State of Georgia

Review of Supported Employment Services

Under the United States v. Georgia Settlement Agreement

and the

Findings from the State Health Authority Yardstick

Requested by Elizabeth Jones, Independent Reviewer

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United States v. Georgia Settlement Agreement

The reviewer was asked to advise again whether the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) has met the requirements of the Settlement Agreement regarding the provision of Supported Employment programs, and then to evaluate the quality of these services by completing a State Health Authority Yardstick (SHAY) review. The Settlement Agreement section on Supported Employment contains the following language:

> "Supported Employment
> i. Supported Employment will be operated according to an evidence-based supported employment model, and it will be assessed by an established fidelity scale such as the scale included in the Substance Abuse and Mental Health Administration ("SAMHSA") supported employment tool kit.
> ii. Enrollment in congregate programs shall not constitute Supported Employment.
> iii. Pursuant to the following schedule…
>
> (E) By July 1, 2015, the State shall provide Supported Employment services to 550 individuals with SPMI."

While it is beyond the scope of the work of this reviewer to check the validity and the reliability of the specific data provided by DBHDD, the data presented from DBHDD and the information confirmed by a variety of stakeholders (including providers) who were interviewed do indicate that DBHDD is in compliance with the Supported Employment provisions of the Settlement Agreement.

As of June 1, 2015, there were 1,270 individuals receiving Supported Employment services, with in excess of 550 identified individuals receiving SE who met the ADA criteria, based on the document received from DBHDD titled "Supported Employment (SE) (Supplemental Information-7/30/15)."

According to data received from Dr. Timberlake, the monthly rate of employment was 51.5 percent across Supported Employment programs in May 2015. It is worth noting that 51.5 percent employment represents a slight increase in the employment rate from last year and it constitutes a reasonable and appropriate rate for people in Supported Employment services.

The SHAY, which was focused on the supported employment “slots” under the Settlement Agreement, may be viewed as an instrument to measure the extent and quality of that compliance.

SHAY Executive Summary

This document provides a summary of the status of the work that has been done by DBHDD regarding the implementation and dissemination of evidence based Supported Employment (SE) services for adults with severe mental illness (SMI) in the State of Georgia. This is the fifth annual SHAY report that has been completed at the request of Elizabeth Jones, Independent Reviewer. The last SHAY report was completed in September 2014.

SHAY Introduction

The State Health Authority Yardstick (SHAY) was designed by a group of mental health researchers and implementers who were interested in assessing the facilitating conditions for the adoption of Evidence-Based Practices (EBPs) created by a state's health or mental health authority.

The reviewer spent three days in July 2015, specifically; July 06, 07 and 08, reviewing documentation, including: agency fidelity reports, monthly programmatic data for SE programs, SE coalition meeting notes, training documents, fidelity outcomes summary, technical assistance and consultation reports, as well as report summaries from an independent SE consultant. During the three days in July 2015, the reviewer also attended meetings with and interviewed a variety of stakeholders in the State of Georgia. The July 2015 interviews and meetings in Georgia included: staff from DBHDD, providers of SE services for adults with mental illness, family members, consumers participating in Supported Employment services, as well as representatives from consumer and family advocacy organizations and other mental health advocates.

Of particular note, the reviewer also was able to meet in person with Commissioner Frank Berry and Deputy Commissioner Judith Fitzgerald during the July 2015 visit. In addition to the July 2015 visit, the reviewer made one interim visit to Georgia in October 2014.

The reviewer was asked to assess the extent to which policies, procedures and practices are present in Georgia regarding SE services. Evidence-based Supported Employment is a Substance Abuse and Mental Health Services (SAMHSA) recognized practice that has been repeatedly demonstrated to be the most effective means to help adults with SMI to obtain and retain competitive employment as part of their recovery process.

The reviewer is grateful for the warm and friendly professional courtesies that have been kindly extended by the leadership and staff at DBHDD for all of the visits and communications

that have occurred over the past year. The reviewer also appreciates the open and frank discussions that occurred at several levels of the Georgia DBHDD system regarding evidence-based Supported Employment services over the same time frame.

The SHAY is a tool for assessing the state health or mental health authority responsible for mental health policy and Medicaid policies in a state. As with the previous report, the scope (or unit of analysis) for the SHAY is focused on the SE ("ADA" or "DOJ") slots defined by the "Settlement Agreement." The SHAY examines the policies, procedures and actions that are currently in place within a state system, or in this case, part of the state system. The SHAY does not incorporate planned activities; rather it focuses exclusively on what has been accomplished and what is currently occurring within a state. For the purposes of this, DBHDD has been identified as the "State Mental Health Authority (SMHA)." This report details the findings from information gathered in each of fifteen separate items contained in the SHAY. For each item, the report includes a brief description of the item and identifies the scoring criteria. Each item is scored on a numerical scale ranging from "five" being fully implemented to a "one" designating substantial deficits in implementation. Recommendations for improvement also are included with each item. A summary table for the scoring of the SHAY items is contained at the end of the report.

SHAY Findings

1. EBP Plan

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

Narrative

DBHDD developed a well-written document, "2013 Georgia Department of Health and Developmental Disabilities Supported Employment Strategic Plan," that provides a well-described framework for the implementation of Supported Employment services in the State of Georgia. While DBHDD has completed the development of a formal written SE plan, the current strong concerns raised by SE providers across the state warrants revisiting the same recommendation provided in this section last year.

> "Given the approaching end of the "Settlement Agreement," it is strongly recommended that DBHDD leadership develop a concise SE plan that focuses exclusively on sustaining the progress that the Department and its partners have made in the development of SE services and the infrastructure to support those services. This plan should describe all efforts and strategies underway to diversify and secure funding for SE providers after the completion of the "Settlement Agreement" as well as other activities at the state-level to secure and develop strategic partnerships with agencies like the Georgia Vocational Rehabilitation Agency."

2. Financing: Adequacy

Is the funding model for the EBP adequate to cover costs, including direct service, supervision, and reasonable overhead? Are all EBP sites funded at the same level? Do sites have adequate funding so that practice pays for itself?

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

Narrative

For the purposes of the Settlement Agreement, funding for the designated SE slots (sometimes referred to as "ADA (Americans with Disabilities Act) slots") remains fixed at the same rate of $410.00 per slot for each provider. This rate has remained unchanged since the beginning of the Settlement Agreement.

Unlike most SE systems, this funding is "slot-specific" and not specific to individual clients in SE services or tied to SE landmarks or outcomes. Enrollment in the designated SE slots is defined in the Settlement Agreement:

> The target population for the community services described in this Section (III.B) shall be approximately 9,000 individuals by July 1, 2015, with SPMI who are currently being served in the State Hospitals, who are frequently readmitted to the State Hospitals, who are frequently seen in Emergency Rooms, who are chronically homeless, and/or who are being released from jails or prisons.
>
> b. Individuals with serious and persistent mental illness and forensic status shall be included in the target population, if the relevant court finds that community service is appropriate.

The most prominent concern among SE providers remains, specifically, that payments for SE services will be radically reduced at cessation of the Settlement Agreement. As one SE provider stated, “We are all waiting to see if we still have jobs ourselves after the Settlement Agreement ends.”

Another area of prominent concern for SE providers is how the new VR funding will be merged with other State funds to provide financial stability for SE services after the Settlement Agreement is completed.

Additionally, SE providers continue to express anxiety and angst with the ongoing attempts by DBHDD to implement Task Oriented Rehabilitation Services (TORS) as another funding mechanism for SE services. Providers state they have received little technical support and few answers to concerns that using TORS funding via Medicaid will create significant documentation complications as well as a requirement to “focus on diagnosis and symptoms rather than strengths and abilities which is what Supported Employment is supposed to be about,” as one provider stated. Another provider stated, “The Medicaid requirements will be so different that the only way we will be able to provide SE services and bill Medicaid is to hire specific different employment specialists.” It appears the fears and concerns about the use of TORS as a funding mechanism is even stronger this year than last year.

Once again, it is recommended that DBHDD consider developing a written post-settlement SE document that describes the planned funding integration methods. It is also recommended that DBHDD continue its existing outreach efforts to engage SE providers in a hearty dialogue about TORS funding and SE services.

3. Financing: Start-Up & Conversion Costs

Are costs of start up and or conversion covered, including: 1) Lost productivity for staff training, 2) hiring staff before clients enrolled (e.g. ACT), 3) any costs associated with agency planning and meetings, 4) changing medical records if necessary, 5) computer hardware and/or software if necessary, etc.

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

Narrative

DBHDD has continued to add more new SE slots in the past year for providers. To their credit, DBHDD leadership has worked with new SE providers by creating access to some training and consultation activities. DBHDD leadership has verbally expressed a commitment to review any written requests from new SE providers regarding potential financial resources for starting SE services.

4. Training: Ongoing consultation and technical support

Is there ongoing training, supervision and consultation for the program leader and clinical staff to support implementation of the EBP and clinical skills:

Present	1) Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training)
Present	2) Initial agency consultation re: implementation strategies, policies and procedures, etc. (e.g. 1 - 3 meetings with leadership prior to implementation or during initial training)
Present	3) Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (minimum of 3 months, e.g. monthly x 12 months)
Present	4) On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months)
Present	5) Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (minimum of 3 months, e.g. monthly X 12 months)
	No components covered

Narrative

DBHDD has continued their SE training and consultation agreement with the Institute on Human Development and Disability at the University of Georgia. The training has provided specific modules for SE staff who have experience with the practice and for staff who are new to SE services and have had little to no previous training. The training continues to rely heavily on the use of webinars as the primary source of training. While this is an important ingredient, it is not sufficient by itself to help SE provider staff to learn all the skills necessary for high quality SE services.

Staff from several SE programs commented on the current level of training and consultation being provided by DBHDD in collaboration with Doug Crandall and the University of Georgia; some described the training as extremely helpful. Several people described the current model as “being quite effective.” Others commented that the level and quality of the training being provided “Started out good and has been getting better.”

Numerous SE providers cited the training and consultation that they received from Ms. Meka McNeal, an independent SE trainer and consultant from Maryland who has been contracted by GA DBHDD to provide onsite consultation and training to SE sites, as being an excellent resource to help them improve their SE programs.

5. Training: Quality

Is high quality training delivered to each site? High quality training should include the following:	
Present	1) Credible and expert trainer
Present	2) Active learning strategies (e.g. role play, group work, feedback
Present	3) Good quality manual, e.g. SAMHSA Toolkit
Present	4) Comprehensively addresses all elements of the EBP
Present	5) Modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered
Present	6) High quality teaching aides/materials including workbooks/work sheets, slides, videos, handouts, etc., e.g. SAMHSA Toolkit

Narrative

DBHDD has continued their ongoing training relationship with the Institute on Human Development and Disability at the University of Georgia. One frequently praised change in the delivery of training resources includes the opportunity for SE programs with good fidelity scores to act as shadow or demonstration sites for other SE programs. DBHDD has worked diligently to become a partner in the training process for staff at SE provider agencies across the state. Maintaining the quality and consistency of the training resources will play an important role in sustaining good employment outcomes from SE programs.

6. Training: Infrastructure / Sustainability

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

Present	1) Offers skills training in the EBP
Present	2) Offers ongoing supervision and consultation to clinicians to support implementation in new sites
Present	3) Offer ongoing consultation and training for program EBP leaders to support their role as clinical supervisors and leaders of the EBP
	4) Build site capacity to train and supervise their own staff in the EBP
Present	5) Offers technical assistance and booster trainings in existing EBP sites as needed
Present	6) Expansion plan beyond currently identified EBP sites
Present	7) One or more identified model programs with documented high fidelity that offer shadowing opportunities for new programs
Present	8) SMHA commitment to sustain mechanism (e.g. center of excellence, university contracts) for foreseeable future, and a method for funding has been identified
	No components covered

Narrative

As previously recognized, DBHDD has made some enhancements regarding the provision of SE trainings and consultation services for SE providers in the state. The continuation of these training resources will be critical to the sustainability of good quality SE services for the citizens of Georgia. One part of the sustainability for training that would benefit from some investment is the area of developing provider agencies' own ability to train staff to provide SE services. Some states have developed "train-the-trainer" programs where designated provider agency staff are trained on how to train their own new staff to provide good quality SE services.

7. Training: Penetration

What percent of sites have been provided high quality training

(Defined as having a score of "3 or higher" on item #4. Training: Ongoing consultation and technical support)

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

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

	1. 0 – 20 %
	2. 20 – 40%
	3. 40 – 60%
	4. 60 – 80%
Present	5. 80 – 100%

Narrative

DBHDD has dedicated funds and developed important local resources in order to provide SE trainings to provider agencies in their communities. All providers agree they have access to good basic SE training now, thanks to the work done at DBHDD and in partnership with the Institute on Human Development and Disability at the University of Georgia.

8. SMHA Leadership: Commissioner Level

Commissioner is perceived as a effective leader (influence, authority, persistence, knows how to get things done) concerning EBP implementation who has established EBPs among the top priorities of the SMHA as manifested by:

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

Narrative

The Commissioner of the Georgia Department of Behavioral Health and Developmental Disabilities is Frank Berry who, along with Chief of Staff Judith Fitzgerald, was interviewed in person during the review. Nearly all stakeholders describe Commissioner Berry as a leader, "Who talks about Supported Employment and Recovery every chance he gets." Some SE providers cited recent visits to their agencies by the Commissioner as being very supportive.

9. SMHA Leadership: Central Office EBP Leader

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

Narrative

DBHDD has worked to develop better communication, collaboration and leadership regarding Supported Employment services in Georgia over the past few years. During that time, Mr. Vernell Jones has developed a sound reputation in the community as the Central Office SE Leader. One staff member from an SE provider seemed to speak for many when she described Mr. Jones as, “very approachable, accessible and always responds when asked for something.”

Providers were also clear that they now have a variety of resources they can contact regarding SE services, including Dr. Timberlake and staff from the Regional Offices. Several agencies described receiving good consultation and supports for SE services from DBHDD staff at their local Regional Offices.

10. Policy and Regulations: Non SMHA State Agencies

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

Examples of supporting policies:

- Medicaid agency provides reimbursement for the EBP (If Medicaid not under the SMHA)
- The state's vocational rehabilitation agency pays for supported employment programs

Examples of policies that create barriers:

- Medicaid agency excludes EBP, or critical component, e.g. disallows any services delivered in the community (If Medicaid agency not under the SMHA)
- State vocational rehabilitation agency does not allow all clients looking for work access to services, or prohibits delivery of other aspects of the supported employment model

	Virtually all policies and regulations impacting the EBP serve as barriers
	On balance, policies that create barriers outweigh policies that support/promote the EBP
	Policies that support/promote the EBP are approximately equally balanced by policies that create barriers
	On balance, policies that support/promote the EBP outweigh policies that create barriers
Present	Virtually all policies and regulations impacting the EBP support/promote the EBP

Narrative

The Georgia Department of Behavioral Health and Developmental Disabilities and the Georgia Vocational Rehabilitation Agency (GVRA) have developed a positive collaboration over the past two years. Through their work together, they have signed and implemented a Memorandum of Understanding (MOU) regarding how SE services can partner with Vocational Rehabilitation services. They piloted the MOU to work out the implementation of this process in two sites and took the lessons learned from the pilot statewide. They have also been able to identify fourteen local Vocational Rehabilitation Counselors who are considered liaisons to SE programs and have received shared training with SE providers.

Leadership at GVRA appears genuinely passionate and excited regarding providing collaborative employment services to some of Georgia's must vulnerable citizens.

The collaborative partnership, and the resulting changes in shared services with GVRA, received praise from all stakeholders in Georgia.

Several providers described some differences in how their partnership is being rolled out on the ground level. However, the most pronounced concern was the lack of such identified liaisons at other GVRA offices across the state. Many providers commented that they serve several counties and have only one county where the local GVRA office has an SE liaison. Providers nearly universally described their concern that the improved collaboration and partnership has not spread beyond the fourteen offices with designated SE liaisons. As one SE provider stated, "We have made some significant progress, but it is time for another SE and VR roundtable discussion."

11. Policies and Regulations: SMHA

The SMHA has reviewed its own regulations, policies and procedures to identify and remove or mitigate any barriers to EBP implementation, and has introduced new key regulations as necessary to support and promote the EBP. Examples of supporting policies: • SMHA ties EBP delivery to contracts • SMHA ties EBP to licensing/ certification/ regulation • SMHA develops EBP standards consistent with the EBP model • SMHA develops clinical guidelines or fiscal model designed to support model EBP implementation Examples of policies that create barriers: • SMHA licensing/ certification/ regulations directly interfere with programs ability to implement EBP

Present

Score:

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

Narrative

DBHDD previously incorporated language into their contracting procedures that Supported Employment providers are required to provide SE services consistent with the description of evidence-based Supported Employment in the SAMHSA toolkits as well as most of the identified principles of evidence-based Supported Employment services.

As previously described, many providers are concerned about how the use of TORS funding will affect SE services. A number of SE providers voiced concerns about this becoming a significant SE policy barrier.

12. Policies and Regulations: SMHA EBP Program Standards

The SMHA has developed and implemented EBP standards consistent with the EBP model with the following components:	
Present	1) Explicit EBP program standards and expectations, consonant with all EBP principles and fidelity components, for delivery of EBP services
Present	2) SMHA has incorporated EBP standards into contracts, criteria for grant awards, licensing, certification, accreditation processes and/or other mechanisms
Present	3) Monitors whether EBP standards have been met
Present	4) Defines explicit consequences if EBP standards not met (e.g. contracts require delivery of model supported employment services, and contract penalties or non-renewal if standards not met; or licensing/accreditation standards if not met result in consequences for program license.)

Narrative

As stated previously, DBHDD has included language in provider contracts that specifies that SE services will be consistent with the principles of evidence-based Supported Employment services as described in the SAMHSA Supported Employment toolkit. This information is shared with SE providers at some of the Supported Employment Coalition Meetings that occur in the State regularly.

11. Quality Improvement: Fidelity Assessment

There is a system in place for conducting ongoing fidelity reviews by trained reviewers characterized by the following components:

Present	1) EBP fidelity (or functional equivalent designed to assess adherence to all critical components of the EBP model) is measured at defined intervals
Present	2) GOI fidelity (or functional equivalent designed to assess adherence to all critical components required to implement and sustain delivery of EBP) is measured at defined intervals
Present	3) Fidelity assessment is measured independent – i.e. not assessed by program itself, but by SMHA or contracted agency
Present	4) Fidelity is measured a minimum of annually
Present	5) Fidelity performance data is given to programs and used for purposes of quality improvement
Present	6) Fidelity performance data is reviewed by the SMHA +/- local MHA
Present	7) The SMHA routinely uses fidelity performance data for purposes of quality improvement, to identify and response to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.)
Present	8) The fidelity performance data is made public (e.g. website, published in newspaper, etc.)
	No components covered

Narrative

Over the past few years, DBHDD has identified, recruited and trained a small group of staff to provide fidelity reviews for SE providers across the State. During that time, the fidelity team worked to improve provider relationships during the review process and to approach fidelity reviews as a collaborative quality improvement process. During the past year, there have been some changes in staffing and in how fidelity reviews were provided at a few agencies.

When asked about fidelity reviews in the past year, SE providers noted some changes in how the reviews are being conducted. Several providers, who had been very positive regarding

last year's fidelity reviews, stated there was a significant change in the tone and manner in which reviews were completed at agencies. A number of SE providers commented on the conduct of the DBHDD reviewers. Many agencies reported comments from reviewers about their needing to leave agencies early and not completing the review thoroughly. As one provider stated, "I spend days pulling together information and scheduling for the review and they (reviewers) were more worried about their commute home than about assessing the quality of our program." Staff from other agencies echoed the same comments and concerns. Additionally some programs also stated the reviewers have returned to conducting the review more in audit fashion. Several people experienced the reviewers as having the "we got you" approach to reviews rather than the collaborative approach that has characterized reviews in the past two years.

On the other hand, some agencies reported their reviews were much like last year in that they were, as described by one SE supervisor, "Very fair and consistent. The reviewers at our agency were very open with us and receptive, they took lots of time with us to do the review."

A handful of agencies were given the opportunity to participate in "desktop" reviews where the fidelity reviewers were off-site and gathered information via web-based video meetings and other electronic means. The agencies that experienced these reviews found them to be less intrusive and a much less complicated process. It will be important for DBHDD to carefully watch outcomes at agencies where a desktop review is permitted to ensure the desktop reviews are capturing all the critical quality improvement information for SE services.

Given the significantly increased concerns and comments regarding the DBHDD SE fidelity review process, it is worth revisiting the recommendation made in this section in 2014:

> In order to maintain the successful progress that has been made to integrate fidelity measures into the DBHDD system, it is vital for DBHDD leadership to find ways to address and remediate these provider concerns and questions regarding SE fidelity.

14. Quality Improvement: Client Outcomes

A mechanism is in place for collecting and using client outcome data characterized by the following:

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

Narrative

DBHDD has made some progress in this area. Outcome reports are now made available to providers on a regular basis. Providers were aware of the general outcomes for people in SE services across the state. However, the outcomes for SE programs (specifically the percent of people in SE service who are competitively employed at a point in time) do not appear to be available on the DBHDD website where SE fidelity reports remain accessible.

It is not clear how outcomes are being used by the leadership at DBHDD or by specific SE providers as a mechanism for quality improvement. For example, SE fidelity reports are being used to identify which providers should provide shadowing opportunities for other providers

who are struggling in identified areas. A similar process has not been established regarding employment rates or outcomes.

15. Stakeholders

The degree to which consumers, families, and providers are opposed or supportive of EBP implementation.

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

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

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

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

Narrative

The support and engagement among providers, consumers and family members in Georgia for Supported Employment continues to develop based on the successes that have occurred.

The improved partnerships between DBHDD and provider organizations; the vocal active leadership from the Commissioner's office; the collaborative training and shadowing programs; an increased presence at the Georgia APSE conference; and a significantly improved relationship between Georgia Vocational Rehabilitation and DBHDD have all contributed to strong support for Supported Employment services for Georgia's citizens whose lives are affected by mental illness.

Summary Table of Georgia SHAY Scores 2015

1. EBP Plan	5
2. Financing: Adequacy	3
3. Financing: Start-up and Conversion Costs	3
4. Training: Ongoing Consultation & Technical Support	5
5. Training: Quality	5
6. Training: Infrastructure / Sustainability	5
7. Training: Penetration	5
8. SMHA Leadership: Commissioner Level	5
9. SMHA Leadership: EBP Leader	5
10. Policy and Regulations: Non-SMHA	5
11. Policy and Regulations: SMHA	4
12. Policy and Regulations: SMHA EBP Program Standards	5
13. Quality Improvement: Fidelity Assessment	5
14. Quality Improvement: Client Outcome	4
15. Stakeholders: Average Score (Consumer, Family, Provider)	5
Total SHAY Score	69
Average SHAY Item Score	4.6

Summary Table of Georgia SHAY Scores 2012 – 2015

SHAY Item	2012 score	2013 score	2014 score	2015 score
1. EBP Plan	4	5	5	5
2. Financing: Adequacy	3	3	3	3
3. Financing: Start-up and Conversion Costs	1	2	3	3
4. Training: Ongoing Consultation & Technical Support	2	4	4	5
5. Training: Quality	3	4	4	5
6. Training: Infrastructure / Sustainability	3	4	5	5
7. Training: Penetration	1	5	5	5
8. SMHA Leadership: Commissioner Level	4	5	5	5
9. SMHA Leadership: EBP Leader	3	5	5	5
10. Policy and Regulations: Non-SMHA	2	3	4	5
11. Policy and Regulations: SMHA	4	4	4	4
12. Policy and Regulations: SMHA EBP Program Standards	3	5	5	5
13. Quality Improvement: Fidelity Assessment	3	4	5	5
14. Quality Improvement: Client Outcome	3	3	4	4
15. Stakeholders: Average Score (Consumer, Family, Provider)	4	5	5	5
Total SHAY Score	43	61	66	69
Average SHAY Item Score	2.9	4.0	4.4	4.6

Sustainability

Over the past five years, DBHDD has worked effectively at improving their infrastructure, policy and resource allocations to better facilitate the adoption and practice of evidence-based Supported Employment services by a wide range of providers in the State. During that time, DBHDD has developed its own internal SE team that provides leadership, support, consultation, regular communication and fidelity reviews to ensure the quality of SE services in the State. DBHDD has also written a comprehensive State plan regarding SE services and developed a multi-media training and consultation partnership with the Institute on Human Development and Disability at the University of Georgia. DBHDD has also instituted regular SE coalition meetings with providers and has been developing a much more collaborative partnership with SE agencies regarding the provision of good quality Supported Employment services. Most recently, DBHDD has made noteworthy progress in their collaborative relationship with the Georgia Vocational Rehabilitation Agency. All stakeholders noted the benefits and effects of this collaboration during a recent visit. Most, if not all, of these changes, would not have happened without the committed and focused leadership support that SE has received at all levels of DBHDD, including the Commissioner.

It is incumbent on the leadership at DBHDD to carefully and regularly monitor these significant improvements and transformative changes for erosion. As was demonstrated by the provider feedback regarding changes in the staffing of fidelity reviews, some positive changes can be quickly lost (i.e. several providers commented that the reviews were back to the tone of compliance audits versus the desired tone of collaboration and partnership) and recovering from those changes presents a new challenge.

Some areas that appear to be at high risk for potentially losing progress include the improvement to the fidelity process and the partnership around ongoing funding mechanisms and strategies for SE services. Providers have expressed, over the past two years, a strong reservation and many misgivings regarding the use of Medicaid dollars to fund SE in GA.

The training and consultation work through the Institute of Human Development and Disability at the University of Georgia has been well received and has given agencies the chance to have staff trained in providing SE services which is critical to the success of the service.

Fortunately, Georgia has a pool of experienced SE providers, effective leadership at DBHDD regarding Supported Employment, and a system now built to capture useful ongoing quality improvement data at many levels, all of which will be critical to sustaining the opportunity for Georgia's citizens who live with mental illness to have effective services to help them further their own recovery through competitive employment in their communities.