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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Department of Justice 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…
> (C) By July 1, 2013, the State shall provide Supported Employment services to 440 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) that were interviewed do indicate that DBHDD is complying with the Supported Employment provisions of the Settlement Agreement. According to the "FY 13 Programmatic Report Data: Supported Employment Services," as of the end of May 2013, there were 682 individuals receiving Supported Employment services under the Settlement Agreement. The monthly rate of employment was 42.1 percent. 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 the 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 third SHAY report that has been completed at the request of Elizabeth Jones, Independent Reviewer. The previous SHAY report was completed in September 2012.

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 four days in July 2013, specifically; July 14, 15, 16 and 17, meeting with and interviewing a variety of stakeholders in the State of Georgia as well as reading and reviewing relevant documentation provided by DBHDD. In addition to that visit, the reviewer made several interim visits to Georgia in 2013, specifically one in January, two in April and one in May. The July interviews and meetings that were arranged by a number of stakeholders in Georgia included: staff from DBHDD, providers of SE services for adults with mental illness, family members, consumers participating in Supported Employment services, staff from the Georgia Vocational Rehabilitation Agency (GVRA), staff from the Institute on Human Development and Disability at the University of Georgia as well as representatives from consumer and family advocacy organizations and other mental health advocates. Of particular note, the reviewer was also able to meet with Commissioner Frank Berry and Deputy Commissioner Judith Fitzgerald in person during the July 2013 visit.

The reviewer was asked to assess the extent that 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 graciously 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 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

The leadership at DBHDD has 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.

The plan provides a working definition of Supported Employment services and describes the ongoing development of two vital partnerships for SE services. First, the partnership between DBHDD and the Georgia Vocational Rehabilitation Agency, and second, the partnership between DBHDD and their SE training and consultation provider, the University of Georgia Institute on Human Development and Disability Center of Excellence Facilitation. More information regarding the

status of these partnerships is discussed in later sections of this report. The plan also briefly describes ongoing SE Coalition Meetings that have been occurring for the past two years between DBHDD staff and community SE providers.

While DBHDD is to be commended for the development of a well-prepared SE Strategic Plan, the next important step will be to assure a broad understanding of this plan across the provider, consumer, family member, and other State agency stakeholder groups in the immediate future. Copies of the plan should be widely circulated combined with the use of existing forums to present and review the plan.

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 $410.00 per slot for each provider. 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.

While this slot based funding structure is required as part of the Settlement Agreement, as was recommended last year, this rate structure warrants a careful cost-based examination in collaboration with SE providers to evaluate if the rate is adequate for provider. It will be important to transparently share the findings of that cost rate study as well as the data and calculation process that are used in completing the cost rate study with SE providers and other stakeholders in Georgia.

Several providers continue to voice their perception that the current funding structure for SE services is not sufficient. For example, one provider stated, "We love working with the DOJ slots folks we are serving. We understand the reimbursement rates are not sufficient given all the time we need to spend in meetings and the reviews." While the perception of providers may or may not be accurate, until the results of a thorough cost analysis are completed and published, the perception will continue to be very strong.

A second ongoing complication that warrants further exploration is the process of paying for SE services by funding SE slots rather than funding specific clients or specific outcomes. For example, an SE provider who is given a fixed number of SE slots may feel strong unintended pressures to make sure that clients (that meet the above criteria) in those slots are the best candidates for rapid employment to keep SE slot outcomes up. This may have the unintended

consequence of providers re-assigning clients both into and out of their designated SE slots to improve outcomes and reduce the time and subsequent staffing and other costs that they invest in clients in SE slots. The leadership at DBHDD remains aware of this complication however, at this point, there has been no changes to the SE data that are collected in order to gather more information about the use of slots and its potential negative impact on consumers in 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
Present	2. Few costs are covered
	3. Some costs are covered
	4. Majority of costs are covered
	5. Programs are fully compensated for costs of conversion

Narrative

DBHDD has added some new providers of SE slots in the past year. To its credit, DBHDD leadership has worked with new providers by creating access to some training and consultation activities. Typically, DBHDD does not currently reimburse start up costs for a new provider to deliver SE services. Some typical start up costs might include the purchase of laptop computers, cell phones and transportation resources for employment specialists to be providing the majority of SE services in the community. However, given that new providers have been

able to start SE services, it does appear that these start up costs for SE services in Georgia are not prohibitive.

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)
	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

As described earlier, DBHDD has continued and enhanced their formal training 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 providers, working with DBHDD, have established feedback loops about the training effectiveness and have solicited specific ideas for ongoing training needs from SE providers.

Previous concerns regarding specific training content that was not consistent with the evidence-based Supported Employment model were raised and presented to DBHDD. To its credit, DBHDD leadership worked immediately with the training providers to promptly correct this in a satisfactory way. Provider feedback on the training that is being provided is positive and grateful. For example, one provider stated, “Doug (Doug Crandell, UGA/IHDD SE consultant/trainer) has been very supportive to us. Some of our staff have gone the training and learned more about the SE principles, it has been very helpful.”

The amount of time that is available vis-à-vis the training contract for on-site agency consultations (technical assistance) regarding SE services has been increased in the current contract. “Provide on-site technical assistance to the 21 MH SE programs…. Each site can use up to two days (16 hours) of on-site technical assistance.” While DBHDD has developed a foundational training method for employment specialist and SE supervisor skills, it is still vitally important to provide agency-based technical assistance to help providers put those skills and the principles of Supported Employment into their daily workflow. The increased technical assistance time will play an important role in improving SE fidelity scores as well as the quality of SE services evidence by increased employment outcomes. It is strongly recommended that DBHDD leadership work closely with the training and consultation providers to assure that on-site technical assistance is used to address provider deficits identified by the SE fidelity reviews, the SE outcome reporting and feedback from consumers in SE services at each provider in a systematic way.

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
	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

As noted previously, DBHDD has worked to establish an ongoing training mechanism with the Institute on Human Development and Disability at the University of Georgia. They have worked to develop and enhance the credibility of the training and technical assistance being provided through this arrangement and have developed feedback loops about the training. The training is focused on Supported Employment skills and strategies and includes the use of different multi-media activities to support learning. One remaining gap in providing high quality training is the formal designation and use of high fidelity mentor sites to supplement the training that is currently being provided. It is recommended that DBHDD develop a specific method to designate high fidelity (very good SE practice sites) provider sites where staff and leadership from other providers can visit to observe and shadow good SE services being provided in their natural environment. This has been shown to be an important training tool both for new SE providers and for SE providers who need to learn more effective ways to provide employment services at their agencies.

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
	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 important improvements and modifications in the provision of SE trainings and consultation services for SE providers in the state. They have set up a model that incorporates feedback from providers both about their training experiences as well as their self-identified training needs for the future. There continues to be a lack of DBHDD designated SE demonstration sites where staff from other programs can make formal visits to observe the modeling of good SE services. These sites should have good SE fidelity scores and should work with the staff from the Institute on Human Development and Disability at the University of Georgia to set up shadowing and observation experiences in a structured and purposeful way. At this point, it is understandable that DBHDD has not developed any formal plans yet to help SE

providers to develop their own internal capacity to train new SE staff; however, this will be an important consideration in the near future.

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

Over the past year, DBHDD has worked to ensure that all SE providers have access to the SE training and technical assistance services provided in cooperation with the Institute on Human Development and Disability at the University of Georgia. Schedules for training opportunities are well publicized, documented and reviewed at SE coalition meetings. SE providers have found the trainings to be helpful, relevant and engaging. New SE providers have also been provided with access to the training and technical assistance opportunities.

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. It is noteworthy that Commissioner Berry and Deputy Commissioner Judith Fitzgerald both made themselves available to meet with the reviewer during the July 2013 visit. The feedback provided regarding the Commissioner as an effective leader in relation to Supported Employment services in the state was overwhelmingly positive and

hopeful across all stakeholder groups. Some samples of quotes about the Commissioner and his leadership regarding Supported Employment services include:

> "The Commissioner is phenomenal, he is into mainstream services such as supported employment. He is good at the daily reality of things."
>
> "The Commissioner has done a lot to improve the state office and provider partnerships, he sees the value of all of that in the state. He definitely understands recovery."
>
> "I have been a mental health advocate for 24 years in this state, this is the best Commissioner-led opportunity that we have had with this Commissioner right now. It is important that he knows how important that his role is. We know it. It is important that he takes the same message to our state legislature too."

Nearly everyone interviewed stated that they have seen or heard statements from the Commissioner, in public and private meetings, about the value of employment and Supported Employment services to the residents of the State of Georgia. The profound change of tone and demeanor from the Commissioner's office, as well as the elevation of Supported Employment services, along with the value of employment in relationship to recovery, appears to be resonating well across many different levels of the Georgia DBHDD system.

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

Georgia DBHDD has produced some significant changes and improvements in their relationships with other stakeholders, especially SE providers. Numerous people commented on the difference in communication, responsiveness and openness within the DBHDD leadership regarding SE services. While there remains some confusion among stakeholders as to who the specific SE point person is at DBHDD, this concern pales in comparison to the value of comments that providers and other stakeholders made about the SE team within DBHDD. For example, many people chimed in with agreement when one person stated, "They (DBHDD SE Leadership) get the big picture and they work with us to get solutions to things immediately. They are becoming a good partner." Many people stated that they have asked questions about SE services or asked for assistance from DBHDD; all indicated that they found the SE team at DBHDD to be responsive in a timely and collaborative way.

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
Present	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
	Virtually all policies and regulations impacting the EBP support/promote the EBP

Narrative

The successful implementation and sustaining of effective supported employment services on a statewide basis often relies upon effective policy and funding collaborations with other important agencies in a state, specifically the state's Vocational Rehabilitation agency and the state's Medicaid Authority or Agency. The DBHDD leadership has been able to develop and has signed a "Memorandum of Understanding Between Georgia Vocational Rehabilitation Agency and Georgia Department of Behavioral Health and Developmental Disabilities Regarding Supported Employment" in February 2013.

While the official signing of this MOU is an important step in aligning the resources and policies of the Georgia Vocational Rehabilitation Agency (GVRA) and DBHDD, it clearly does not address all of the ongoing concerns in the relationship between GVRA services and DBHDD Supported Employment services on the ground level. It is important for DBHDD and GVRA to move ahead in a very public and timely way with their plans to designate specific regions for pilot sites to implement the concepts in the MOU in the daily interactions between the two agencies. Lessons learned from these pilot sites should be used to inform the larger system about improvements in the working relationship between GVRA services and DBHDD SE services.

One person summed it up this way, "We have been told the MOU is a beginning, like we will play nice together, but it has no specifics, it is just the 2 Peachtree

folks and the VR leadership developing an agreement. We need meetings to hash out the details of this on the ground."

As another person stated, "It is good that the MOU is signed, now we need to blend the two agencies' policies and procedures, we need to figure out how to mesh the SE and VR models and identify opportunities for a more seamless process. We need to be looking at what GVRA can do with SE to help people." This important vision is in stark contrast to the ongoing weighty challenges that continue to exist with the DBHDD and GVRA relationship across the state.

Some of those multiple concerns include: how providers will be able to potentially use Medicaid funds for SE services and still access GVRA funds; how services will be seamless to customers of both systems, even when funding changes; how GVRA will resume providing services to SE clients; and how GVRA and SE can work together to better serve young adults with mental illness who desire employment.

Some specific comments about the relationship between GVRA and DBHDD SE services included:

> "It seems like there is lots of good stuff going on here in the relationship, but VR is still into just providing training for our (SE) clients. VR seems to want to stay away from our clients (with mental illness) because they can not work in their eyes."
>
> "The funding at VR is too limited to be helpful with SE clients. They (GVRA) take the client's application for services but they do not open the client into the job search process, they either open our clients (with mental illness) into assessment but not into job placement services."
>
> "We have been told that there will be no new VR cases opened up for our clients (with mental illness) until sometime between October and January."
>
> "Several GVRA counselors are not allowing Supported Employment clients to apply for or to attempt to enroll in Vocational Rehabilitation services."

> And one provider shared a very profound and personal perspective, "Without the Vocational Rehabilitation services that I received in the past, there is no way that I would be where I am right now. VR helped me several years ago to get a job. I would not have my job right now if it were not for them. I am sad that this type of VR service is not available to many people like me in Georgia right now."

A second equally important state agency relationship is between Georgia DBHDD SE services and Medicaid. The leadership at DBHDD has been working for over a year on establishing a mechanism to use Medicaid funding to pay for some Supported Employment services. This process has been used successfully in many different states. The use of Medicaid funds represents a potentially very strong sustainable funding mechanism for SE services in the state and the leadership should be commended for working on addressing this issue. DBHDD has received approval from the Centers for Medicare & Medicaid Services (CMS) for Medicaid State Plan Language regarding Task Oriented Rehabilitation Services (TORS) to promote recovery and wellness.

There is a significant amount of fear, apprehension and perhaps strong misunderstanding in the SE provider community about how the use of Medicaid funds to reimburse for SE services will affect SE providers. There were numerous concerns raised about this both as it relates to fears of "double-dipping" related to other SE funding mechanisms and as it relates to a perceived fundamental change in the conceptualization and provision of SE services.

Several providers stated their perception that the use of Medicaid funds will force SE service into focusing more on the client's mental illness diagnosis and will require SE providers to be working with deficits and symptoms rather than strengths and skills. Nearly all providers present voiced concerns with the implications and fears they have about using Medicaid to support SE services. It is strongly recommended that GA DBHDD continue to use existing communication methods to gather more information about these perceptions and to provide good accurate billing and funding information to providers to address their concerns.

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

Score:
Present

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 has incorporated language into their contracting procedures with the SE providers linked to the Settlement Agreement. This language specifies that Supported Employment providers provide SE services that are 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.

An important area for DBHDD to address is a relatively new concern that seems to be emerging and has been reportedly experienced by a number of SE providers who have approached Assertive Community Treatment (ACT) Teams

for potential referrals of ACT clients to SE services. Several providers indicated that the ACT teams' vocational counselors told them that they did not have anyone (ACT clients) on their team that would be a good referral for SE services. As one provider stated, and many agreed strongly, "The vocational counselors on ACT teams are telling us they are assessing who is ready to work and then they say that there is no one who is a client of their ACT services who has reached readiness for employment." This type of employment readiness approach is in direct contrast to the zero exclusion principle of SE services and should be addressed aggressively within the ACT teams across the state.

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 toolkit and as described by the work of the Dartmouth Psychiatric Research Center regarding updated principles and SE fidelity.

The 2013 DBHDD Supported Employment Strategic Plan includes the following:

“Fidelity reviews are conducted on-site and in a collaborative manner, with focus on quality improvement. SE providers are expected to maintain a minimum fidelity score of 74 (out of a possible 125).”

Additionally, the document, “FY2014-AMH SE Provider Annex-A: Expectations, Outcomes and Payment Method Mental Health and Addictive Disease Adult Specialty Services, “ under section “D. Consumer Outcomes” contains the following, “5. Increase in Competitive Employment: At least 35% of adults actively enrolled in Supported Employment services will be competitively employed in integrated settings that pay minimum wage or better.”

While both of these represent the establishment of desired benchmarks for SE services from a quality perspective, there does not appear to be any common knowledge about the written description or formal process regarding the explicit consequences for providers who do not achieve these benchmarks. This has not been lost on the providers. During one interim visit to a provider, when asked what DBHDD leadership could do to improve SE services, a CEO stated, “We need to be held more accountable for our employment outcomes.”

However, the following language is included in #11 of Annex A in all SE contracts; “Contractor performance for individuals served and outcome measures will be evaluated on an ongoing basis. If Contractor fails to deliver the Consumer Outcomes in Section D. or meet the Contractor Expectations, listed above, Contractor will be notified and may be required or permitted to develop a plan of correction. Continued underperformance may result in contract modification or other contract action, including termination of the contract.”

During the July visit, a different provider summed it up this way, “It would be good for DBHDD leadership to incentivize employment outcomes with more money. Right now, we get money just on enrollment of clients to the SE slots so we can

get lots of money without worrying about outcomes. We still get paid the same even if no one gets a job."

It is strongly recommended that the DBHDD leadership develop and implement a formal and documented method to actively hold SE providers accountable for employment outcomes through policy and funding mechanisms on a systemic basis. This accountability might incorporate additional funding or recognition for high performing providers and sanctions or other required quality improvement actions for low performing providers.

13. 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
	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.)
	8) The fidelity performance data is made public (e.g. website, published in newspaper, etc.)
	No components covered

Narrative

The DBHDD leadership invested a significant amount of work and resources into the Supported Employment fidelity review process that enabled them to recently complete a full round of SE fidelity reviews at all SE providers in the State of Georgia. In addition to investing in the personnel and travel expenses, the DBHDD leadership also invested in skills training, shadowing and observing fidelity reviews and other learning opportunities for the personnel that conducted the full round of reviews. This investment appears to have paid dividends not only in the completion of a full round of reviews and subsequent fidelity reports but also in a notably improved fidelity monitoring relationship that is growing with providers that was described during interim visits as well as the July visit. This significant improvement is well described by several SE providers when asked about their fidelity reviews, including:

> "The fidelity reviewers were over-the-top with pleasantries and helpfulness. They worked carefully and professionally with us."
>
> "The reviewers sat in on meetings and making observations for hours, they went out into the community with us doing job development. They were sensitive to our culture and our employer relationships."
>
> "The reviewers were more supportive than auditing, it was not a threatening process. They went out to the community with us, they lived with us for two days."
>
> "We were very disappointed in our fidelity score. Our fidelity review showed us we were doing things the old way and some things that we were doing the old way were punitive to our score. People in our agency have been very responsive to the changes we need to make."

Many providers said the most important use of their fidelity review, the findings, and the subsequent report was within their own organizations. Several SE supervisors stated that they took their SE fidelity report to their own administration to highlight what the SE model looks like and what the agency needed to do to improve SE services.

It appears that DBHDD has invested significant and meaningful work into the fidelity review process in order to complete a full round of reviews with numerous providers across the state in a collaborative, quality-improvement focused manner. The next step for the DBHDD leadership is to use the substantial amount of information that is now available from the fidelity review process and feed it all into a carefully constructed comprehensive quality improvement process. DBHDD has shared some information about the fidelity findings with other SE providers but that should be just the beginning of the process.

The leadership at DBHDD has shared some information regarding the fidelity reviews with the SE provider group. Providers have been informed that the information will also be available on the DBHDD website in the near future which will allow public access to this information at that point.

It is strongly recommended that DBHDD in collaboration with providers, consumers and other stakeholders, review the fidelity data for important quality improvement themes including, but not limited to: providers who are outliers for high fidelity scores—and how to publically recognize and support their effectiveness; providers who are outliers for low fidelity scores—and how to best assist them to improve; areas where there are significant strengths in the system (e.g. caseload size) and how to keep those in place; areas where there are significant challenges in the system (e.g. work incentive counseling services) and how to improve that systemically.

While reviewing the SE fidelity data, it is also important to review the lessons learned from the data gathered at all the reviews that may not show up in the fidelity reports. For example, fidelity reviewers gather a list of jobs that have been obtained by clients in the program, combining these lists together would present a systemic picture of what types of jobs SE programs are helping people to obtain. This list should be reviewed to assure that people are obtaining a diverse set up of competitive jobs (not just entry level food service and retail

positions) that match with people's own individual employment goals. It is possible that programs are focusing too much on easier to get positions and not on making good matches with people's hopes and specific recovery goals. As one client stated,

> "I wish that our mental health Supported Employment staff would set higher expectations for us. They seem to put us (clients) into categories or placements where they feel that we (clients) will not have too much stress. We need job opportunities that are much more broad and diverse, not just food services and retail."

Two other recovery-oriented Supported Employment concerns to address with information from fidelity reviews include access to work incentive counseling and helping clients with coping skills to be successful in the work place through integrated services. All clients that were interviewed during interim visits and during the July visit stated that their work incentive counseling consisted primarily of being told that they just can not earn income above the substantial and gainful activity (Social Security SGA). This means that clients are being told they can not earn an annual income over $12,000.00 which virtually eliminates client goals and dreams of home ownership, developing careers, becoming full time employees, and becoming economically self-sufficient. As one client astutely observed, "They tell me that I can not make more than a thousand dollars a month. That means I can only work part-time and I can never work my way up to a career or advancement."

The second important area to examine and address is what types of integrated services are clients in SE getting to help them with developing coping skills and other strategies to manage symptoms and illness-related challenges to help them develop work skills and attributes. When asked what things they were learning to help in this area, every client in the July meeting (including clients from different agencies) stated they have been told, "If you want to work you need to take your medications." This is clearly not a recovery-oriented, strength-based, individualized method of helping clients to learn important skills for employment and their own recovery process.

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
	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 established a client outcome reporting mechanism that has been in place for over a year with SE providers. Providers are required to submit monthly reports about SE outcomes including reports on the percentage of clients who are in the SE DOJ slots and their employment rate. Concerns from the SE providers about the time consuming and cumbersome nature of the SE outcome system that is still in place were previously documented. Many providers continue to have the same concerns, as the system has not yet been changed. However, DBHDD reports that they are working on developing and installing a user-friendlier outcome reporting system.

The leadership at DBHDD has shared some information regarding the SE outcomes with the members of the SE provider group. Supported Employment providers have been informed that the information will also be noted on the DBHDD website in the near future which will allow public access to this information at that point.

In the outcome system redesign, it is recommended that DBHDD incorporate measures to address the challenges inherent in the DOJ SE slots mechanism. Currently, providers report only the percentage of people in those slots who were working in competitive employment during the month. While this is an important data component it is not sufficient for assuring that SE services are being effective. For example, a program may be helping clients to get jobs but not helping them to keep jobs, so clients may be quickly losing jobs and are not able to benefit from employment. This non-recovery-oriented approach to SE would not be detected with the current outcome process. As another example, a program may be helping the clients who are working to keep their jobs but not helping any of the unemployed clients to obtain jobs. Once again, this non-recovery-oriented approach to SE would not be detected in the current SE outcome process.

It is recommended that DBHDD move quickly to add data elements to the SE outcome reporting that helps develop a more accurate picture of how well SE services in Georgia are truly helping clients to advance their own recovery process through sustained and successful employment.

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 for SE services in Georgia has grown even stronger among some of the stakeholder groups. Georgia has a very active chapter of APSE (Association

for People in Supported Employment). The Georgia Consumer Advocacy Network has a large annual conference. Numerous people cited that that group has chosen employment and supported employment as their top priority for numerous years. It will be important for the leadership at DBHDD to work on developing formal positions or affiliations with the Georgia Consumer Advocacy Network and family advocacy organizations in the near future, thereby officially sanctioning their place at the table in assuring the overall quality of SE services in the state. The network of providers who have the Settlement Agreement slots remain enthusiastic and committed to the delivery of SE services, especially with the emergence of several new promising actions and activities that have been propagated by DBHDD. Family members and mental health advocates are clear about their support for supported employment and the importance of employment in helping their loved ones to make progress with their recovery process. One consumer summed it all up this way:

> "When I am at my job, I don't feel like I have a mental health issue. When I am at my job, people treat me like a person who does his job. I look forward to getting up and going to work everyday."

National Implementing Evidence Based Practices Project SHAY Data

The overall average SHAY item score for states participating in the Substance Abuse and Mental Health Services (SAMHSA) National Implementing Evidence Based Practices Project was 3.14. In those states, the overall average item fidelity score across all five identified EBPs was 3.47. In those states where provider agencies were able to successfully implement EBPs (average EBP fidelity item score of 4.0 or higher), the State Mental Health Authority had an average SHAY item score of 3.82. States with higher SHAY scores also had better EBP implementation. In other words, the actions of the State Mental Health Authority described in the contents of the SHAY are associated with the fidelity and quality of services provided at the local level.

Summary Table of Georgia SHAY Scores 2013

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

Georgia SHAY Scores 2012 and 2013

The SHAY score earned by the Georgia Department of Behavioral Health and Developmental Disabilities in 2013 is considerably higher than the score earned in 2012. In comparing the SHAY item scores between 2012 and 2013, DBHDD managed to increase the score they earned on thirteen of the items and maintained their progress on the two remaining items. The DBHDD SHAY score did not decrease on any item. The increase in SHAY item scores and in the SHAY total score measures a change in actions, behaviors, policies and procedures on the part of DBHDD regarding evidence-based Supported Employment services for Georgia adults with mental illness.

While recognizing the substantial amount of work that DBHDD has invested in these improvements, it is likewise important to note that sustaining the gains that have been made will be equally challenging and will require an ongoing focused investment of time, energy and resources on the part of DBHDD. In the next twelve months, it will be vitally important for DBHDD to make the most efficient and effective use of the tools they have now put in place to actively and comprehensively monitor the effectiveness, quality and accountability of Supported Employment services within their state. It is critical that DBHDD ensures that SE is being provided in way that is faithful to the evidence and, most importantly, ensures that SE is being provided in a recovery-oriented fashion to help as many Georgians with mental illness as possible to be successful with employment in their recovery process.

Summary Table of Georgia SHAY Scores 2012 – 2013

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