CENTER OF EXCELLENCE FOR
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GEORGIA SYSTEM OF CARE STATE PLAN 2017

Created by the Interagency Directors Team,
Pursuant to O.C.G.A. § 49-5-220

Prepared by the Center of Excellence for Children's Behavioral Health

Georgia Health Policy Center

Georgia State University | Andrew Young School of Policy Studies

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State Agencies

- **Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)***
- Georgia Department of Community Health (DCH)
- Georgia Department of Early Care and Learning (DECAL)
- Georgia Department of Education (DOE)
- Georgia Department of Human Services (DHS), Division of Family and Children Services (DFCS)
- Georgia Department of Juvenile Justice (DJJ)
- Georgia Department of Public Health (DPH)
- Georgia Vocational Rehabilitation Agency (GVRA)

Partner Organizations

- Amerigroup Community Care
- CareSource (as of January 2017)
- Center of Excellence for Children's Behavioral Health (COE), Georgia State University
- Center for Leadership in Disability, Georgia State University
- Children's Healthcare of Atlanta (CHOA; as of January 2017)
- Georgia Alliance of Therapeutic Services for Children and Families (GATS)
- Georgia Parent Support Network (GPSN)
- Get Georgia Reading – Campaign for Grade Level Reading
- Peach State (as of January 2017)
- The Carter Center
- Together Georgia
- Voices for Georgia's Children
- WellCare (as of January 2017)

Consulting Member

- Centers for Disease Control and Prevention (CDC)

National Training and Technical Assistance Center for Children's Behavioral Health (TA Network)

The TA Network is a partnership of 13 organizations with expertise in systems of care for children, led by the Institution for Innovation and Implementation at the University of Maryland, School of Social Work.

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***DBHDD,** in partnership with the Georgia Health Policy Center, founded the Center of Excellence (COE), funds the operations of the IDT, and funded the backbone support from the COE in this effort.

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Executive Summary

The state of Georgia has made significant investments in programs to improve children's mental health over the past 30 years. Within the past five to six years, Georgia has seen a flurry of activities, programs, and funding aimed at improving children's mental health. The success of these programs has been enhanced by interagency collaboration and communication. The 2017 Georgia System of Care (SOC) State Plan outlined in this report is the result of a renewed commitment to improving mental and behavioral health services for Georgia's children on behalf of state child-serving agencies, legislators, and community organizations representing youth, family, and providers.

SOC is an organizational framework for how behavioral health services and supports delivery systems can work together to fit the needs of a community, county, region, or state. The SOC framework is based on three core values: child-, family-, and person-centeredness; being community-based; and cultural competency. From 1984 to the present, Georgia has made numerous investments to develop its SOC. It is crucial that at this moment, with such a large amount of activity and investment in children's behavioral health, to create a new SOC to help support successful outcomes for Georgia's children.

Children, adolescents, and emerging adults (ages 4-26) with severe emotional disturbance (SED) are the focus of the 2017 Georgia SOC State Plan, as they are a prevalent, vulnerable population that requires an SOC approach to service and support delivery to truly function and thrive. Historically, when services and supports are delivered in a manner that is not in line with SOC core values or guiding principles, children, adolescents, and emerging adults with SED are at an increased likelihood of facing diminished functioning, with negative, recurrent, and more costly systems interactions over the course of their lives. In Georgia in state fiscal year (SFY) 2014, state agencies served over 100,000 children, adolescents, and emerging adults with SED and spent an estimated $263,976,378 of state funds on SED services and supports. The 2017 Georgia SOC State Plan aims to decrease costs and strains across systems while improving quality and access to care by streamlining and coordinating care for this vulnerable population.

In 2011, Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) created the Interagency Directors Team (IDT), which was composed of director-level members from all child-serving agencies in Georgia, as well as partner organizations. The IDT is the state's multiagency SOC leadership collaborative, whose mission it is to manage, design, facilitate, and implement the SOC in Georgia. Over 15 months (March 2016–May 2017), under direction of the Behavioral Health Coordinating Council (BHCC), and with the support of the Center of Excellence for Children's Behavioral Health and the National Training and Technical Assistance Center for Children's Behavioral Health, the IDT developed the 2017 Georgia SOC State Plan.

The IDT identified the five focus areas of this plan: **Access, Coordination, Workforce Development, Funding and Financing,** and **Evaluation**. **Access** and **Coordination** were deemed the most critical areas of focus. **Workforce Development** and **Funding** and **Financing** strategies can be conceptualized as methods through which to increase **Coordination** and **Access**. **Evaluation** wraps around the entire plan and feeds back into future planning efforts. Each focus area is aligned to a goal as well as short- and long-term strategies for achieving these goals. The timeline for implementation and summary of measures used to assess the success of the strategies that make up the 2017 Georgia SOC State Plan can be found later in this document.

Access

Access to an array of community-based services and supports is a core component of any functional behavioral health care system. For children and emerging adults, access to mental health services is critically important for early identification of mental health concerns and linkage to appropriate services. A focus on access was chosen to support children and families in their access to and navigation of mental health care services in Georgia. Short-term strategies to increase access to care include service mapping for behavioral health service utilization, increasing behavioral health services in schools, and improving families' abilities to navigate the current system. Long-term strategies include recruiting practitioners in shortage areas, strategically increasing the use of telemedicine and telehealth services, and increasing continuity of care.

Coordination

At the heart of the SOC approach are coordination and collaboration between child-serving agencies and organizations, and between the child, family, and the larger system. Coordinated communication systems between local, county, regional, and state bodies are a vital feedback loop to ensure that local and regional needs and resources are understood, and state and county-level policy objectives are being achieved. This area of focus was chosen as an integral part of a coordinated network that serves children and families. Short-term strategies to increase coordination include increasing training on SOCs for stakeholders and building and maintaining feedback loops between local, regional, and state agencies and systems. Long-term strategies include creating and utilizing a common language as it relates to discussing SOC principles, and addressing gaps in the crisis continuum by adding additional levels of care that will address capacity and acuity concerns: Crisis Respite; Intensive Care Coordination (IC3), and therapeutic foster homes.

Workforce Development

The behavioral health workforce in the United States is inadequate to meet current and growing service demands and behavioral health needs. Workforce issues can be compounded by geographic regions and characteristics, with rural areas at even more risk of experiencing workforce shortages. As over half of Georgia counties are designated as rural, the IDT has identified workforce as a major barrier to access to care for children and families. To develop, maintain, and support a culturally competent, trauma-informed workforce to meet the needs of children and youth, short-term strategies including targeted expansion of educational and financial incentives to address behavioral health workforce shortages and developing a clearinghouse of evidence-based educational materials that will be employed along with the long-term strategy of developing a state mental health workforce plan across agencies.

Financing

Cross-agency commitment to effective and efficient spending is necessary for a comprehensive, community-based, family-driven, youth-guided, culturally competent and trauma-informed SOC framework to operate in Georgia. The braiding and blending of interagency funds is a key way for multiple agencies to achieve more effective and efficient spending. In the short term, strategies to solidify interagency funding of the IDT as the oversight body for the SOC in Georgia and create and utilize SOC guiding principles for contract development will help to address this focus area. The long-term strategies to establish funding and financing for the SOC consist of reviewing financial mapping reports to find opportunities to braid or blend funding and the collaboration of IDT agencies in applying for and releasing funding opportunities and procurements when behavioral health is a key component.

Evaluation

Ongoing evaluation of Georgia's child-serving systems is critical to sustainability and success. To ensure that the proposed SOC is achieving its desired goals, the IDT will review evaluation tools to identify key metrics applicable to Georgia and provide these tools to the state, local, and regional teams as well as other child-serving systems to self-evaluate their SOC work. The long-term strategy for evaluation is for the IDT to institute and maintain a continuous quality-improvement process utilizing identified metrics that will be reviewed annually and regularly reported to the BHCC.

The following report is composed of four key parts that make up the 2017 Georgia SOC State Plan. First, the background of the SOC framework and the history of how this plan was created are described, including the need for a SOC in the state of Georgia and the plan development methods and structure. Then, the current landscape in Georgia is examined. Next, the proposed 2017 Georgia SOC State Plan is presented, including the conceptual framework, goal statements, strategies, and action items for each of the five focus areas. Finally, the timeline for implementation and summary of measures for the SOC State Plan are outlined in detail.

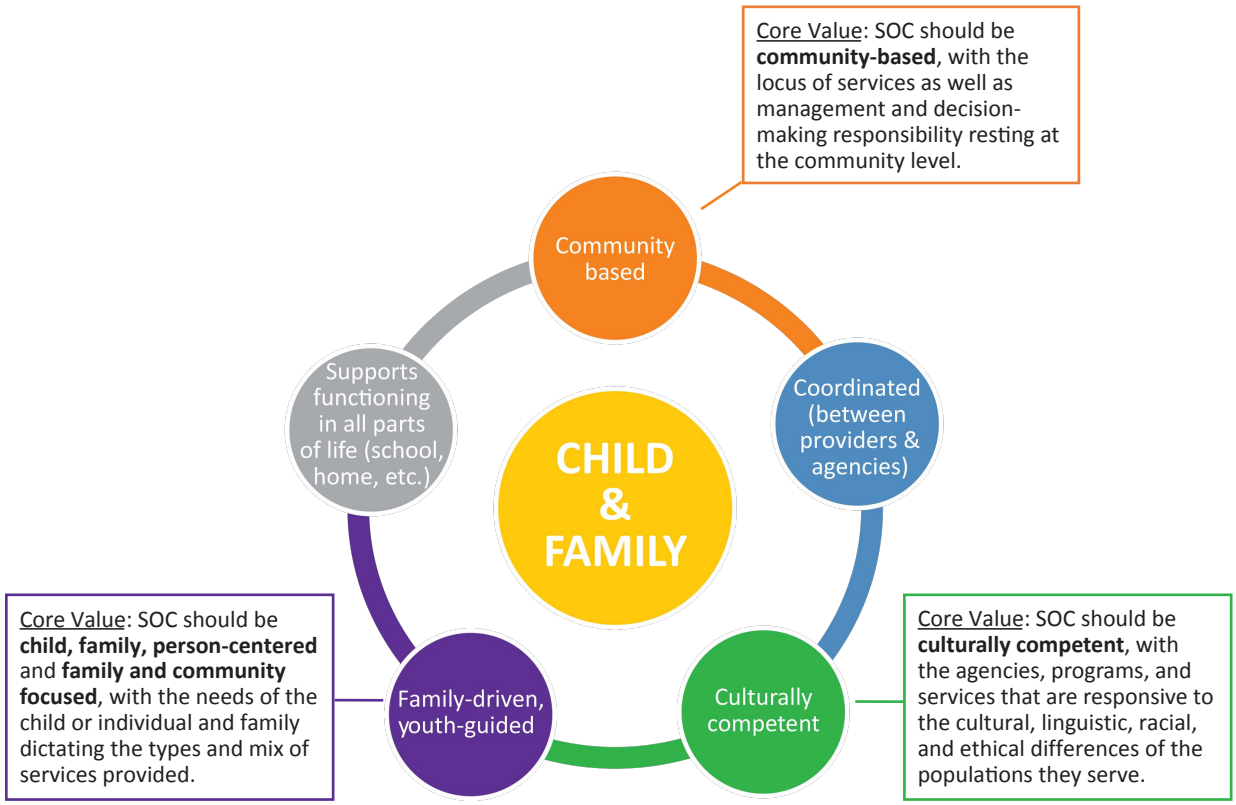
Introduction

Background of System of Care — Nationally and in Georgia

Definitions and Values

According to federal definition, the System of Care (SOC) framework involves "a spectrum of *effective, community-based services and supports* for children and youth with or *at risk* for mental health or other challenges and their families, that is organized into a *coordinated network*, builds meaningful *partnerships with families and youth*, and addresses their *cultural and linguistic needs*, in order to help them to *function better* at home, in school, in the community, and throughout life." (Stroul, Blau, & Friedman, 2010). SOC is an organizational framework for how a mental or behavioral health services and supports delivery system should work (not a program or intervention) and can be adapted to fit any community, county, region, or state.

Figure 1. SOC Approach to Service and Support Delivery



The framework, initially articulated by Beth Stroul and Robert Friedman in *A System of Care for Children with Severe Emotional Disturbance* (1986), focused on children with serious disorders. These values and core principles are now also being used to develop effective service-delivery systems for all children, including those with or who are at risk of emotional and behavioral problems. Over the past 30 years, SOC has become an increasingly prevalent guiding philosophy for the provision of children's mental health services, including the integration of scientific evidence-based practices into a formal systems framework. The SOC approach is based on three core values: child-, family-, and person-centeredness; being community-based; and cultural competency. These values are further supported by 13 guiding principles (detailed in **Appendix A**).

History of SOC — Key Events Nationally and in Georgia

The impetus for the SOC concept can be traced back to a 1982 study, which found that approximately 66% of children with serious emotional disturbance were not getting proper services due to a lack of coordination among child-serving agencies (Children's Mental Health Network, 2017). In response, the National Institute of Mental Health (NIMH) began the Child and Adolescent Service System Program (CASSP) in order to help states, through funding and technical assistance, better coordinate multiple state agency services for SED children. Two years later, Congress appropriated the first CASSP funds for a select number of states, and *Georgia was one of 10 initial states chosen*. At the same time, Georgia's Southeastern Regional Troubled Children Committee was awarded one of the first local SOC development grants. In 1986, Congress passed the State Comprehensive Mental Health Services Plan Act to cultivate coordinated community-based mental health services, and the term "System of Care" was defined. In 1992, the Substance Abuse Mental Health Services Administration (SAMHSA) and Children's Mental Health Initiative (CMHI — aimed at strengthening community-based services and supports for children and their families) were created by the federal government, and the SOC family-centered, community-based, coordinated approach to service delivery for children with SED spanned the entire nation, with CASSP grants in every state and CMHI funding to develop and implement SOCs in over 170 communities, tribal regions, or states (Children's Mental Health Network, 2017). By 2009, the federal CMHI budget had grown to $114 million.

From 1984 to the present, Georgia has made numerous investments in order to develop its SOC. These key investments and other important events have been outlined in Figure 2.

Figure 2. Georgia SOC: Key Events and Investments 1984-2016

1984	Georgia receives SAMHSA CASSP grant. 1986 Southeastern Regional Troubled Children Committee receives SAMHSA local SOC grant.
1987 - 1988	Georgia receives federal children and adolescent mental health (CAMH) Capacity Building grant and develops SED capacity building plan for expansion of community-based services.
1989	Based on Capacity Building Plan, Georgia Department of Human Resources, Division of Mental Health, Mental Retardation, and Substance Abuse (DMHMRSA) secures initial separate funding for expansion of CAMH through legislative appropriation.
	Georgia Parent Support Network Inc., Georgia's Federation of Families for Children's Mental Health chapter, founded.
1990	O.C.G.A. §§ 49-5-220 – 226 calls on Department of Education (DOE) and Department of Human Resources (DHR) to craft a five-year SOC State Plan and officially establishes local interagency committees.
1992	SAMHSA requires all states receiving mental health block grant funds to develop a separate children's plan addressing an organized, comprehensive, community-based SOC.
1993	SAMHSA requires all states receiving mental health block grant funds to spend no less than 10% to support the implementation of the children's mental health plan. DHR/DMHMRSA uses these funds and state funds to continue to support funding of the Capacity Building Plan.
1999	DHR/DMHDDAD completes Phase I of the Capacity Building Plan, garnering over $35 million for child and adolescent mental health services.
	U.S. Supreme Court delivers *Olmstead v. L.C.* decision.
2000	SAMHSA grant awarded to Rockdale and Gwinnett counties to create SOC collaboratives called Peachstate Wraparound Initiative (PSWI), eventually renamed KidsNet.
2004	Georgia receives SAMHSA Child and Adolescent State Infrastructure Grant (CASIG) funding. KidsNet Georgia becomes statewide SOC collaborative.

2005 DBHDD gets SAMHSA Substance Abuse Coordination (SAC) grant to develop and implement strategies to expand SOC approaches to service delivery for substance use disorders (SUDs) among children.

2006 Georgia receives Centers for Medicare and Medicaid Services (CMS) Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration grant and SAMHSA grants to create Community Based Alternatives for Youth (CBAY) program and Wraparound Initiative Northwest Georgia (WIN GA).

First state-sponsored annual SOC Academy is held.

Georgia DOE receives Positive Behavioral Interventions and Supports (PBIS) grant.

2009 Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) is created. O.C.G.A. § 37-2-4 creates Behavioral Health Coordinating Council (BHCC).

DBHDD gets CMS Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and SAMHSA Healthy Transitions grants.

The Department of Justice sues Georgia (citing *Olmstead*) for lack of community-based services (settlement agreement is reached in 2010).

2010 Interagency Directors Team (IDT) is founded from KidsNet Georgia statewide SOC collaborative. Governor's Office of Children and Families is created.

2011 DBHDD creates updated draft five-year state SOC plan; plan guides IDT.

Georgia Center of Excellence for Children's Behavioral Health (COE) is founded.

2012 DBHDD establishes Resiliency Support Clubhouse Program.

2013 HB 242 reforms juvenile justice code with large focus on community alternatives to detention and Children in Need of Services (CHINS).

IDT creates Georgia CAMH systems maps; The Centers for Disease Control and Prevention (CDC) joins IDT as consultant; IDT works on attention-deficit/hyperactivity disorder (ADHD) services.

DBHDD receives SAMHSA SOC Expansion and Implementation Cooperative Agreement Grant to create sustainable SOC infrastructure in the state and designates IDT as the grant's advisory body.

Georgia DOE hosts PBIS Summit.

2014 DOE receives Project AWARE (Advancing Wellness and Resilience in Education) grant.

Department of Public Health (DPH) receives Project LAUNCH grant in partnership with DBHDD.

Foster care youth transition to Medicaid managed care.

DBHDD and Department of Juvenile Justice (DJJ) initiate joint High Fidelity Wraparound pilot for SED youth in custody.

IDT creates CHINS reference sheets for judges.

2015 State child-serving agencies sign IDT memorandum of understanding (MOU). IDT drafts Operational Guidelines.

DBHDD initiates statewide, school-based mental health pilot.

Legislature passes school suicide prevention training; Senate initiates study committees on behavioral health and SUDs; House creates school-based health study committee.

Division of Family and Children Services (DFCS) initiates state blueprint for change for child welfare.

DOJ publishes findings and remediation requirements for DOE regarding Georgia Network for Educational and Therapeutic Support (GNETS).

2016 Department of Community Health (DCH) Medicaid works to further telehealth and telepsychiatry. DFCS implements Family First Prevention Services Act.

Multiple juvenile justice code rewrite initiatives continue to work on implementation.

DBHDD transitions school-based mental health pilot to program.

Why Does Georgia Need a SOC Plan Now?

Over the last 30 years Georgia has made significant investments through grants, agency policies, legislation, and other initiatives to develop its SOC, including two prior draft state SOC plans (illustrated in the previous timeline, Figure 2, pp. 11). Within the past five to six years in particular, Georgia has seen an expanded focus on activities, programs, and funding aimed at improving children's mental health, supporting the SOC philosophy in various ways. Thus it is crucial that at this moment, with such a large amount of activity and investment, a new SOC plan be created in order to help coordinate and enable the best outcomes from all of these moving parts.

Georgia is at a critical juncture with its SOC and in meeting the behavioral health needs of its children and young adults. At the end of 2015 there were four study committees of the Georgia General Assembly committed to children and child services. Georgia has had great success in agency collaboration with Project LAUNCH, Project AWARE, and the Cooperative Agreements for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Grant, and our SOC initiatives continue to grow. To facilitate implementation, the 2017 Georgia SOC State Plan will include a detailed implementation plan with a schedule of deliverables, accountability, and an evaluation plan to measure its outcomes. As a workgroup of the BHCC, consisting of the experts in the field, the IDT is uniquely designed and qualified to craft a SOC plan that will further guide the work of both groups and strengthen Georgia's SOC efforts over the next several years. Given the interest in children's behavioral health from both our state and national partners, and Georgia's proven success, the time is now to create a SOC state plan, and the IDT is the group to best do it. The last SOC draft plan was created in 2010 and was not fully implemented; a new 2017 Georgia SOC State Plan is needed in order to reflect the most recent updates to national SOC philosophy and teachings, the Georgia CAMH system and available services, and current needs of children with SED in the state.

Scope of the SOC State Plan

The 2017 Georgia SOC State Plan focuses on children, adolescents, and emerging adults (ages 4-26) with SED. SED is defined as:

> Diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-[V] that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities (*Federal Register,* 1993).

This definition only includes substance use or developmental disorders when they co-occur with another diagnosable SED. Further, functional impairment is defined as:

> Difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in their environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition (*Federal Register*, 1993).

In Georgia, during state fiscal year (SFY) 2014:

- State agencies served an estimated 100,395[1] children, adolescents, and emerging adults with SED.
- The most prevalent diagnoses of children served included ADHD, posttraumatic stress disorder (PTSD), bipolar disorder, anxiety disorder, and depressive disorder.
- Five primary state agencies provided services or supports to these children, adolescents, and emerging adults with SED: DCH (50,423), DBHDD (28,377), DOE (12,912), DJJ (5,683), and DFCS (3,000).
- The state spent an estimated $263,976,378 of state funds on SED services and supports.
- A grand total of $442,300,971 (state and federal funds combined) was spent on children, adolescents, and emerging adults with SED, equaling an estimated $4,405.61 per child.

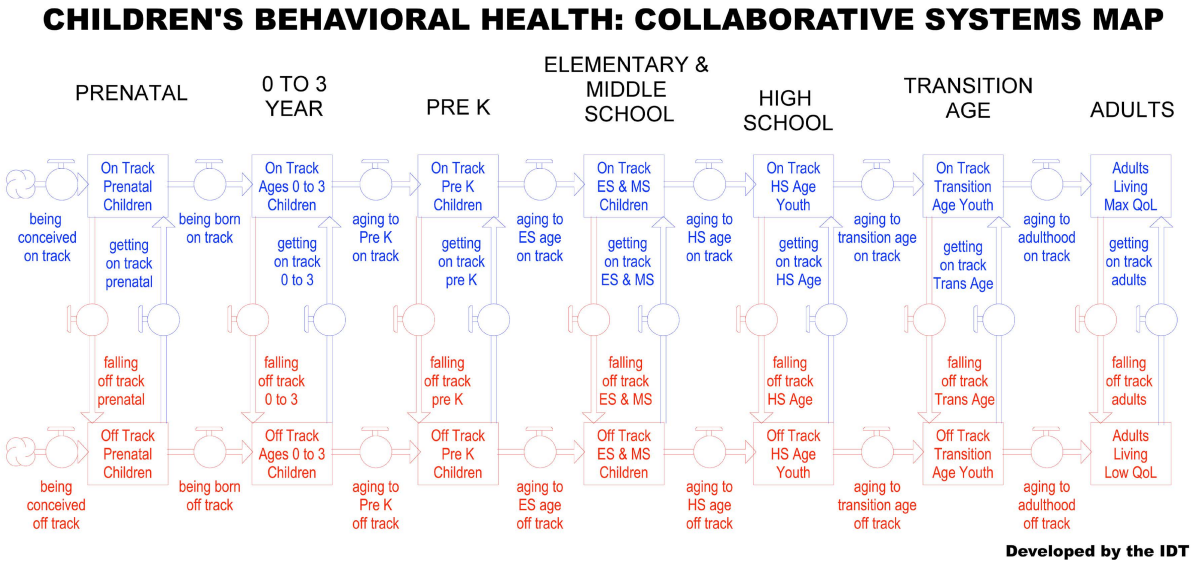
Children, adolescents, and emerging adults with SED are the focus of the 2017 Georgia SOC State Plan, as they are a prevalent, vulnerable population that requires a SOC approach to service and support delivery to truly function and thrive. Services and supports for children with SED and their families have historically been fragmented and lacked coordination (CMHN, 2017). Moreover, when services and supports are delivered in a manner that is not in line with SOC core values or guiding principles (highly coordinated, community-based, family- and child-focused), children, adolescents, and emerging adults with SED, due to their vulnerability, are at an increased likelihood of facing diminished functioning, with negative, recurrent, and more costly systems interactions over the course of their lives. In particular, children, adolescents, and emerging adults with SED are more likely to experience:

- SUD or other co-occurring disorders (Perou et al., 2013);
- Initial and repetitive juvenile and criminal justice system interaction (Hammond, 2007);
- Lower academic functioning and higher dropout rates (National Association of School Psychologists, 2012);
- Chronic health conditions, emergency department visits, and in-patient hospital stays (Perou et al., 2013); or
- Suicide ideation, suicide attempts, or suicide (Perou et al., 2013).

The following CAMH systems map, created by IDT in 2013 (Figure 3), illustrates how a child with SED can fall off track from functioning at any time, and if they are not provided with the right services and supports, can remain off track and suffer numerous difficulties through adulthood. A SOC approach to service and support delivery seeks to ensure that children with SED and their families receive what they need to stay on, or get back on, track.

[1] This figure may include duplicate counts of children who experienced multiple agency contacts in 2014.

Figure 3. IDT Systems Map — Child Development On- and Off-Track



It is undeniable that preventive care (particularly in early childhood) is extremely important in starting children on track to identify and inhibit (where possible) the development of SED in a child. However, because of the pressing need for coordinated and appropriate service delivery for children (ages 4-26) *currently diagnosed* with SED, which is the basis of the SOC concept, the three-year 2017 Georgia SOC State Plan focuses on aligning Georgia's resources in order to create a targeted SOC approach to help those children remain or be returned back on track. In future years, it is possible that an updated Georgia SOC State Plan could be expanded to include broader preventive services and supports for children not yet diagnosed with SED.

Roles of the IDT and BHCC

In 2011, DBHDD created the IDT as the working group of the BHCC, devoted to developing and maintaining Georgia's SOC for children and youth with SEDs. The IDT helps promote and realize the initiatives of the BHCC, and the BHCC provides high-level support and guidance to the IDT.

The IDT, as the state's multiagency SOC leadership collaborative, whose mission it is to manage, design, facilitate, and implement the CAMH SOC in Georgia, has led the development of the 2017 Georgia SOC State Plan. IDT is a working group of the BHCC[2] and is composed of director-level members from all child-serving agencies in Georgia, as well as a number of partner organizations representing youth, family, and providers. IDT has been in operation since 2011 (and prior to that in the form of the KidsNet Georgia state collaborative since 2004). IDT state agency members include DBHDD, DOE, Georgia Vocational Rehabilitation Agency (GVRA), the Department of Early Care and

[2] The BHCC was created by O.C.G.A. § 37-2-4 to identify and ensure the coordination of overlapping behavioral health services, funding, and policy within the state and between state agencies. The BHCC is led by the commissioner of DBHDD and is composed of commissioners from each relevant state agency, as well as legislators, consumers, consumer family members, and state ombudsman.

Learning (DECAL), DCH, DFCS, DJJ, and DPH. Provider groups, care management organizations, and family and child advocacy organizations serve as partner agencies, and the CDC as a federal consultant. For a full list please see the Acknowledgements section.

From its inception, the IDT was created to further develop Georgia's SOC for children, adolescents, and emerging adults, and serves as the multiagency oversight body for Georgia's System of Care Expansion Implementation grant for children and youth with SED. Over the past few years, IDT has gained momentum in its ability to successfully coordinate between agencies and take on particular children's mental health challenges for the state. Given its member composition, SOC mission, expertise, and track record of success, IDT was the natural body to take the lead on developing the Georgia SOC State Plan. The IDT will create and modify the plan with high-level guidance, review, and input from the BHCC.

Plan Development, Methods, and Structure

How Was the SOC Plan Created?

Over 15 months (March 2016–May 2017), under direction from the BHCC, the IDT developed the 2017 Georgia SOC State Plan. Georgia has developed SOC plans in the past, and, as documented previously, possesses a great deal of expertise and experience in SOC work. In addition to local expertise, the IDT enlisted the help of the National Training and Technical Assistance Center for Children's Behavioral Health (TA Network). The TA Network is a partnership of 13 organizations with expertise in SOCs for children, led by the Institution for Innovation and Implementation at the University of Maryland, School of Social Work. The TA Network provides training and technical assistance to SAMHSA SOC grantees and other state and local agencies seeking to improve children's behavioral health care. Through funding from the SAMHSA's Child, Adolescent and Family branch, the TA Network was able to provide support to the process in the form of:

- Process guidance;
- Regularly scheduled and ad hoc phone and email contact and support;
- Document review and feedback;
- Two-day on-site group facilitation (July 2016); and
- Direct mentorship and provision of expertise to COE staff to collaboratively produce draft documents.

The work began in March 2016 when a workgroup, specific to SOC state plan creation, convened and began to explore consultants and to devise the plan process. By May 2016, the TA Network had agreed to assist in plan creation by providing the supports listed above.

With support from the TA Network, the COE solicited and gathered historical SOC documents from Georgia. A matrix was created with descriptions and recommendations for each report. Additionally, the COE collected SOC state plans from Connecticut, Nebraska, Maryland, and Vermont, and created a matrix of methods, summaries, and focus areas. These materials were shared with the SOC workgroup prior to their July 2016 meeting to inform the discussion and ensure that historical work and documents were built upon, rather than duplicated. Two representatives from the TA Network facilitated a workgroup meeting July 11–July 12, 2016. During this meeting, the IDT identified the five focus areas of this plan: Access, Coordination, Workforce Development, Funding and Financing, and Evaluation. On the second day, then-DBHDD Chief of Staff Judy Fitzgerald spoke to the group, supporting the work of the plan and providing high-level guidance.

Over the course of the two days, the workgroup:

- Completed an environmental scan to ground and contextualize the work;
- Determined broad goals and needs to be met by the plan;
- Agreed upon a scope and timeframe for the plan;
- Utilized historical Georgia documents to identify focus areas;
- Created and refined goal statements for each of the chosen focus areas;
- Identified agency-specific outcome measures; and
- Created both short-term (one-year) and long-term (two- to three-year) objectives for each focus areas.

The COE then synthesized this information, which was presented to the larger IDT for input and feedback at the November 2016 meeting. After this input was integrated by the COE, the information and work was presented to the BHCC in December 2016 in the form of a PowerPoint presentation. The BHCC granted its permission and support in moving forward. Again, the COE and IDT consulted with the TA Network for guidance, and it was decided to utilize the IDT meetings as working meetings to create a fully fleshed-out draft for presentation to the BHCC in May 2017. The COE facilitated and supported the IDT meetings as the group formed workgroups around the following focus areas: Access, Coordination, Workforce Development, and Funding and Financing. For each area, workgroups identified both short-and long-term Action Items. These were integrated into the sections that you will see below. After vetting from the entire IDT, the group created the Implementation Plan and Summary Table.

IDT and Larger Stakeholder Input

After feedback and input from the BHCC, the IDT plans to engage the broader stakeholder community. Feedback will be solicited via an online form on the IDT webpage, where the plan will be made public. Additionally, IDT will plan and host focus groups for children, youth, and families to solicit real-time feedback for later incorporation.

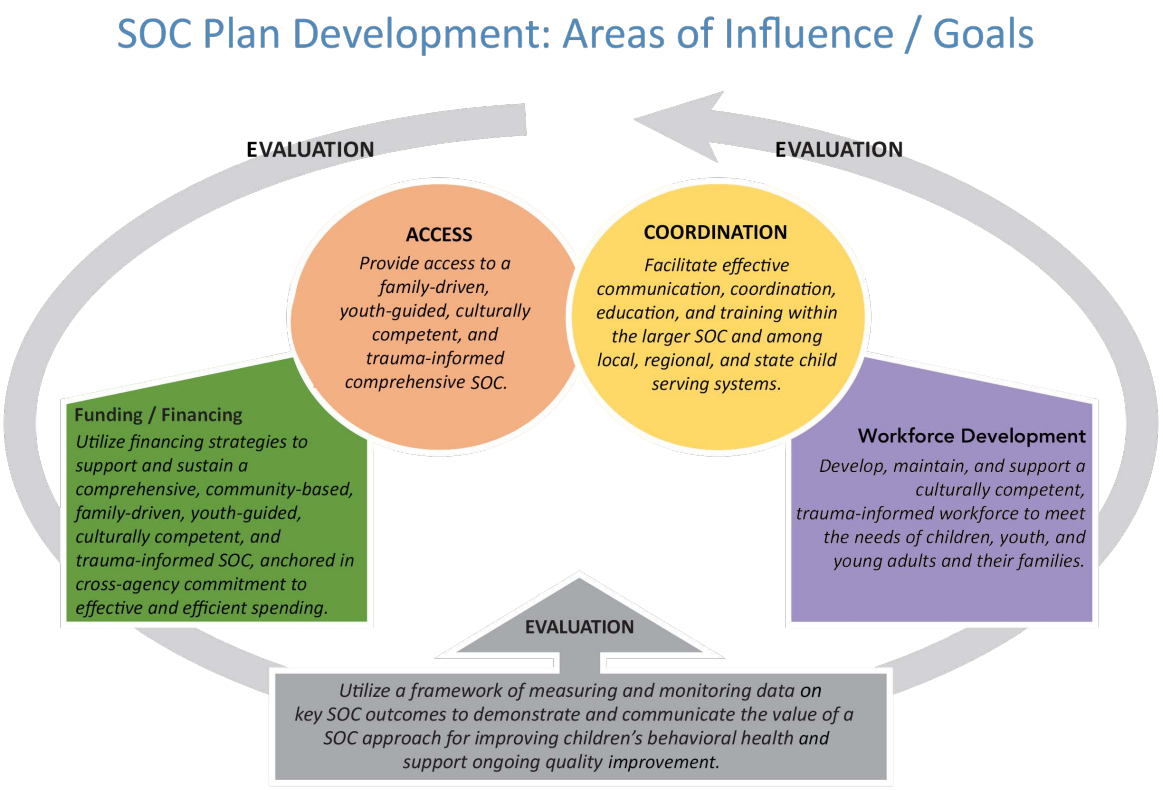
Plan Structure

The Georgia SOC State Plan is built around the following five areas of focus:

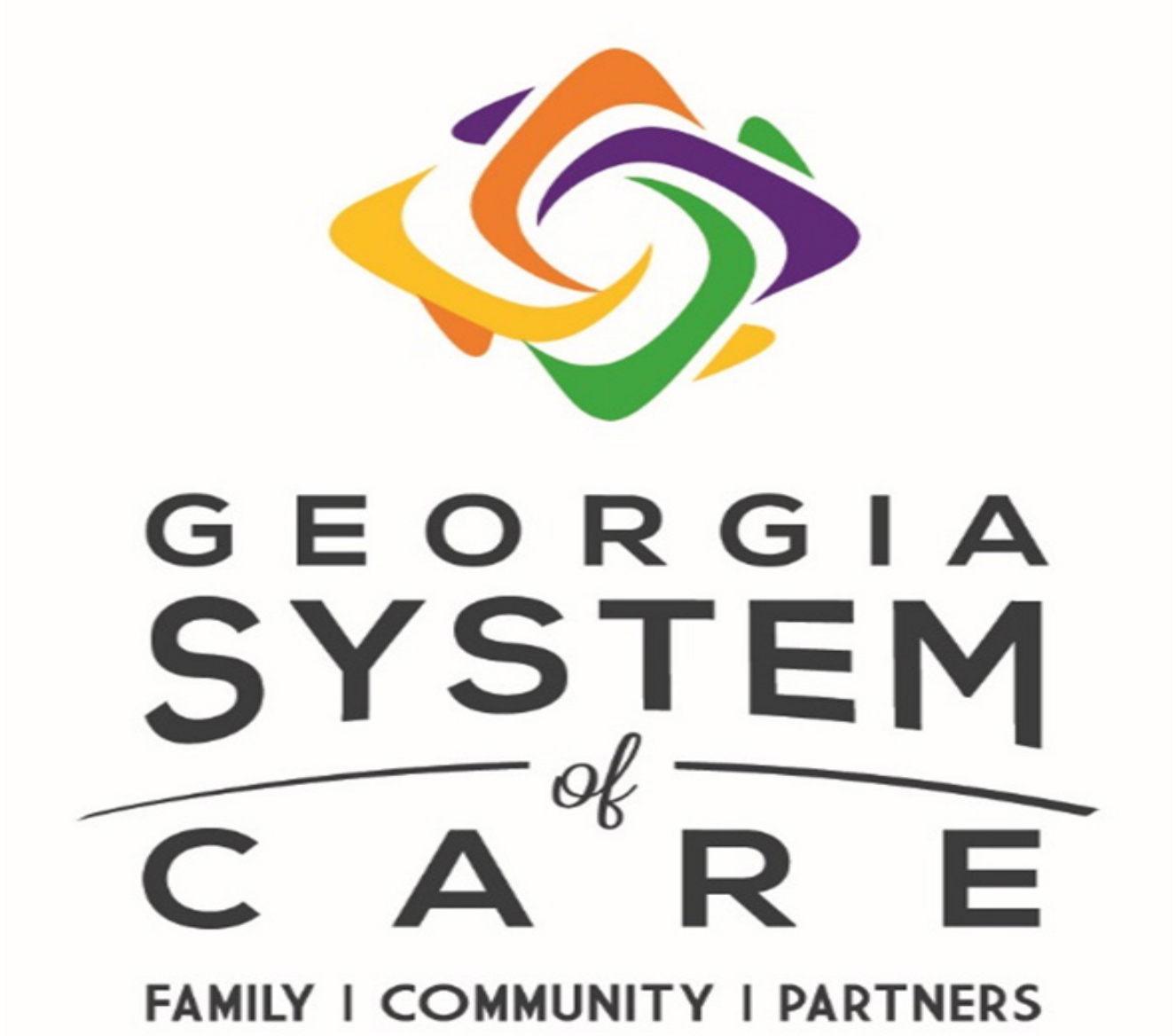
- Access;
- Coordination;
- Workforce Development;
- Funding and Finance; and
- Evaluation.

During the two-day in-person meeting, facilitated by the TA Network, the group identified these areas as the most salient and in need of attention. Additionally, the IDT created the following conceptual framework, integrating the focus areas and providing clarity to their relationships. Access and Coordination were deemed the most critical areas of focus. Workforce Development and Funding and Financing strategies can be conceptualized as methods through which to increase Coordination and Access. As a focus area, Evaluation wraps around the entire plan and feeds back into future planning efforts.

Figure 4: SOC State Plan Conceptual Framework



For each of the focus areas, the SOC State Plan workgroup created goal statements. Utilizing previous Georgia documents, goal statements were updated and revised by the group. They then created both long-term and short-term strategies for each area. The next section details the focus areas, provides justification and rationale for why they were chosen, and presents and explains the Action Items for each, chosen by the group, and how they hope to achieve the goals.


GEORGIA
SYSTEM
of
CARE
FAMILY | COMMUNITY | PARTNERS

Focus Area 1: Access

Goal statement: Provide access to a family-driven, youth-guided, culturally competent and trauma-informed comprehensive System of Care to meet the needs of children, youth, and young adults with severe emotional disturbance (SED), substance use disorders, and co-occurring disorders.

Short-term Strategies		Long-term Strategies	
1.1	Service mapping for behavioral health service utilization	1.5	Utilize data to inform a strategic approach to access
1.2	Increase behavioral health services available in schools	1.6	Recruit practitioners in shortage areas
1.3	Improve families' abilities to navigate the current system	1.7	Support continuity of care by addressing continuity of eligibility for Medicaid (address children and youth going on and off the Medicaid roll)
1.4	Increase utilization of Intensive Care Coordination (IC-3) services	1.8	Strategically increase the use of telemedicine/telehealth services within child-serving agencies

Access to an array of community-based services and supports is a core component of any functional behavioral health care system. For children and emerging adults, access to mental health services is critically important for early identification of mental health concerns and linkage to appropriate services. One in five children in the United States has a diagnosable mental health disorder, but only 21% of those children needing mental health services receive care (American Academy of Pediatrics, 2017). Lack of care can be due to multiple factors, including cost, stigma, and a lack of available services, particularly in rural areas. In Georgia, approximately 19% of children live in rural areas (Georgia's Online Analytical Statistical Information System, 2015), where access to medical, dental, and mental health care services is impaired by an inadequate provider base, long distances to clinics, and less insurance coverage for rural Georgians (Georgia DCH, 2015). In particular, there is a lack of rural mental health care providers of services for children in Georgia (Knopf, 2013). A recent report noted that there were 185 practicing child and adolescent psychiatrists in Georgia. Given the population of children in Georgia, this equates to approximately seven child and adolescent psychiatrists per 100,000 children (American Association of Child and Adolescent Psychiatry, 2015). In this report, 123 (77%) of the 159 counties in Georgia did not have a practicing child and adolescent psychiatrist (American Association of Child and Adolescent Psychiatry, 2015). Behavioral health provider shortages impair access to timely mental health services for children. As we know that behavioral health issues can impact a child's and family's well-being, academic progress, and future productivity, as well as the problems we see in the education, juvenile justice, and child welfare systems, this lack of care must be addressed. A focus on access was chosen to support children and families in their access to and navigation of mental health care services in Georgia, a persistent challenge in the current system. The group arrived at the following short- and long-term strategies to address this challenge.

Short-term Strategies

Strategy 1.1 Service mapping for behavioral health service utilization

To strategically reduce barriers to accessing services, it is important to obtain data on behavioral health service utilization and the specific counties and service areas where access is heavily impaired. We must know what we have before we can determine what we need. This data-driven approach will allow for targeted service expansion and provider recruitment in areas with greater barriers to service access.

Action Item 1.1.1	Utilize the following data sources: DCH/DBHDD and Voices, MH professional shortage areas; analyze by service area and county; identify proxies for key indicators to track and share
Action Item 1.1.2	Create a centralized location for data sources

There is no clear repository for data on available services, particularly those that serve Medicaid and care management organization (CMO)-covered lives, state-contracted services, and private practitioners who accept only private insurance or self-pay clients. Much of this data exists and will need to be synthesized and interpreted to be effectively utilized to discover gaps and opportunities to strengthen the system and improve access for children and families.

Strategy 1.2 Increase behavioral health services available in schools

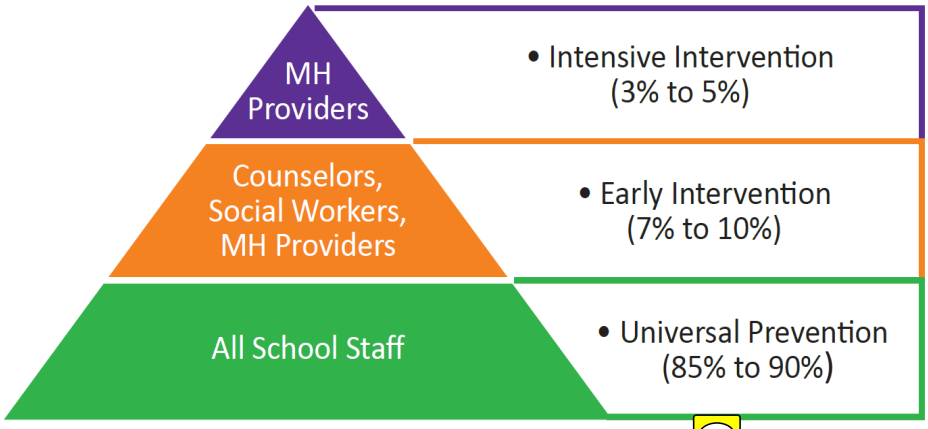
School-based mental health (SBMH) programs promote access to mental health services, increase early identification of mental health needs, and provide interventions for children in need of behavioral health services. Based in the school setting, these programs provide a continuum of behavioral health care to students and their families. Further, such programs foster collaboration between school systems, mental health providers, and other community stakeholders (Georgia Health Policy Center, 2015).

Framework for School-Based Mental Health Services

Although there are a variety of frameworks that guide SBMH programs, one of the most common is a three-tiered conceptual model (Colorado Department of Education, 2007; Costello-Wells, Ladrienne, Reed, & Walton, 2003; Fox et al., 1999). Under this design, the provision tiers of school-based mental health services can be viewed as a triangle with three distinct levels (Figure 5). At the base of the triangle lies Tier 1: Universal Prevention. Tier 1 services are geared toward the entire school population (i.e., schoolwide programs that promote positive behavior, such as Positive Behavior Intervention and Supports [PBIS] or Mental Health First Aid programs). Approximately 85% to 90% of students have their needs met in this tier, with the ultimate goal of preventing the need for more intensive interventions. As services in Tier 1 are generalizable to an entire

school, providers of Tier 1 services include all school staff members. Above Tier 1 lies Tier 2: Early Interventions. Services in Tier 2 are geared toward a subset of students in a school who are at risk for developing mental health concerns (e.g., social skills trainings and short-term counseling). Approximately 7% to 10% of students have their needs met in this tier. Because services in Tier 2 target at-risk students, providers of these services are more specialized, such as school counselors, social workers, or mental health providers. Finally, at the top of the triangle lies Tier 3: Intensive Interventions. Services in Tier 3 are tailored to high-risk students and are highly individualized (e.g., personalized, function-based behavior intervention plans and long-term counseling). Approximately 3% to 5% of students require supports in this tier. Because of the increased intensity of services provided in Tier 3, providers of these services are generally school mental health providers (Colorado Department of Education, 2007; Costello-Wells, Ladrienne, Reed, & Walton, 2003; Fox et al., 1999).

Figure 5. Three-Tiered Approach to School-Based Mental Health



Source: Miles, J., Espiritu, R., Horen, N., Sebian, J., & Waetzig, E. (2010). *A Public Health Approach to Children' Mental Health: A conceptual framework*. Washington, D.C.: Georgetown University Center for Children and Human Development, National Technical Assistance Center for Children's Mental Health.

In recent years, several initiatives have launched in Georgia that utilize behavioral health services in schools as an approach to reducing barriers to access. The Georgia Apex Project, supported by DBHDD, is focused on building infrastructure and increasing access to mental health services for school-aged youth throughout the state. The Apex Project, which began in school year 2015-16, recognizes that schools are a natural environment for identification and intervention and aims to reduce the number of youth with unmet mental health needs, and supports community mental health providers to partner with schools and provide school-based mental health services. In addition, the program increases coordination between local schools and the state's community behavioral health system. Also situated in schools, Project AWARE is a five-year SAMHSA grant that was awarded to the Georgia DOE in September 2014. Project AWARE, currently implemented in three school districts, provides training in youth mental health first aid and focuses on developing processes and procedures for connecting youth and families to community-based mental health services. These programs, as well as others in Georgia, are a valuable resource for increasing behavioral health services in schools. The DOE has also worked in current years to expand implementation of Positive Behavioral Intervention and Supports (PBIS) programs to districts and schools throughout the state.

Action Item 1.2.1	Establish a baseline measure of schools that self-identify as having access to all three tiers of school-based mental health services
Action Item 1.2.2	Increase the number of schools with access to all three tiers of school-based mental health services
Action Item 1.2.3	Increase the number of students receiving services in the school setting

Child-serving agencies will continue to coordinate school-based services to increase access and reduce barriers for children and their families. Again, the IDT will first measure what exists in order to expose gaps and opportunities to strategically support the continued expansion of all three tiers of SBMH services throughout the state. This information can provide guidance for future program and strategic interventions.

Strategy 1.3 Improve families' abilities to navigate the current system

Understanding the types of services and supports offered, where to receive them, the continuum of care when transferring between child-serving systems, how to navigate this system, and other processes of behavioral health care can be a challenging and complex task. For many parents and youth, this serves as a barrier to accessing services. Creating resources to help families navigate the system could enhance the ability of youth and their families to access services in Georgia.

Action Item 1.3.1	Create resource tools for families and youth
Action Item 1.3.2	Create an orientation to services for families and youth for each IDT member agency
Action Item 1.3.3	Create resources for youth ages 18-26 to assist with self-navigation of services

Mental health services for children and youth can be fragmented and difficult to access, creating delays in care and unmet needs. As the Georgia SOC continues to evolve and become more cohesive, agency services can remain in silos that are difficult to navigate. As a first step, short-term action items pertain to the creation and dissemination of resource materials for youth and families to help in navigating what can be a complex and difficult system.

Strategy 1.4 Increase utilization of Intensive Care Coordination (IC-3) services

The SOC approach holds at its center the principle of keeping youth and families together, in their own home, with appropriate services and supports.

Beginning in 2006, the state was awarded a grant for the CMS PRTF demonstration waiver. As a part of the grant, the state Medicaid and behavioral health authorities collaborated on implementing High Fidelity Wraparound services. Subsequently, the state was required to submit a 1915 C waiver application to CMS, which created the CBAY waiver as the mechanism for implementing the grant. A small subset of providers were trained in the High Fidelity Wraparound (HFW) model and worked with national fidelity experts to implement and refine the service-delivery model. At the termination of the grant the state was charged with a sustainability plan that included multiple funding mechanisms to continue the HFW model. Given that the fund sources also have variable termination dates, the state has chosen to rename that service as Intensive Customized Care Coordination (IC3) and will implement that service in summer 2017 as a part of the state's Medicaid plan. Because the original grant was targeted to a limited number of individuals, it is expected that the state plan will cover a larger number of covered youth eligible to receive the service.

For Medicaid providers to receive reimbursement for these services, it is essential that they have an understanding of these services and authorizations. Thus, trainings on this service model are critical to implementation.

Action Item 1.4.1	Add this service to the Medicaid State Plan
Action Item 1.4.2	Produce baseline utilization data for year 2016 to create a benchmark
Action Item 1.4.3	Train providers on this service model
Action Item 1.4.4	Perform quality-assurance activities to ensure fidelity; use data for decision-making in place

Not only should providers have a clear and thorough understanding of the IC3 service codes, fidelity to the Wraparound model should still be monitored. Data can then be utilized to inform future training and implementation efforts.

Long-term Strategies

Strategy 1.5 Utilize data to inform a strategic approach to access

Utilizing data for dissemination, recommendations, and monitoring of access-related action items is crucial to ensuring strategic and data-driven systems change (Preskill, Parkhurst, & Juster, 2014). Data gathered in strategy 1.1 will be evaluated, analyzed, and incorporated into efforts that inform programmatic improvement and support the increase of children's access to behavioral health services.

Action Item 1.5.1	Compile data from strategy 1.1 and create a communication and dissemination plan
Action Item 1.5.2	Share information with key stakeholders that can influence the access process (purchasing authorities and state agencies)
Action Item 1.5.3	Utilize data to develop recommendations for improved care

A central repository for data will be key in coordinating data-sharing and integration. Georgia agencies do not currently have a shared data repository and very few shared measures. To better coordinate agency funding and services, data about child and youth behavioral health providers, education, and juvenile justice efforts should be compiled, analyzed, and then utilized to identify opportunities for system improvement.

Strategy 1.6 Recruit practitioners in shortage areas

The behavioral health workforce has faced shortages for decades, contributing to problems with access. This is particularly salient in rural areas. It is estimated that in Georgia, there are about 11 psychiatrists per 100,000 people, and only about six child and adolescent psychiatrists per 100,000 youth — ratios that are below national averages (Walker et al., 2015). These workforce shortages are felt even more acutely in rural areas, where children and families are even less likely to have access to a provider (New Freedom Commission on Mental Health, 2003). Targeted interventions to recruit and incentivize providers in shortage areas aim to reduce disparities in access.

Action Item 1.6.1	Research shortage area plan from other states and Georgia
Action Item 1.6.2	Work with schools of social work, psychology, etc. to identify incentives and ensure training programs address the needs of youth and families in shortage areas
Action Item 1.6.3	Increase the number of peer specialists for parents and youth throughout the state

The IDT prioritizes the three approaches above and will present them to the BHCC as a potential budget request that state agencies can support. A number of strategies have been employed nationally, by other states, and in state by the DPH in attempts to address the workforce shortage. The IDT will examine previous efforts and identify strategies that could work in Georgia.

DBHDD is currently working with the University of Georgia's School of Social Work to ensure that training systems are responsive to the needs of the state in terms of public-sector workforce. This partnership may be expanded and used as a model for implementing similar partnerships that promote the training and recruitment of mental health service providers to strengthen the workforce that serves children in Georgia.

Georgia is a leader in Certified Peer Specialist Services. In 2017, Youth and Parent Peer Support services were added to the Georgia Medicaid State Plan. An important component in recovery and adjunct to the care team, peer support services can ameliorate some of the provider shortages throughout the state, and the IDT sees value in continuing to increase the number of available supports.

Strategy 1.7 Support continuity of care by addressing continuity of eligibility for Medicaid (address children and youth going on and off the Medicaid rolls)

In 2016, Georgia had three CMOs, by far the largest segment of children. Each CMO has its own contract with the state that may cover slightly different things and require authorizations for some services. Agency directors and local provider stakeholder groups came to notice that children often lost coverage when premiums were not paid and that children went on and off the rolls often. This created an access issue, as the providers had to check coverage status each time a service was provided. It also left some providers unable to collect payment if the child was in a coverage gap. To ensure continuity of care, it is critical that children maintain coverage without jumping on and off the Medicaid and CMO rolls.

Action Item 1.7.1	Provide more resources for training, navigation, and paid eligibility workers in social service agencies
Action Item 1.7.2	Provide support and education about eligibility for youth aging out of foster care
Action Item 1.7.3	Create baseline data; evaluate improvement annually

The IDT sees this as an issue of education and misunderstanding. Through an analysis of Medicaid eligibility policies and training to various stakeholders, the group hopes to address this issue. A more clear understanding on the provider side could also contribute to a decrease in service provision for uncovered children.

Strategy 1.8 Strategically increase the use of telemedicine/telehealth services within child-serving agencies

In addition to strategy 1.6, telemedicine technology exists as an opportune vehicle to increase provider capacity and reach, particularly to rural areas. Telemedicine for behavioral health services stands as one possible solution to the problem of limited mental health care access in rural Georgia (Knopf, 2013). Telemedicine for behavioral health is the delivery of mental health services via electronic means, usually videoconferencing (American Telemedicine Association, 2013). In 2016, according to the Georgia Partnership for Telehealth, there were 45 partner locations in Georgia that offered behavioral health services through telemedicine (Georgia Partnership for Telehealth, 2016). In addition, Georgia's DPH currently has telecommunication capacity in 157 out of 159 counties and is actively engaged in developing a network of telemedicine-capable clinics and offices (Georgia Department of Public Health, 2016). In regard to children, school-based health centers (SBHCs) are an increasingly common site for the provision of mental health services, and comprehensive SBHCs include both a primary care and behavioral health provider on-site (School-Based Health Alliance, 2014). Currently, there are 22 comprehensive SBHCs operating in Georgia (Georgia School-Based Health Alliance, 2016). Nationally, utilization of telemedicine technology is low in SBHCs (7.3%) but somewhat higher in rural areas (12.7%; School-Based Health Alliance, 2014). Broadly, Georgia has many of the necessary policies in place to support behavioral health services delivered through telemedicine as a strategy for increasing children's behavioral health service access, particularly in rural areas.

Action Item 1.8.1	Service mapping of behavioral health services provided through telemedicine (subset of 1.1 using a GT billing modifier)
Action Item 1.8.2	Current status scan on public payer policy on the use of telemedicine
Action Item 1.8.3	Mapping of where telemedicine facilities are located for behavioral health services

Understanding the current utilization of telemedicine for behavioral health services will allow a baseline measurement for determining where and how much to increase the use of these services. Additionally, understanding the current public payer policy on the use of telemedicine will allow for the closure of gaps in service continuity. An understanding of where these services are offered will allow for the strategic placement of additional resources for telemedicine in areas that are underserved in terms of children's behavioral health services.

Access to an array of appropriate services is a struggle for any system but undeniably key in meeting the needs of children and youth with SEDs and their families. The IDT hopes that the above strategies will increase access across the state.

Focus Area 2: Coordination

Goal statement: Facilitate effective communication, coordination, education, and training within the larger System of Care and among local, regional, and state child-serving systems.

Short-term Strategies	Long-term Strategies
2.1 Build and maintain feedback loops between local, regional, and state agencies and systems	2.3 Create and utilize a common language (as it relates to discussing SOC principles and making the business case to internal and external stakeholders)
2.2 Increase training on SOC for all stakeholders	2.4 Address gaps in the crisis continuum by adding additional levels of care that will address capacity and acuity concerns: Crisis Respite; IC3; therapeutic foster homes

At the heart of the SOC approach are coordination and collaboration between child-serving agencies and organizations, and between the child, family, and larger system. The IDT serves as the multiagency leadership collaborative that strives for an integrated and coordinated approach to serving children in the community. Not only is coordination between child-serving agencies conducive to an effective and efficient system, coordinated and communication systems between local, county, regional, and state bodies are a vital feedback loop to ensure that local and regional needs and resources are understood, and state and county-level policy objectives are being achieved. This area of focus was chosen as an integral part of a coordinated network that serves children and families.

Short-term Strategies

Strategy 2.1 Build and maintain feedback loops between local, regional, and state agencies and systems

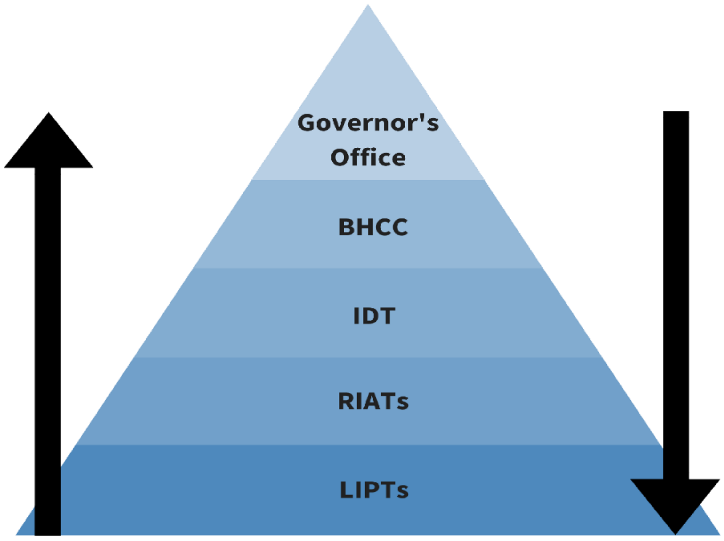
Georgia's system is designed with local, regional, and state-level SOC infrastructures that complement and support each other. Local Interagency Planning Teams (LIPTs), required by Georgia Code § 49-5-220-227, were established at the local level to improve and coordinate services for children and youth with SEDs. LIPTs often exist at the county or multicounty level, and some are more active than others. Their main charge is to ensure that children and youth receive necessary and coordinated services in the community. In 2009, DBHDD created Regional Interagency Action Teams (RIATs) in each of DBHDD's six service regions to support the work of the LIPTs. LIPT chairs in each of the DBHDD regions formed the makeup of RIATs. Meetings were held quarterly to identify

challenges and barriers to service delivery at the regional level. RIATs were also able to identify training needs, share successes and challenges, and plan for services throughout the region. Some RIATs discontinued meeting a few years ago, and currently some LIPTs are more active and efficient than others. One of the reasons for this variability has been the lack of a legislative or formal mandate for the RIATs as well as a point of accountability identified at the state level or capacity needed to support continued operations of these bodies. The IDT recommends reconstituting the RIATs, an important link missing from Georgia's SOC infrastructure.

Per Georgia Code § 37-2-4, Georgia's BHCC was created in 2010 to "to identify overlapping services regarding funding and policy issues in the behavioral health system." The BHCC is a commissioner-level collaborative that supports behavioral health services throughout the state. The BHCC is chaired by the commissioner of DBHDD, and members include commissioner- and director-level representatives from each state agency that is impacted by behavioral health, as well as members of the Georgia Legislature, and family and consumer representatives.

In 2011, DBHDD created the IDT as the working group of the BHCC, devoted to developing and maintaining Georgia's SOC for children and youth with SEDs. The IDT helps promote and realize the initiatives of the BHCC, and the BHCC provides high-level support and guidance to the IDT. State-level support should be provided by the IDT and BHCC to the RIATs and LIPTs; however, without effective feedback loops between these levels of coordination and collaboration, local needs may go unmet. Additionally, state-level initiatives and priorities need to be passed down to the local level for implementation. Georgia has a clear structure for how collaboratives are organized at the local, regional, and state level. A clear communication protocol and active feedback loops are vital to the SOC approach, as is support for the infrastructure of the RIATs and LIPTs.

Figure 6: Feedback Loops



Action Item 2.1.1	Create and distribute a list of all LIPT chairs to all SOC partners
Action Item 2.1.2	Identify a point person to facilitate organizational structure and communication among and between the LIPTs, RIATs, IDT, and the BHCC
Action Item 2.1.3	Create a communication protocol and template among and between the LIPTs, RIATs, IDT, and the BHCC

As explained above, Georgia has a multilevel infrastructure responsibility for supporting and implementing the SOC approach. As of the creation of this plan there are few formal protocols in place that guide continuous communication between these levels, often leaving a disconnect between state-level policymakers and local communities. A regularly scheduled, formal communication protocol could ensure timely sharing of information for necessary financial and policy supports.

Strategy 2.2 Increase training on SOC principles for all stakeholder groups

Not all stakeholders in children's behavioral health are aware of what a SOC approach entails, its guiding principles, or the benefits of such an approach. Training and awareness for all stakeholders should contribute to a family-driven, youth-guided, comprehensive SOC for children and youth with SEDs. The ability to speak the same language and utilize an agreed-upon framework could contribute to a more effective and efficient system, with greater stakeholder and community buy-in.

Action Item 2.2.1	Develop uniform definition of care coordination for CMOs and operationalize roles for all agencies and stakeholder groups
Action Item 2.2.2	Collect all information/training materials about SOC and care coordination across member organizations
Action Item 2.2.3	Create new or modify existing trainings for LIPTs, LIPT chairs, RIATs, and other groups on the Systems of Care approach
Action Item 2.2.4	Create and disseminate new culturally and linguistically appropriate materials for parents, caretakers, and family members about the SOC approach

Care coordination is defined differently for different populations and by different care providers. Without care coordination, the SOC cannot function collaboratively, and families will face a fragmented system in which children and youth may not receive the support that they need. However, as a service code, care coordination is not well-defined, and agencies and organizations may have different understandings of its definition. A clear and agreed-upon definition for both practice and billing purposes is vital if this service, at the core of a SOC approach, is to be utilized effectively. New, culturally competent materials for providers and for families and caregivers about SOC principles and values could contribute to better service delivery, coordination, and advocacy.

Long-term Strategies

Strategy 2.3 Create and utilize a common language for discussing SOC principles and making the business case to internal and external stakeholders

The process of creating and accepting an agreed-upon language may also help to shore up support for the SOC approach and expedite the diffusion of SOC principles. This could encourage team and relationship building and coordination among members of different state agencies and partner organizations.

Action Item 2.3.1	Develop a pocket guide/dictionary to define and describe SOC language
Action Item 2.3.2	Disseminate the guide widely through trainings and conferences, including at the SOC Academy

It is important to use a common language to better communicate the benefits of SOC to decision-makers and policymakers. The "branding" of the SOC framework is an important step in the dissemination of these principles. The IDT proposes the creation of a pocket guide for SOC principles, describing the language that would be widely distributed at trainings, conferences, and the SOC Academy.

Strategy 2.4 Address gaps in the crisis continuum by adding additional levels of care that will address capacity and acuity concerns: Crisis Respite; IC3; therapeutic foster homes

Without appropriate community supports and appropriate placements, children and youth with SEDs can have limited options for placement, particularly during difficult times. PRTFs are not appropriate for all youth with SEDs but may be the only option available in the absence of therapeutic foster care or other levels of care in the community.

Action Item 2.4.1	Develop a network of therapeutic foster homes
Action Item 2.4.2	Develop a step-down level of care between that of a Psychiatric Residential Treatment Facility (PRTF) and therapeutic foster home

To service children in the community at an appropriate level of care and address placement issues, Georgia will increase the utilization of IC3 and Wraparound services, and provide an array of appropriate service levels. Therapeutic foster care is an intervention that is a clinical intervention that involves placement in specially trained foster homes for children and youth with SEDs. Placements with these supports could help to prevent unnecessary trips to emergency departments and unnecessary stays in Crisis Stabilization Unit (CSUs) or Psychiatric Residential Treatment Facilities (PRTFs). Additionally, a step-down level of care between PRTFs and therapeutic foster care could prevent re-entry to the PRTF and support a smooth transition back into the community.

Focus Area 3: Workforce Development

Goal statement: Develop, maintain, and support a culturally competent, trauma-informed workforce to meet the needs of children, youth, and young adults and their families.

Short-term Strategies	Long-term Strategies
3.1 Targeted expansion of education/ financial incentives to address behavioral health workforce shortages	3.4 Develop a state mental health workforce plan across IDT agencies with a managed and budgeted scale-up plan
3.2 Develop a clearinghouse of evidence-based/evidence-informed educational materials related to children's behavioral health	
3.3 Explore issues related to scope of practice and workforce shortages	

The behavioral health workforce in the United States is inadequate to meet current and growing service demands and behavioral health needs (American Hospital Association, 2016). This is particularly true for child and adolescent needs. It is estimated that one in five children in the United States has a diagnosable mental health disorder, but only about 20%of those children needing mental health services receive care (American Academy of Pediatrics, 2017). Workforce issues can be compounded by geographic regions and characteristics, with rural areas at even more risk of experiencing workforce shortages. Well over half of Georgia counties are designated as rural, and an estimated 85% of all federally designated mental health professional shortage areas are in rural areas (Annapolis Coalition on the Behavioral Health Workforce, 2007).

SAMHSA has taken note of the workforce crisis, and the expected impacts of the Mental Health Parity and Addictions Equity Act and the Affordable Care Act in its 2013 strategic plan outlined in its report to Congress (Substance Abuse and Mental Health Services Administration, 2013). SAMHSA reports that high turnover, inadequate compensation, and an aging workforce contribute to shortages. Some of the strategic plans to address these issues focus on educational opportunities and incentives, and funding for specialty services with unmet needs. The Georgia IDT has also identified workforce as a major barrier to access to care for children and families, and created both short- and long-term strategies aimed at addressing this issue. These strategies, which directly relate to workforce creation and development, also contribute to larger strategies to address *access* and *coordination*.

Short-term Strategies

Strategy 3.1 Targeted expansion of education/financial incentives to address behavioral health workforce shortages

Not only is there a shortage of appropriately trained and licensed providers to meet the needs of children and families, those providers who are appropriately licensed may lack the specific training and skills necessary to meet commonly identified needs and problems. Prior to the 2016 legislative session, Georgia had four study committees pertaining to issues of children's behavioral health. In the 2015 House Study Committee on Children's Mental Health report, it was noted that in Georgia, there were only six graduating child psychiatrists per year (Children's Mental Health Study Committee, 2015) and that families faced difficulties when trying to access child psychiatrists and psychologists. The committee recommended strategies to address workforce shortages, including education incentives, expanded behavioral health training for primary care providers, the creation of a clearinghouse of best practices, and coordinated training activities. The IDT has incorporated several of the recommendations into this plan.

Action Item 3.1.1	Prioritize specialties to increase workforce capacity in strategic subject areas (e.g., autism, suicidality, trauma)
Action Item 3.1.2	Identify targeted workforce segments to support with education/ financial incentives (e.g., pediatricians, psychologists, teachers)
Action Item 3.1.3	Identify the method to bring this to scale

Georgia has already taken some steps to help alleviate the workforce shortage; however more progress is required to meet the state's growing child and family needs. To provide critical services, targeting segments of the workforce, including psychologists, psychiatrists, and psychiatric nurse practitioners, for educational and financial incentives in exchange for their services could boost access to these much-needed professionals. In order to meet the needs of the entire state, these incentives will need to be funded and sustained. This was also recommended in the 2015 House study committee report, and it was recommended that the mental health workforce development initiatives offer loan forgiveness in exchange for a minimum of three years of work solely with Georgia's children. Additionally, the report recommended the development of a community psychiatry fellowship program funded with a private-public partnership.

Strategy 3.2 Develop a clearinghouse of evidence-based/evidence-informed educational materials related to children's behavioral health

Although several groups house information on evidence-based and evidence-informed practice with children and families, state and partner agencies do not currently have access to a clearinghouse of organized and updated information related to children's behavioral health.

To ensure that the behavioral health workforce has access to quality training materials and evidence-based practices, it is worth the investment for the state partners to obtain and maintain this information so that it is readily available.

Action Item 3.2.1	Identify if a clearinghouse resource is available in Georgia or elsewhere
Action Item 3.2.2	Develop a list of existing clearinghouse resources; determine the evidence-based practice criteria for inclusion/exclusion
Action Item 3.2.3	Determine where the clearinghouse will be housed, who will maintain the site, and how information will be disseminated

In an effort to streamline the work and inform sharing, the IDT proposes to first research existing clearinghouse resources. Instead of creating a clearinghouse themselves, the IDT proposes the creation of a list and linkage to existing evidence-based practice clearinghouse resources on the SOC website. Even this will require housing and maintenance, and the group will need to determine who will house and maintain this site.

Strategy 3.3 Explore issues of scope of practice related to workforce shortages

As the statewide group of experts, the IDT is well-positioned to understand workforce issues as they relate to scope of practice. Given the workforce shortage, it would be helpful to determine what skillsets are needed to meet the needs of children and families, and ensure that those in the field have those skill sets through continuing education or licensure requirements.

Action Item 3.3.1	Research issues related to scope of practice
Action Item 3.3.2	Create a position paper related to policies that impact scope of practice

As with many of the proposed action items in the SOC plan, it will first be important to understand what issues are related to scope of practice. Once these are more thoroughly understood, the IDT will propose recommendations aimed at leveraging policy and training opportunities to address scope of practice issues.

Long-term Strategies

Strategy 3.4 Targeted expansion of education/financial incentives to address behavioral health workforce shortages

To truly have an informed, adequately trained workforce to meet the needs of children and their families, better coordination will need to exist between the state agencies serving these children. The 2015 House study committee also called for the creation of a state mental health workforce plan across state agencies with a managed and budgeted scale-up plan that included the following as mental health service professionals: psychiatrists, psychologists, clinical social workers, mental health counselors and therapists, school nurses, school psychologists, and school social workers.

Action Item 3.4.1	Examine opportunities for the sharing of knowledge and alignment of training strategies across systems (i.e., trauma-informed care)
Action Item 3.4.2	Identify the shared core competencies across partner child-serving agencies
Action Item 3.4.3	Draft state mental health workforce plan across IDT agencies and get feedback from agencies

In addition to a comprehensive State Mental Health workforce plan, it will be important that partner agencies begin to share resources and expertise. State agencies should come together to identify core, shared competencies across agencies and ensure accessibility and quality workforce development and training activities. The following core competencies in children's mental health have been identified by the University of Maryland: cultural and linguistic competence; child development and disorders; youth and families as partners; screening, assessment, and referrals; treatment plan-ning and service provision; outcomes and quality management; behavior management; health and safety; community development; and communication (Maryland Children's Cabinet, 2008). These competencies are necessary across all child-serving agencies, and coordination could lead to a more efficient and less costly workforce development plan.

Focus Area 4: Funding and Financing

Goal statement: Utilize financing strategies to support and sustain a comprehensive, community-based, family-driven, youth-guided, culturally competent, and trauma-informed System of Care anchored in cross-agency commitment to effective and efficient spending.

Short-term Strategies		Long-term Strategies	
4.1	Interagency funding of the IDT as the oversight body for SOC in Georgia	4.4	Review financial mapping reports and implement recommendations from these (look for opportunities to braid or blend funding)
4.2	Interagency funding of the COE to support training, education, and evaluation related to SOC	4.5	IDT agencies will collaboratively plan, apply for, and release funding opportunities and procurements when behavioral health is a key component.
4.3	SOC philosophies and outcomes are incorporated in current and future procurement/contracting throughout all child-serving agencies represented on the BHCC		

In order for a comprehensive, community-based, family-driven, youth-guided, culturally competent, and trauma-informed SOC framework to operate in Georgia, there must be a cross-agency commitment to effective and efficient spending. In SFY 2014, Georgia state agencies spent a combined estimated $379 million on approximately 100,395 children and youth with SED (Georgia Health Policy Center COE, 2014). Roughly two-thirds of this money was state funds. Although there have been some efforts over the years to optimize behavioral health spending between the child-serving agencies, to date, there has been no overarching plan to guide the agencies toward more deliberate, concrete collective action.

The braiding and blending of interagency funds is a key way for multiple agencies to achieve more effective and efficient spending. Blending of funds occurs when two or more funding sources are used to fund a specific part of a program, while braiding of funds refers to when two or more funding sources are coordinated to support the total cost of a service (Wallen & Hubbard, 2013). These methods allow for decreased funding duplication through improved resource coordination. In addition, they allow increased stability through diversified funding sources. Accordingly, all strategies in this Funding and Financing section incorporate an element of interagency braiding or blending of funding. Short-term strategies 4.1 and 4.4 propose interagency funding for IDT and SOC training, education, and evaluation. Long-term strategies 4.4 and 4.5 aim to identify additional opportunities for braiding and blending funding, as well as collaborative funding opportunities. Additionally, short-term strategy 4.3 proposes a collective approach to embedding SOC objectives within relevant state vendor procurements and contracts. Through implementation of these five strategies, Georgia will move closer to its goal of more effective and efficient spending, within a SOC framework, in order to support its children with behavioral health needs.

Short-term Strategies

Strategy 4.1 Interagency funding of the IDT as the oversight body for SOC in Georgia

For over six years, the IDT, composed of representation from Georgia's child-serving agencies, providers, families, and youth, has served as the state's SOC oversight body. In spite of IDT's varied membership, leadership, and initiatives, which benefit the entire state across agencies, DBHDD has served as the sole funder of the group since its inception. This includes financing all related administrative, project management, and research support.

For the IDT to continue its successful SOC work within Georgia, its financing should be supported by varied state agencies for three key reasons: First, if all agencies are to benefit from IDT's success, all agencies should help to fund its work. Second, multiple contributors will diversify the funding stream and may increase the group's ability to sustain itself beyond a single donor's ability to pay and enhance its ability to garner additional grant funding. Third, and perhaps most importantly, equity in funding would support parity among agency members within the collabora-tive. A collaborative with only one funding member may result in a perceived (or real) imbalance in the partnership. The IDT, as an independent body, would have an increased ability to make changes based on the needs of the youth and families and within the SOC framework. Therefore, in order for IDT to ensure its continued sustainability and success, and have its funding be truly reflective of the collaborative that it is, all agency members should support the group and its nu-merous beneficial initiatives through financial contributions.

Action Item 4.1.1 Request that each child-serving agency member of the BHCC financially support the operation of IDT

IDT state agency members will work together to design a request for funding from their respective agencies. This process will include identifying a fiscal agent, determining the necessary agreements, exploring potential funding mechanisms (state budget line item v. separate agency contributions), and other key details. IDT state agency members will design this request together while concurrently gathering feedback from the executive leadership of their respective agencies. Once the official request has been drafted by IDT, the IDT chair and co-chair will present the request to the BHCC. The BHCC will be asked to determine the best funding mechanism. IDT state agency members will incorporate and align BHCC and individual agency commissioner feedback into a final document. State agency members will follow through with the final recommendations of the BHCC and facili-tate the development and execution of funding agreements.

Strategy 4.2 Interagency funding of the COE to support training, education, and evaluation related to SOC

The Georgia SOC State Plan identifies workforce development, including education and training (Focus Area 3, pp. 32), general stakeholder education on value of provision of services within a SOC framework (Focus Area 2, pp. 28), and evaluation (Focus Area 5, pp. 42) as some of the key areas for action to improve Georgia's SOC. The SOC framework requires a broad workforce that is properly trained in children's behavioral health best practices in key areas such as trauma, cultural competency, mental health education, suicide prevention, etc. Additionally, it is critical that broad stakeholders (beyond the typical mental health service providers) are educated about the value of the provision of services within a SOC framework and what is needed to support this approach.

The COE, housed within Georgia State University's Georgia Health Policy Center, works in close partnership with DBHDD to provide fidelity monitoring, program evaluation, policy and financing analysis, workforce development and training, and quality improvement technical assistance (TA) within a SOC framework, for the child and adolescent behavioral health system in Georgia. As a university partner already active in SOC-related training, education, and evaluation, as well as IDT facilitation, the COE is a natural collaborator for further work in this area.

Braiding or blending interagency funds to expand the COE's SOC-related training, education, and evaluation activities will allow the system as a whole, as well as multiple child-serving agencies, to benefit in these areas. Moreover, allowing SOC-related training, education, and evaluation efforts to be led by one organization will increase state agency coordination and decrease duplication of efforts and resources in these areas.

Action Item 4.2.1	Develop a cost proposal to conduct coordinated training, TA, and evaluation activities that support multiple state agencies
Action Item 4.2.2	Present to BHCC for funding request/discussion
Action Item 4.2.3	Develop MOUs between DBHDD and child-serving agencies for allocated amount

IDT members will develop a cost proposal that identifies the general scope of work; amount of funding required to carry out coordinated SOC-related training, TA, and evaluation activities that support multiple state agencies; and a mechanism for the repository of the funding to be allocated. The cost proposal will take into account the final funding mechanism determined under Strategy 4.1, and if possible, coordinate. This cost proposal/request for funding will be presented to the BHCC for discussion and eventual approval. Using the cost proposal as a guide, the MOU will be developed, and agencies will take the necessary steps to follow through with their financial commitments. IDT state agency members will track and facilitate this process at their respective agencies.

Strategy 4.3 Create and utilize SOC guiding principles for contract development

The IDT strongly believes in the value of SOC as a framework for service delivery. Therefore, IDT believes that incorporating SOC philosophies and outcomes into current and future relevant procurement and contracting activities and documents for BHCC-member child-serving agencies (whether conducted through the Department of Administrative Services (DOAS) or individual agencies) will better ensure that wherever possible, vendors support the state in achieving its SOC-related goals. IDT's breadth and depth of knowledge about children's behavioral health, Georgia's CAMH system, and the SOC framework make it the appropriate partner to draft policy and procedure recommendations in this area.

Action Item 4.3.1	IDT subcommittee will research contractual language at each agency
Action Item 4.3.2	IDT will develop policy/procedure recommendations of SOC universal language to be adopted by BHCC to meet this strategy
Action Item 4.3.3	IDT will solicit BHCC to adopt policy/procedure recommendations to ensure that SOC philosophies and outcomes are incorporated in current and future procurement/contracting

In order to carry out this strategy, an IDT subcommittee will be formed to research and compile information on relevant contracting procedures at each agency. Based on these findings, IDT will develop policy and procedure recommendations for how SOC philosophies and outcomes could be incorporated into current and future procurement and contracting activities (including specific language for inclusion in contracts and requests for proposals) and present these recommendations to the BHCC. IDT will work with BHCC to incorporate feedback and implement agreed-upon policies within each agency, as well as DOAS.

Long-term Strategies

Strategy 4.4 Review financial mapping reports and implement recommendations from these (look for opportunities to braid or blend funding)

DBHDD has previously developed financial mapping reports, which trace amounts and flow of funding from all relevant state agencies, for services and supports for children in Georgia with SED. In addition to outlining the current funding structure and dollars for SED services and supports, these reports highlight existing braiding of funding and opportunities for future braiding or blending of funding in the state.

Action Item 4.4.1	Review previous mapping reports
Action Item 4.4.2	Update mapping reports
Action Item 4.4.3	IDT will develop recommendations to be presented to the BHCC

As a first step, the IDT will review existing financial mapping reports, merge content, and update where possible. Next, using these reports as a base, the IDT will identify opportunities for the state to braid or blend funding for SED services and supports, make recommendations to the BHCC, and work to implement approved recommendations within relevant agencies.

Strategy 4.5 IDT agencies collaboratively plan and apply for and release funding opportunities and procurements when behavioral health is a key component

The federal government, private foundations, and other organizations provide a variety of funding opportunities to support child and adolescent behavioral health within a SOC framework at the state and local level. Historically, many Georgia state agencies have applied for these opportunities separately, and sometimes without coordination. In some cases, this has resulted in duplicative or poorly coordinated efforts. However, more recently, IDT has become a platform for agencies to announce their interest in, coordinate applications for, and serve as advisory interagency bodies for funding. As a result, a number of successful grants and outcomes have ensued. In order to further this coordination between state agencies, maximize resources, and increase impact, IDT would like to grow its ability to collaboratively plan and apply for child and adolescent behavioral health funding.

Additionally, state agencies provide a number of separate child and adolescent behavioral health funding opportunities for service providers, education and advocacy organizations, and other nongovernmental organizations. Greater interagency coordination with respect to these funding opportunities (including pooling funding to offer larger or longer awards, or simply supporting each other's funding efforts through partnership) could increase the possibility for more sustained, successful outcomes among awardees and the children they serve.

Action Item 4.5.1	Potential investment in COE position (grant developments and maintaining relationships with foundations and other potential funding sources)
Action Item 4.5.2	Compilation of budget and develop job description (researching grant and other funding opportunities)
Action Item 4.5.3	Execute an ongoing strategic financing plan (encompassing public, private, and grant funding) to support SOC improvement

In order to achieve this level of coordination, IDT would research and pursue the possibility of creating and jointly funding a dedicated grant manager position (possibly housed at the COE), to have primary responsibility for developing state agency grant opportunities for child and adolescent behavioral health within the SOC framework. The position's work would include identifying and responding to funding requests for proposals and maintaining relationships with foundations and other potential funding sources. If IDT determines that this position should be created, the group will work to further outline the details of the job (including creating a job description, budget, initial duration of position and funding, and where the position will be housed) and seek appropriate approval from relevant state agencies, and the BHCC if needed. To sustain the work of the group, an ongoing strategic financing plan would be necessary and should be created and reviewed annually.

Focus Area 5: Evaluation

Goal statement: Utilize a framework of measuring and monitoring data on key SOC outcomes to demonstrate and communicate the value of a SOC approach for improving children's behavioral health, and support ongoing quality and improvement.

Short-term Strategies	Long-term Strategies
5.1 The IDT will review SOC Evaluation tools to identify key metrics applicable to Georgia	5.3 The IDT will institute and maintain a continuous quality-improvement process utilizing identified metrics that will be reviewed annually and will regularly be reported to the BHCC
5.2 Provide tools to Local Interagency Planning Teams (LIPTs), Regional Interagency Action Teams (RIATs), and other child-serving systems to self-evaluate System of Care outcomes	

Evaluation

Evaluation activities are important to ensure that SOC values are present in the activities outlined in this plan, and the goals, strategies, and action items are not only situated with the SOC framework but are also effectively reaching the goals and improving services for children and families. Evaluation, as a core component of the SOC State Plan, does not relate directly to any one focus area, strategy, or action item, but rather to the plan as a whole.

Short-term Strategies

Strategy 5.1 The IDT will review SOC Evaluation tools to identify key metrics applicable to Georgia

Review key metrics applicable to Georgia and SOC Evaluation practices.

Action Item 5.1.1	Limited environmental scan of measures in Georgia and other states
Action Item 5.1.2	Reach out to TA Network and SAMHSA for support and expertise
Action Item 5.1.3	Finalize what IDT chooses to utilize

Measures of effective services within the SOC framework have been created and are utilized in other states. In an effort to be efficient and not duplicative, IDT will complete a brief environmental scan of measures used in other states and determine the best measures for Georgia. IDT will reach out to the TA Network and SAMHSA for their expertise and guidance, and determine the best possible option for Georgia.

Strategy 5.2 Provide tools to LIPTs, RIATs, and other child-serving systems to self-evaluate their Systems of Care outcomes

The IDT will utilize evaluation tools to monitor the child-serving system in Georgia as a whole; however it will be important for local and regional bodies to perform evaluation activities as well that can feed back into quality-improvement efforts. The IDT will also identify tools that are appropriate for local and regional systems, develop tools and trainings around these tools, provide for a plan to distribute these, and provide for evaluation TA for local and regional SOC bodies.

Action Item 5.2.1	Develop materials and trainings
Action Item 5.2.2	Disseminate tools

The IDT will also identify tools that are appropriate for local and regional systems, provide for the development of trainings around these tools, provide for a plan to distribute these regionally and locally, and provide for evaluation TA for local and regional SOC bodies.

Long-term Strategies

Strategy 5.3	The IDT will institute and maintain a continuous quality-improvement process utilizing identified metrics that will be reviewed annually and will regularly be reported to the BHCC

IDT will come together to define a quality-improvement process using the metrics identified in the short-term goals. These processes will be defined and reported to the BHCC to demonstrate the success of the SOC State Plan implementation.

Action Item 5.3.1	The IDT will incorporate the metrics identified in the short-term goals into a quality-improvement process
Action Item 5.3.2	Metrics will be reviewed annually and reported back to the BHCC for input and guidance
Action Item 5.3.3	The IDT will provide for continuous TA to local Systems of Care in sustaining a service-delivery system based on SOC principles

Once measurement tools are identified, the group has chosen those that are most appropriate, and trainings have been developed and disseminated to local and regional SOC bodies, it will be important to identify challenges and opportunities via the communication feedback loops created in the coordination section of the plan. The BHCC will continue to provide high-level support and guidance to the IDT work, which will be informed by the SOC metrics. Additionally, it will be important for local SOC bodies to continue to monitor and evaluate their own systems, so the IDT will provide for a mechanism for the provision of continued TA around local evaluation.

Implementation Plan and Timeframe

The following pages outline a high-level implementation plan and timeframe. The IDT tracks its work utilizing work plans, which are much more detailed, living documents. The work plans include responsible parties, deadlines, action items, and next steps. The implementation plan guides the quarterly work of the group.

Key:

- • **Ongoing Operation/Work**
- o **Initiate Process**
- ❖ **Plan/Report**
- √ **Action Complete**

		Action Item by Strategy and Focus Area	SFY 2018				SFY 2019	SFY 2020
			Q1	Q2	Q3	Q4		
Focus Area 1. Access								
Short-term Strategies	**1.1**	**Service mapping for behavioral health service utilization**						
	1.1.1	Utilize the following data sources: DCH/DBHDD and Voices, MH professional shortage areas; analyze by service area and county; identify proxies for key indicators to track and share	o	•	•	❖		
	1.1.2	Create a centralized location for data sources	o	√				
	1.2	**Increase behavioral health services available in schools**						
	1.2.1	Establish a baseline measure of schools that identify as having access to all three tiers of school-based mental health services	o	•	•	❖		
	1.2.2	Increase the number of schools with access to all three tiers of school-based mental health services		o	•	•	•	•
	1.2.3	Increase the number of students receiving services in the school setting		o	•	•	•	•
	1.3	**Improve families' abilities to navigate the current system**						
	1.3.1	Create resource tools for families and youth	o	•	•	❖		
	1.3.2	Create an orientation to services for families and youth for each IDT member agency	o	•	•	•		
	1.3.3	Create resources for youth ages 18-21 to assist with self-navigation of services	o	•	•	❖		
	1.4	**Increase utilization of Intensive Care Coordination (IC-3) services**						
	1.4.1	Add this service to the Medicaid State Plan	o	√				
	1.4.2	Produce baseline utilization data for year 2016 to create a benchmark	o	•	❖			
	1.4.3	Train providers on this service model	o	•	√			
	1.4.4	Perform quality assurance activities to ensure fidelity; use data for decision-making in place	o	•	•	•	•	•

	Action Item by Strategy and Focus Area		SFY 2018				SFY 2019	SFY 2020
			Q1	Q2	Q3	Q4		
Long-term Strategies	**1.5**	**Utilize data to inform a strategic approach to access**						
	1.5.1	Compile data from strategy 1.1 and create a communication and dissemination plan					o	•
	1.5.2	Share information with key stakeholders that can influence the access process (purchasing authorities and state agencies)					o	•
	1.5.3	Utilize data to develop recommendation for improved care					o	•
	1.6	**Recruit practitioners to shortage areas**						
	1.6.1	Research shortage area plan from other states and Georgia			o	•	❖	
	1.6.2	Work with schools of social work, psychology, etc. to identify incentives and ensure training programs address the needs of youth and families in shortage areas				o	•	•
	1.6.3	Increase the number of peer specialists for parents and youth throughout the state	o	•	•	❖	•	•
	1.7	**Support continuity of care by addresing continuity of eligibility for Medicaid (address children and youth going on and off the Medicaid rolls)**						
	1.7.1	Provide more resources for training, navigation, and paid eligibility workers in social service agencies					o	√
	1.7.2	Provide support and education about eligibility for youth aging out of foster care					o	√
	1.7.3	Create baseline data; evaluate improvement annually					o	√
	1.8	**Strategically increase the use of telemedicine/ telehealth services within child-serving agencies**						
	1.8.1	Service mapping of behavioral health services provided through telemedicine (subset of 1.1 using a GT billing modifier)				o	•	❖
	1.8.2	Current status scan on public payer policy on the use of telemedicine				o	•	❖
	1.8.3	Mapping of where telemedicine facilities are located for behavioral health services			o	•	❖	

		Action Item by Strategy and Focus Area	SFY 2018				SFY 2019	SFY 2020
			Q1	Q2	Q3	Q4		
		Focus Area 2: Coordination						
Short-term Strategies	**2.1**	**Build and maintain feedback loops between local, regional, and state agencies and systems**						
	2.1.1	Create and distribute a list of all LIPT chairs to all SOC partners	o				•	•
	2.1.2	Identify a point person to facilitate organizational structure and communication among and between LIPTs, RIATs, IDT, and the BHCC	o				•	•
	2.1.3	Create a communication protocol and template among and between the LIPTs, RIATs, IDT, and the BHCC	o		❖			
	2.2	**Increase training on SOC principles for all stakeholder groups**						
	2.2.1	Develop uniform definition of care coordination for CMOs and operationalize roles for all agencies and stakeholder groups	o	•	❖	•	❖	
	2.2.2	Collect all information/training materials about SOC and care coordination across member organizations	o	√				
	2.2.3	Create new or modify existing trainings for LIPTs, LIPT chairs, RIATs, and other groups on the Systems of Care approach			o	√		
	2.2.4	Create and disseminate new culturally and linguistically appropriate materials for parents, caretakers, and family members about the SOC approach				o	•	•
Long-term Strategies	**2.3**	**Create and utilize a common language for discussing SOC principles and making the business case to internal and external stakeholders**						
	2.3.1	Develop a pocket guide/dictionary to define and describe SOC language			o	•	❖	
	2.3.2	Disseminate the guide widely through trainings and conferences, including the SOC Academy					o	•
	2.4	**Address gaps in the crisis continuum by adding additional levels of care that will address capacity and acuity concerns: Crisis Respite; IC3; therapeutic foster homes**						
	2.4.1	Develop a network of therapeutic foster homes					o	•
	2.4.2	Develop a step-down level of care between that of a PRTF and therapeutic foster home					o	•

		Action Item by Strategy and Focus Area	SFY 2018				SFY 2019	SFY 2020
			Q1	Q2	Q3	Q4		
Focus Area 3: Workforce Development								
Short-term Strategies	**3.1**	**Targeted expansion of education/financial incentives to address behavioral health workforce shortages**						
	3.1.1	Prioritize specialties to increase workforce capacity in strategic subject areas (e.g., autism, suicidality, trauma)	o	•	√			
	3.1.2	Identify targeted workforce segments to support with education/financial incentives (e.g., pediatricians, psychologists, teachers)	o	•	√			
	3.1.3	Identify the method to bring this to scale		o	❖	❖	√	❖
	3.2	**Develop a clearinghouse of evidence-based/ evidence-informed educational materials related to children's behavioral health**						
	3.2.1	Identify if a clearinghouse resource is available in Georgia or elsewhere	o	•	√			
	3.2.2	Develop a list of existing clearinghouse resources; determine the evidence-based practice criteria for inclusion/exclusion	o	•	❖			
	3.2.3	Determine where the clearinghouse will be housed, who will maintain the site, and how information will be disseminated		o	√	•	•	•
Long-term Strategies	**3.3**	**Explore issues of scope of practice related to workforce shortages**						
	3.3.1	Research issues related to scope of practice		o	•	•		
	3.3.2	Create a position paper related to policies that impact scope of practice			o	•	❖	√
	3.4	**Develop a state mental health workforce plan across IDT agencies with a managed and budgeted scale-up plan**						
	3.4.1	Examine opportunities for the sharing of knowledge and alignment of training strategies across systems (i.e., trauma-informed care)	o	•	•	•	❖	
	3.4.2	Identify the shared core competencies across partner child-serving agencies	o	•	•	•	√	
	3.4.3	Draft state mental health workforce plan across IDT agencies and get feedback from agencies				o	❖	❖

Action Item by Strategy and Focus Area			SFY 2018				SFY 2019	SFY 2020
			Q1	Q2	Q3	Q4		
Focus Area 4: Funding and Financing								
Short-term Strategies	**4.1**	**Interagency funding of the IDT as the oversight body for SOC in Georgia**						
	4.1.1	Request that each child-serving agency member of the BHCC financially support the operation of the IDT	o	❖	√			
	4.2	**Interagency funding of the COE to support training, education, and evaluation related to SOC**						
	4.2.1	Develop a cost proposal to conduct coordinated training, TA, and evaluation activities that support multiple state agencies	o	√				
	4.2.2	Present to BHCC for funding request/discussion		❖				
	4.2.3	Develop MOUs between DBHDD and child-serving agencies for allocated amount			❖	√		
	4.3	**Create and utilize SOC guiding principles for contract development**						
	4.3.1	IDT subcommittee will research contractual language at each agency	o					
	4.3.2	IDT will develop policy/procedure recommendations of SOC universal language to be adopted by BHCC to meet this strategy		o				
	4.3.3	IDT will solicit BHCC to adopt policy/procedure recommendations to ensure that SOC philosophies and outcomes are incorporated in current and future procurement/contracting			❖			

Action Item by Strategy and Focus Area			SFY 2018				SFY 2019	SFY 2020
			Q1	Q2	Q3	Q4		
Long-term Strategies	**4.4**	**Review financial mapping reports and implement recommendations from these (look for opportunities to braid or blend funding)**						
	4.4.1	Review previous mapping reports	o					
	4.4.2	Update mapping reports		•				
	4.4.3	IDT will develop recommendations to be presented to the BHCC			❖		√	❖
	4.5	**IDT agencies collaboratively plan, apply for, and release funding opportunities and procurements when behavioral health is a key component**						
	4.5.1	Potential investment in COE position (grant developments and maintaining relationships with foundations and other potential funding sources)	o	•	•	❖	√	
	4.5.2	Compilation of budget and crafting job description (researching grant and other funding opportunities)			o	❖	√	
	4.5.3	Execute an ongoing strategic financing plan (encompassing public, private, and grant funding) to support SOC improvement						o

Action Item by Strategy and Focus Area			SFY 2018				SFY 2019	SFY 2020
			Q1	Q2	Q3	Q4		
Focus Area 5: Evaluation								
Short-term Strategies	**5.1**	**The IDT will review SOC Evaluation tools to identify key metrics applicable to Georgia**						
	5.1.1	Limited environmental scan of measures in Georgia and other states		o				
	5.1.2	Reach out to TA Network and SAMHSA for support and expertise			o			
	5.1.3	Finalize what IDT chooses to utilize				√		
	5.2	**Provide tools to LIPTs, RIATs, and other child-serving systems to self-evaluate their Systems of Care work**						
	5.2.1	Develop materials and trainings	o	•	•	•	√	
	5.2.2	Disseminate tools					•	•
Long-term Strategies	**5.3**	**The IDT will institute and maintain a continuous quality-improvement process utilizing identified metrics that will be reviewed annually and will regularly be reported to the BHCC**						
	5.3.1	Use tools identified in short-term goals				•	o	
	5.3.2	Create protocol for reviewing self-evaluation of local SOC to determine TA needs					o	•
	5.3.3	Continuous TA for local SOC bodies to ensure that SOC values are present						•

Summary Table of Strategies, Goals, and Action Items

Cost: Symbols assigned based on low cost ($), Moderate Cost ($$), or High Cost ($$$, $$$$)

Access	Cost	Outcomes
Strategy 1.1 **Service mapping for behavioral health service utilization**		
Action Item 1.1.1 Utilize the following data sources: DCH/DB-HDD and Voices, MH professional shortage areas; analyze by service area and county; identify proxies for key indicators to track and share	**$**	Service map of behavioral health providers and utilization patterns
Action Item 1.1.2 Create a centralized location for data sources	**$ $**	Centralized data hub realized
Strategy 1.2 **Increase behavioral health services available in schools**		
Action Item 1.2.1 Establish a baseline measure of schools that self-identify as having access to all three tiers of school-based mental health services	**$**	Baseline report about SBMH services in the state
Action Item 1.2.2 Increase the number of schools with access to all three tiers of school-based mental health services	**$ $**	More schools with all three tiers of SBMH services available
Action Item 1.2.3 Increase the number of students receiving services in the school setting	**$ $**	Increased number of students served in the school setting
Strategy 1.3 **Improve families' abilities to navigate the current system**		
Action Item 1.3.1 Create resource tools for families and youth	**$**	Resource tools available
Action Item 1.3.2 Create an orientation to services for families and youth for each IDT member agency	**$**	Family orientation tools created
Action Item 1.3.3 Create resources for youth ages 18-21 to assist with self-navigation of services	**$**	Resource tools created and disseminated

Strategy 1.4 **Increase utilization of Intensive Care Coordination (IC-3) services**		
Action Item 1.4.1 Add this service to the Medicaid State Plan	**$**	IC is part of Medicaid State Plan
Action Item 1.4.2 Produce baseline utilization data for year 2016 to create a benchmark	**$**	Baseline report, benchmark created
Action Item 1.4.3 Train providers on this service model	**$ $**	Trainings created, disseminated
Action Item 1.4.4 Perform quality-assurance activities to ensure fidelity; use data for decision-making in place	**$ $**	Ongoing QA process implemented
Strategy 1.5 **Utilize data to inform a strategic approach to access**		
Action Item 1.5.1 Compile data from strategy 1.1 and create a communication and dissemination plan	**$**	Communication and dissemination plan created
Action Item 1.5.2 Share information with key stakeholders that can influence the access process (purchasing authorities and state agencies)	**$**	Stakeholders have access to information
Action Item 1.5.3 Utilize data to develop recommendations for improved care	**$**	Recommendations are developed by the IDT
Strategy 1.6 **Recruit practitioners in shortage areas**		
Action Item 1.6.1 Research shortage area plan from other states and Georgia	**$**	Short report created
Action Item 1.6.2 Work with schools of social work, psychology, etc. to identify incentives and ensure training programs address the needs of youth and families in shortage areas.	**$ $**	Incentives for schools are developed
Action Item 1.6.3 Increase the number of peer specialists for parents and youth (CPS-Ys and CPS-Ps) throughout the state	**$ $**	More CPS-Y and CPS-Ps are available throughout the state

Strategy 1.7 **Support continuity of care by addressing continuity of eligibility for Medicaid (address children and youth going on and off the Medicaid rolls)**		
Action Item 1.7.1 Provide more resources for training, navigation, and paid eligibility workers in social service agencies	**$**	Training materials are available for workers in social service agencies
Action Item 1.7.2 Provide support and education about eligibility for youth aging out of foster care	**$ $ $**	Training materials available; training and support available to transitioning youth
Action Item 1.7.3 Create baseline data; evaluate improvement annually	**$ $**	Data is created and made available via report, updated annually
Strategy 1.8 **Strategically increase the use of telemedicine/telehealth services within child-serving agencies**		
Action Item 1.8.1 Service mapping of behavioral health services provided through telemedicine (subset of 1.1 using a GT billing modifier)	**$**	Service maps are available
Action Item 1.8.2 Current status scan on public payer policy on the use of telemedicine	**$**	Scan complete; report available
Action Item 1.8.3 Mapping of where telemedicine facilities are located for behavioral health services	**$**	Map created; map available

Coordination	Cost	Measures
Strategy 2.1 **Build and maintain feedback loops between local, regional, and state agencies and systems**		
Action Item 2.1.1 Create and distribute a list of all LIPT chairs to all SOC partners	**$**	Online list/resource Notification of receipt by partners
Action Item 2.1.2 Identify a point person to facilitate organizational structure and communication among and between the LIPTs, RIATs, IDT, and the BHCC	**$ $**	Hiring of one FTE SOC PM Structure/outline developed
Action Item 2.1.3 Create a communication protocol and template among and between the LIPTs, RIATs, IDT, and the BHCC	**$**	Protocol developed and disseminated to partners Adoption of protocol Adherence to protocol among all entities
Strategy 2.2 **Increase training on SOC principles for all stakeholder groups**		
Action Item 2.2.1 Develop uniform definition of care coordination for CMOs and operationalize roles for all agencies and stakeholder groups	**$**	Creation of uniform definition Training and refresher training for agencies and stakeholders
Action Item 2.2.2 Collect all information/training materials about SOC and Care Coordination across member organizations	**$ $**	Database of training materials
Action Item 2.2.3 Create new or modify existing trainings for LIPTs, LIPT chairs, RIATs, and other groups on the Systems of Care approach	**$**	Updated training manual Training calendar for chairs and team members Incentives developed for the chairs to travel for organization to approve time away

Action Item 2.2.4 Create and disseminate new culturally and linguistically appropriate materials for parents, caretakers, and family members about the SOC approach	**$ $**	Printed materials for family members and stakeholders Number of SOC materials created and received by family members and guardians
Strategy 2.3 **Create and utilize a common language for discussing SOC principles and making the business case to internal and external stakeholders**		
Action Item 2.3.1 Develop a pocket guide/dictionary to define and describe SOC language	**$**	Pocket guide template/final doc
Action Item 2.3.2 Disseminate the guide widely through trainings and conferences, including at the SOC Academy	**$ $**	Number of guides disseminated Number of agencies implementing use of guide
Strategy 2.4 **Address gaps in the crisis continuum by adding additional levels of care that will address capacity and acuity concerns: Crisis Respite; IC3; Therapeutic Foster Homes (TFH)**		
Action Item 2.4.1 Develop a network of therapeutic foster homes	**$ $ $ $**	Increase in funding to support TFH Creation of network of homes Number of households with trained family members Number of families enrolled in TFH program Number of trainings conducted for TFH
Action Item 2.4.2 Develop a step-down level of care between that of a PRTF and therapeutic foster home	**$ $ $** 	Policy developed Number of clinicians/ mental health professionals hired and/or trained % of clinicians using new level of care

Workforce Development	Cost	Measures
Strategy 3.1 **Targeted expansion of education/financial incentives to address behavioral health workforce shortages**		
Action Item 3.1.1 Prioritize specialties to increase workforce capacity in strategic subject areas (e.g., autism, suicidality, trauma)	**$**	Determine preferred ratio of specialty providers to patient population
Action Item 3.1.2 Identify targeted workforce segments to support with education/financial incentives (e.g., pediatricians, psychologists, teachers)	**$**	List of providers who are already successfully delivering specialty care in strategic subject areas
Action Item 3.1.3 Identify the method to bring this to scale	**$ $**	Report on ratio of providers, average salary, timeline to drive recruitment and workforce development activities for specialty care
Strategy 3.2 **Develop a clearinghouse of evidence-based/evidence-informed educational materials related to children's behavioral health**		
Action Item 3.2.1 Identify if a clearinghouse resource is available in Georgia or elsewhere	**$**	Report or summary of existing resources; mine IDT membership for resources
Action Item 3.2.2 Develop a list of existing clearinghouse resources; determine the evidence-based practice criteria for inclusion/exclusion	**$**	Consolidated list of resources Formalized criteria for EBPs presented in a brief/ report
Action Item 3.2.3 Determine where the clearinghouse will be housed, who will maintain the site, and how information will be disseminated	**$ $**	Formal agreement about which partner is responsible for housing and updating the information ($$ is dependent on resources and capacity of host organization; maintenance may contribute to accumulated higher cost over time)

Strategy 3.3 **Explore issues of scope of practice related to workforce shortages**		
Action Item 3.3.1 Research issues related to scope of practice	**$**	Summary report of common issues related to scope of practice between children's BH providers
Action Item 3.3.2 Create a position paper related to policies that impact scope of practice	**$**	Publication/dissemination of position paper
Strategy 3.4 **Develop a state mental health workforce plan across IDT agencies with a managed and budgeted scale-up plan**		
Action Item 3.4.1 Examine opportunities for the sharing of knowledge and alignment of training strategies across systems (i.e., trauma-informed care)	**$ $**	Summary report prepared by COE or point person aggregating the training strategies from all the IDT departments
Action Item 3.4.2 Identify the shared core competencies across partner child-serving agencies	**$**	Included in summary report above Number of trainings delivered and number of staff attending
Action Item 3.4.3 Draft state mental health workforce plan across IDT agencies and get feedback from agencies	**$ $**	Workforce plan draft

Funding and Financing	Cost	Measures
Strategy 4.1 **Interagency funding of the IDT as the oversight body for SOC in Georgia**		
Action Item 4.1.1 Request that each child-serving agency member of the BHCC financially support the operation of IDT	**$**	Request to BHCC made (May 2017) Financing obtained ($)
Strategy 4.2 **Interagency funding of the COE to support training, education, and evaluation related to SOC**		
Action Item 4.2.1 Develop a cost proposal to conduct coordinated training, TA, and evaluation activities that support multiple state agencies	**$**	Proposal developed by COE Proposal approved by IDT
Action Item 4.2.2 Present to BHCC for funding request/ discussion	**$**	Proposal presented to BHCC Funding granted by BHCC/ Legislature ($)
Action Item 4.2.3 Develop MOUs between DBHDD and child-serving agencies for allocated amount	**$**	MOUs are implemented among all child-serving agencies (number of MOUs executed)
Strategy 4.3 **Create and utilize SOC guiding principles for contract development**		
Action Item 4.3.1 IDT subcommittee will research contractual language at each agency	**$**	Sample language identified from environmental scan for adoption
Action Item 4.3.2 IDT will develop policy/procedure recommendations of SOC universal language to be adopted by BHCC to meet this strategy	**$**	IDT presents policy/procedure recommendations to BHCC BHCC adopts IDT proposed policy/ procedure recommendations Number of contracts executed using contract language

Action Item 4.3.3 IDT will solicit BHCC to adopt policy/ procedure recommendations to ensure that SOC philosophies and outcomes are incorporated in current and future procurement/contracting	**$**	BHCC adopts IDT proposed policy/ procedure recommendations Number of contracts that incorporate SOC outcomes/philosophies
Strategy 4.4 **Review financial mapping reports and implement recommendations from these (look for opportunities to braid or blend funding)**		
Action Item 4.4.1 Review previous mapping reports	**$**	IDT indicates what elements of mapping report require updates
Action Item 4.4.2 Update mapping reports	**$ $**	New mapping report completed
Action Item 4.4.3 IDT will develop recommendations to be presented the BHCC	**$**	Recommendations presented to BHCC BHCC adopts IDT recommendations Number of contracts/ initiatives executed using blended and braided funds (#/$)
Strategy 4.5 **IDT agencies collaboratively plan and apply for and release funding opportunities and procurements when behavioral health is a key component**		
Action Item 4.5.1 Potential investment in COE position (grant developments and maintaining relationships with foundations and other potential funding sources)	**$ $**	BHCC or Legislature allocates funds to support COE position (via IDT funding) ($)
Action Item 4.5.2 Compilation of budget and craft job description (researching grant and other funding opportunities)	**$**	Position filled
Action Item 4.5.3 Execute an ongoing strategic financing plan (encompassing public, private, and grant funding) to support SOC improvement	**$**	Funding secured ($) by type

Evaluation	Cost	Measures
Strategy 5.1 **The IDT will review SOC Evaluation tools to identify key metrics applicable to Georgia**		
Action Item 5.1.1 Limited environmental scan of measures in Georgia and other states	**$**	Environmental scan complete, presented to IDT
Action Item 5.1.2 Reach out to TA Network and SAMHSA for support and expertise	**$**	Guidance from TA Network, SAMHSA
Action Item 5.1.3 Finalize what IDT chooses to utilize	**$**	Measure is chosen
Strategy 5.2 **Provide tools to LIPTs, RIATs, and other child-serving systems to self-evaluate their Systems of Care work.**		
Action Item 5.2.1 Develop materials and trainings	**$ $**	Tools for local systems identified, developed
Action Item 5.2.2 Disseminate tools	**$ $**	
Strategy 5.3 **The IDT will institute and maintain a continuous quality-improvement process utilizing identified metrics that will be reviewed annually and will regularly be reported to the BHCC.**		
Action Item 5.3.1 Use tools identified in the short-term goals in the QI process	**$**	Annual report to the BHCC for guidance
Action Item 5.3.2 Create protocol for reviewing self-evaluation of local SOC to determine TA Needs		IDT presents policy/procedure recommendations to BHCC
Action Item 5.3.3 Continuous TA for local SOC bodies to ensure that SOC values are present		

Summary and Conclusions

This plan has been created by the IDT team and incorporated the work of representatives from the various child-serving agencies, provider groups, advocacy groups, care management organizations, partner organizations, family organizations, and our federal consultant, the CDC. The group has worked to identify high-leverage activities to further entrench the SOC approach into Georgia's children's behavioral health system to improve quality and access to appropriate services for Georgia's families.

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Appendices

Appendix A. SOC Guiding Principles

Child-, Family-, and Person-centeredness

- Members should have access to a comprehensive array of services that address their physical, emotional, social, and educational needs.
- Services and supports should utilize a child/ family/ person-directed focus on wellness and recovery. Members should receive individualized services in accordance with their unique needs and guided by their individually tailored service plan.
- Choice by the individual, youth or family should be respected. And their human dignity valued.
- The families and surrogate families of participants should be full participants in all aspects of the planning and delivery of services, they (families) should be integrated into care whenever possible.
- Treatment and support services should be based on condition, and not on insurance status.
- The rights of individual users should be protected and effective advocacy efforts promoted.

Community based

- Members should receive services within the least restrictive, most normative environment that is clinically appropriate.

Cultural competancy

- Enrollees should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and specific needs.

Coordination

- Participants should receive services that are integrated, with linkage between agencies and programs and mechanisms for planning, developing, and coordinating services.
- Members should be provided with a case manager or similar mechanism to ensure that multiple services are delivered in a coordinate way and therapeutic manner and which will allow them to move through the system of service in accordance with their changing needs.
- There should be a “no wrong door” approach so that no matter where an individual, child or youths enters the system, they are guided to the right provider that will address their unique needs.
- Early identification and intervention for individuals should be promoted by systems of care in order to enhance the likelihood of positive outcomes.
- Children and Youth should be ensured smooth transitions to the adult service system as they reach maturity.