounted for 18% of the complaints and grievances received. Individuals and family members complained about the need for mental health services for their loved one and the need for additional long term mental health services in their communities. All issues were triaged to the regional office where staff reviewed each case and addressed each individuals concern.

In 2013, the Office of Public Relations will identify other tools to enhance its database to allow for more robust reporting. OPR anticipates that data collected through the constituent services process will be used to identify trends and efficiencies within our service delivery system.

3. Provider Network Analysis Results

The Department engages in community behavioral health planning 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.

During 2012 each Region performed a Region specific analysis that identified current services. In addition, each Region identified specific service needs/gaps based upon community input. Each Region will be working towards minimizing their identified gaps. Examples of those gaps include: “the need for a wider array of community services (adults, children and addictive diseases), expansion of service capacity, funding (both increased and flexible), improved coordination and communication between programs & services, and system enhancements."

4. Implementation and Results of Practice Guidelines:

- **Beck Initiative Overview**
  The Beck Initiative is a collaborative clinical, educational and administrative partnership between the Aaron T. Beck Psychopathology Research Center of the University of Pennsylvania (PENN) and Georgia’s Department of Behavioral Health and Developmental Disabilities (DBHDD) to disseminate Cognitive Therapy (CT) training and consultation throughout the DBHDD network. Through intensive workshops and ongoing consultation, tangible tools are placed in the hands of those working with people in recovery across the network to provide quality care. A continuity of care system, informed by CT, will be developed across the state of Georgia to help those in recovery to integrate back into their communities and have an increased quality of life. The initiative began in Region 4 on July 1, 2012 with a series of trainings and consultations. Additionally, it is expected that an evaluation plan will be finalized in February 2013 wherein the outcome measures will be agreed upon to determine the effectiveness of the training.

- **Suicide Prevention Program Best Practice Initiative:**
  During 2012, efforts were initiated to institute a DBHDD statewide suicide prevention program with a focus on adult community behavioral health providers (CBHP).

The Department's Suicide Prevention Program, reviewed and analyzed suicide deaths from July 2010 through 2011 looking for systemic issues that needed to be addressed. Prominent among the issues identified were:

- lack of awareness of risk of suicide,
- lack of common language to describe and report suicidal behavior,
- consistent screening, and
- safety planning and monitoring consumers at high risk of suicide between programs and systems of care.

The Suicide Prevention Program (SPP) then identified evidence based or best practice models to tackle each of these systemic issues. The SPP is in the process of developing best practice policies and a training program for DBHDD and DBHDD providers. Specific best practices that will be utilized are the Uniform Definitions related to suicide from the CDC, the Columbia Suicide Severity Rating Scale (C-SSRS) and Drs. Stanley and Brown's Suicide Prevention Safety Plan and monitoring model.

The SPP in collaboration with the DBHDD Division of Training and Organizational Development is working with Drs. Posner and Stanley from Columbia University Medical School to develop training that can be disseminated statewide on these best practices. Training has been piloted throughout Georgia. Additionally, onsite consultation is offered and provided to any community provider who has had a consumer who died by suicide.

5. Behavioral Health Contracted External Review Organization

APS Healthcare is the External Review Organization for DBHDD's behavioral health services. 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. The information that most informs management of the network are the on audits. These are on-site provider audits conducted approximately twice per year for each community service provider. Audits are conducted by licensed clinicians and review provider's documentation specific to:

- Assessments
- Treatment planning
- Programmatic integrity
- Documentation
- Billing

The overall result of the audit is a provider-specific summary of audit findings. The audit summary provides both strengths and areas of improvement for the provider. The summaries are posted publically on APS's website, www.apsero.comEach of the audit summaries are shared with the provider, Department staff, and staff from The Department of Community Health. The findings of these audits are tracked and used in several ways:

- APS uses the audit findings to offer direct technical assistance with the provider while on site for the audit.
- Providers are expected to incorporate the findings into their own internal quality assurance and improvement systems.
- Aggregate audit trends are used by the Department to target specific needs for training and technical assistance.
- APS monitors reoccurring issues and findings in subsequent audits to provide direct feedback to the provider.

- Repeated poor audit scores are used to manage the provider's contract compliance through adverse action or termination if indicated.

In addition to audits, APS provides a variety of reports that reflect the utilization of services by provider, region, and statewide. This information is also available for public view on the APS website. The Department's State and Regional offices use this information to identify and address providers or services that are outliers by over or under usage. This information informs the Department of service areas that may need stronger utilization review and tighter management. It also informs us of geographical areas that are both rich and poor with regards to service access and availability.

APS Healthcare authorizes services in their Care Management Office; this function also impacts quality of services delivered through these various roles:

- The Ambassador Program is an opportunity for new providers to spend both online and telephonic time with a licensed clinician (Care Manager) who provides orientation to the new providers and new agency staff. This includes support in navigating the DBHDD Provider Manual and policies to provide guidance on consumer eligibility, prior authorization requests, and appropriate documentation of service delivery.
- Care Managers review a random sample of authorization requests as well as those flagged or due to a disparity between assessment results and the services requested. This review often includes a phone conversation with the provider staff to provide a clinical review and technical assistance regarding the appropriate services, intensity, and documentation.
- Some high intensity services such as Assertive Community Treatment and Inpatient Hospitalization require a manual review by a Care Manager for all authorizations. This review offers the opportunity to provide one-on-one technical assistance to support the provider in serving the right person with the right service and encourages an ongoing relationship between the provider and their designated Care Manager. This review and technical assistance impacts the quality of the services provided by the agency and ensures that service resources are effectively allocated.

6. Hospital System Quality Management - In addition to the quality management activities described in this document, the DBHDD Hospital System has implemented a number of initiatives in the areas of policy development, training, information system development, performance measurement, clinical supervision. A substantial auditing system continues to be developed utilizing the Plato Data Analyzer system and staff are being trained and given inter-rater reliability testing to assure consistency and data integrity. That system allows for data entry and analysis at the local hospital level as well as the Hospital System level. Results of these activities are reviewed in Quality Council meetings.

- Additionally, the Department Medical Executive Committee, under the direction of the Department Medical Director, maintains oversight of peer review and medical staff credentialing for the state hospitals, the description of which is detailed in the medical staff bylaws. That body is also responsible for assuring that consulting and agency physicians, nurses and other professional staff are properly credentialed.

- Each hospital is also responsible for performing utilization review activities for their respective hospitals. Those activities involve the review of appropriateness for admission and continued stay. Utilization review staff coordinate and communicate with the Hospital

Clinical Director, as appropriate, when data show patterns of inappropriate utilization and with Hospital social workers and Regional Office staff when individuals no longer meet continued stay criteria.

- An example of a performance improvement project related to hospital service utilization is focused on reducing the rate of readmission of consumers within 30 days of discharge. Each of the hospitals has, on staff, a Readmission Review Coordinator (RARC) whose job it is to evaluate the factors that contributed to the rapid readmission and to work with treatment teams to develop treatment and discharge plans that will result in longer, more supportive community stays. Along with the RARC activities staff responsible for the hospitals' utilization review processes, under the direction of each facility's clinical director, evaluate the appropriateness of admissions to each facility. Those activities, along with a major commitment to community based services has succeeded, over the last several years in virtually eliminating the over utilization of those inpatient psychiatric services. Also, they have succeeded in maintaining, during the past year, a 30-day readmission rate of 8.5%. That rate is a substantial improvement over the 13% rate that the Hospital System maintained several years ago. Efforts continue to reduce that rate even further.

7. Division of DD QM Reviews of Individuals Served is performed through Support Coordination Monitoring and the Person Centered Review Process. The Person Centered Review (PCR) process is designed to assess the overall quality of the supports and services a particular person receives though interviews with the individual and his or her provider(s), record reviews, and observations. The process explores the extent to which the system enhances the person's ability to achieve self-described goals and outcomes, as well as individuals' satisfaction with the service delivery system. Each PCR includes a face to face interview with a randomly selected individual using the National Core Indicator (NCI) individual survey tool and additional interview questions using an EQIO Individual Interview Instrument (III).

In addition to the interview, records of the most recent twelve (12) months of services received by the person are reviewed and used to help determine the person's achievement of goals that matter most. Onsite observations are conducted for individuals who receive day supports or residential services to observe the person in these environments, the individual's reaction to supports, and how well supports interact with the person. Interviews with the individual's support coordinator and provider/staff further assist the consultant in gathering information to help determine how the person is being supported and the person's knowledge of the supports and services being provided. A review of the person's central record is also part of this process and includes a review of how well the person's Individual Support Plan (ISP) reflects the person, including goals, talents, strengths and needs. A total of 480 PCRs are completed annually. Individual participation in any interview as part of the QA process is voluntary. Individuals may refuse to participate for any reason and may also have anyone present at the interview they choose to have present.

Specific findings and recommendations based on the Person Centered Reviews, and actions being taken by the DDD can be found in Section 10 (below) and in Attachment 1 GQMS FY12 Annual Report.

8. Division of DD QM Reviews of Providers: Quality Enhancement Provider Reviews (QEPR) are a significant part of the Georgia Quality Management System for Developmental Disabilities.

The QEPR is used to evaluate the effectiveness of the provider's supports and services, organizational systems, records, and compliance with Division of DD standards for policy and procedures, as well as staff training and qualifications. The intent of the GQMS contract is for the EQIO to complete a QEPR with all providers at least one time over the course of five years. During the each contract year, 39 providers and one support coordinator agency will participate in a QEPR. For each provider, a representative sample of individuals is chosen to participate in an interview using the III, which begins the QEPR process and helps determine what individuals receiving services perceive as strengths and/or areas needing improvement within the provider's service delivery system.
Other resources used during the QEPR to gather information regarding the provider's supports and services are individual record reviews, onsite observations for individuals receiving day supports and/or residential services, and administrative review of the organization's policies and procedures, as well as staff training and qualifications, and provider/staff interviews. Information from the PCR interviews will be used to enhance the QEPR findings, as appropriate, to help support the provider in identifying trends, strengths, and areas needing improvement. The QEPR was implemented in January 2009.

Specific findings and recommendations based on the Person Centered Reviews, and actions being taken by the DDD can be found in Section 10 (below) and in Attachment 1 GQMS FY12 Annual Report.
The Division also has four Support Coordination agencies which monitor providers and advocates for individuals. Support Coordinators assure the completion of the written Individual Service Plan (ISP) document and any revisions. Support Coordinators are also responsible for monitoring the implementation of the ISP and the health and welfare of participants. Monitoring includes direct observation, review of documents, and follow up to ensure that service plans have the intended effect and that approaches to address challenging behaviors, medical and health needs and skill acquisition are coordinated in their approach and anticipated outcome. Monitoring includes reviewing the quality and outcome of services. Support Coordinators are also responsible for the ongoing evaluation of the satisfaction of waiver participants and their families with the ISP.

Support Coordination Agencies use a summary rating system to report findings from their monitoring efforts. The summary rating system is designed to reflect a point-in-time status of an individual's services related to health, safety and service issues. The primary focus is on health and safety issues but the support coordinator must also evaluate the appropriateness and adequacy of services. A description can be found in Attachment 2 Summary Rating Guidelines for Primary Services.

9. Division of Developmental Disabilities (DDD) Quality Management Program
As stated above, the Division of Developmental Disabilities has contracted with a QIO since 2008. The Georgia Quality Management System for Developmental Disabilities (GQMS) contract mandates that each provider rendering services through the Medicaid waivers to individuals with developmental disabilities has one annual review over the course of five years. Therefore, 40 providers are reviewed each year through the Quality Enhancement Provider Review (QEPR) process (39 service providers and one Support Coordination Agency). Providers who receive the QEPR are randomly selected each year and 480 individuals for the Person Center Reviews (PCR) are randomly selected from the caseloads of the 39 service providers. The PCR sample is stratified by region and providers, meaning providers are first randomly selected proportionately from each region, and then individuals are randomly selected from those providers, excluding individuals who have had a PCR.

For the QEPR process, a sample of individuals, excluding individuals who have had a PCR, are randomly selected from the 39 service providers, with at least one and a maximum of 34 individuals per provider. The sample is stratified by service to ensure all services are represented. In addition to the sample of individuals for the QEPR, staff personnel records are reviewed for each service offered by the provider. A random sample of staff rendering supports and services, including sub-contractors, are selected from a list of all staff working with the provider. A minimum of two staff per service are selected, or 25 percent, whichever is greater. A maximum of 30 records are selected for review. For Support Coordination, up to 30 records are randomly sampled from the support coordinators rendering services.

Individuals from both the PCR and QEPR samples participate in the Individual Interview Instrument (III) activity and Individual Support Plan Quality Assurance Checklist (ISP QA). Both processes also include a Provider Record Review (PRR), Staff/Provider Interview (SPI), and onsite observations of day and/or residential programs.

In addition to the PCRs completed for the sample of individuals, as described above, the Division's (EQIO) has implemented processes to complete PCRs for Individuals Recently Transitioned to the Community (IRTC) from an institutional setting. Many of these transitions are the result of an agreement between the State of Georgia and the United States Department of Justice to accommodate individuals with developmental disabilities to live in the community and to provide services necessary for them to do so. Individuals from this transition process participate in all aspects of the PCR with the exception of the NCI interview. IRTC findings are analyzed and presented separately from the findings for individuals already established in the community.

A DDD Quality Management report (Attachment 1 GQMS FY12 Annual Report) is generated annually that includes aggregate data from the Person-Centered Reviews, Quality Enhancement Provider Reviews, and the Follow Up with Technical Assistance Consultations. The report also contains recommendations based on the data. The Division uses this report and it recommendations in its quality improvement efforts for the next year.

10. Discussion from the FY 12 DDD ANNUAL QUALITY MANAGEMENT REPORT (Attachment 1):

Attachment 1, the GQMS FY12 Annual Report was submitted to the DDD on August 31st, 2012. The Division is currently reviewing the data and the recommendations. The Division has already taken steps to address certain recommendations, but all quality improvement steps will be discussed in the next report.

The QIO completed 480 Person Centered Reviews (PCR) and 40 Quality Enhancement Provider Reviews. As part of these reviews, the EQIO consultants completed 961 interviews with individuals that included a random sample of 480 individuals who participated in the National Core Interview using the NCI Consumer Survey. Consultants also completed 514 Support Coordinator Record Reviews, 1,414 Provider Record Reviews, 927 Staff/Provider Interviews, 775 onsite observations of residential and day program facilities, and 40 Administrative Reviews.

An additional 203 individuals who were recently transitioned to the community (IRTC) from an institution participated in a PCR. Compared to individuals already established in the community, IRTC results indicate recently transitioned individuals were much more likely to have a profound

intellectual disability, much more likely to live in a group home, and more likely to have an ISP written to support a Service Life. They were much less likely to be developing desired social roles, have choice of services and supports or be involved in the design of their service plan. Support Coordinator and provider records were much less likely to show they are included in the larger community or given choice of community services. In addition, IRTC results indicate goals on the ISP are less likely to be person centered and the HRST information is less likely to be updated as required. See Attachment 3 IRTC Report for CY 2012.

The Division's External Quality Review Organization made recommendations to the Division based on the findings of the report which are listed below:

Recommendation 1: The Division of DD should explore how the transition planning process is implemented for individuals transitioning from an institution. The planning process should ensure the person has input and is being connected to the community as desired even prior to the transition.
Comment: The Division will be conducting an evaluation of the current transition planning process to determine where quality improvement steps can be taken.

Recommendation 2: Support Coordinators should review the ISP for each person transitioned from an institution and update the plan as necessary to ensure goals are person centered and ensure the HRST is adequately and appropriately completed as required or necessary.
Comment: The Division is evaluating the provision of services and supports provided by Support Coordination Agencies (SCA) in an effort to better define the responsibilities of the SCAs

Recommendation 3: Because outcome scores for people living in host homes tend to be higher, the Division should help ensure a variety of residential settings, specifically host homes, are available and presented as an option for newly transitioned individuals. This will help support the person in making an informed choice related to supports and services available.

Face to face interview results across various demographics were similar to previous years, and results are fairly positive on average (90.2 %), an increase since Year 1 of the contract (83.2%). Year 4 results reflect a higher percent of outcomes met than the combined average for the previous three years, particularly in key areas of choice, having input into the design of the service plan and life's decisions, achieving outcomes and satisfaction with supports and services, health and safety, education about exercising rights, and community participation. In addition, although the previous two years ISP QA checklist results indicated a decline in the proportion of ISP written to support a Community Life, data for Year 4 indicate a shift up.

Provider documentation has shown improvement since Year 3 in some critical areas: a person centered focus in provider documentation; medication oversight and management; offering individuals a choice of services and supports and allowing them to direct their services and supports; and identifying health and safety needs of individuals served. Support coordinator documentation has also improved in key areas such as showing a person centered focus in the documentation and ensuring human and civil rights for the person are maintained.

Extensive statistical analysis has not been completed to determine all the factors that may be positively impacting outcomes for individuals. However, a recently completed QI study suggests that adequately implementing policies and procedures (measured though the Provider Record) improves outcomes. In addition, conducting person centered reviews to help determine how well

the provider systems are responding to individuals raises awareness of person centered practices for individuals, families and providers. Furthermore, the QEPR and FUTAC processes focus on improving practices for the provider's service delivery system.

Recommendation 4: People will perform to the test. Therefore, a continued focus on person centered practices and a person centered quality assurance/improvement process as well as continuing to include individual interviews as part of the Quality Enhancement Provider Review are recommended.

Administrative review of employee records reflected relatively low provider compliance on required qualifications and training. Approximately 17 percent of employees reviewed did not have adequate background screening documentation in place; 42 percent of staff did not receive the minimum of 16 hours of annual training; and 27 percent with oversight for medication did not follow rules, regulations or best practices.

Recommendation 5: Maintaining proper background screening practices and documentation are critical when working with a vulnerable population. The Division should consider a stricter policy and/or sanctions for noncompliance if appropriate.
Comment: The Division is currently evaluating its adverse action policies and procedures for when a provider does not meet performance requirements. Updates will be provided in the next report.

Recommendation 6: A workgroup including the EQIO, the Division, and provider representation should be convened to develop a training curriculum providers can use to ensure staff receives the annual training as required by the Division. The workgroup should also develop a training curriculum for medication administration that providers can use for staff who monitor the self administration of medications for individuals and/ or develop best practice guidelines providers can use to develop internal quality assurance checks to ensure accuracy of the implementation of these procedures.

Findings continue to show that individuals who receive supported employment have better outcomes than individuals who receive any other service. Community integration and development of social roles are improved when individuals are employed in integrated settings.

Recommendation 7: The state should continue to emphasize supported employment initiatives (becoming an Employment First state, the Alliance for Full Participation) and access to community resources. Develop a stakeholder workgroup to identify barriers to this with the outcome being a plan and recommendations to the State to overcome the barriers.
Comment: The Division is implementing steps to meet this recommendation. Georgia will become an Employment First state. Georgia will convene an Alliance for Full Participation (AFP) State Team. The AFP State Team will assist the division with drafting and implementing policy and procedures to increase the number of individual in supported employment services. This state team will be comprised of developmental disabilities stakeholders who will also engage the provider and business community on the benefits of integrated employment. It is a goal of the Department to increase the number and percentage of individuals in supported employment from 1345 to 2700 by July 1, 2015.

Recommendation 8: Support the Statewide QI Council's initiative to try and educate individuals and families regarding the employment supports and services available. This could include an

initiative requiring support coordination to educate individuals and family members not already involved with employment services using the supported employment brochure and guide. Comment: Steps are being taken to educate individuals and families on supported employment. A full description of the work done by the Statewide QI Council in this area can be found in Attachment 1 GQMS FY12 Annual Report.

Other findings are similar to results reported in previous years. Results continue to reflect possible issues surrounding health and/or safety, Community Access/Integration, and Person Centered Practices.

Health and Safety:

- HRST is not updated in the ISP as needed (48.6% present in ISP QA Checklist).
- Annual informed consent for psychotropic medications is present (24.7% present in ISP QA Checklist).
- Behavior support plan, crisis plan, and safety plan are signed (54.3% present in ISP QA Checklist).
- Medical support section of the ISP is fully completed including plans for an emergency (50.6% present in ISP QA Checklist).
- Although higher than in Year 3, only 31 percent of provider records reviewed documented a means to identify health status and safety needs.
- Approximately 37 percent of providers scored not met on the Qualification and Training element: indicating employees are educated on medication administration and proper laws and regulations related to medication oversight were followed, or best practices were used.
- Health and Safety represented over 50 percent of the FUTAC Focused Outcome Areas addressed during the consultation.

Community Access:

- 19 percent of individuals interviewed were not developing or being supported to maintain desired social roles.
- The proportion of ISPs written to support a Community Life has increased since Year 3 but remains low, at 7.5 percent.
- Only 26 percent of provider records indicated the person had choice of community services and supports.
- Approximately 52 percent of support coordinator records documented how individuals are included in the larger community.
- QEPR recommendations for half of the 40 providers reviewed to date this year indicated a need to identify ways to expose individuals to new opportunities in the community.

Person Centered Practices:

- Over 190 individuals (20 percent) were not involved in the routine review of their supports and services.
- Approximately 24 percent of ISPs did not contain goals that were all person centered and 32 percent of the service plans had two or fewer expectations met in the checklist section indication goals are person centered.
- Provider Record Reviews often do not use a person centered focus in documentation (33.9% present).

- Less than half (47%) of the Support Coordinator Record Reviews showed person centered documentation.
- Several recommendations provided during the QEPR address person centered practices such as regularly reviewing progress with the person, documenting that information is reviewed by the person, and document how individuals are being included in the planning process for outings.

Recommendation 9: The training developed on social roles and community connections should be a mandatory training for all staff, and should be competency based.
Comment: The Division will examine the feasibility of implementing this recommendation, and other quality improvement steps needed to address issues in Health and Safety, Community Integration, and Person-Centered Practices

Recommendation 10: With the development of the new ISP process and template submitted to the Division of DD, it is recommended the State begin developing strategies to implement this new system which by design ensures the person's goals and needs change as the person desires and/or as necessary.
Comment: The Division will be developing new case management information systems in FY13. The new ISP will be incorporated into the new system

Recommendation 11: The EQIO nurse provided training across the state specific to medications, possible reactions to medications, and medication administration. These standards should be tracked through the next reporting period and a new and possibly revised training session offered if necessary.
Comment: The data appears to reflect some differences in outcomes and results for individuals receiving services through the NOW versus the COMP waivers. The COMP waiver is designed for people who need residential services and these individuals showed better health and safety outcomes than NOW recipients. However, they were less likely to be involved in the review of their supports and services, less likely to be educated on and exercise their rights, and less likely to have community access and involvement. In addition, they were more likely to have an ISP written to support a Service Life and provider documentation was less likely to have a person centered focus or to show the individuals was offered a choice of supports and services. An assumption might be made that because COMP services include Community Residential Alternative services which include more restrictive group home residential settings may be impacting the scores.

Recommendation 12: It is not clear why differences exist between NOW and COMP waiver results. Perhaps the Division should revise the standards for the COMP waiver and ensure they more explicitly define how areas of choice and rights should be addressed.
Comment**:** The Division will review the COMP waiver policies and make any needed changes.

Appendix A

The Executive and Program Quality Council Membership

as of December 31, 2012

The DBHDD Executive Quality Council (EQC):

Commissioner	co-chair of the EQC, sets policy for the DBHDD, and provides oversight and guidance to QM activities.
Medical Director	co-chair of the EQC and providers oversight and guidance to QM activities.
Deputy Commissioner/COO	responsible for the Departments fiscal management strategy and provides guidance to QM activities related to fiscal planning, budgeting, cash flow and other policy matters.
Deputy Commissioner/Programs	oversees the provision of the Departments programs and activities related to behavioral health services/DD and provides guidance related to infrastructure and service delivery.
Director of Hospital Operations/Assistant Commissioner for DD	is responsible for coordinating the needs of the hospitals and provides oversight for the DD population. Provides input to the EQC regarding operational successes, challenges and improvement projects.
Deputy Assistant Commissioner/ADA Settlement Coordinator	provides oversight for the ADA settlement agreement for Community Mental Health & DD as well as the quality management component.
Addictive Disease Services Executive Director	directs and manages DBHDDs addictive disease program and provides QM guidance related to Addictive Disease (AD) services.
Director of Forensic Services	directs and manages DBHDD's forensic programs and services and provides QM guidance related to forensic services.
Director of Community Mental Health Services	directs and manages DBHDDs adult and child community mental health programs and provides QM guidance related to community based services.
Director of Quality Management	oversees DBHDDs quality management system .

Appendix A

Program Quality Council Membership

as of December 31, 2012

The Hospital System Program Quality Council:

Director of Hospital Operations	chair of the Hospital System PQC, sets policy and provides oversight to the hospital and DD programs.
Regional Hospital Administrators	chair their respective hospital's QCs and represents them on the Hospital System Program Council..
Hospital Quality Managers	support the quality management activities of their respective hospitals and the system-wide committees and teams.
Director of Forensic Services	directs and manages DBHDD's forensic programs and services and provides QM guidance related to forensic services.
Director of Hospital System Quality Management	coordinates and supports the Hospital System Quality management activities.
Director of Quality Management	oversees DBHDDs quality management system.

Appendix A

Program Quality Council Membership

as of December 31, 2012

The Behavioral Health Program Quality Council:

Assistant Commissioner for Behavioral Health	is chair of the Behavioral Health PQC and provides direction and guidance related to community behavioral health services.
Deputy Assistant Commissioner/ADA Settlement Coordinator	provides oversight for the ADA settlement agreement for Community Mental Health & DD as well as the quality management component.
Addictive Disease Services Executive Director	directs and manages DBHDDs addictive disease program and provides QM guidance related to AD services.
Addictive Disease Services Assistant Executive Director	assists the addictive disease services executive director with managing the DBHDD addictive disease program.
Director Community Mental Health Services	directs and manages DBHDDs adult and child community mental health programs and provides QM guidance related to community based services.
Director Adult Mental Health Services	provides administrative and clinical oversight for adult mental health services
Suicide Prevention Manager	directs and manages DBHDDs suicide prevention program and provides guidance related to suicidality issues.
Transitions Director	provides input related to consumers transitioning from inpatient to community settings and acts as an information resource for the Regional Offices and hospitals.
Regional Coordinator Representative	provides a regional perspective on behavioral health and DD issues.
Federally Funded Program Manger	provides oversight for Federally funded programs such as jail diversion.
Director Quality Management	oversees DBHDDs quality management system

Appendix A

Program Quality Council Membership

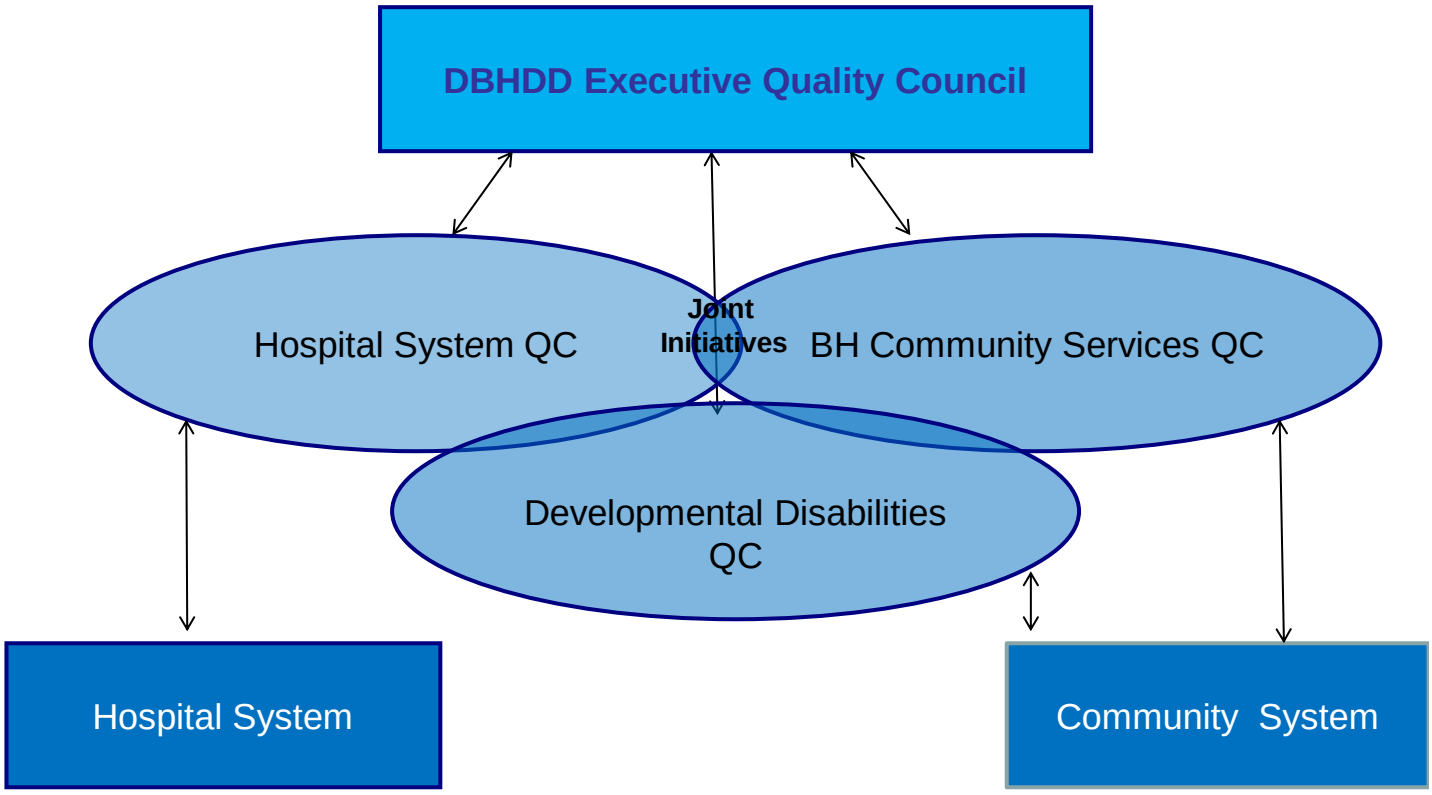
as of December 31, 2012

The Developmental Disabilities Program Quality Council:

Assistant Commissioner for Developmental Disabilities	oversees the provision of the Division of Developmental Disabilities programs and activities and provides guidance related to infrastructure and service delivery.
DD Director of Quality Assurance	oversees the Division of Developmental Disabilities quality management system and crisis response system
State Level DD Staff	assists with various duties related to areas such as training, provider compliance, supported employment, and others.
Self-Advocates	individuals who are currently receiving DD services and supports and are able to participate in DD Council and bring their perspective to the council.
Parents of Individual's receiving DD supports and services	parents of individuals who are currently receiving DD services and supports but are not able to participate in DD Council. During 2012 a parent of a consumer acted as co-chair for the DD council.
Representatives from DD Service Providers	oversees the operations of a DD Service Provider and brings the provider perspective/input to the DD Council. During 2012 a provider representative acted as co-chair for the DD council.
Representation from DD Support Coordination Agencies	oversees the operations of a DD Support Coordination Agency Provider and brings the support coordination perspective/input to the DD Council
Advisory Members (ERO) and DD Advocates such as the DD Director for the Georgia Advocacy Office and the State Director for Georgia ARC	advisory/advocate members do not have voting privileges If there is more than the identified number of voting representatives from any of the stakeholder groups, those individuals will be considered a part of the Advisory Group. Involvement of such individuals will be on an as needed basis.

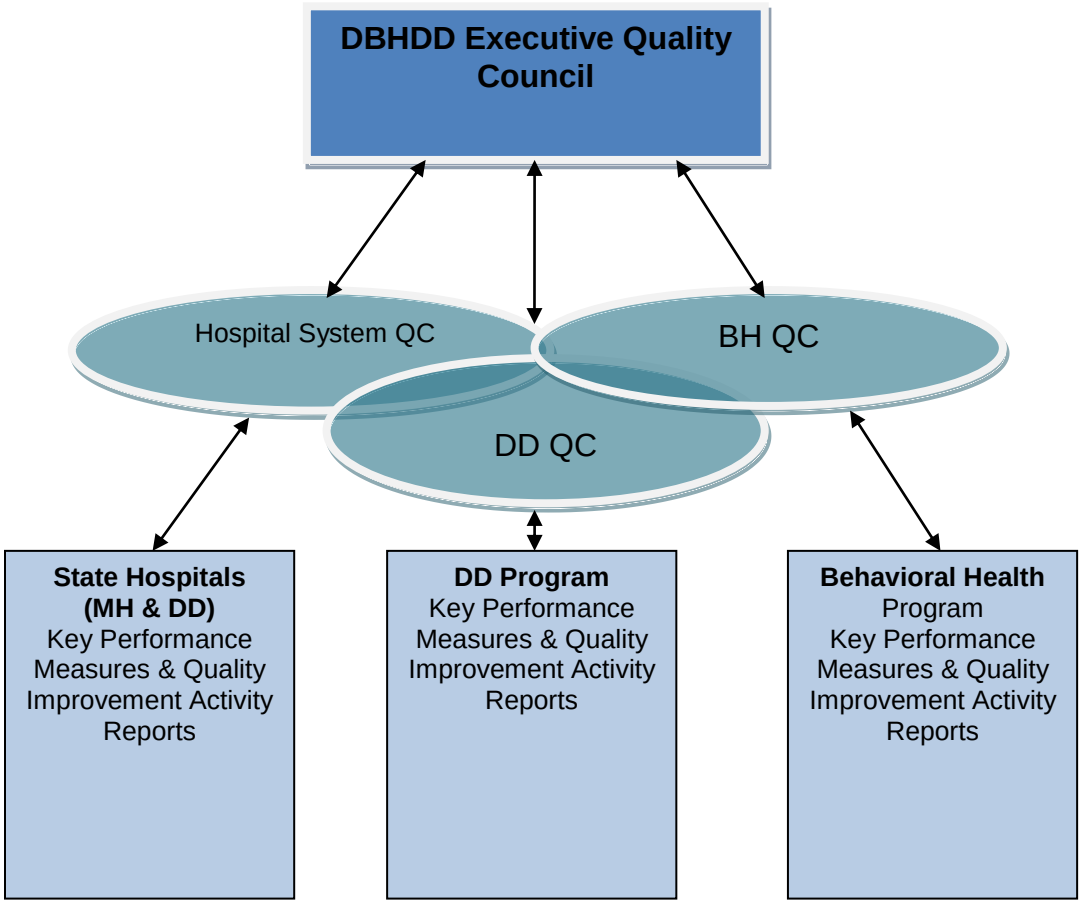
Appendix B

DBHDD Quality Structure



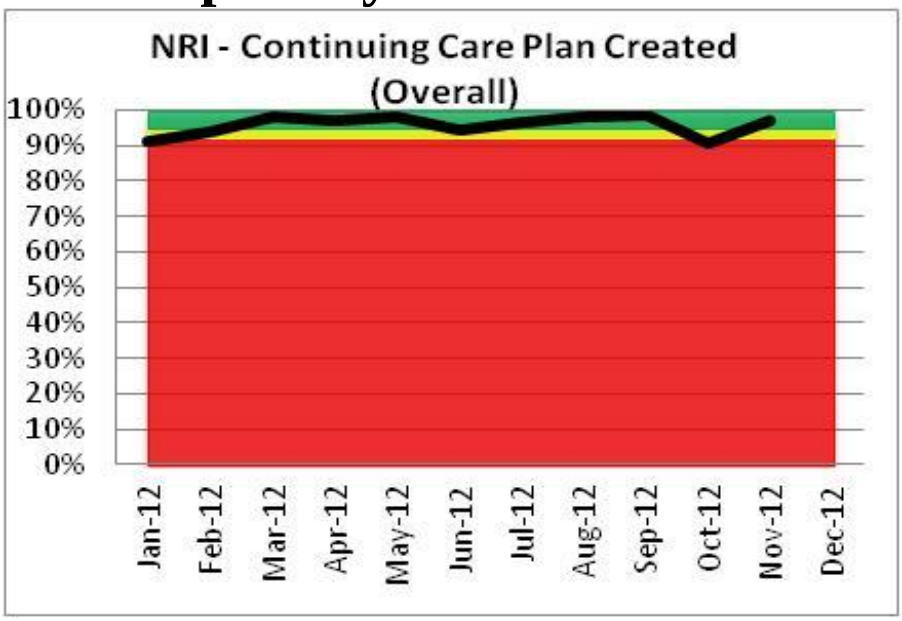
Appendix C

Quality Management System Structure



Appendix D

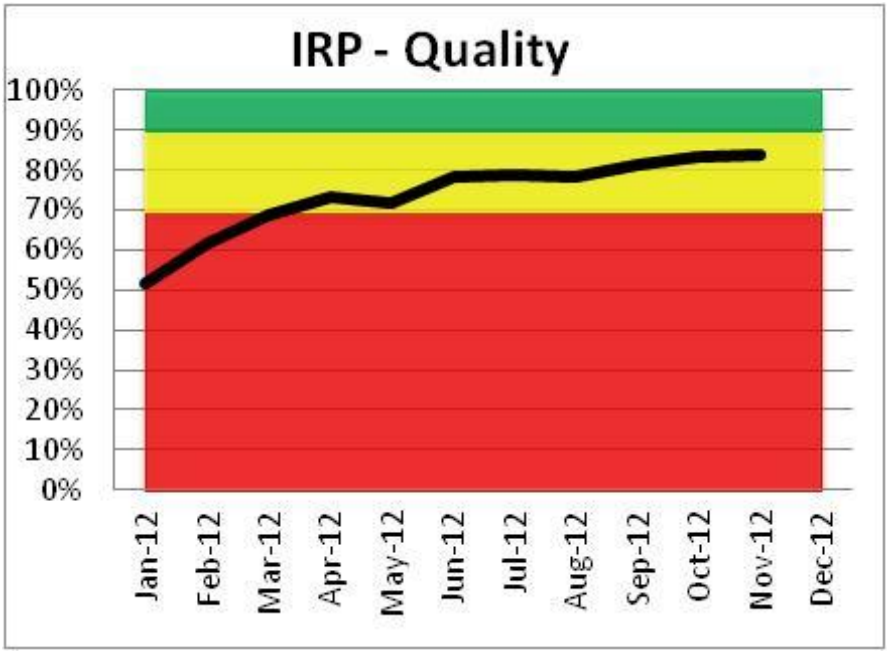
Hospital System Dashboard



NRI Continuing Care Plan Created--Overall	Numerator	Denominator	%
Jan-12	520	571	91%
Feb-12	541	575	94%
March-12	619	630	98%
April-12	543	559	97%
May-12	570	581	98%
June-12	527	559	94%
July-12	311	322	97%
Aug-12	343	350	98%
Sept-12	297	301	99%
Oct-12	253	279	91%
Nov-12	109	112	97%
Dec-12	520	571	91%

Appendix D

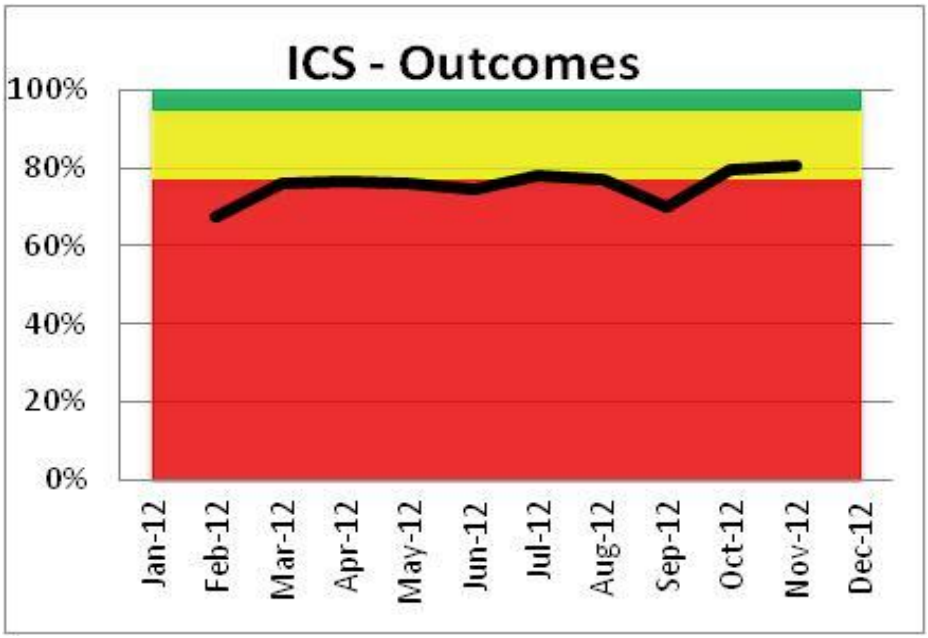
Hospital System Dashboard



IRP-Quality			
	Numerator	Denominator	%
Jan-12	1466	2833	52%
Feb-12	1846	2983	62%
March-12	2181	3168	69%
April-12	2538	3465	73%
May-12	1751	2433	72%
June-12	2175	2770	79%
July-12	2113	2687	79%
Aug-12	2234	2858	78%
Sept-12	2428	2986	81%
Oct-12	2065	2470	84%
Nov-12	1669	1988	84%
Dec-12	In Process	In Process	In Process

Appendix D

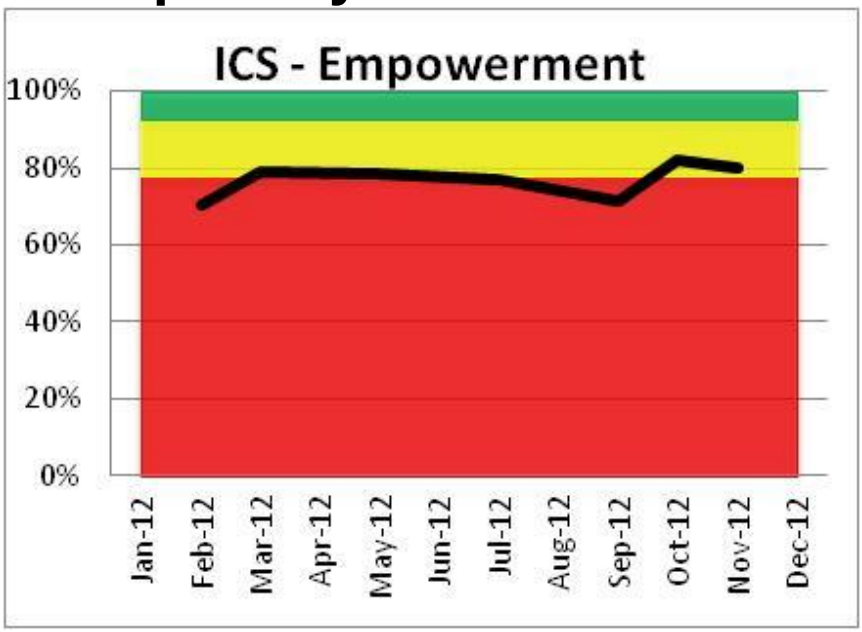
Hospital System Dashboard



Inpatient Consumer Survey-Outcomes	Numerator	Denominator	%
Jan-12	NA	NA	NA
Feb-12	132	195	68%
March-12	125	164	76%
April-12	116	152	76%
May-12	115	151	76%
June-12	156	209	75%
July-12	139	178	78%
Aug-12	97	126	77%
Sept-12	61	87	70%
Oct-12	70	88	80%
Nov-12	37	46	80%
Dec-12	In Process	In Process	In Process

Appendix D

Hospital System Dashboard



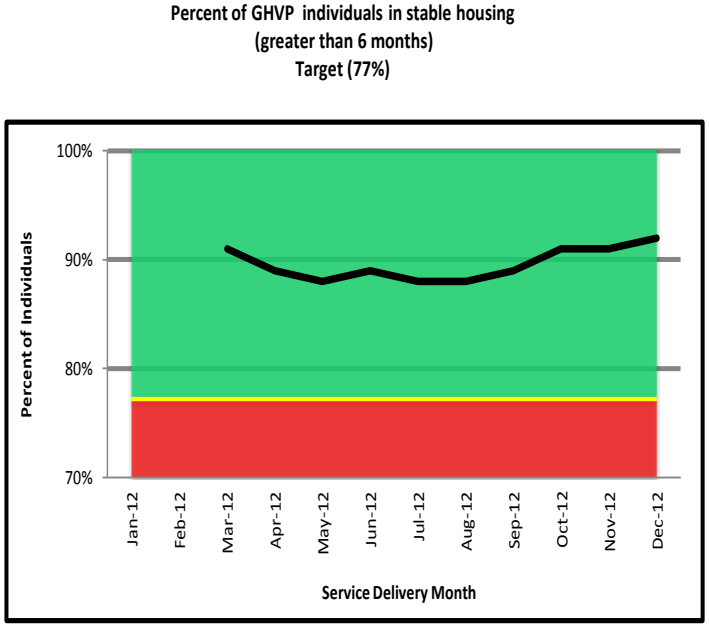
Inpatient Consumer Survey-Empowerment	Numerator	Denominator	%
Jan-12	NA	NA	NA
Feb-12	95	135	70%
March-12	89	113	79%
April-12	82	102	80%
May-12	117	149	79%
June-12	164	208	79%
July-12	136	177	77%
Aug-12	99	129	77%
Sept-12	62	87	71%
Oct-12	72	88	82%
Nov-12	36	45	80%
Dec-12	In Process	In Process	In Process

Appendix E

Community Behavioral Health Dashboard

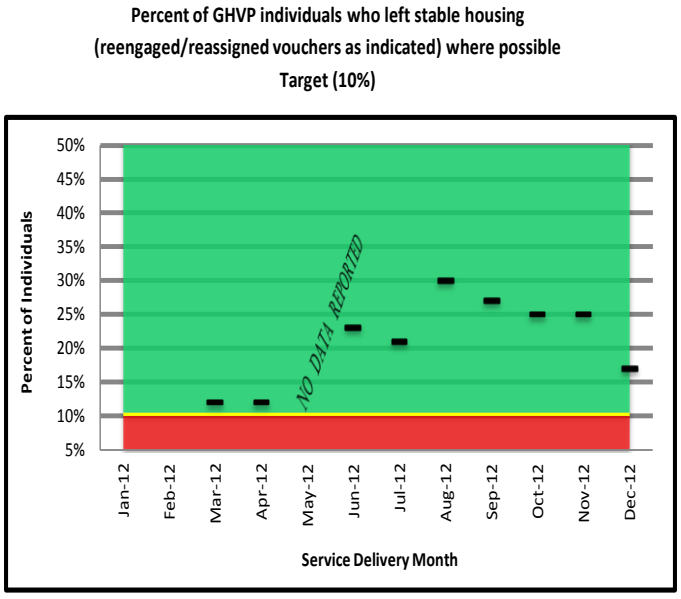
All Community Behavioral Health KPI data is specific to adult consumers. The statistical data contained within Appendix D is accurate as of 1/25/2013.

Housing Stability



% of GHVP individuals in stable housing > 6 months	Consumers		
	Numerator	Denominator	%
Jan-12	N/A	N/A	N/A
Feb-12	N/A	N/A	N/A
Mar-12	19	215	91%
Apr-12	23	205	89%
May-12	27	226	88%
Jun-12	27	243	89%
Jul-12	33	272	88%
Aug-12	38	313	88%
Sep-12	42	380	89%
Oct-12	42	468	91%
Nov-12	47	526	91%
Dec-12	47	583	92%

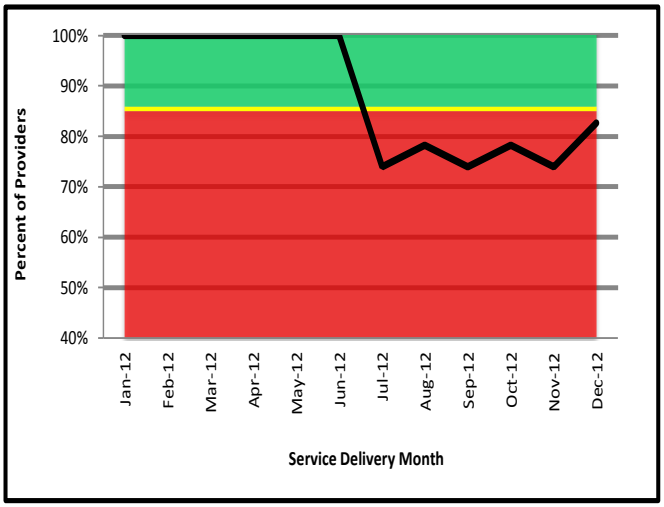
Housing Stability Con't



% of GHVP individuals who left stable housing reengaged/reassigned where possible	Consumers		
	Numerator	Denominator	%
Jan-12	N/A	N/A	N/A
Feb-12	N/A	N/A	N/A
Mar-12	N/A	N/A	12%
Apr-12	N/A	N/A	12%
May-12	N/A	N/A	N/A
Jun-12	7	31	23%
Jul-12	8	38	21%
Aug-12	14	47	30%
Sep-12	14	51	27%
Oct-12	16	55	27%
Nov-12	16	63	25%
Dec-12	15	90	17%

Supported Employment

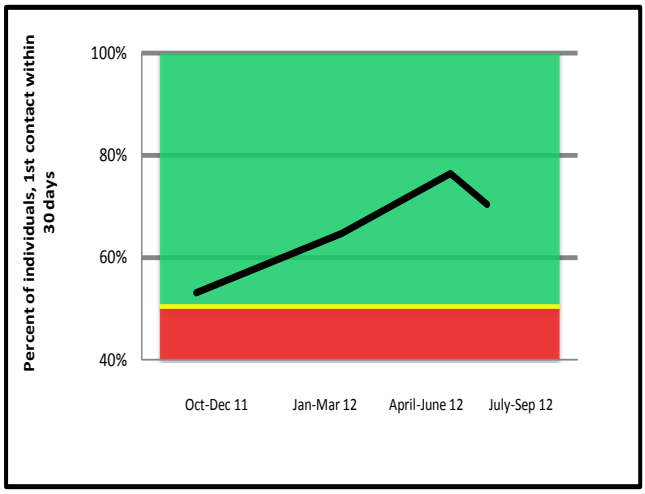
Percent of adult mental health S.E. providers that meet caseload average of staff to consumer
(ratio of 1:20)
Target (85%)



% of adult mental health S.E. providers that meet caseload average of staff to consumer ratio 1:20	Provider - Sites		
	Numerator	Denominator	%
Jan-12	3	3	100%
Feb-12	3	3	100%
Mar-12	3	3	100%
Apr-12	3	3	100%
May-12	3	3	100%
Jun-12	3	3	100%
Jul-12	17	23	73.9%
Aug-12	18	23	78.3%
Sep-12	17	23	73.9 %
Oct-12	18	23	78.3%
Nov-12	17	23	73.9%
Dec-12	19	23	82.6

Supported Employment Con't

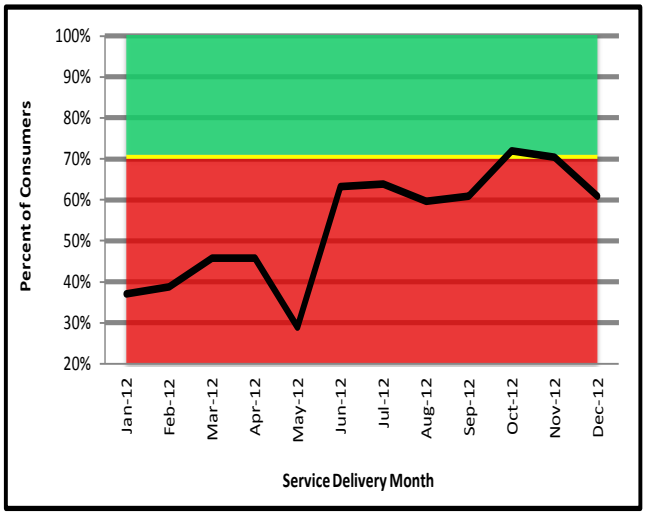
Unduplicated individuals 1st contact with an employer
(within 30 days of enrollment)
Target (50%)



% of unduplicated individuals 1st contact with an employer within 30 days of enrollment	Consumers		
	Numerator	Denominator	%
Oct-Dec 11	17	32	53.1%
Jan-Mar 12	55	85	64.7%
April-June 12	42	55	76.4%
July-Sep 12	100	142	70.4%

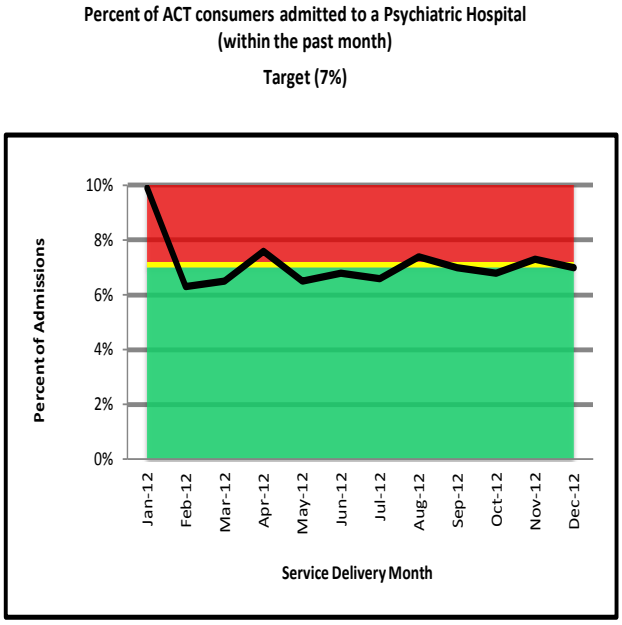
Assertive Community Treatment

The percent of ACT consumers who are enrolled within 3 days of referral
Target (70%)



% of ACT consumers enrolled within 3 days of referral	Consumers		
	Numerator	Denominator	%
Jan-12	27	73	37.0%
Feb-12	36	93	38.7%
Mar-12	43	94	45.7%
Apr-12	47	107	45.7%
May-12	33	114	28.9%
Jun-12	55	87	63.2%
Jul-12	69	108	63.9%
Aug-12	62	104	59.6%
Sep-12	56	92	60.9%
Oct-12	141	196	71.9%
Nov-12	157	223	70.4%
Dec-12	109	179	60.9%

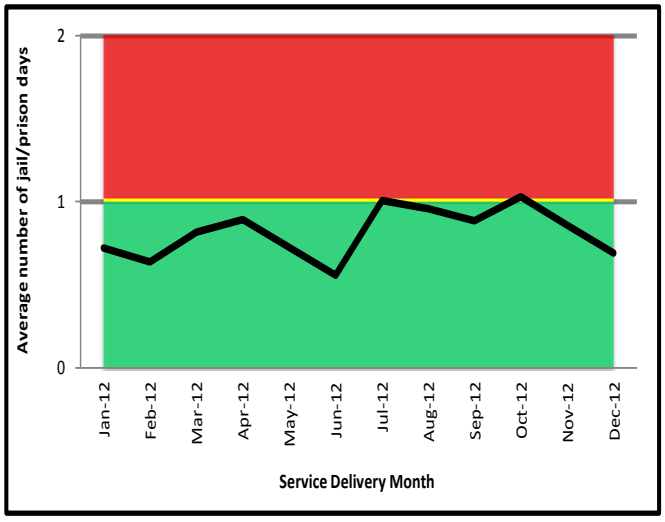
Assertive Community Treatment Con't



% of ACT consumers admitted to a Psychiatric hospital within the past month	Consumers		
	Numerator	Denominator	%
Jan-12	92	926	9.9%
Feb-12	65	1024	6.3%
Mar-12	73	1116	6.5%
Apr-12	89	1175	7.6%
May-12	80	1238	6.5%
Jun-12	87	275	6.8%
Jul-12	102	1771	6.6%
Aug-12	111	1699	7.4%
Sep-12	99	1405	7.0%
Oct-12	81	1191	6.8%
Nov-12	85	1170	7.3%
Dec-12	82	1169	7.0%

Assertive Community Treatment Con't

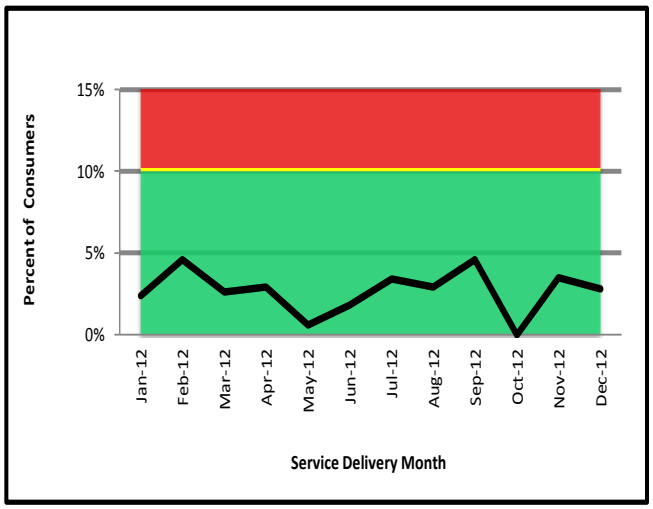
Average # of jail/prison days utilized
(per enrolled ACT consumer)
Target (1.0 days)



Average # of jail/prison days utilized per enrolled ACT consumer	Consumers		
	Numerator	Denominator	%
Jan-12	669	926	0.722
Feb-12	653	1024	0.638
Mar-12	910	1116	0.815
Apr-12	1050	1175	0.894
May-12	896	1238	0.724
Jun-12	713	1275	0.559
Jul-12	1786	1771	1.008
Aug-12	1624	1699	0.956
Sep-12	1459	1651	0.884
Oct-12	1605	1555	1.032
Nov-12	1435	1674	0.857
Dec-12	959	1387	0.691

Intensive Case Management

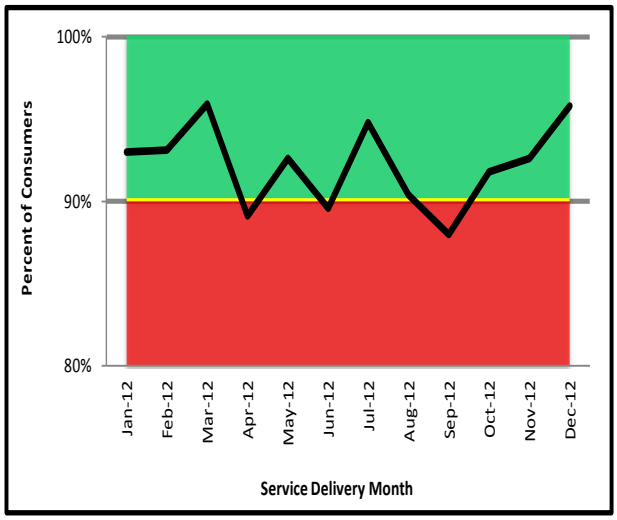
Percent of ICM consumers with a Psychiatric Inpatient Admission
(within the past month)
Target (10%) or less



% of ICM consumers with a Psychiatric inpatient admission within the past month	Consumers		
	Numerator	Denominator	%
Jan-12	N/A	N/A	2.4%
Feb-12	N/A	N/A	2.6%
Mar-12	5	192	2.6%
Apr-12	5	173	2.9%
May-12	1	157	0.6%
Jun-12	3	163	1.8%
Jul-12	5	102	3.4%
Aug-12	5	170	2.9%
Sep-12	10	217	4.6%
Oct-12	0	207	0.0%
Nov-12	8	231	3.5%
Dec-12	6	215	2.8%

Intensive Case Management Con't

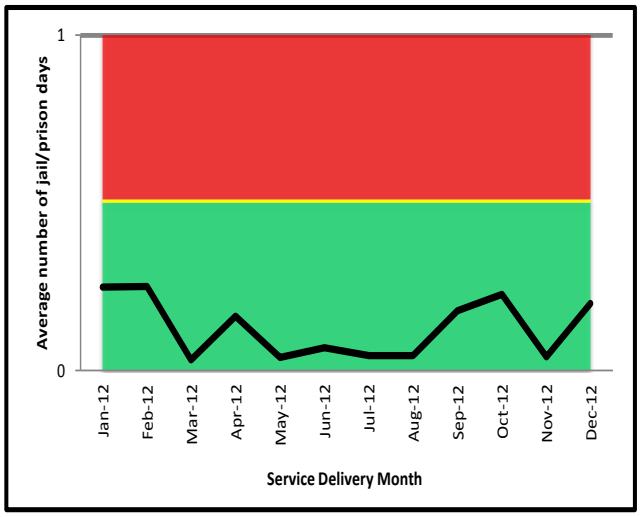
Percent of ICM consumers housed (non homeless)
(within the past month)
Target (90%)



% of ICM consumers housed (non homeless) within the past month	Consumers		
	Numerator	Denominator	%
Jan-12	172	185	93.0%
Feb-12	163	175	93.1%
Mar-12	165	172	95.9%
Apr-12	147	165	89.1%
May-12	144	155	92.6%
Jun-12	112	125	89.6%
Jul-12	147	155	94.8%
Aug-12	160	177	90.4%
Sep-12	191	217	88.0%
Oct-12	190	207	91.8%
Nov-12	214	231	92.6%
Dec-12	206	215	95.8%

Intensive Case Management Con't

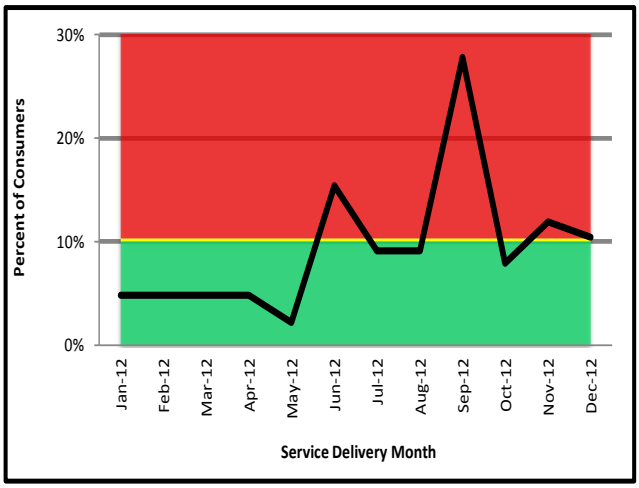
Average # of jail/prison days utilized
(per enrolled ICM consumer)
Target (0.50 days)



Average # of jail/prison days utilized per enrolled ICM consumer	Consumers		
	Numerator	Denominator	%
Jan-12	46	185	0.249
Feb-12	44	175	0.251
Mar-12	6	192	0.031
Apr-12	28	173	0.162
May-12	6	157	0.038
Jun-12	23	163	0.067
Jul-12	1	199	0.043
Aug-12	10	232	0.043
Sep-12	43	242	0.178
Oct-12	63	278	0.227
Nov-12	11	267	0.041
Dec-12	56	281	0.199

Community Support Teams

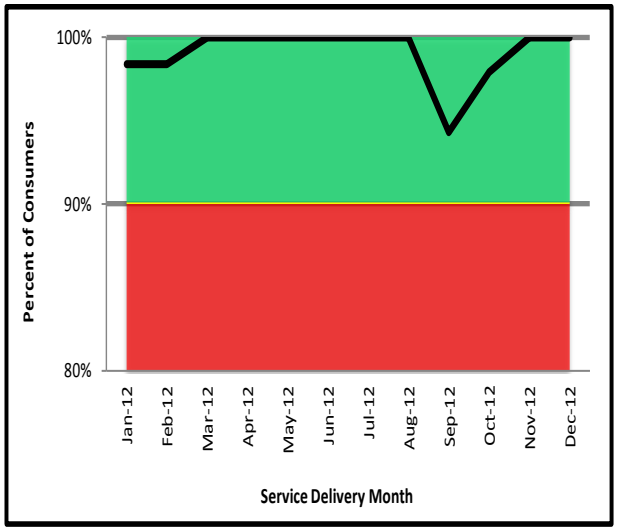
Percent of CST consumers with a Psychiatric Inpatient Admission
(within the past month)
Target (10%) or less



% of CST consumers with a Psychiatric inpatient admission within the past month	Consumers		
	Numerator	Denominator	%
Jan-12	N/A	N/A	4.8%
Feb-12	N/A	N/A	4.8%
Mar-12	3	62	4.8%
Apr-12	3	63	4.8%
May-12	1	45	2.2%
Jun-12	4	26	15.4%
Jul-12	1	11	9.1%
Aug-12	1	11	9.1%
Sep-12	5	18	27.8%
Oct-12	3	38	7.9%
Nov-12	5	42	11.9%
Dec-12	7	67	10.4%

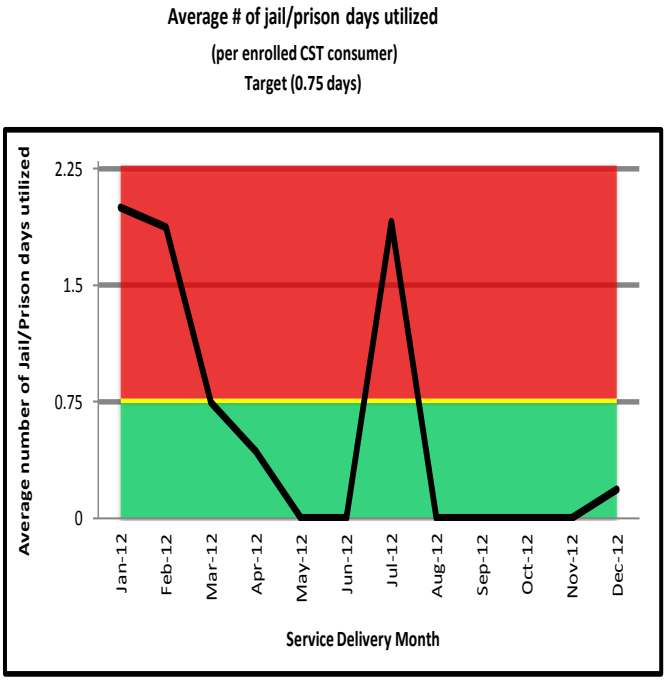
Community Support Teams Con't

Percent of CST consumers housed (non homeless)
(within the past month)
Target (90%)



% of CST consumers housed (non homeless) within the past month	Consumers		
	Numerator	Denominator	%
Jan-12	61	62	98.4%
Feb-12	61	62	98.4%
Mar-12	61	61	100.0%
Apr-12	44	44	100.0%
May-12	26	26	100.0%
Jun-12	24	24	100.0%
Jul-12	11	11	100.0%
Aug-12	18	18	100.0%
Sep-12	33	35	94.3%
Oct-12	47	48	97.9%
Nov-12	65	65	100%
Dec-12	75	75	100%

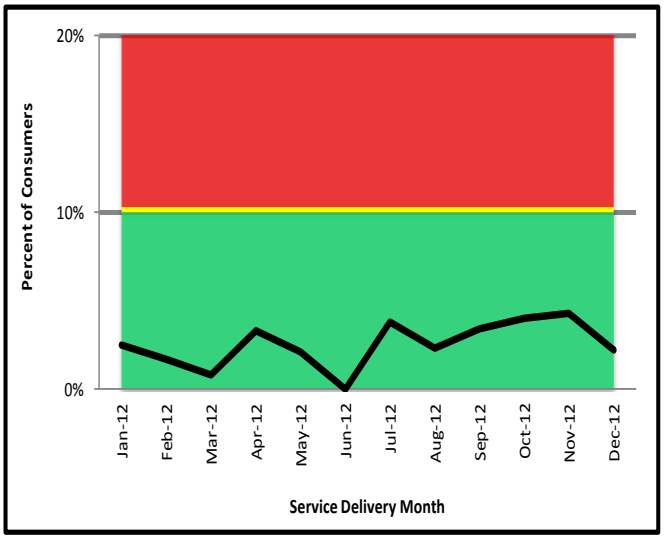
Community Support Teams Con't



Average # of jail/prison days utilized per enrolled CST consumer	Consumers		
	Numerator	Denominator	%
Jan-12	124	62	2.000
Feb-12	116	62	1.871
Mar-12	46	62	0.742
Apr-12	27	63	0.429
May-12	0	45	0.000
Jun-12	0	26	0.000
Jul-12	21	11	1.909
Aug-12	0	18	0.000
Sep-12	0	46	0.000
Oct-12	0	58	0.000
Nov-12	0	80	0.000
Dec-12	18	99	0.182

Case Management

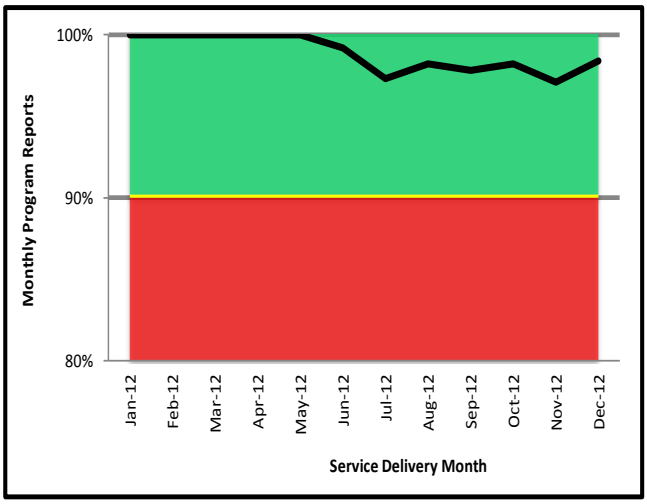
Percent of CM consumers with a Psychiatric Inpatient Admission
(within the past month)
Target (10%) or less



% of CM consumers with a Psychiatric inpatient admission within the past month	Consumers		
	Numerator	Denominator	%
Jan-12	N/A	N/A	2.5%
Feb-12	N/A	N/A	1.7%
Mar-12	1	129	0.8%
Apr-12	3	90	3.3%
May-12	3	141	2.1%
Jun-12	0	148	0.0%
Jul-12	5	132	3.8%
Aug-12	4	177	2.3%
Sep-12	8	238	3.4%
Oct-12	12	303	4.0%
Nov-12	15	347	4.3%
Dec-12	9	406	2.2%

Case Management Con't

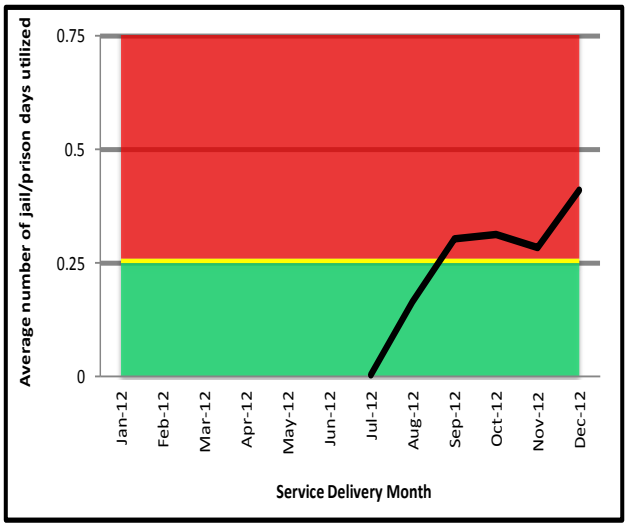
Percent of CM consumers housed (non homeless)
(within the past month)
Target (90%)



% of CM consumers housed (non homeless) within the past month	Consumers		
	Numerator	Denominator	%
Jan-12	84	84	100.0%
Feb-12	109	109	100.0%
Mar-12	128	128	100.0%
Apr-12	70	70	100.0%
May-12	130	130	100.0%
Jun-12	132	133	99.2%
Jul-12	183	188	97.3%
Aug-12	219	223	98.2%
Sep-12	263	269	97.8%
Oct-12	268	273	98.2%
Nov-12	404	416	97.1%
Dec-12	426	433	98.4%

Case Management Con't

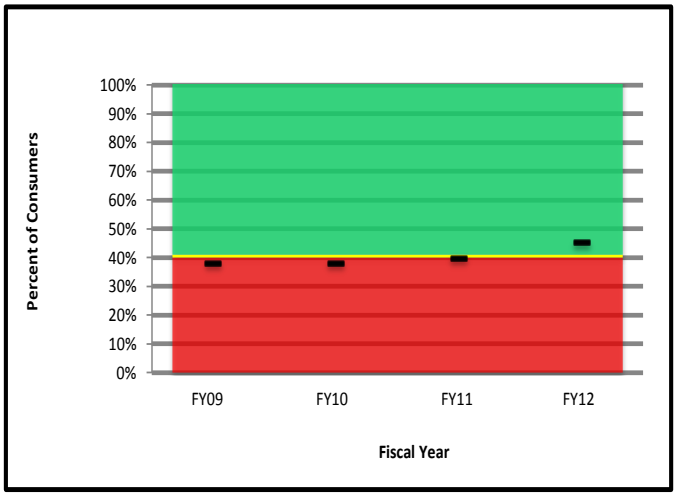
Average # of jail/prison days utilized
(per enrolled CM consumer)
Target (0.25 days)



Average # of jail/prison days utilized per enrolled CM consumer	Consumers		
	Numerator	Denominator	%
Jan-12	N/A	N/A	N/A
Feb-12	N/A	N/A	N/A
Mar-12	N/A	N/A	N/A
Apr-12	N/A	N/A	N/A
May-12	N/A	N/A	N/A
Jun-12	N/A	N/A	N/A
Jul-12	1	223	0.004
Aug-12	43	261	0.165
Sep-12	99	326	0.304
Oct-12	126	402	0.313
Nov-12	133	469	0.284
Dec-12	215	525	0.410

Addictive Disease

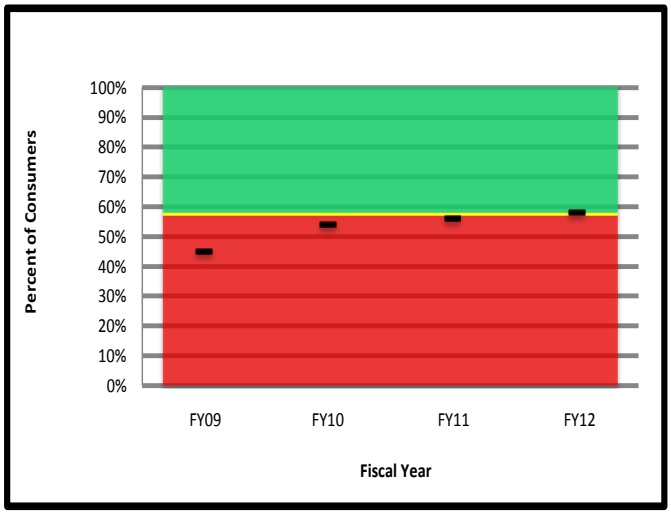
Percent of Adult consumers who abstain from use or experience reduction in use (while in treatment)
Target (40%)



% of adult consumers who abstain from use or experience reduction in use while in treatment	Consumers		
	Numerator	Denominator	%
FY 09	N/A	N/A	38.0%
FY 10	11,017	28,853	38.0%
FY 11	9,782	24,656	39.7%
FY 12	10,457	23,455	45.0%

Addictive Disease Con't

Percent of Youth consumers who abstain from use or experience reduction in use (while in treatment)
Target (56%)

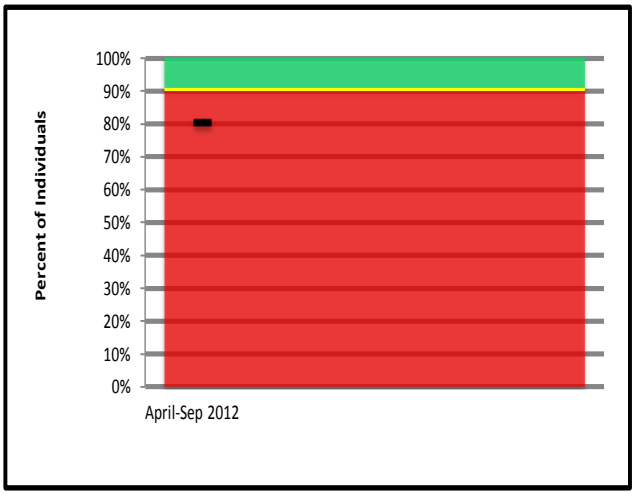


% of youth consumers who abstain from use or experience reduction in use while in treatment	Consumers		
	Numerator	Denominator	%
FY 09	N/A	N/A	45.0%
FY 10	716	1,334	54.0%
FY 11	595	1,067	56.0%
FY 12	329	571	58.0%

Customer Satisfaction Survey

Percent of individuals receiving ADA services and that are satisfied with the services they are receiving

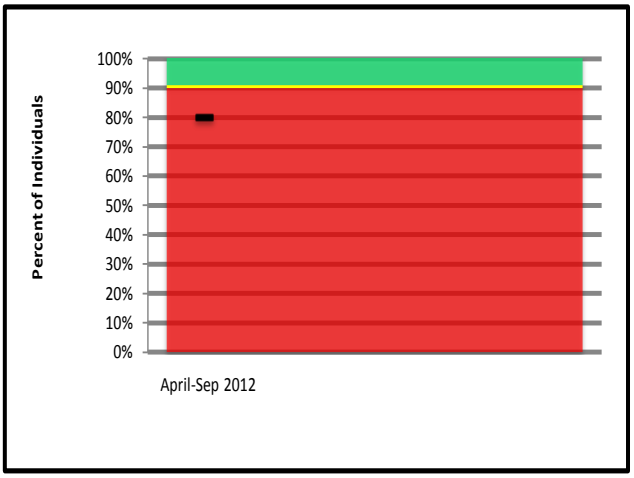
Target (90%)



% of individuals receiving ADA services and that are satisfied with the services they are receiving	Consumers		
	Numerator	Denominator	%
April-Sep 2012	40	51	80.4%
October-March 2012/2013	N/A	N/A	N/A

Customer Satisfaction Survey Con't

Percent of individuals receiving ADA services which feel their quality of life has improved as a result of services
Target (90%)

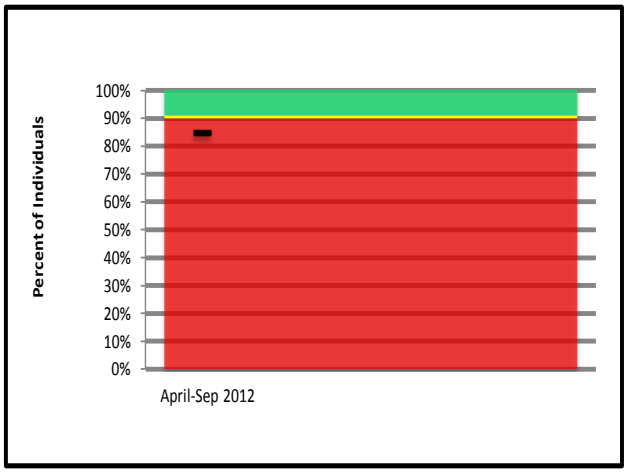


% of individuals receiving ADA services which feel their quality of life has improved as a result of services	Consumers		
	Numerator	Denominator	%
April-Sep 2012	40	50	80.0%
October-March 2012/2013	N/A	N/A	N/A

Customer Satisfaction Survey Con't

Percent of individuals receiving ADA services which feel the location of service is convenient for them

Target (90%)

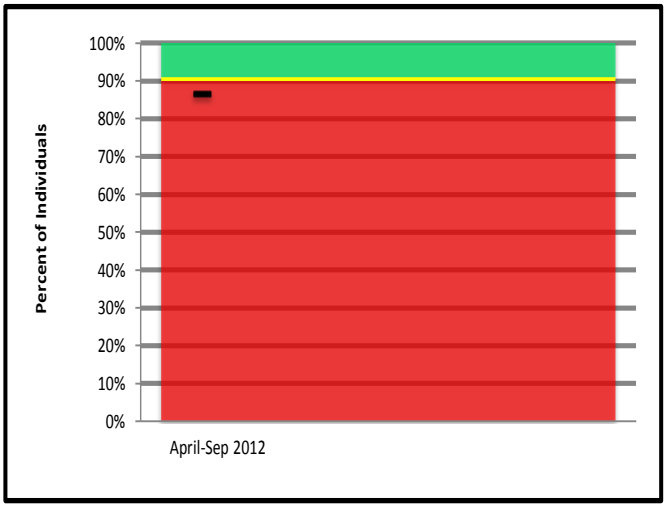


% of individuals receiving ADA services which feel the location of service is convenient for them	Consumers		
	Numerator	Denominator	%
April-Sep 2012	44	52	84.6%
October-March 2012/2013	N/A	N/A	N/A

Customer Satisfaction Survey Con't

Percent of individuals receiving ADA services which feel staff treats them with respect

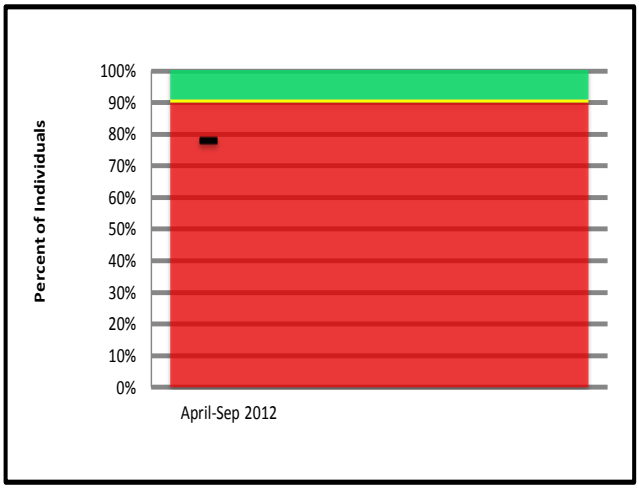
Target (90%)



% of individuals receiving ADA services which feel staff treats them with respect	Consumers		
	Numerator	Denominator	%
April-Sep 2012	45	52	86.5%
October-March 2012/2013	N/A	N/A	N/A

Customer Satisfaction Survey Con't

Percent of individuals receiving ADA services which state they regularly discuss goals with staff
Target (90%)



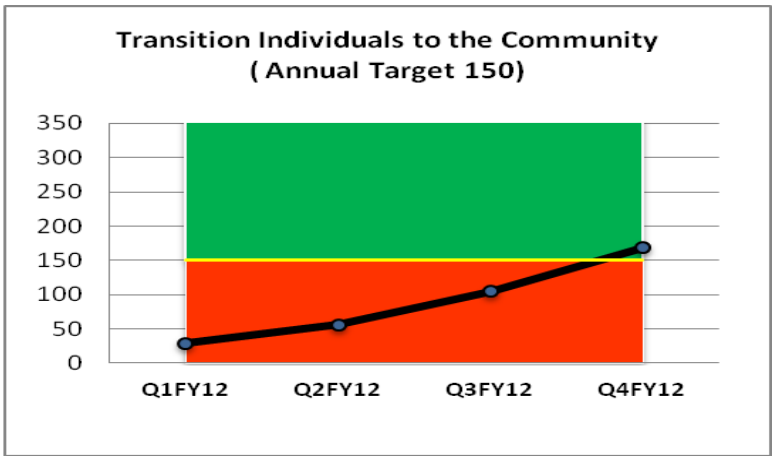
% of individuals receiving ADA services which state they regularly discuss goals with staff	Consumers		
	Nominator	Denominator	%
April-Sep 2012	39	50	78.0%
October-March 2012/2013	N/A	N/A	N/A

Appendix F

Community Developmental Disabilities Dashboard

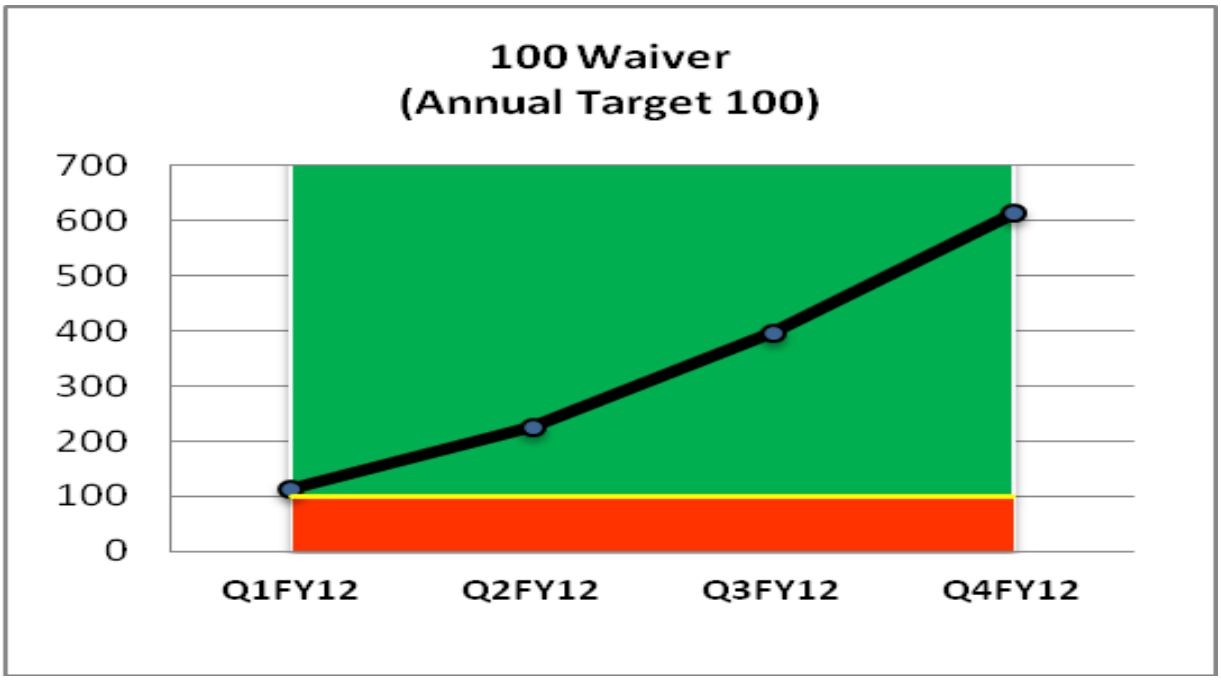
Data includes community consumers as well as the "target population".
Data is reported for State Fiscal Year 2012 (July 1, 2011 through June 30, 2012)

Number of Individuals Transitioned from a State Hospital to the Community



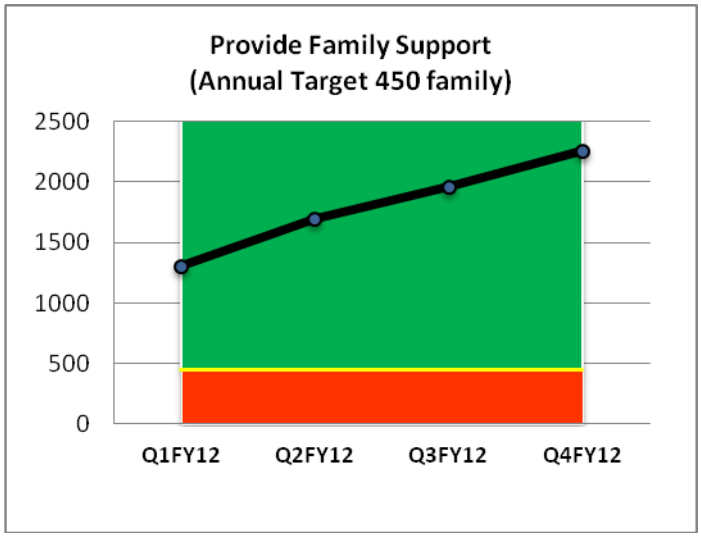
% of DD Transition Goal that was Met FY12 (Cumulative)	Consumers		
	Nominator	Denominator	%
July 1, 2011 through September 30, 2011	29	150	19.4%
July 1, 2011 through December 31, 2011	53	150	35.4%
July 1, 2011 through March 31, 2012	102	150	68%
July1, 2011 through June 30, 2012	165	150	100.1%

Number of Individuals already residing in the community newly enrolled in Waiver Services



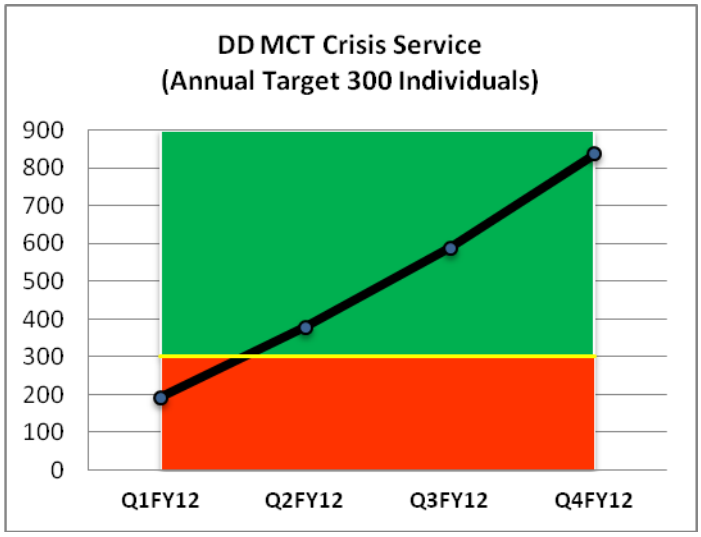
% of DD Community Waiver Goal that was Met FY12 (Cumulative)	Consumers		
	Nominator	Denominator	%
July 1, 2011 through September 30, 2011	100	100	100%
July 1, 2011 through December 31, 2011	200	100	200%
July 1, 2011 through March 31, 2012	490	100	490%
July1, 2011 through June 30, 2012	625	100	625%

Number of Families/Individuals Receiving Family Support Services



DD Family Support Goal that was Met FY12 (Cumulative)	Consumers	
	Nominator	Denominator
July 1, 2011 through September 30, 2011	2136	450
July 1, 2011 through December 31, 2011	2617	450
July 1, 2011 through March 31, 2012	2935	450
July1, 2011 through June 30, 2012	3287	450

Number of DD Mobile Crisis Team Dispatches



% of DD Mobile Crisis Team Dispatch Goal that was Met FY12 (Cumulative)	Consumers		
	Nominator	Denominator	%
July 1, 2011 through September 30, 2011	192	300	64%
July 1, 2011 through December 31, 2011	388	300	100.0%
July 1, 2011 through March 31, 2012	598	300	199.3%
July1, 2011 through June 30, 2012	825	300	275%

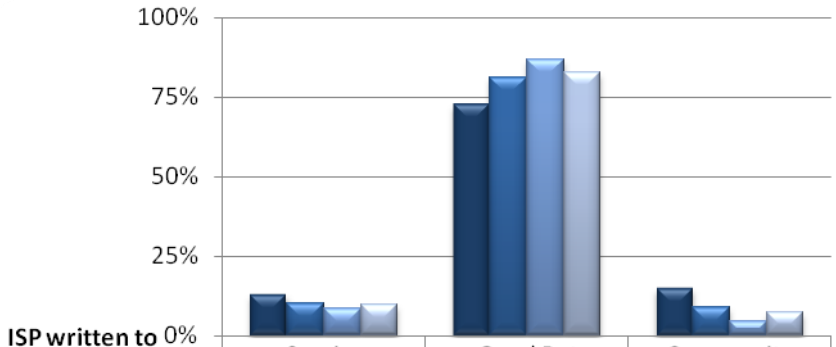
Appendix F

Individual Support Plans

The Individual Support Plan (ISP) Quality Assurance (QA) Checklist is used in both Person Center Reviews (PCR) and Quality Enhancement Provider Reviews (QEPR). The ISP QA Checklist was developed by the Division of Developmental Disabilities to assess support plans. When completing the checklist, Delmarva Quality Improvement Consultants (QICs) determine the extent to which support plans are written to help individuals maintain a life in their communities, as they indicate. An overall rating is given to each support plan reviewed by Delmarva Quality Improvement Consultants, based upon how well the support plan is written to provide a meaningful life for the individual receiving services. An ISP can be written to support a Service Life, a Good by Paid Life, or a Community Life. Criteria used on this rating are based on definitions from the Good-to-Great (G2G)/Person-Centered Organizations.

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 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 following tables and graphs show the distribution of the overall ratings by contract years.



ISP written to support	Service Life	Good But Paid Life	Community Life
Year 1 (1,283)	12.8%	72.4%	14.8%
Year 2 (1,260)	10.2%	81.0%	8.9%
Year 3 (1,160)	8.4%	86.9%	4.7%
Year 4 (961)	9.8%	82.7%	7.5%