

Security Act to support systems of care and to provide earlier intervention for two very high risk populations:

- foster children
- juvenile offenders on probation in the community

- Redesign accountability, management, and information systems.

Accountability for investment in terms of outcomes is crucial, but it is a massive shift in current thinking and management systems. In such a system, rather than counting units of service, the end results for a child are tracked; e.g., improved school performance, fewer crimes, acceptable behavior with peers. Individual programs cannot be accountable for these broad outcomes because they cannot control the basic variables. But a system of integrated care can be accountable—and extraordinary results have been achieved by the communities discussed in Chapter 3.

One task is to develop broad consensus on core statewide outcomes that can be tailored by each community to its unique needs and strengths. This will require new baseline data, and management information systems will need to collect information needed for ongoing decision systems.

Georgia is fortunate to have "building blocks," not only in children's behavioral health services but also in The Family Connection community collaboratives. Georgia is a national leader in supporting community partnerships which are focused on children and families, have forged integrated service strategies, and have experimented with new outcomes accountability and self-evaluation tools.

GEORGIA'S NEXT STEPS

This study found much consensus among both Georgia's diverse stakeholders and national leaders concerning the changes needed for improved results. Georgia is well positioned to take the next steps.

These steps should move Georgia toward designing a system of care for our children with serious emotional disorders and their families. We have learned from other states that the system of care should be designed by each community and for each community's unique strengths as well as its weaknesses. This requires that the state develop a framework for the policy, fiscal, and accountability structures of a system of care without creating a "cookie cutter" program to be overlaid on each community.

The recommended next steps discussed here are based on Georgia's current strengths and weaknesses, Georgia's stakeholder perceptions, and lessons from other states. These steps will improve Georgia's current track record for children and families, using community coalitions,

developing new accountability for results, and changing the nature of the state-local relationship to one of trading accountability for flexibility.

These recommendations represent work that will be complex. It will also be intense work if we are to turn the current patchwork of programs into an integrated, family supportive and child-focused system of care for SED children. The complexity and intensity can be tackled, based on Georgia's history of public initiatives, by taking a deliberate, joint state and community approach.

Design Systems of Care in Select Communities

Identify a set of communities that have demonstrated innovation for children with severe emotional disturbance and have collaborative mechanisms for managing local change.

Confirm the state's commitment to be a partner in this process and the program components that will be a part of the system of care at a minimum: e.g., MATCH, the SED funding, First Placement/Best Placement, Medicaid, and DJJ community treatment.

Engage local leadership and negotiate basic agreements that delineate the community and state roles, responsibilities, and projected time frame for action. Provide training and technical assistance to each community as it crafts strategic and operational plans, as it identifies constraints, and as it tests innovations. Further explore the design and operation of successful approaches in other states.

Identify the basic principles to be tested in the select communities and the questions that need to be addressed through local experimentation, such as the following:

- What does the system of care look like with a community's unique public and private array of resources?
- What forms does the local collaborative structure take; what are the pros and cons to using/creating a local legal partnership entity?
- What is needed to improve ease of access by children and families to the system of care? What strategies for integrated intake, assessment, and case management work?
- How can parents be included as partners in the child's treatment, in designing the system of care, and in educating providers and the community?
- How can the array of public and private providers be expanded to create a "wraparound" menu of services? What flexibility can be created with what management controls?

- How can a provider network be created to provide "wraparound" services? How can it best negotiate rates and set service standards across purchasers of care?
- What training and technical assistance needs surface for purchasers, for community collaborative partners, for system of care managers, for families, and for providers?
- How can the system of care become flexible enough to identify and address other companion diagnoses, specifically substance abuse, developmental delays, and mental retardation?
- How to use existing early identification/diagnoses systems for behavioral health needs, specifically Children 1st, Early Periodic Screening Diagnosis and Treatment (EPSDT) and Babies Can't Wait? (Note: There are nationally tested screens for behavioral health that have been linked with EPSDT for use by pediatricians, public health nurses, and parents.)
- How will the new Child Health Insurance Program (CHIP), which will provide insurance coverage to any child in a family below 200 percent of poverty, expand the ability to identify early and serve children before they have complex, high-cost needs?

Identify and Explore Fiscal Options to Create Flexibility and to Improve Capacity

Georgia has invested over \$200 million in a fragmented, inflexible array of services—each program grew with the best of intentions, targeted to specific children and with its own legal mandates, management structures, and fiscal rules/constructs. The result is that we currently fit children into program services rather than addressing the child's needs through flexibility and earlier intervention. Many communities in other states have found the means within current federal and state laws to tailor these fund streams to support a more flexible system of care.

Georgia has demonstrated its ability to take advantage of federal and state fiscal options in addressing many other challenges. The time is right to explore what a system of care could include through creatively blending funds, increasing fund flexibility, and capitalizing on federal revenue opportunities. Georgia should investigate its options to

- link Foster Children with appropriate treatment at the first opportunity. First Placement/Best Placement will allow us to identify their needs, but we need a systemic means of using their Medicaid coverage and ensuring that they receive appropriate treatment, both mental and physical.
- link DJJ children who are not incarcerated to the same treatment system described above for foster children. Many of these children could receive early intervention through Medicaid services if there was a deliberate system of oversight and referrals to providers. The potential to turn a child's life around is worth every effort.

- use federal Medicaid options to support the community's system of care with flexible funds. Other states and communities have used federal rules to achieve flexibility within a managed system, such as the Rehab Option and waivers of statewide coverage and institutional care. Additional options include developing case management systems and improving Medicaid eligibility.
- test the Medicaid "under 21 option" in select communities to expand the use of private sector providers.
- increase eligibility for IV-E (Social Security Act) to improve federal reimbursement for services to foster children. This increase would allow not only improved services to children but also improved training capacity for state and local partners.

Develop Results Accountability Systems

Working in the selected Georgia communities, determine the results desired for children with serious emotional disturbance and then the data measures that are meaningful, that are central to the result, and that can have reliable data produced regularly. The process of developing agreement on the results and measures is crucial to developing ownership of the accountability. Georgia can build on the MATCH Outcomes Project as well as the work of communities in other states.

Once measures are selected, the Georgia and community baseline data should be prepared, creating trend lines if historical data are available. Trend data are critical to determining if the new service strategies are slowing the current growth in costly high-end services, prior to realizing an overall reduction in the measure.

The results and measures can be used by the selected communities as a basis for their strategic planning and to determine over time if the service strategies selected do, in fact, make a difference. In order to create the accountability systems, communities and the state will need to develop the capacity to establish their evaluation questions and a means of producing regular data feedback to inform both ongoing policy decisions and point-in-time assessment of progress.

Adjust or Develop Data Systems Required to Manage Integrated Services

Each purchaser/division/agency currently has data systems to inform decisions. These data systems are fragmented and cannot interface over either a child or a provider. The analysis of the current investments in care, described in Chapter 1, was unable to compare clients, services, or outcomes because the stand-alone data systems had no common fields. An analysis of how to create common data elements within the current data systems is crucial to future interagency assessments of a child's plan of care, costs, and outcomes.

In addition to the interface of state data systems, the development of community management information systems is essential to controlling the costs of a system of care. Data systems need to be designed which will track plans of care to authorized services to service delivery costs to child outcomes.

Identify and Address Constraints to Developing Systems of Care

As the communities implement the systems of care, they may encounter current practices, policies, regulations, or laws that are blockages. Communities must build in processes that identify these constraints as early as possible and that address them through the state partners if they cannot be managed locally. This attention to the communities' experience in developing the system of care will provide valuable information about how to streamline and refine replication of the first set of communities.

These recommended actions will move Georgia closer to being a "wise purchaser" of children's behavioral health services and will result in a more accessible, responsive system of care for children and families. Combining Georgia's current innovative "building blocks" with lessons gleaned from nationally tested models will enable deliberate testing of what works for our state.

Acronyms and Glossary

ACRONYMS

CAFAS: Child and Adolescent Functional Assessment Scale
C&A: Child and Adolescent
CHIP: Children's Health Insurance Program
CM: Case Management
CMHS: Center for Mental Health Services
CSB: Community Service Board
DFCS: Division of Family and Children Services (within DHR)
DHR: Department of Human Resources
DJJ: Department of Juvenile Justice
DMA: Department of Medical Assistance
DOE: Department of Education
DMH/MR/SA: Division of Mental Health, Mental Retardation, and Substance Abuse (within DHR)
DRG: Diagnostically Related Groups
EBD: Emotionally or Behaviorally Disturbed
EPSDT: Early Periodic Screening, Diagnosis, and Treatment
HCFA: Health Care Financing Administration
MATCH: Multi-Agency Treatment for Children Program
MH: Mental Health
MHSPY: Mental Health Services Program for Youth
MR: Mental Retardation
OTP: Outdoor Therapeutic Programs
RB: Regional MH/MR/SA Boards
RTC: Residential Treatment Centers
SA: Substance Abuse
SED: Severe Emotional Disturbance
TCM: Targeted Case Management
TRIS: Therapeutic Residential Intensive Service
UM: Utilization Management
UR: Utilization Review

GLOSSARY

C&A: Children and adolescents. There is some confusion around the state in the usage of the terms C&A and SED, especially as it relates to the services being described. In some parts of the state, nearly all youth being served in the community mental health system are described as SED. As such, in these areas, the terms SED and C&A tend to be synonymous. It may also be that in these areas, the "most in need" criteria has the effect of excluding from service children or youth who are not SED. In other areas, however, a distinction is still made between C&A and SED. This distinction probably grew out of the development of SED funds that were directed for the most part to a set of more intensive, higher-end services than outpatient services. Functionally, the distinction between C&A and SED in these areas tends to lie in the distinction between outpatient services on the one hand and the higher-end services such as day treatment and therapeutic foster care on the other hand.

C&A Capacity Building Plan: The C&A Capacity Building Plan was first developed in 1988 and subsequently received the endorsement of the Division of MH/MR/SA. This plan laid out a set of services that would be available in each area of the state in amounts proportional to the at-risk SED youth population in the area. The plan was to be implemented in two phases. Phase I funding will be completed in FY1999.

C&A Outpatient: This is the basic level of service provided by a community mental health program to children and adolescents ages 0 through 17. Such services begin with psychological assessments and, if warranted, involve a variety of counseling services (e.g., individual, group, family) and case management.

Day Treatment: Treatment programs that are run after school hours and on weekends in a peer group setting where troubled youth learn how to handle difficult situations, get help with schoolwork, and make friends.

Disability: Disability results in serious functional limitations due to two or more indicators. These are

- behavior leading to public demand for intervention;
- substantial risk of harm to self or others;
- substantial inability to demonstrate daily living skills at an age-appropriate level;
- need for assistance from multiple community agencies;
- substantial need for care to augment or replace insufficient or unavailable natural support, i.e., capacity for living in a family or family equivalent;
- homeless and needing assistance in accessing public services and entitlements; and
- significant delay in perceptive and expressive language development and/or learning ability.

EBD: Emotionally or behaviorally disturbed. Similar to SED, but does not necessarily imply a severe level of disturbance.

First Placement/Best Placement: A pilot program (currently being tested in a few counties) designed to improve the assessment and placement process for children put into the custody of the Division of Family and Children Services. The goal of the program is to address the special needs of special need children from the beginning of their placement in DFCS custody. The program endeavors to reduce the possibility that a child will have to fail in several placements before being placed in a residential/treatment setting that will allow for success.

In-Home Crisis: When originally outlined in the C&A Capacity Plan, in-home crisis services were conceived as a set of services provided by a multidisciplinary team of approximately three providers. Teams could include persons with expertise in psychological counseling, behavioral management, general family support, child development, etc. This in-home crisis team model has been modified in a number of communities in order to individualize service. For example, a family may receive the services of only one or two crisis intervention workers who may have one or more various skills or who may be therapeutic generalists.

J.L. and J.R.: J.L. and J.R. versus Ledbetter Federal Court Case (hereafter referred to as J.L. / J.R.) was originally filed in 1975 against DHR. The case challenged the admission and confinement of children placed in psychiatric hospitals by parents and guardians without hearings and periodic reviews. DHR is still under a federal consent order as a result of the case. This order requires the state to proceed as expeditiously as is reasonably possible (1) to provide the necessary physical resources and personnel for whatever nonhospital facilities are deemed to be appropriate for these children and (2) to place these children in such nonhospital facilities as soon as reasonably appropriate (412 Federal Supplement p. 113, 1976). In 1991 Georgia Legal Services filed a contempt motion that alleged that DHR had violated the consent agreement by continuing to place children in state hospitals for extended periods. In response, DHR mandated that upon admission to a DHR-operated hospital, a discharge plan for each child is established, in order to ensure that children are placed in residential treatment according to their diagnosis and treatment needs. If there are no extenuating circumstances, a child must leave the hospital within 14 days of the date for discharge recommended by the hospital psychiatrist.

Level of Care Program: The generic term "level of care" which refers to the intensity of services provided to an at-risk child should not be confused with the Level of Care program which provides for increased payments based on the child's needs and increased resources for treatment and support services at the local level. Level of Care dollars flow from the state DFCS offices to the local DFCS offices where they are managed so as to support a higher level of care for emotionally disturbed and medically fragile children.

Respite: Foster home-like care used to give families and substitute families temporary rest and relief from the strain of caring for a youngster with severe problems.

SED Child or Adolescent: This is a child or adolescent having a clinically significant disorder of thought, mood, or behavior that is listed as an Axis I or II mental disorder in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-R). The disorder must have been at least one year in duration or is likely to be at least one year in duration, with the following exceptions and or conditions: Axis I—Primary diagnosis of Psychoactive Substance Abuse Disorder and V Codes will be excluded. Organic Mental Disorders are included only if behaviors are a danger to self or others. Axis II—Any level of mental retardation as the primary diagnosis will be excluded; however, on a case-by-case basis mild and/or moderate mental retardation with a mental disorder on Axis I may be included in the SED group. Autistic Disorder under Pervasive Developmental Disorders will be excluded. Primary Diagnosis of Specific Developmental Disorder, Other Developmental Disorder, and Borderline Intellectual Functioning will be excluded. Age: children and adolescents up to 18 years of age (in special circumstances, children and adolescents under 21 years of age) may be allowed to stay in treatment services, determined on a case-by-case basis.

Step-down: A residential placement that is at a level of treatment/care intensity that is less than the previous placement. A step-down placement is also less costly than the previous placement.

Therapeutic Group Homes: These offer 24-hour staff supervision for adolescents or older children whose emotional or behavior problems prevent them from living with a family.

Therapeutic Foster Care: A specially trained substitute family that is able to give a child a more intensive kind of support than the usual foster care.

TRIS: Therapeutic Residential Intensive Services is the name that the Department of Medical Assistance gives to the part of the MATCH program that involves reimbursement of Medicaid-allowed treatment expenses.

Wraparound Services: Wraparound services are services that can be individualized to the needs of the child and that tend to fall outside traditional service categories. Examples of wraparound services include behavioral health aides (in-school or at home), mentoring services, assistance with daily living, general family support, purchasing a club membership for a child, or hiring someone to accompany a child on a field trip so as to make the trip possible for the child. Wraparound services are considered to be an important part of best-practice treatment plans. Funding provided to the regions for SED services includes funding for wraparound services.

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