Georgia Behavioral Health Reform and Innovation Commission

2023 Annual Report

ACKNOWLEDGMENTS

This report was prepared with support from Georgia State University's Georgia Health Policy Center and the Center of Excellence for Children's Behavioral Health.

Thank you to the Office of Health Strategy and Coordination, the commission's chair, and the subcommittee chairs for their work throughout the year and in preparation of this final report.

Behavioral Health Reform and Innovation Commission Leadership

- Commissioner Kevin Tanner, Chair, Behavioral Health Reform and Innovation Commission
- Dr. Brenda Fitzgerald, Subcommittee Chair, Hospital and Short-Term Care Facilities
- Dr. Eric Lewkowicz, Subcommittee Chair, Children and Adolescent Behavioral Health
- Chief Justice Michael Boggs, Subcommittee Chair, Mental Health Courts and Corrections
- Judge Sarah Harris, Subcommittee Chair, Involuntary Commitment
- Rep. Mary Margaret Oliver, Subcommittee Chair, Workforce and System Development
- Judge Kathlene Gosselin, Advisory Subcommittee Chair, Forensic Competency Advisory Committee

Office of Health Strategy and Coordination
Elizabeth Holcomb, Director

2023 COMMISSION APPOINTEES, COMMISSION MEMBERS, AND SUBCOMMITTEE MEMBERS

Governor's Appointees	Lieutenant Governor's Appointees
Commissioner Kevin Tanner, Chairman Dr. Sarah Y. Vinson Dr. DeJuan White Dr. Michael R. Yochelson Jason Downey Dr. Karen Bailey Miriam Shook Nora Lott Haynes Dr. Mark C. Johnson	Sen. Brian Strickland Sen. Kim Jackson Sheriff Robert Markley Anne G. Hernandez Dr. David Bradley Cindy Levi
Speaker of the House's Appointees	**Chief Justice's Appointees**
Rep. Don Hogan Rep. Mary Margaret Oliver Chief of Police Louis Dekmar Gwen Skinner Kim Jones Judge Brenda Weaver	Chief Justice Michael Boggs Judge Stephen Kelley Judge Sara S. Harris
Commissioner Tanner's Appointees and Ex Officios	
Judge Kathleen Gosselin Commissioner Timothy Ward Commissioner Michael Nail Judge Bedelia Hargrove Dr. Karen Bailey Dr. Nicoleta Serban Commissioner Russel Carson Commissioner Michael Nail Commissioner Chrisotpher Nunn Commissioner Shawanda Reynolds-Cobb	Sallie Coke Dr. Eric Lewkowiez Dr. Garry McGiboney Dr. Brenda Fitzgerald Commissioner Tyrone Oliver Dr. Lucky Jain Commissioner Candice Broce Donna Hyland Commissioner Caylee Noggle GBI Director Chris Hosey
Forensic Competency Advisory Committee	
Judge Phillip Jackson Judge Michael Key Brandon Bullard Chris Van Rossem Dr. Emily Risby Dr. Julie Oliver Dr. Kiana Wright Judge Eric Brewton	DA Herb Cranford Judge Patsy Porter Judge Penny Freesemann Judge Sara S. Harris Judge Victoria Darrisaw Marilyn Leake ADA Nikia Smith Sellers

Note: Subcommittee members for each subcommittee are identified in their respective subcommittee reports included in the appendices of this report.

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ABOUT THE BEHAVIORAL HEALTH REFORM AND INNOVATION COMMISSION

Georgia House Bill 514 in the 2019 legislative session created the Georgia Behavioral Health Reform and Innovation Commission (BHRIC). The commission was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. In the 2022 session, the Georgia General Assembly passed House Bill 1013, the Georgia Mental Health Parity Act (MHPA), which was informed by the commission's first report. The act includes provisions for comprehensive behavioral health reform, specifically elements that align Georgia law with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and help monitor compliance with MHPAEA. The Georgia law also outlines new work for the commission and extends the commission's work for two additional years. BHRIC has 24 appointed members and is chaired by former state representative and current Department of Behavioral Health and Developmental Disabilities (DBHDD) Commissioner Kevin Tanner. The commission is currently due to expire on June 30, 2025.

As outlined in the Official Code of Georgia (OCGA) Section 37-1-111, BHRIC is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues facing children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; the impact that behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact that untreated behavioral illness can have on children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission has five subcommittees tasked with reviewing these focus areas:

1. Children and Adolescent Behavioral Health (CABH), chaired by Dr. Eric Lewkowiez
2. Involuntary Commitment (IC), chaired by Judge Sarah Harris
3. Hospital and Short-Term Care Facilities (HSCF), chaired by Dr. Brenda Fitzgerald
4. Mental Health Courts and Corrections (MHCC), chaired by Chief Justice Michael Boggs
    a. Forensic Competency Advisory (FCA) Committee, chaired by Judge Kathlene Gosselin
5. Workforce and System Development (WFSD), chaired by Rep. Mary Margaret Oliver

The commission held a public meeting in Atlanta at the DBHDD office on Dec. 4, 2023. Each subcommittee also held meetings separately and heard hours of testimony from subject matter experts, state executive agency representatives, major interest groups and advocates, and behavioral health professionals. Meeting recordings and materials are archived on the Georgia General Assembly's website. Each subcommittee independently drafted an appendix to this

annual report to provide further details and recommendations identified by its respective committee. This summary report compiles the findings and recommendations identified as most pressing for immediate action to reform Georgia's behavioral health system.

EXECUTIVE SUMMARY

The Behavioral Health Reform and Innovation Commission (BHRIC) created a road map for reform through its initial findings and recommendations summarized in its Year 1 report. Following the release of this report in early 2021, the Georgia Office of Health Strategy and Coordination partnered with Accenture, a global consulting firm, to find ways to operationalize the commission's recommendations through legislative, budgetary, and executive actions. The resulting Accenture report concluded that Georgia's system as a whole is often fragmented and that organizations within it "act as a loose confederation rather than an intentionally designed mental health system that is coordinated and effective."[1] The authors noted, "Georgia needs a centralized mental health *system,* designed to serve its residents with appropriate care *when* and *where* they need it,"[2] emphasizing the need for a coordinated and comprehensive system.

As a result of the recommendations from both the commission's report and Accenture's report, the members of the Georgia General Assembly crafted the bipartisan Georgia Mental Health Parity Act under the sponsorship and leadership of the late speaker of the house, David Ralston. The act was passed during the 2022 legislative session and signed by Gov. Brian P. Kemp into law. This act paved the way for substantial behavioral health system reform in the state. The Mental Health Parity Act addressed several key areas needed for improved access to behavioral health services in Georgia, including enforcing and monitoring implementation of mental health parity; growing the behavioral health workforce; enhancing law enforcement awareness and response to mental health challenges; and building capacity to identify, prevent, and address mental health concerns. The act also created a blueprint for future reform efforts, including creating clear systems for coordination, outlined studies to better understand current system barriers, and defined future work for the commission and other collaborating entities to pursue. For the commission specifically, the act indicated new members to be appointed to the commission, outlined topics for further exploration by its subcommittees, and extended its work until 2025.

Following the legislative session and passage of the Mental Health Parity Act, the subcommittees convened monthly meetings to create a refreshed set of goals published as their Year 2 Annual Report. In the report, the commission identified seven priority areas for behavioral health reform: (1) address the behavioral health workforce shortage; (2) promote data collection and information sharing; (3) build a robust crisis system with a full continuum of

[1] Accenture. (2021, December 2). *Mental health reform action plan.* Prepared by Accenture for the Georgia Governor's Office of Health Strategy and Coordination, page 27.
[2] Accenture, page 5.

services; (4) build capacity within Medicaid to provide a full continuum of services; (5) expand successful community-based practices, services, and programs; (6) study practices, services, and programs that need improvement; and (7) expand existing policies and statutes.

Several activities emerged in 2023 pertaining to recommendations set by the commission in the Year 2 report. These activities directly respond to, illuminate, and bring clarity to existing recommendations. An executive order from Gov. Kemp was executed in 2023 pertaining to data sharing. Additionally, three reports emerged in 2023 that align with recommendations from the Year 2 report: The *Behavioral Health Rate Study* (June 2023), the *Georgia DBHDD Bed Capacity Study* (August 2023), and the DBHDD *Workforce Innovations Report: Preliminary Results* (August 2023; Appendix G).

On Sept. 1, 2023, Gov. Kemp signed an executive order into place instructing the Georgia Data Analytics Center (GDAC) to facilitate data-sharing between executive state agencies. This order responds to Year 2 priority area 2. Established in 2019 by House Bill 197, GDAC has the authority to seek out data from state agencies to support the health, safety, and security of Georgia citizens. From this executive order, GDAC is tasked with establishing a template for data sharing requests, data sharing agreements, and data formatting. Data sharing across executive state agencies will support a baseline understanding of how the system is functioning as a whole and the identification and troubleshooting for individuals who have high levels of utilization across the entire system.

DBHDD and the Georgia Department of Community Health (DCH) engaged an external consulting agency, Deloitte, to complete the *Behavioral Health Rate Study,* which compares Georgia reimbursement rates with those of other similar states.[3] The *Behavioral Health Rate Study* was an activity required under the Mental Health Parity Act, which compared the reimbursement rates for Georgia's Community Behavioral Health Rehabilitation Services top four mental health services[4]: peer supports, assertive community treatment, psychosocial rehabilitation, and individual counsel. The report gave a recommended target rate for each service examined that, if approved, will be anywhere between a 16% and 51% increase.

DBHDD engaged external consulting agency Alvarez and Marsal (A&M) to develop a model to determine needed bed capacity for department beds serving uninsured adults, children, and incarcerated individuals. The study concluded that DBHDD would need five additional facilities by 2025 to meet the growing needs of mental health care, with eight additional facilities needed by 2032. The projection and recommendations come with the caveat that the report assumes that Georgia has addressed the workforce challenges that limit the utilization of existing beds and specifies that existing beds must be used in order to ensure success of new facilities.

[3] Comparable states were Maryland, Ohio, North Carolina, Kentucky, Illinois, and Pennsylvania. They were selected based on similarity to Georgia in population, economic conditions, access to care, and Medicaid program.

[4] Based on Georgia Fee for Service Medicaid.

DBHDD engaged Deloitte, which completed the *Workforce Innovations Report*, to align with the goals of workforce diversification, enhance employee experience, establish DBHDD as a career destination, and make a high return on investment. The study analyzed human resources data; conducted focus groups and interviews; and performed environmental scans to present hospital turnover rates and compensation comparisons; and determined 19 goals for the short term, medium term, and long term.

Following the precedent set in 2022, the subcommittees met regularly in 2023 to extend and refine previous recommendations and develop new guidance based on updated guidance from new studies and data. The commission's five subcommittees heard from numerous experts in the behavioral health field on topics spanning the full continuum of practices, services, and supports. Several themes arose across the subcommittees, highlighting systemic challenges in certain aspects of the behavioral health system. Similar to experiences from 2022, workforce shortages were discussed in nearly every meeting held, no matter the overarching topic for that meeting. It quickly became clear that decisive action is needed to address the growing workforce challenges throughout the state and that continued work needs to be done to address these challenges in the long run as well. The Workforce and System Development Subcommittee was critical in defining these challenges in building the behavioral health workforce and crafting recommendations to address these barriers to care. While these recommendations were understood in the 2022 report, recent studies and reports have illuminated specific actions that are reflected in recommendations described by the subcommittees.

Another overarching theme was the lack of capacity in the state's current behavioral health crisis continuum. As subcommittees heard about challenges for specific populations gaining access to crisis services, it was clear that it is not a single group, geography, or service issue, but a capacity issue throughout the system that must be addressed. The Hospital and Short-Term Care Facilities Subcommittee was instrumental in further defining the challenges in the current system and how they extend across aspects of the system. Using information from the *DBHDD Bed Capacity Study,* as well as information presented about Emergency Psychiatry Assessment Treatment and Healing (EmPATH) units, the Hospital and Short-Term Care Facilities Subcommittee addressed specific solutions to the rapidly approaching crisis for behavioral health beds. Again, immediate steps are needed to build capacity on multiple levels, and further study can supplement this work to better illustrate what the structure should look like in the long run to maintain a robust crisis continuum.

Subcommittees also heard about the challenges faced by specific populations experiencing unique access challenges and barriers to care. The Children and Adolescent Behavioral Health Subcommittee heard testimony on mental health issues for unhoused and foster care children, including barriers in access to behavioral health care among this population. The subcommittee also heard expert testimony on the importance of screening and addressing maternal mental health issues, as caregiver mental health impacts child health and well-being. In addition, the

subcommittee heard testimony about school-based behavioral health models of care, and experts provided information about programs and opportunities that would increase collaboration amongst providers who work with children (e.g., first responders, school staff, pediatricians, etc.), which is key for ensuring that youth behavioral health needs are identified and addressed. Last, the subcommittee heard about national and state perspectives on children's behavioral health, including national policies that have been implemented to address the children's behavioral health crisis brought on by the COVID-19 pandemic, and opportunities to increase access to youth substance use disorder services in Georgia.

The Involuntary Commitment Subcommittee continued its review of best practices in coordinating care for individuals involved in the criminal justice system who are also experiencing behavioral health challenges. The 2022 Mental Health Parity Act implemented provisions that provided law enforcement with additional options to transport individuals experiencing a mental health crisis. This year the subcommittee studied the implementation and effectiveness of this provision. In addition to studying the effectiveness of the transportation provision, the subcommittee also heard testimony on the Assisted Outpatient Treatment Program (AOT) created in the 2022 Mental Health Parity Act. Prompted by discussion of the role of certified peer specialists (CPSs) in AOT, the subcommittee also examined the CPS workforce landscape in Georgia, particularly barriers to their employment following training. The subcommittee heard testimony from the Division of Aging and Public Guardianship Office on the growth of their caseload of individuals who suffer from serious and persistent mental illness.

The Mental Health Courts and Corrections Subcommittee focused on the challenge of addressing the needs of individuals who have repeated interactions with the behavioral health system, homeless services, and the criminal justice system. These individuals have been termed *familiar faces*. The subcommittee created a Forensic Competency Advisory Committee with the support of the Council of State Governments Justice Center. The Forensic Competency Advisory Committee heard testimony regarding the need to investigate options for jail-based competency restoration services, noting that there is frequently a lengthy wait for forensic beds. In addition, recommendations were made to increase the number of staff available to complete the restoration process. Establishment of jail-based restoration services would allow individuals to move quickly through the process and spend less time in both jails and forensic hospital beds. In addition, the subcommittee heard testimony related to the number and availability of forensic hospital beds in the state. Recommendations were also made to develop guidance for judges to help guide the decision to order competency evaluations.

This report is the product of the meetings held by the commission's five subcommittees and the expert testimony heard by its members. This report does not cover the depth and breadth of testimony heard across all five subcommittees but instead aims to highlight the most pressing challenges identified. The chair and the preparers of this report met with each subcommittee chair to identify and refine their priorities to be presented to the commission and for inclusion in this report. The full commission convened on Dec. 4, 2023, and each subcommittee reported its findings and recommendations. This summary includes those priority recommendations and

is followed by appendices for each subcommittee that provide more detail on their individual work. These appendices give further information on the depth of testimony heard and outline additional recommendations that subcommittee members have proposed.

The recommendations here are not grouped by subcommittee but by overarching themes of the challenges and opportunities heard across the subcommittees. This approach further emphasizes the importance of building a collaborative and comprehensive system rather than a siloed approach to system reform. The recommendations are framed in actions that can be taken immediately by the state in order to improve Georgia's behavioral health system.

The compilation of priorities and action steps identified by the commission's five subcommittees resulted in the following priority areas for behavioral health reform:

- **Address the behavioral health workforce shortage** through recommendations of the various research and studies done in 2023. This includes a multipronged approach to ensure immediate solutions to current shortages and long-term solutions for a robust pipeline of behavioral health professionals.
- **Build capacity to provide a full continuum of behavioral health services and supports** through leveraging funding supports and maximizing treatment beds.
- **Expand effective community-based practices, services, and programs** so that more Georgians have access to supports proven effective for people with behavioral health needs.
- **Study practices, services, and programs that need improvement***,* acknowledging that there is still much work to be done to improve the state's systems and that further study is needed to identify the best solutions for Georgia's system.
- **Streamline existing policies and statutes** to ensure Georgia laws promote best practices in working with people with behavioral health conditions.

Supporting documentation for each of these recommendations can be found in the repository of meeting recordings, presentations, and agendas on the commission's page on the Georgia General Assembly's website. Additionally, each subcommittee has provided additional information about its activities in 2023, the recommendations they have proposed, and supporting documents for those recommendations, which are documented in the appendices to this annual report. Each subcommittee may have additional recommendations beyond the ones included here. The recommendations compiled here are considered the most pressing and most actionable to address behavioral health system reform in the next year.

RECOMMENDATIONS FOR BEHAVIORAL HEALTH REFORM AND INNOVATION

The following recommendations were crafted from the testimony heard across the five subcommittees of BHRIC. All recommendations are endorsed by the full commission. The recommendations are grouped by target areas for systems improvement. A brief description of the target area is provided, followed by the recommendations addressing that topic. For each recommendation, a brief description of the recommendation is provided first, followed by information on the challenge it is addressing and relevant supporting testimony. In italics is the full detailed recommendation of the commission, followed by a note on the subcommittees that heard testimony on the topic and a diagram outlining which subcommittees crafted a supporting recommendation that informed the commission's recommendation.

Address the Behavioral Health Workforce Shortage

In nearly every subcommittee meeting across all five subcommittees, testimony was heard on the extreme challenge of workforce shortages among all levels of behavioral health practitioners in the state. Addressing workforce shortages in any field requires a multipronged approach including retaining and maintaining the currently trained workforce in the field, creating an environment that encourages practitioners to come to and stay in the state, and building a robust pipeline for the future workforce across practitioner types. All levels of the workforce are important from peer support specialists and service navigators to psychiatrists and psychologists. Workforce shortages are also multifaceted and may impact various practitioner types, geographic regions, and payer statuses differently.

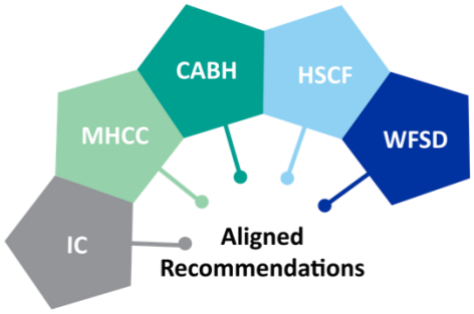
Recommendations from the Year 2 report included addressing the behavioral workforce shortage. Between the publication of that report and the recommendations listed below, two pivotal reports were published and testified on: The *Behavioral Health Rate Study* and the DBHDD *Workforce Innovations Report*. The following recommendations follow the recommendations and findings from those reports and aim both to address the immediate crisis of workforce shortages and provide a long-term pipeline with adequate capacity for Georgia's growing population.

<u>Implement the Behavioral Health Rate Study Findings</u>

The *Behavioral Health Rate Study* illuminated two main themes that DBHDD is facing in retaining and growing the workforce. The first issue identified is that Medicaid reimbursement rates in Georgia are much lower than those in other states. This finding matches previous testimony about practitioners who opted out of providing services due to low reimbursement rates. The second aspect it focused on was the ways in which improved reimbursement rates would allow an increase in benefits that would incentivize individuals to remain employed in the state of Georgia.

The commission recommends that the state adopt the findings from the *Behavioral Health Rate Study*, indicating that additional emphasis should be given to ensuring that rates are sufficient for services that support specific populations with unique behavioral health needs. This recommendation is carried over from the Year 2 report.

The recommendation was endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' recommendations, please see their respective appendices. Below are specific recommendations around implementing the findings of the *Behavioral Health Rate Study* in Georgia.

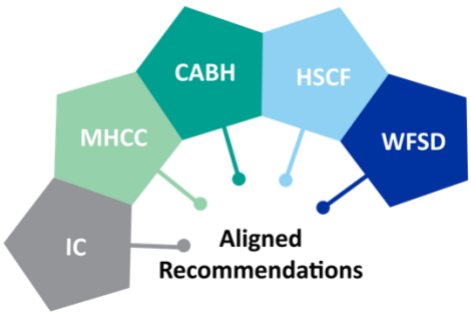


Increase Medicaid Reimbursement Rates for the Behavioral Health Workforce

Paying behavioral health practitioners fair rates encourages those trained in the field to remain in the field. The Accenture report noted that Georgia has some of the lowest reimbursement rates in the country, and the Georgia Mental Health Parity Act called on DCH to conduct a study of Medicaid reimbursement rates in Georgia compared with reimbursement rates in other states. The DCH study was published in August 2023 and showed similar findings to those of the Accenture report and testimony from the subcommittees in 2022. The subcommittees also heard testimony about a Virginia Medicaid initiative that demonstrated success in increasing the number of behavioral health practitioners working in the field after increasing reimbursement rates. This experience suggests that the state had available trained practitioners who opted out of providing services due to low reimbursement rates. This finding presents an immediate opportunity for action to improve the workforce shortage in Georgia by increasing Medicaid reimbursement rates for behavioral health practitioners.

The commission recommends that the state increase reimbursement rates in line with the findings of the 2022 DCH study. The commission further recommends that additional emphasis should be given to ensuring that rates are sufficient for services that support specific populations with unique behavioral health needs, including children experiencing mental health and substance use disorders, children dually diagnosed with autism and behavioral health challenges, and children and adults involved with both the behavioral health and criminal justice systems.

Supporting testimony was heard by the Workforce and System Development, Hospital and Short-Term Care Facilities, Children and Adolescent Behavioral Health, Involuntary Commitment, and Mental Health Courts and Corrections subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding

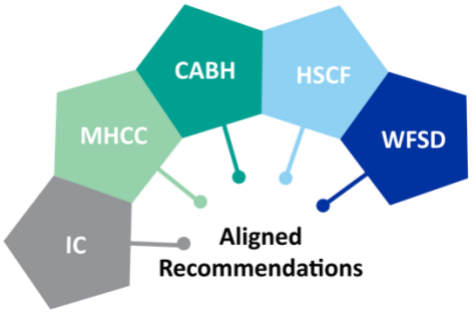


recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.

Competitive Salaries

The behavioral health workforce is facing several sustainability challenges, one of which is below-market compensation rates. The Deloitte compensation analysis found that, on average, DBHDD salaries are 19% below the national market data. When looking at specific job codes, it was reported that, on average, DBHDD minimum salaries for psychiatrists, forensic psychiatrists, and physicians are 24% below market median. Currently, there are upward of 75 counties in the state that do not have a full-time psychiatrist, 52 counties without a licensed social worker, and 60 without a pediatrician. With 29% of employees becoming eligible for early retirement within the next five years and a 57% turnover rate amongst the millennial generation, DBHDD will not be able to sustain and grow its current workforce if it is unable to offer competitive salary rates. Supporting evidence from the *Behavioral Health Rate Study* indicates that an increase in reimbursement rates will support providers in efforts to increase pay and other compensation for the workforce. This increase in pay would be a motivating factor for trained professionals to maintain employment in Georgia.

Supporting testimony was heard by the Workforce and System Development, Hospital and Short-Term Care Facilities, Children and Adolescent Behavioral Health, Involuntary Commitment, and Mental Health Courts and Corrections subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.



Loan Repayment/Forgiveness

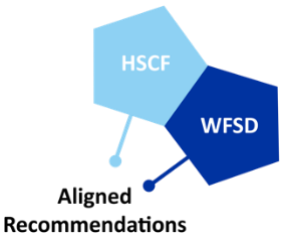
Considerable discussion centered on the establishment of a new loan forgiveness and loan repayment program for mental health professionals. This new program would be in addition to the service cancelable loan program established in the Georgia Mental Health Parity Act. This recommendation is carried over directly from the Year 2 report.

The Georgia Mental Health Parity Act called for the creation of a service cancelable loan program for students enrolled in any degree program for mental health and substance use professionals that would be administered by the Georgia Student Finance Commission. This program creates an incentive for students to enter degree programs to become mental health and substance use professionals by awarding loans to students that can be repaid through service once they are licensed and practicing in the field. The commission and the Georgia Office of Health Strategy and Coordination reviewed other states' programs and related workforce data and believe it would be worthwhile for Georgia to also incentivize its current workforce to practice in mental health professional shortage areas through a loan repayment

assistance program for individuals who are no longer students but are actively practicing in the workforce as licensed mental health or substance use professionals. This would be a new program separate from the service cancelable loan program established by the Georgia Mental Health Parity Act.

The commission recommends that the state incentivize its current workforce through a loan repayment assistance program for individuals who are no longer students but are actively practicing in the workforce as licensed mental health or substance use professionals. Participants in the program would receive loan repayment assistance that is conditioned on five consecutive years of service in a facility with a Health Professional Shortage Area designation and that serves the Medicaid and PeachCare for Kids populations. The *Behavioral Health Rate Study* indicates that funds from increases in reimbursement rates would allow for the fiscal ability to pay for additional loan forgiveness programs.

Supporting testimony was heard by the Hospital and Short-Term Care Facilities and the Workforce and System Development subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.



<u>Modernize Licensing Practices Across All Levels of the Behavioral Health Workforce</u>

Another barrier to growing and sustaining the behavioral health workforce in the state that has been identified by the commission is the need to modernize and streamline the licensing system. These updates would address the workforce shortage by ensuring that the new and existing workforce can get or maintain their license to practice in the state without facing delays or overly burdensome requirements. Testimony was heard by the Workforce and System Development Subcommittee and others that indicated Georgia's licensing processes are out-of-date and not comparable to those in surrounding states. Review, modernization, and improvement of Georgia's licensing practices must also recognize the particular need for service providers at all levels that demonstrate cultural competence and have the ability to speak multiple languages. Other states have created special initiatives and leadership positions to address the increasing percentage of residents who do not speak English and have unique cultural histories. Revising these practices can help ensure those qualified to practice in Georgia are able to maintain the appropriate licensure level to provide services in the state and meet the diverse needs of Georgia's residents.

The commission recommends the state modernize its licensing practices by (1) reviewing and updating its systems and processes used by licensing boards to receive and review license applications and renewals, (2) creating a pathway for foreign-trained practitioners to gain licensure in Georgia, (3) simplifying and strengthening the processes that allow clinicians who

are licensed in other states to obtain reciprocity for their licensure, and (4) reviewing and updating practicum and supervision requirements for licensure to more closely align with requirements in surrounding states.

Supporting testimony was heard by the Workforce and System Development, Hospital and Short-Term Care Facilities, and Children and Adolescent Behavioral Health subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.

<u>Strengthen Georgia's Peer Support Workforce</u>

The peer support professional is an essential behavioral health practitioner within the system of care. Peer support specialists bring their lived experience overcoming varying behavioral health challenges paired with training to support individuals currently navigating their mental health or substance use disorder. Subcommittees heard testimony supporting the continued use of the peer support workforce to bolster the behavioral health system and on the need to expand opportunities for this workforce.

The commission recommends that DBHDD review and revise policy and procedures for the allowance of certain offense histories in an individual's criminal history record when they are seeking agency employment.

Supporting testimony was heard by the Involuntary Commitment Subcommittee. This recommendation is endorsed by the full commission and was informed by the corresponding recommendations from the noted subcommittee. For more details on the subcommittee's recommendations, please see its respective appendix.

<u>Conduct Rate Studies of the Public Behavioral Health Care Workforce at DBHDD Hospitals and Community Service Boards</u>

Understanding gaps and challenges among the existing behavioral health workforce will allow for targeted solutions to address shortages impacting Georgians most in need of behavioral health care. Studying salaries of the public behavioral health workforce, including DBHDD providers, state hospitals, and the Community Service Board (CSB) workforce, will help the state better understand recruitment and retention challenges among these professionals.

The commission recommends that DBHDD conduct a study of the public behavioral health workforce to include a review of salaries, vacancy rates, and a comparison to private practice salaries and salaries in Georgia's neighboring states. This recommendation is continued over from the Year 2 report.

Supporting testimony was heard by the Workforce and System Development and the Involuntary Commitment subcommittees. This recommendation is endorsed by the full commission and was informed by the corresponding recommendation from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendix.

Build Capacity to Provide a Full Continuum of Behavioral Health Services and Support Through Leveraging Funding Supports and Maximizing Treatment Beds

A growing challenge for Georgia is the capacity to serve the growing population in a way that is effective to mitigate individuals from re-entering the behavioral health care system in Georgia. The first and most pressing issue identified in the *DBHDD Bed Capacity Study* is to increase the capacity of Georgia to serve individuals in crisis through the number of beds and utilizing funding sources. The recommendations under this theme rely heavily on testimony in the Hospital and Short-Term Care Facilities Subcommittee.

Address the Shortage of Psychiatric Beds in Georgia

The *DBHDD Bed Capacity* Study examines facilities in Georgia that served uninsured adults and children and adolescents as well as adults in the criminal justice system. In this specific term, it is estimated that there are 199 beds needed by 2025 to respond to the impending behavioral health bed crisis. The study determined that a total of eight facilities will be needed in the next 10 years, five of which are needed by 2025. To address gaps in care that directly impact the bed crisis, the commission recommends utilizing and creating pathways for EmPATH units and identifying funds needed to complete an Institutions for Mental Disease (IMD) waiver.

Utilize and Create Pathways for EmPATH Units

EmPATH units are environments in existing medical hospitals that allow for the assessment and stabilization of individuals experiencing a mental health crisis outside of the facility emergency departments (EDs). This allows ED beds to be utilized for medical crisis services while allowing patients with behavioral health needs to be assessed and evaluated in a more therapeutic environment. Unlike the ED, EmPATH units are structured in such a way that gives social support and freedom of movement. EmPATH units also reduce the demand for psychiatric beds, decreasing the amount of time individuals wait to be stabilized. When patients are treated in EmPATH units, the majority of psychiatric emergencies can be resolved in less than 24 hours, with most patients stabilizing within 14 to 18 hours of entry.

The commission recommends that the state fund one or more grant programs to establish EmPATH units at EDs in Georgia. The commission further recommends that DBHDD develop and implement the EmPATH grant program(s) with input from relevant agencies, organizations, and programs.

Supporting testimony was heard by the Hospital and Short-Term Care Facilities Subcommittee. This recommendation is endorsed by the full commission and was informed by the corresponding recommendation from the noted subcommittee. For more details on the subcommittee's recommendations, please see its respective appendix.

Identify a Pathway to Submit the Institutions for Mental Disease Waiver

The IMD exclusion prohibits states from claiming Federal Financial Participation for individuals under the age of 65 who are patients in IMDs, with only a few exceptions to this rule. In turn, this exclusion has left states with limited pathways to pay for these services. As of 2019, 26 states had received approval for IMD waivers for substance use disorder services, and states are also exploring IMD waivers for mental health services. In the 2022 legislative session, the Georgia General Assembly passed Senate Bill 610, which called on DCH to submit an IMD waiver for both mental health and substance use disorder treatment. This waiver will also assist in achieving the commission's recommendations to fund additional behavioral health crisis services and to expand the crisis continuum of care, two recommendations of the commission in the Year 2 report. The commission supports this action but recognizes that cost and workforce are large components.

The commission recommends that an IMD waiver work group be established in collaboration with DCH leadership to identify funding. In addition to identifying funding, the workgroup should work to identify any additional barriers, beyond funding, that may prevent DCH from following the directive prescribed to the agency in SB 610 and submit an IMD waiver to Centers for Medicare and Medicaid Services to allow for IMDs to qualify for Medicaid reimbursement for mental health and substance use disorder treatment.

Supporting testimony was heard by the Hospital and Short-Term Care Facilities Subcommittee. This recommendation is endorsed by the full commission and was informed by the corresponding recommendation from the noted subcommittee. For more details on the subcommittee's recommendations, please see its respective appendix. This recommendation is continued over from the Year 2 report.

Optimize Use of Existing Psychiatric Beds

The *DBHDD Bed Capacity Study* illuminated the discrepancy in occupancy rates across CSBs throughout the state. The report indicated that the optimal occupancy rate for facilities is 85%. There are locations that meet or exceed this occupancy standard, while others fall far short. The commission recommends that it is imperative to develop and implement processes to optimize intra- and inter-region access to existing CSB beds.

Supporting testimony was heard by the Hospital and Short-Term Care Facilities Subcommittee. This recommendation is endorsed by the full commission and was informed by the corresponding recommendation from the noted subcommittee. For more details on the subcommittee's recommendations, please see its respective appendix.

Aligned Recommendations

Establish a Plan for Medicaid to Allow a Portion of Funding to Be Used to Address Social Determinants of Health

States continue to acknowledge the important role that environments play in impacting health. Social determinants of health are the factors influencing individuals' health, including where people live, work, and play. Addressing these factors can improve health in the long run and has the potential to decrease future health care costs if done early.

The commission recommends that Medicaid pursue a plan to allow for funding to be used to address social determinants of health. Other states have been successful in these plans by using contracting requirements with their care management organizations in which they have incorporated language and provisions in their contracts about social determinants of health. These may include requiring interventions for members at risk, establishing minimum touchpoints, or mandating care coordination for high-needs diagnoses or conditions. DCH should consider and pursue these avenues to allow for supports to be provided that address the social determinants of health for plan members.

Supporting testimony was heard by the Children and Adolescent Behavioral Health Subcommittee. This recommendation is endorsed by the full commission and was informed by the corresponding recommendation from the noted subcommittee. For more details on the subcommittee's recommendations, please see its respective appendix. This recommendation is continued over from the Year 2 report.

Aligned Recommendations

Expand Effective, Community-Based Programs, Practices, and Services

Subcommittees heard from service providers and state executive agencies responsible for delivery of behavioral health services throughout the state. Many of the subcommittees identified specific programs that have clear evidence of supporting practices, programs, and services within the behavioral health system of care. These programs often reach only small geographic regions of the state and would benefit from additional funds to expand their reach to more areas.

Expand Effective Programs and Services for Children and Adolescents

The Children and Adolescent Behavioral Health Subcommittee identified programs that are effective in promoting optimal youth behavioral health outcomes. These programs should be expanded to increase their reach throughout the state.

The commission recommends the expansion of the following services aimed at improving behavioral health outcomes for children and adolescents:

1. Encourage Georgia CSBs to adopt the Certified Community Behavioral Health Center model, which is designed to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age — including developmentally appropriate care for children and youth.
2. Expand the Apex program to more schools throughout Georgia. In addition, provide and expand access for tele–mental health access in schools and consider expanding the Apex program reach to rural areas by use of tele–mental health as part of a plan to expand school-based behavioral health services.
3. Expand and plan for future funding of the Georgia Mental Health Access in Pediatrics program.

Supporting testimony was heard by the Children and Adolescent Behavioral Health Subcommittee. This recommendation is endorsed by the full commission and was informed by the corresponding recommendations from the noted subcommittee. For more details on the subcommittee's aligned recommendations, please see its respective appendix.

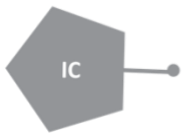
Aligned Recommendations

Expand Effective Programs and Services for Adults

Streamline Processes for Communication Between DBHDD and the Division of Aging

1. It is recommended that strategies be implemented to improve communication and collaboration between the Division of Aging, the Public Guardianship Office, and DBHDD, including cross-agency training to understand the roles and limitations of each agency.
2. It is recommended that DBHDD establish a liaison to work and coordinate with the Division of Aging and the Public Guardianship Office for guidance and direction and to troubleshoot complex cases.

Supporting testimony was heard by the Involuntary Commitment Subcommittee. This recommendation is endorsed by the full commission and was informed by the corresponding recommendations from the noted subcommittee. For more details on the subcommittee's recommendations, please see its respective appendix.



Aligned Recommendations

Expand and Study the Assisted Outpatient Treatment Program

The AOT program established by the Mental Health Parity Act is still in its infancy, with three of the programs close to capacity. To continue the work that has been begun, the commission recommends:

1. Funding to continue for five pilot projects across the state.
2. Targeted training for all CSBs and treatment providers about the use of AOT.
3. Studying AOT pilot site implementation to understand how each site utilizes funding to support staffing and operations.
4. Conducting a study to inform building an additional AOT pilot project in conjunction with misdemeanor diversion.

Supporting testimony was heard by the Involuntary Commitment Subcommittee. This recommendation is endorsed by the full commission and was informed by the corresponding recommendations from the noted subcommittee. For more details on the subcommittee's recommendations, please see its respective appendix.

Study Programs, Practices, and Services That Need Improvement

Subcommittees noted areas where additional study will help the commission identify appropriate solutions to address ongoing challenges within the behavioral health system. The following studies are recommended to be undertaken by the commission in the coming year:

1. Study and conduct an environmental scan to identify evidence-based and evidence-informed practices other states are utilizing for defining and implementing jail-based and outpatient restoration programs and diverting individuals with low-level criminal offenses from state hospitals.
2. Study and conduct an environmental scan to identify best practices for defendants with intellectual developmental disabilities or who have dementia and are currently not included in the code for involuntary commitment.
3. Study and conduct an environmental scan of the use of alternative transportation options when directed by a 1013 form or order to apprehend. In addition to transportation, an environmental scan on evidence-based policies and evidence-informed practices to determine where a person is sent for crisis intervention, how it is determined, and who makes the determination should be conducted.
4. Study the use of Children's Medical Services school-based services and Early and Periodic Screening, Diagnostic and Treatment benefits in Georgia to identify and address gaps in service provision.

5. Study and evaluate the findings of the report currently being conducted that reviews Juvenile Justice Court resources and best practices on behalf of the Forensic Competency Advisory Committee.

Streamline Existing Statutes and Policies

Subcommittees also identified specific statutes and policies that need refining to support system reform. The commission recommends the following changes be made to the noted statutes and policies.

Refine Policies and Practices Impacting Adults

1. Amend OCGA Section 50-14-1 to allow for telephonic CSB board meetings. Subsection (f) provides that "an agency with statewide jurisdiction or committee of such agency shall be authorized to conduct meetings by teleconference, provided that any such meeting is conducted in compliance with this chapter."
2. Based on Georgia Code, OCGA Section 31-6-1, update Certificate of Need program to allow for the creation of EmPATH units.

Refine Policies Impacting Access to Services for Children and Adolescents

1. Revise DCH requirements for tuberculosis symptom screening to allow nonmedical professionals, who are qualified, to complete substance use assessments for intake of children and adolescents who need substance abuse treatment.
2. Eliminate the requirement for prevention/early intervention, Level 1 (Outpatient), or Level 2 (Intensive outpatient/partial hospitalization) treatment modalities.

Refine Policies and Practices Impacting Services for Persons Involved in the Criminal Justice and Behavioral Health Systems

1. Amend OCGA Section 37-3-42(a)(2) and OCGA Section 37-7-42(a)(2) to specifically reference back to OCGA Section 37-3-4 and OCGA Section 37-7-5 to clarify transportation liability concerns for law enforcement.
2. Amend OCGA Section 37-3-42(a)(2) and OCGA Section 37-7-42(a)(2) to clarify the definition of *physician* in paragraph (2). Suggested amended language can be found in the Involuntary Commitment Subcommittee report.
3. Revise language within the restoration statute to clearly identify that DBHDD has three options for the provision of restoration services: outpatient, jail-based, and inpatient. DBHDD will determine the most appropriate setting for the delivery of restoration services for each individual. If DBHDD recommends provision of outpatient restoration services, the presiding judge will determine whether the defendant is eligible for bond.

Georgia Behavioral Health Reform and Innovation Commission

Appendix A: Subcommittee on Children and Adolescent Behavioral Health

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on Children and Adolescents

2023 Annual Report

Chair

Eric Lewkowiez, M.D.

Members

Garry McGiboney, Ph.D.

Gwen Skinner

Miriam Shook

Sarah Vinson, M.D.

Commissioner Shawanda Reynolds-Cobb

David Bradley, D.M.D.

December 8, 2023

Report prepared with assistance from the Center of Excellence for Children's Behavioral Health, Georgia Health Policy Center, Georgia State University

Table of Contents

Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The Commission, chaired by Representative Kevin Tanner from House District 9 and current Commissioner at the Georgia Department of Behavioral Health and Developmental Disabilities, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The Commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The Commission created five subcommittees in order to review these focus areas including the Subcommittee on Children and Adolescent Behavioral Health chaired by Dr. Sarah Vinson (2020-2021) and by Dr. Eric Lewkowiez (2022-2023).

During 2023, the Subcommittee on Children and Adolescents held six public meetings on topics vital to the mental health of children and adolescents, including updates on DBHDD's current and future directions for serving children and adolescents with behavioral health needs, mental health issues for unhoused and foster care children, maternal and infant mental health, school based behavioral health, children and community mental health, and integrated children's mental health.

The Behavioral Health Reform and Innovation Commission's Subcommittee on Children and Adolescents believes that the information and recommendations included in this report will help Georgia build capacity and improve access to mental health services for infants up to 18 years of age and into adulthood. Research shows that untreated mental health issues in infancy, childhood, and adolescence transfer to adulthood and become significantly more difficult to treat.[1] It is estimated that 1 in 6 U.S. children aged 2-8 has a mental, behavioral, or developmental disorder; this prevalence is higher among children who live in poverty.[2] In Georgia, 1 in 4 youth aged 3-17 has one or more emotional, behavioral, or developmental condition, and suicide is the 2nd leading cause of death for children aged 10-17.[3] During the 2022-2023 school year, 52% of Georgia's middle and high school students reported feeling depressed, sad, or withdrawn over the past 30 days.[4] Moreover, 26% of students reported

[1] Copeland WE, Wolke D, Shanahan L, Costello EJ. Adult Functional Outcomes of Common Childhood Psychiatric Problems: A Prospective, Longitudinal Study. JAMA Psychiatry. 2015;72(9):892–899. doi:10.1001/jamapsychiatry.2015.0730.

[2] Centers for Disease Control and Prevention (2023). Data and Statistics on Children's Mental Health. Retrieved from https://www.cdc.gov/childrensmentalhealth/data.html.

[3] Georgia Child Fatality Review Panel (2019). https://gbi.georgia.gov/document/document/2019-cfr-annual-report/download.

[4] 2022-2023 Georgia Student Health Survey, Georgia Department of Education.

that they felt overwhelmed with fear for no reason, sometimes including a racing heart or fast breathing.[4] Of note, data from previous school years show that Georgia's youth had been experiencing increasing rates of mental health challenges even before the start of the COVID-19 pandemic.[4] Nonetheless, in 2021, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and the Children's Hospital Association jointly declared child and adolescent behavioral health a public health crisis, amplified by the COVID-19 pandemic.[5]

Given these alarming statistics, the members of the Subcommittee on Children and Adolescent Behavioral Health believe it is imperative for the State of Georgia to develop an implementation plan that provides access[6] to a wide range of mental health support services for infants, children, and adolescents, regardless of their economic status, complication of need, or where they live.

This report includes information and recommendations on how to address the child and adolescent behavioral health crisis from numerous presentations from children's mental health experts, including pediatricians and mental health providers, researchers, advocates, individuals with lived experience, educators, and others with a vital interest in children and adolescents.

[5] American Academy of Child and Adolescent Psychiatry. (2021). A Declaration from the American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, and Children's Hospital Association.
[6] Access: affordable, accommodating, and appropriate.

List of Presenters to the BHRIC Subcommittee on

Children and Adolescents 2023

BHRIC Subcommittee on Children and Adolescents Members Dr. Eric Lewkowiez (Chair), Miriam Shook, Dr. Sarah Vinson, Gwen Skinner, Commissioner Shawanda Reynolds-Cobb, Dr. David Bradley, Dr. Garry McGiboney		
Support to the BHRIC Subcommittee on Children and Adolescents Ashley Dickson (United Way), Dr. Ann DiGirolamo (Georgia State University), Dr. Kelsey Corallo (Georgia State University), Kaleb Whitfield (Georgia State University), Ashlie Oliver (Georgia State University)		
Date	**Topic**	**Presenter** Presenter's Title
June 22, 2023	Updates from the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)	**Commissioner Kevin Tanner** DBHDD **Brenda Cibulas** Director of Behavioral Health DBHDD **Dante McKay, JD, MPA** Director of the Office of Children, Young Adults & Families DBHDD
July 27, 2023	Mental Health Issues of Homeless Children, Children in Insufficient Housing, and Foster Children	**Michael Waller** Executive Director Georgia Appleseed Law and Justice Center **Dr. Alie Redd** Executive Director Covenant House GA **Chad Jones** Vice President-Business Operations ViewPoint Health **Gevontae Ford** Former Homeless and Foster Care Youth **Glenene Lainer** Senior Director-Safety and Permanency

		Division of Family and Children Services Department of Human Services
August 24, 2023	Maternal and Infant/Children's Mental Health	**Dr. Rebecca Woo** Perinatal Psychiatrist Associate Professor Emory University School of Medicine **Dr. Jennifer Barkin** Professor and Vice Chair Community Medicine Mercer University School of Medicine Barkin Index of Maternal Functioning **Madison Scott** Director of Policy and Research Health Mothers, Healthy Babies Coalition of Georgia
September 28, 2023	School-Based Mental Health-Effective Practices	**Mary Elizabeth Davis** Superintendent Henry County School System **Fred Williams** Superintendent Dublin City School System **Will Schofield** Superintendent Hall County School System **Dimple Desai & Sarah Phillips** The Georgia Collaborative for School-Based Behavioral Health (The Carter Center, Voices for Georgia's Children, Georgia Appleseed, and Resilient Georgia)
October 19, 2023	Community Mental Health and Children	**Dr. April Hartman** Vice Chair for DEI Associate Professor Department of Pediatrics and Adolescent Medicine Medical College of Georgia
	Handle With Care	**Dr. Emily Anne Vall**

		Executive Director Resilient Georgia **Arianne Weldon** Strategic Innovation Manager and Get Georgia Reading Campaign Director Georgia Family Connection Partnership **Lizann Roberts** Executive Director of Coastal Georgia Indicators Coalition Georgia Family Connection Partnership
	Georgia Mental Health Access in Pediatrics (GMAP)	**Josephine Mhende, DrPHc, MPH** Program Manager, GA Mental Health Access in Pediatrics (GMAP) Center of Excellence for Children's Behavioral Health Georgia Health Policy Center Georgia State University
	Medicaid and Children's MH: New Rate Study Content and Potential Impact	**Wendy Tiegreen** Director Office of Medicaid Coordination and Health System Innovation DBHDD
November 16, 2023	Integrated Children's Mental Health – National and State Perspectives	**Anne Dwyer, Esquire** Research Professor Georgetown University McCourt School of Public Policy's Center for Children and Families **Kimberly Johnson** Director of Willowbrooke Counseling Center Tanner Medical Center
	The DBHDD Provider Network	**Wendy Tiegreen** Director Office of Medicaid Coordination and Health System Innovation DBHDD

Summary of Presentations to Subcommittee

June 22, 2023

Updates from DBHDD

The Department of Behavioral Health and Developmental Disabilities (DBHDD) plays an integral role in building Georgia's behavioral health system of care. DBHDD works alongside other agencies and organizations across the state to implement behavioral health services for Georgia's children and youth.

Presentations from Commissioner Kevin Tanner, Brenda Cibulas, Director of Behavioral Health, and Dante McKay, Director of the Office of Children, Young Adults, & Families, Georgia DBHDD

Commissioner Tanner shared that the goal of this meeting is to understand DBHDD's role in the subcommittee's mission to 'fill in the gaps' where children are currently not being served in Georgia's behavioral health system. He shared that Mr. McKay will be speaking about the roles DBHDD, DCH, and other state agencies play in serving Georgia's youth with behavioral health needs. He will be highlighting the work of the MATCH committee, which was founded in response to a recommendation from this subcommittee. He shared that there will be a substantial amount of money set aside in DBHDD's budget for MATCH to address behavioral health issues for high-risk youth, such as those who are involved in foster care hoteling; this work will include a pilot study. DBHDD will be working with Community Service Boards (CSBs) and Emergency Rooms (ERs) to embed people within the main ERs seeing children to divert high-risk youth who show up at the ER to community services. They will also be working with Gwen Skinner (member of C & A Subcommittee) and Devereux Advanced Behavioral Health to create step down opportunities. Commissioner Tanner expressed gratitude for this committee for coming up with the big ideas, and credited Mr. McKay's team for putting together a plan of action.

Commissioner Tanner then shared that a developmental disability crisis center for the state is being developed; it will include 16 inpatient crisis beds in Macon, and River's Edge will be the CSB partner. In addition to behavioral health care, the center will have dental, physical, and specialty health care. There is also a youth crisis center being developed in Savannah.

Commissioner Tanner shared his thoughts on the two areas the state can focus on to have the largest impact on Georgia's children and families. First, the findings from two rate studies on behavioral health and developmental disabilities can be implemented to inform workforce expansion. Second, guidance around the procurement of managed care, promoting greater managed care accountability for vulnerable children, can expand access – DBHDD created a white paper on what is needed for this to happen.

Ms. Brenda Cibulas provided a brief introduction of herself. She began her career in behavioral health care working for NIMH, where she focused on substance use disorder medication-assisted treatment. Then, she transitioned to Emory's behavioral health team, and then on to DeKalb Community Service Board (CSB). Prior to DBHDD, she worked within

the Mercy Care hospital system in which she focused on implementing integrated behavioral health. She noted that she is excited to take on this new role and believes that integrated behavioral health (e.g., Certified Community Behavioral Health Clinics, or CBHCCs) that is inclusive of rural families and at-risk youth is where the state should focus.

Mr. Dante McKay transitioned into giving an overview of the Office of Children, Young Adults and Families (OCYF) and child and adolescent mental health, substance use disorder, and ASD treatment services offered by DBHDD. The OCYF sits within the Division of Behavioral Health at DBHDD, and it has a tiered network of community-based services. Tier 1 includes Comprehensive Community Providers (CCPs), Tier 2 includes Community Medicaid Providers (CMPs), and Tier 3 includes Specialty Providers.

The children's behavioral health public payer system is currently structured such that the Department of Community Health (DCH) and Care Management Organizations (CMOs) jointly cover the state's Medicaid, CHIP, and foster care youth, whereas DBHDD and DCH jointly cover the state's un- or underinsured youth and a sub-population of fee-for-service Medicaid youth. As such, DBHDD covers services for only a small portion of the state's youth; however, these services are comprehensive and broken down by medical treatment, outpatient behavioral health treatment, inpatient behavioral health treatment, Autism services/treatment, and crisis services.

OCYF provides clinical/crisis services, community-based services, parent/youth peer support; organizes the Multi-Agency Treatment for Children (MATCH) committee; and conducts workforce development initiatives. These services are provided across a continuum of need: prevention/early screening (e.g., nurse and pediatrician trainings); early intervention (e.g., Apex, mental health clubhouses); intervention (e.g., Apex, mental health clubhouses, Certified Peer Support – Parent [CPS-P] and Certified Peer Support – Youth [CPS-Y] services); and late intervention (e.g., MATCH, Local Interagency Planning Teams [LIPTs], Crisis Stabilization Units [CSUs]). Across the continuum, OCYF provides 24/7 crisis response, a core benefits package, public health education, and training opportunities.

Historically, most services and funding have applied toward late intervention services. OCYF is working towards shifting to a focus on prevention and early intervention services, to address child and adolescent behavioral health needs early on – before they become a crisis. The MATCH committee met in January, February, and March of this year to discuss this issue. Experts have been providing testimony and a final report was generated in March, which included recommendations to explore causes of complex children's behavioral health issues and to develop a pipeline from LIPTs to MATCH clinical subcommittee.

OCYF provides a continuum of care for substance use disorder (SUD) treatment. Prevention/screening/early intervention services are provided at Prevention Clubhouse, and intervention services are provided via Substance Abuse Intensive Outpatient Programs, Intensive Residential Programs, Non-Intensive SUD Outpatient Servies, and Recovery Support Clubhouses. Late intervention is provided via Crisis Stabilization Units; currently, there are CSUs located in Macon, Savannah, Newnan, and Decatur.

Autism Spectrum Disorder (ASD) services, which are required per the Medicaid state plan, are primarily provided via the Department of Public Health (DPH) with DCH oversight. These services include ASD screening, diagnosis, and comprehensive assessment. DBHDD supplements these services by providing mobile crisis support; there are 16 inpatient beds across two centers, and intensive in-home intervention is also available.

During the post-presentation Q&A, Ms. Cibulas provided additional information about the transition of CSBs into CBHCC models. CCBHCs have distinct guidelines to follow per SAMHSA (https://www.samhsa.gov/certified-community-behavioral-health-clinics). CCBHC doors should be open to all, however, this doesn't exactly align with DBHDD's mission, because it is to provide services for under- or uninsured individuals. Nevertheless, DBHDD is encouraging CSBs to adopt the CCBHC Model. For integrated behavioral health, screenings are required; some CSBs have hired nurse practitioners to do this, which opens the door to recognition of more physical illnesses and symptoms – this means that the centers will need to work with Federally-Qualified Heath Centers (FQHCs) and other primary care/dental service providers (and requirements of CCBHCs include substantial partnerships among health service providers). There will be challenges to shift to this model as far as workforce capacity; the behavioral health rate studies have suggested that non-competitive salaries are a barrier in expanding the workforce. Moreover, BH reimbursement rates have not been updated since the early 2000s. CCBHCs operate under a Prospective Payment System (PPS) rate, and it is unclear whether Georgia will agree to this payment scale.

July 27, 2023

Mental Health Issues of Homeless Children, Children in Insufficient Housing, and Foster Children

Children experiencing homelessness or housing instability, as well as children within the foster care system, often need behavioral health support to help overcome trauma associated with their circumstances. Behavioral health services for this population of children need to be comprehensive and high-quality to ensure equitable access and positive outcomes.

Presentation from R. Michael Waller, Executive Director, Georgia Appleseed Center for Law and Justice

Georgia Appleseed is a non-partisan, non-profit law center that focuses on removing barriers to justice for children of color, and LGBTQ+ children, children experiencing poverty, children in foster care, and children with disabilities. The Center has two main program areas: 1. School Justice (keeping children in class instead of the juvenile justice system and increasing access to behavioral and academic resources) and 2. Housing Justice (ensuring stable, healthy housing for low-income families).

Mr. Waller shared the goal of the presentation is to recommend best policies and practices to support the behavioral health needs of children experiencing homelessness and foster care. The recommendations are based on the Center's experience providing legal support to children in foster care, feedback from the children and caregivers served, and cross-functional input from other child-serving entities. Information was presented from Mr.

Waller and four additional community speakers: 1) Mr. Gevontae Ford (goes by "Ford") who aged out of the foster care system and directly into homelessness 10 years ago, 2) Ms. Glenene Lanier, the placement and permanency senior director at DFCS, who served as Ford's case manager at one point while he was in foster care, 3) Dr. Alie Redd, who is the Executive Director of Covenant Georgia, which is an organization that addresses youth homelessness and trafficking and 4) Mr. Chad Jones, the Vice President for Business Development at View Point Health. Both Ford and Ms. Lanier offered their testimony via pre-recorded video.

Mr. Waller cited that 25% of children in foster care experience at least one episode of homelessness by age 21. The Georgia Department of Education reported in 2021 that almost 32,000 children were unsheltered or precariously housed. Children experiencing homelessness have disproportionately high rates of mental health conditions and are six times more likely to meet the criteria for 2+ psychiatric disorders compared to their housed peers. By not preventing and addressing these mental health issues, these children are at-risk for increased criminal justice involvement, school discipline, and lower graduation rates. He added that Black, Brown, and LGBTQ+ children and children with disabilities disproportionately experience foster care and homelessness.

Testimonies from Mr. Gevontae Ford ("Ford"), Former Homeless and Foster Care Youth, and Ms. Glenene Lanier*, Placement and Permanency Senior Director for the Division of Family and Children Services (DFCS)

Ford was five-years old when he entered foster care after being separated from his mother, who had a substance use disorder but was trying to recover. His first foster parent was not really engaging, and he stayed with her until 11-12 years old. After, he went to several different foster homes. Ford preferred solitude and often kept to himself; he was diagnosed with schizophrenia and received medication, which adversely affected his well-being. From a young age, Ford was aware that the Georgia Division of Family & Child Services (DFCS) was understaffed because he experienced constant turnover of case workers and did not recall ever meeting with an attorney.

From ages 16-18 years, Ford experienced labor trafficking. His foster parent threatened him with eviction (intentionally citing that he was aging out of foster care) if he did not do handyman and other manual labor for free. At 18, Ford left that foster parent and became homeless, living in places like abandoned playgrounds. While he enjoyed school and was able to enroll in high school, Ford could not finish high school due to being homeless.

Ford realized that he was experiencing mental health challenges as a child, such as depression. While he had the drive to seek help, he did not have access to resources. Ford later received assistance from Hearts to Nourish Hope. He passed his GED very quickly and finally got support from providers.

*Mr. Waller prefaced that Ms. Lanier's testimony is her own views and opinions, not those of DFCS.

Ms. Lanier has served as Senior Director for Placement and Permanency for almost two years and has worked for DFCS for 29 years. She served as one of Ford's case managers and recalled him discussing his trauma and behavioral health needs. At that time, Ms. Lanier had

a load of up to 55 cases. Ms. Lanier said that most children in foster care have already suffered a prior trauma and removals from/being placed in and out of homes continues to be traumatizing. She believes that the system [DFCS] often misdiagnoses children [with mental illness] and moves their placements due to behavioral concerns. However, behavioral issues often arise because children are not equipped to manage and communicate their emotions or process their trauma and moving them to other placements exacerbates their trauma.

Ms. Lanier was an advocate for evidence-based, multifaceted approaches to permanent home outcomes for children. She cited the Family First Prevention Act (https://www.childwelfare.gov/topics/systemwide/laws-policies/federal/family-first/), which provides birth families with support from trained foster caregivers who help families work towards safe reunification, which can reduce the risk of out-of-home placements. Ms. Lanier also discussed the importance of partnerships among DFCS, the Department of Public Health, the Department of Behavioral Health and Developmental Disabilities, the Department of Juvenile Justice, the school system and the court system to collaborate in efforts to support children and families in their care.

Ms. Lanier also highlighted the need for the child to have a voice in their own case management, reducing the high turnover of case managers, and having trauma-informed caregivers to distinguish between delinquent and mental health related behavior.

The agency [DFCS] faces challenges in being able to provide trauma-informed care for children with behavioral health needs. The absence of trauma-informed care may lead to further trauma and incarceration in some cases. Therefore, there is a need for appropriate assessments and referral processes to provide trauma-informed prevention and treatment services for children.

After Ms. Lanier's testimony, Mr. Waller reiterated the importance of retaining high-quality case workers in agencies. Dr. Lewkowiez added that if children are involved in their own care, the outcomes are much better.

Testimony from Dr. Alie Redd, CEO, Covenant House Georgia

Dr. Alie Redd has worked in social services in Georgia for 30 years. Covenant House Georgia addresses youth homelessness and trafficking (ages 16-24) with emergency short-term services as well as long-term housing support, among other things (e.g., outreach, health care, workforce development, and academic support).

Dr. Redd cited the statistic that 50% of youth aging out of foster care experience homelessness within 6 months and 1 in 5 homeless youth will be approached for trafficking within 72 hours. Many young people experiencing homelessness and trafficking (including labor trafficking, like in Ford's case) also experience moderate to severe mental health challenges (around 40%) – such as PTSD, depression, anxiety, and attachment disorder, and these needs are often not addressed. When their mental health needs are not addressed, youth may become unsuccessful in academics, workforce development, stable housing,

physical health, and relationships. In the long term, this can lead to adverse outcomes and generational poverty.

Testimony from Mr. Chad Jones, Vice President for Business Development, ViewPoint Health

ViewPoint Health (VPH) is a Community Service Board (CSB) that serves over 16,000 individuals annually across the continuum of care. They are one of 22 CSBs that serve as a safety net for the underinsured or uninsured. Mr. Jones oversees youth and young adult services including Apex, the statewide High Fidelity Wraparound program, and supportive education and employment and child welfare services. VPH received the Certified Community Behavioral Health Clinic (CCBHC) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for their social determinants of health model.

Mr. Waller, Dr. Redd, and Mr. Jones each provided several recommendations to the committee on how to address behavioral health challenges faced by foster care and unhoused youth. The full set of recommendations are included in the recommendations section of this report.

August 24, 2023

Maternal and Infant/Children's Mental Health

Caregivers need to be healthy for their infants and children to be healthy. The pre- and post-natal periods can be extremely stressful and isolating, particularly for individuals who lack access to services and social support. Therefore, it is imperative to ensure that caregivers receive universal mental health screening and treatment services when needed to support families and children who may be experiencing distress.

Presentations from Dr. Rebecca Woo, Perinatal Psychiatrist, Associate Professor, Emory University School of Medicine; Dr. Jennifer Barkin, Professor and Vice Chair of Community Medicine, Mercer University School Medicine, Barkin Index of Maternal Functioning; and Madison Scott, Director of Policy and Research, and Ky Lindberg, CEO, Healthy Mothers, Healthy Babies Coalition of Georgia

Dr. Rebecca Woo, who refers to herself as a "gynechiatrist," covered the topics of 1) relating the risks of mental health conditions to maternal morbidity and mortality, 2) anticipating barriers patients may face when trying to obtain mental health services, and 3) describing processes that may increase access to maternal mental health services. The Alliance for Innovation on Maternal Health released new guidelines around improving maternal outcomes, which include addressing postpartum transitions, substance use in maternal care in the peripartum period, and peripartum mental health care. OB/GYNs and other obstetric providers have a responsibility to adhere to these guidelines.

Screening for peripartum depression has been a HEDIS (Healthcare Effectiveness Data and Information Set) measure for 3 years now; however, it still is not the universal standard of care. The United States is one of the worst countries in the developed world to give birth when it comes to maternal mortality, and Georgia's maternal mortality rate is more than 2x

the national rate, disproportionately affecting women of color and women of low socioeconomic status. Maternal mental health conditions are a common complication of pregnancy, and the World Health Organization has identified suicide as a leading cause of death worldwide in the first year postpartum. Just because we are not addressing maternal mental health doesn't mean it is not a monumental issue. There is a new medication on the market to treat postpartum depression, with the goal of preventing suicides and overdoses in the first year postpartum.

Perinatal Mood and Anxiety Disorders, or PMADs, are the most common complications during pregnancy. PTSD (related to trauma during pregnancy or at birth), obsessive compulsive disorder (OCD), and postpartum psychosis (often a manifestation of bipolar disorder, which is often diagnosed during women's 20s and 30s, or peak childbearing age) can also manifest during the peripartum period. PMADs are a costly problem – the average cost of Postpartum Depression (PPD) is $32,000 per mother/infant dyad, and the cost of untreated PMADs was estimated at $14 billion in U.S. in 2017.

Mental health impacts pregnancy outcomes, and vice versa. For example, 40% of pregnant patients who were hospitalized due to a mental health disorder had a diagnosis of other significant health disorders (e.g., diabetes, hypertension, asthma, substance abuse, obesity, etc.). Additionally, women with depression are more likely to develop gestational diabetes., and anxiety in pregnancy is associated with gestational hypertensive disease. Women with psychiatric disorders are more likely to experience hemorrhage, preterm labor, and preterm birth, cesarean delivery, and higher rate of low-birth-weight infants; conversely, women with adverse obstetric events and pregnancy outcomes are more likely to develop postpartum depression, anxiety, postpartum PTSD, and suicidal ideation – this can become a cycle and may impact subsequent pregnancies.

Roadblocks to maternal mental health treatment exist at the patient, provider, and system levels. At the patient and provider levels, patients may not self-identify as needing mental health treatment due to stigma, and providers may not recognize mood or anxiety disorders; moreover, once mental health challenges are identified, it may be difficult to find accessible resources for patients. Behavioral health parity is a helpful step toward increasing access to mental health care, but only about 55% of psychiatrists accept Medicaid, and Georgia Medicaid does not cover psychotherapy services outside of certain centers for those who are 21+. Even those with private insurance have issues finding a mental health provider. At the systemic level, mental health care and obstetric provider shortages create access barriers. In 2022, Georgia was ranked 47th in the nation regarding access to mental health care workers – there is 1 mental health worker for every 730 adults in the state, and 65% of adults with any mental illness at all report not being able to access mental health care. There are similar statistics for obstetric providers in terms of workforce shortages in Georgia.

Collaborative care models are one way to address the maternal mortality crisis. Suicide rates peak 6-9 months postpartum; this is when doctors (e.g., pediatricians and obstetricians) visits tend to drop off. Collaborative care through direct consultation or embedded mental health services can bring specialist care into broader settings. Relatedly, non-specialist provision of care (e.g., nurse navigators, social workers, peer support specialists) and task-sharing can help combat workforce shortage issues and increase access to care. Use of

technology (e.g., telemedicine, interactive case review through Project ECHO, and AI-driven teletherapy and coaching) and Mental Health Access programs in which specialty mental health providers consult with primary care and non-specialty mental health providers can also help increase access to care.

An estimated 35% of mental health physician's office visits for adults aged 18 and older are conducted by primary care providers. The goal of Psychiatric Access Programs is to empower and increase capacity for primary care and general providers to treat mental health issues on-site and immediately, rather than deferring care. Perinatal Psychiatric Access Programs, which have been established in over 20 states, address the critical public health issue of maternal mortality through innovative, cost-effective approaches to treating mental health in frontline health care settings. They are not gateways to clinics, crisis management, and typically are not direct-to-patient; rather, they provide clinical support for medication management, to help with diagnosis, access to resources, and increase overall capacity of other providers. The Massachusetts Child and Adolescent Psychiatry Access Program (MCPAP), which is a flagship program that has been around for 15 years, is an example of this.

The impact Psychiatric Access Programs can have can be illustrated by two different scenarios of someone who is screened for depression during pregnancy. In the care as usual scenario, the obstetrician might say they're not comfortable treating mental health, and they make a referral to psychiatry. In the meantime, weeks or months may go by, and a pregnant person's behavioral health condition might have been getting worse and/or they may deliver in the meantime. Care may be delayed even further if a psychiatrist isn't able to treat the condition adequately or right away. In the Psychiatry Access Service scenario, the obstetrician/health care provider can consult with a psychiatrist in real-time for recommendations for medications, interventions, psychiatric care, etc. The patient's psychiatric care comes within the moment or at least within a couple days, and their condition is stabilized before their baby is born.

The PEACE for Moms program is a Psychiatric Access Program that provides psychiatric referrals, clinical support, and education, with the goal of uniting stakeholders (e.g., prescribers, therapists, and birth support personnel). PEACE for Moms clinical services include medication recommendations, diagnostic clarification, care plan development, telehealth consultations, and skills group referrals (which is direct patient interfacing). The PEACE for Moms consult process starts with the primary provider gathering information from the patient, and then the provider calls the consult line. A mental health specialist calls the provider back same-day or the next day and provides recommendations and resources. Importantly, the patient consents to PEACE for Moms to reach out to them.

PEACE for Moms also provides Mothers and Babies training, which is a program developed by Northwestern that uses a cognitive-behavioral based therapy approach to teach caregivers stress management, mindfulness, and communication skills. It is less intensive than group therapy and requires meeting virtually for 6-9 weeks for 1 hour at a time. PEACE for Moms is attempting to expand the program to other sites across the state and is offering training for other organizations who want to implement Mothers and Babies (e.g., labor and delivery units, CSBs, peer support programs, etc.). The program does not have to be

implemented by a clinician; it can be run by anyone who understands maternal mental health (e.g., peer educators or nurse navigators) and can be provided one-on-one or in group settings.

To prepare a consult for PEACE for Moms, a clinician (or someone who works with the clinician) just needs to provide the clinician's name, cell number, and email address, as well as the patient's name, date of birth, date of delivery or estimated date of gestation, cell number, email, zip code, and consent for contact. The PEACE for Moms team includes Toby Goldsmith, MD, Whitney Adams, PhD, Arica Washington, Jill Mast, Mekia Blackmon, Michaela Kitchens, and Kathryn Black.

Dr. Jennifer Barkin presented on the Barkin Index of Maternal Functioning (BIMF), which is a 20-item self-report measure to assess the domains of social support, physical health, mental health, infant care, maternal/child interaction, management, and adjustment among postpartum mothers. The BIMF was first published in 2010. It takes approximately five minutes to complete, and it can be administered in clinical and non-clinical settings during the first 1-2 years postpartum.

We have known for a long time that when women and mothers aren't well, there are consequences for their pregnancy and the baby. Maternal mental wellness affects the whole family. When PMADs aren't addressed, they can impact parental cognition, attachment and bonding, neurosynaptic development, regulatory development, and developmental milestones. In a recent study conducted in the UK with 2 million women, the risk for premature birth was 50% higher in mothers with poor mental health. Women with a history of mental illness had an increased risk of premature delivery, small-for-gestational-age infants, and other adverse neonatal outcomes. Untreated PMADs in the U.S. are costly, and in Georgia, there is a lack of mental health providers in non-metropolitan areas.

The BIMF was created using a patient-centered approach by conducting three focus groups (n=31) in the Pittsburgh area, in hospitals and academic centers, with postpartum women. The focus groups produced 156 pages of text, which was analyzed by theme, and themes informed item construction. The patient-centered, focus group approach promoted high levels of participant engagement, content validity, and was inexpensive. A recurring theme that came up during focus groups was: The invisible labor of motherhood; confusion around self-care – e.g., when you have children, it's all about them. In the same conversation, mothers would say "when I'm not doing well, the whole family suffers." There was a lot of ambiguity and cognitive dissonance around self-care and its role in motherhood.

Rather than measuring mood and depression directly, the BIMF measures: How are you managing all your responsibilities concurrently? This framing lends itself to therapeutic skill-building. It is not meant to replace depression and anxiety screening, but rather to be used in conjunction with it. Scores from items on the BIMF are summed and the total score can range from 0-120 (with 120 being perfect functioning). As far as interpretation, there are different categories based on score (suboptimal/needs intervention, developing/needs support, good, and excellent), and it is helpful to examine changes in scores over time. The BIMF has been translated into 22 languages, and has been modified for NICU moms, mothers with children up to 3 years old, as well as caregivers of school-aged children.

Several articles that confirm the BIMF's reliability/construct validity have been published in peer-reviewed journals. Additionally, the BIMF received an "A" grade in the American Journal of Obstetrics & Gynecology in November 2022, which is the highest rating possible for structural validity, internal consistency, and measurement error.

The BIMF can be used in industry and commercial research (e.g., clinical trials), academic studies, clinical settings, and community-based settings. The strengths of the BIMF are that it is engaging to participants, clearly worded, quick and easy to administer, taps into a unique but related construct (to depression and anxiety), evokes less stigma than depression, and lends itself to therapeutic skill-building. However, researchers are still working to pinpoint a clinical threshold that indicates when a postpartum mother may need intervention or follow-up. Additionally, in clinical settings, it may be hard to treat women if they have a high score on the BIMF due to the low volume of women's mental health providers. Moreover, scores on the BIMF may not be accurate if it is administered before discharge, right after childbirth (because hospital settings are different than the home environment).

Ky Lindberg has been the CEO of Healthy Mothers, Healthy Babies Georgia (HMHBGA) for 3 years. The topic of maternal mental health resonates with her because she comes from a community where expressing mental health concerns is taboo. She experienced postpartum depression twice herself, and both times she did not have resources or support. Lindberg's personal mission is to ensure that women or birthing persons do not walk their journey alone whenever possible.

HMHBGA has been around for almost 50 years, with the goal of being an advocacy organization and a "watch dog" for the legislature to prioritize the needs of moms and babies. When first established, the coalition was formed to combat mental retardation in babies (a now-taboo topic), which resulted in 70 organizations coming together to form the multi-sectoral coalition. Today, HMHBGA steeps itself in advocacy work, however, it is non-profit and non-partisan and takes a data informed and community informed approach in its work.

Over the last 8 years, HMHBGA has focused on understanding the needs of families in Georgia and has made efforts to gather information from over 500 Georgians. They provide services in all 159 counties. From this outreach, they established digital peer support groups and classes, which are centered on those directly impacted by maternal health issues such as SUD and intimate partner violence. Additionally, they have launched funds that address social determinants of health needs (e.g., Safe Under the Lilies Fund, which gives women $1,000 to leave unsafe conditions). They work in close collaboration with others such as the Department of Public Health.

Madison Scott transitioned into the data and recommendations part of the presentation. Prenatal mood disorders are associated with increased risk for depression in offspring and obstetric risks (e.g., preterm birth, low birth weight) and short-term neonatal effects (e.g., increased distress after delivery and disrupted sleep patterns). PMADs also can lead to engaging in less prenatal care, having less gestational weight gain, a greater likelihood of smoking or using alcohol, and self-injurious behaviors. Moreover, maternal mental health problems in the prenatal or postnatal periods increase the likelihood that school-aged

children will experience suboptimal development. Taken together, maternal depression is a confounding source for a lot of the risk we see in our communities.

The Maternal Mortality Review Committee (2018-2020) found that mental health conditions are the leading preventable cause of maternal death in Georgia. They contribute to other pregnancy-related deaths, and the majority of deaths occurred in the postpartum period. Suicide was the most common cause of maternal death (73%), with substance use also related to pregnancy related deaths. Causes of maternal mortality included inadequate case management services, lack of standardization in assessment tools for postpartum depression and suicide, and patient history of trauma (e.g., housing instability, perinatal loss, and intimate partner violence).

To address maternal mortality, it is important to look across all sectors and address social determinants of health. Additionally, it will be imperative to expand resources and support groups, increase care coordination and referrals, and increase screening and risk assessment. A recent study done by HMHBGA via provider surveys (n=47) found that 39 accepted new patients, 10 accepted Medicaid, and only 7 accepted new patients on Medicaid. HMHBGA has convened a Perinatal Mental Health Taskforce in partnership with Postpartum Support International with 50+ partners committed to addressing maternal mental health (including departments, funders, providers, advocates). The current aims of the taskforce are to 1) build out a comprehensive guide to resources, research, and programs across Georgia, for patients and providers and 2) formalize policy recommendations across organizations and rank immediate priorities. Future aims include filling gaps and reducing duplicity in maternal mental health spaces and determining an optimal policy framework for Georgia to work towards achieving policy reform.

All presentation speakers offered recommendations around addressing the maternal mental health crisis in Georgia. The full set of recommendations are included in the recommendations section of this report.

September 28, 2023

School Based Behavioral Health

Schools are ideal settings for behavioral health screening, intervention, and treatment services to take place, as it allows providers to serve children and adolescents in a familiar environment. School based behavioral health services promote access among families who may otherwise not be able to receive services in clinical or medical settings.

Presentation from Mary Elizabeth Davis, Superintendent, Henry County School System

Henry County Schools is home to 43,000 students across 52 student campuses with approximately 6,000 faculty/staff. Henry County Schools student body is 67% African American, 20% White, and 12% Hispanic, with 54% qualifying for Free and Reduced Lunch. She shared the purpose of her presentation, which was to highlight and describe what Henry

County School System has done to centralize and prioritize the health and wellness of their students.

Henry County School's Board of Education has structured and led with four key core beliefs. Of those four key beliefs, two set the context for the discussion today and those are: Every child can and will learn at or above their grade-level and will have an equal opportunity to do so; Every learning environment will be supportive, safe, and secure.

They've heard from the community through their community inspired strategic plan that they want a school system that is advancing student health, wellness, and support structures. Kids can't learn until their needs are met. Furthermore, the understanding that school plays an integral role and is a resource for the health and wellness of young people and their family has ultimately increased over time; however, there is still work to be done. The COVID-19 pandemic shed light on this and amplified the role that schools have played as essential service centers in their community. Specifically in the Henry County Schools, there was an urgency to structure their system of support, staff adequately, and formalize partnerships with clinical providers so that all students' needs were met.

Nationally, 1 in 6 youth have a mental health condition but only half receive any mental health service. In Henry County Schools, 4,049 students (nearly 1% of student population of Henry County Schools) self-identified as having no support system (no adult in home, no peer friend, no adult in the building). In addition, nearly 3,000 students also reported being in a period of personal crisis. School leaders across the country are reporting a marked increase in classroom disruptions (up 56% following the pandemic). Nonetheless, relying solely on a consequence driven crisis response approach is overlooking the opportunity to proactively invest in the current health and wellness conditions of youth today. Schools today need to couple prevention / intervention efforts alongside their consequences for behavioral infractions. Some of the key actions they've taken as a school district, their investment, and results are discussed.

Those key actions began with staffing the school district adequately by adding a position of a mental health and wellness facilitator along with adding a schoolwide wellness plan inclusive of proactive health and wellness monitoring (Henry Cares Check-ins).

Key Action 1: Historically student support services have been distributed among the many school personnel (e.g., teachers, social workers, counselors, psychologists, nurses) on top of their regular duties but this has not been in a coordinated, effective fashion nor has it effectively aligned resources with student needs. Using ESSER dollars (district allocated $4M into one position per school), hired a mental health and wellness facilitator: not clinically trained or specifically credentialed mental health provider, but instead they serve as a broker or centralized "hub" of clinical services and resources and alignment for the entire school community. Essentially equating to $90 investment per student per year.

Key Action 2: Developed 8 impact areas around this role as part of a schoolwide wellness plan of proactive health and wellness monitoring (Henry Cares Check In). Three areas are highlighted below:

-Mental health and wellness facilitator can act on monitoring data around student and staff safety and wellness and create proactive wellness plans; review Student Health Survey and use data to inform but that is more retrospective; have implemented periodic proactive Henry Cares Check Ins. Helped to move from "Data Rich" to "Action Rich". Examples of questions included are: 1) Do you have a teacher or an adult at the school that you can count on no matter what; 2) Do you have a family member or adult outside of school that you can count on no matter what; 3) Do you have a friend at school you can count on no matter what. Tiered system of supports employed for any student that indicates "No" to 1 or more of these questions. This is where 4049 students mentioned above were identified as not having a support system. Data led to mental health and wellness facilitators implementing school-wide wellness plan; all schools have this.

-Mental health and wellness facilitator can ensure that there are more students present for more instructional time following classroom disruptive behavior. Code of conduct and consequences in place for infractions but this facilitator can provide more support in a layered approach so that these students don't miss a lot of class time. Support teacher immediately during outburst and provide direct intervention and support. Helps students re-enter the classroom. In 81% instances last year, individual's disruptive behavior led to student re-entering classroom on same day due to involvement of mental health and wellness facilitator. Mental health and wellness facilitator leads a Cares Team at the school who daily look at attendance, discipline, health records and in first 3 days of school contact students' families for students not attending school. This helped recover students who were not present regularly (2000 students recovered during pandemic).

-Mental health and wellness facilitator can provide earlier intervention in personal crisis for students and there is now a "safety net" in place for these students. Averaging 30,000 of 43,000 students in the system having interaction with mental health and wellness facilitator. Often, facilitators can help but can also provide systematic referrals to others for additional needs. 282 times over last year a facilitator made a referral to mental health provider. MOU in place with Family Ties; students have access to 10-12 sessions, if uninsured used Title IV funds to cover service.

Presentation from Dr. Fred Williams, Superintendent, Dublin City School System (2024 Georgia Superintendent of the Year): Addressing Behavioral Health in Dublin City Schools

Dublin City Schools is a rural charter system located in Middle Georgia off I-16 between Macon and Savannah serving approximately 2,400 students. With the make-up of two elementary schools, one middle school, one alternative middle/high school, one high school with a wall-to-wall college and career academy, and one all day gifted elementary/middle academy. The purpose of the presentation is to discuss the impact of Dublin City Schools

Behavioral Mental Health and Wellness Department, which was created to prioritize social and emotional learning. It continually serves and supports the improvement of student achievement and growth. Collaborates monthly with community network partners to strengthen community relationships. Dr. Williams expressed the importance of working with families as well.

The pandemic exposed Dublin City Schools tremendously and there was a great need for Behavioral and Mental Health needs in their school system among faculty/staff and students. This resulted in a 300% increase of mental health counselors (started out with one counselor) and 150% increase in nurses (started with two) with the help of multiple grants such as: The Federal Rural Health Network Development Grant - $900,000 over three years, Federal Rural Health Outreach Services Grant - $800,000 over four years, Federal Small Healthcare Provider Quality Improvement Grant - $800,000, and Medicaid Supplemental Grant - $50,000. With the funding received they were able to support their school district using a 3-tiered approach. They now have counselors in every school.

Tier 1: 5 school counselors, 5 school nurses, and 1 social worker

Tier 2: 2 clinical mental health counselors, and 1 program coordinator

Tier 3: 1 licensed mental health counselor

Their best practices included the Shamrock button, Wellness page on each school website, Be Well Series (weekly and monthly videos), Kids' Minute of Wellness, Nurses Notes, Home Visits, and Wellness Check. The Shamrock button seems to be the most impactful; this can be used by anyone confidentially (students, parents, community) and is 24/7. This has resulted in a decrease in self-harm incidents. Over the span of 3 years the Shamrock button has yielded roughly 3,319 clicks, 2,165 of those coming in Year 3. Also, staff work to identify what relationships students have with teachers and staff, monitor attendance, and reach out to students and families as needed using a multidisciplinary team approach. Psychoeducational training and support for students, teachers and staff are important.

There were three success stories highlighted: Gifted Student, Middle School Student, High School Student. (Can be viewed/listened to on session recording).

Presentation from Will Schofield, Superintendent, Hall County School System; Joyce Schofield, Author of Mental Health Curriculum in Hall County Schools

County School District has about 28,000 students; of that number 2/3 come from homes of poverty. In addition, of 190 school districts in Georgia, they have the three highest percentages of first-generation immigrant children. Their newcomer academy has 60 students from Venezuela as well as Guatemala and Honduras; these youth often experience a lot of trauma, with little previous history of schooling. Mr. Schofield expresses that in order to deal with and manage the mental health crisis that our children and adults face, you have to support and look at emotional dysregulation, which is the purpose of this presentation. Mr. Schofield presented a continuum of emotional wellness, noting that all of us fall

somewhere on this continuum at different points in our lives. He noted the widespread occurrence of mental health challenges and of trauma and notes the importance of acknowledging that all can be affected by this.

He starts his presentation referencing Superintendent Fred Williams regarding the notion that everyone, even adults, deals with mental health and emotional health; there is a continuum of emotional wellbeing. That continuum is representative of us all whether well, becoming unwell, unwell, or recovering. Furthermore 20% of us have a diagnosable mental health illness, which he knows well, being diagnosed with clinical depression himself. Trauma is also important to take into consideration; 2/3 of us are living life differently because of trauma we've experienced as a child. To this point, even if we triple the number of mental health therapists in the state of Georgia over the next three years, that still wouldn't be enough. Hall County School District has looked at "other" options.

Mr. Schofield breaks down percentages and shares results for Hall County from a needs survey administered to every middle and high school student annually in the state of Georgia: "In the past 30 days, on how many days have you felt, experienced, considered, or done…". He highlighted that 53% of 15,000 middle and high school students expressed struggling with depression, 40% expressed having struggled with anxiety, and roughly 9% have seriously considered attempting suicide.

They have a 3-tiered approach similar to some other districts. Tier 1 programs have been in place to support all students that include attendance initiatives, PBIS, Safer/Smarter Kids, Signs of Suicide, and Sources of Strength, as well as training for adults in the system in areas such as mental health awareness and de-escalation. Tier 3 approaches utilize trained therapists and include 17 MOUs with outside providers, already serving 300 students across all 37 schools. They have also implemented Mental Telehealth in all 37 schools at Tier 3 which has been a game changer.

What has really made a difference is the training for the adult employees. They have developed a 3-hour training model around trauma and mental health awareness, a trauma and mental health skills training model, 2.5-hour de-escalation strategies training, and a professional learning series titled "Trauma and Mental Health Best Practices". As it relates to Tier 2 (up to 10% of their students), they established dialectical skill groups which come out of the work of cognitive and dialectical behavioral therapy. Keep in mind these are not therapy; they are the teaching of skills. They involve teaching individual skills in the areas of mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness. They developed a set of 10 digital, interactive lessons, with a manual and training program along with student workbook, which are taught to identified student groups (5-9 students) based on those needing more than Tier 1 services through a trained facilitator. This method was also used to train stakeholders (80 individuals) and other organizations who were interested. Last year they had 1100 middle and high school students participate in the dialectical skills groups and administered pre- and post- tests; they saw 47% increase in students' ability to know these skills and how to use them. They disseminate weekly

newsletters and videos that go home to inform families of what students are doing and learning. Since implementation from 2021 to 2023, Hall County School District has had 40 dialectical skills group certified trainers, over 80 dialectical skill group certified trainers outside the school district, and over 1,000 course completions in 2023 with 47% growth in pre/posttest results. In 2022 alone, there were over 425 course completions, with 25% growth from pre- to post-test. Mr. Schofield acknowledged the importance of putting the oxygen mask on adults so they can better serve the 28,000 students.

Presentation from Dimple Desai (Voices for Georgia's Children) and Sarah Phillips (The Carter Center): The Georgia Collaborative for School-Based Behavioral Health

Ms. Phillips introduced the Georgia Collaborative for School-Based Behavioral Health and their vision. The Collaborative is composed of the Carter Center, Voices for Georgia's Children, Georgia Appleseed, and Resilient Georgia. The vision shared is that "School-Based Behavioral Health (SBBH) will be as common in Georgia's schools as the provision of school lunch". Each organization brings unique strengths and efforts to this work. The Carter Center contributes convening and stakeholder engagement; Georgia Appleseed provides legal and advocacy guides; Voices provides awareness and advocacy; and Resilient Georgia provides Community Collaboration and Teaming. Ms. Phillips describes the work of SBBH by highlighting the tools and resources/guides they've developed, the SBBH Landscape Map, collaborations with school district leadership in McIntosh County to pilot systems-level consultation, and consultation with advocacy experts/school administrators/key stakeholders to develop priority policy recommendations. Ms. Phillips described why SBBH programs are so important and noted that children and adolescents are 6 times more likely to complete mental health treatment in schools than in community settings (Jaycox et al., 2018). The importance of this is to increase much needed access to mental health support by eliminating barriers to care (e.g., transportation, distance, cost).

Ms. Desai follows by discussing the research behind SBBH increasing positive outcomes for students. The first data point of her presentation was based on a study done in Georgia involving the Georgia APEX program and demonstrates the positive effects the program had on overall school climate (DiGirolamo et al., 2021). There was a greater decrease in discipline incidents over time and the program was associated with a more positive overall school climate. A separate study noted that students feeling connected to others at school had a lower prevalence of all risk behaviors and poor mental health (22.0% vs 40.1%) compared with students who reported not feeling connected. The Collaborative is focused on comprehensive SBBH systems: well-educated and trained individuals; multi-tiered system of support; emerging practices; community coming together to meet the needs of the students.

All presentation speakers offered recommendations around increasing access to behavioral health services and support in school settings. The full set of recommendations are included in the recommendations section of this report.

October 27, 2023

Children and Community Mental Health

Collaboration amongst providers who work with children is key for ensuring that behavioral health needs are being identified and addressed. Some, but not all, pediatricians are positioned to screen and identify children's behavioral health issues; however, they often lack the ability to refer children for specialized psychiatric services. Moreover, other community members who work with children (e.g., first responders; teachers; school administrators) may serve as the link between children and behavioral health referrals. As such, it is imperative to build referral networks and community connections into the children's behavioral health system of care.

Presentation from Dr. April Hartman, Vice Chair for Diversity, Equity, and Inclusion, Associate Professor, Department of Pediatrics and Adolescent Medicine, Medical College of Georgia

The field of pediatrics has shifted from treating infectious diseases to understanding and treating developmental and behavioral issues. However, there is slow uptake, or a lack of, necessary pediatric behavioral health training for most pediatricians; this has led to providers feeling uncomfortable and uncertain when it comes to diagnosing behavioral health conditions. Many behavioral health specialists that pediatricians would refer patients to have long waitlists (typically 6-18 months) due to workforce shortages. Moreover, screenings are happening at younger ages (e.g., anxiety screening at 8 years old; ADHD at 3 years old), and thus disorders are being identified at younger ages; this creates a problem because there are no appropriate psychotropic medications to treat these conditions for young children and little guidance around this (due to uncertainty around long-term implications or a lack of data to support medication treatment). This can result in off-label use of these medications with variability in dosing and unknown long-term consequences on child growth and development. There is a growing sentiment among pediatricians of: Should I screen for it if I can't treat it? (when it comes to pediatric behavioral health).

Pediatricians have responded to this conundrum by focusing on prevention, education, collaboration, and integration. At the prevention level, pediatricians have been focusing on learning about what's going on at home through social emotional and social determinants of health (SDOH) screenings, including maternal depression screening. Additionally, pediatricians have been educating themselves about how to provide behavioral health services in primary care settings through programs like Project ECHO, webinars, podcasts with experts, etc. As far as collaboration and integration, many practitioners are adopting collaborative and comprehensive models of care such as CCBHC models, school-based health centers, telehealth services, as well as warm hand-offs and integrated primary and behavioral health care.

The state has supported those who care for children by implementing programs such as 988 and mobile crisis units as alternatives to seeking care in emergency departments. Additionally, HB 1013 (Mental Health Parity Act) seeks to implement mental health parity,

although this is still not at full implementation. The state is also providing funding for school-based health centers and CCBHCs and expanding the mental health workforce via broadening categories of therapists, reimbursement for social workers in clinical settings, and the Apex program. There is also the Georgia Mental Health Access Program (GMAP) and other access lines for consultation, as well as an increased focus and attention on addressing problems and searching for solutions through groups such as the BHRIC and Resilient Georgia.

Despite the positive actions taken by pediatricians and the state, there are still barriers and challenges, such as lack of equitable distribution of resources across the state (i.e., in favor of urban over rural areas), which includes access to technology and connectivity to the internet. Moreover, insurance coverage and networks are an issue – many behavioral health providers refuse to take Medicaid due to low reimbursement rates, and there is often limited coverage of psychotropic medications (e.g., issues with prior authorization approvals, step therapy, age restriction, and other administrative burdens). There are also formulary problems when it comes to prescribing psychotropic medications, such as changes to formularies without notice for providers; different formularies for each Care Management Organization (CMO); and liquid and chewable options are often excluded from formularies, adding to the complexity of treating children who cannot swallow pills or have a neuropsychological disorder like autism. Finally, reporting is often deceptive – mental health services may be listed as a service provided in offices and clinics, but then patients are put on a long waitlist (6-9 months) for therapy services after intake.

Handle with Care

Presentation from Dr. Emily Anne Vall, Executive Director, Resilient Georgia, and Lizann Roberts, Executive Director of Coastal Georgia Indicators Coalition, Georgia Family Connection Partnership

Resilient Georgia is a statewide coalition of more than 80 public-private partners and over 900 stakeholders committed to building a more resilient and trauma-informed Georgia by preventing ACEs and promoting resilience through a collective impact model. Resilient Georgia has three pillars: 1) Convene and Connect, 2) Celebrate and Share Innovation, and 3) Remove Barriers (via macro and micro approaches). There are 16 regional coalitions across the state with 900+ community partners. Coalitions are funded via philanthropic and grant dollars, and Resilient Georgia provides them with trainings and technical assistance to build out 2-year action plans. The coalitions are in 120 of Georgia's counties (75% of the state).

The Handle with Care (HWC) program is a collaboration between the Georgia Center for Child Advocacy, the Georgia Family Connection Partnership, and the Criminal Justice Coordinating Council. The purpose of HWC is to support children who have experienced trauma and violence by creating a communication loop between first responders and schools, with the goal of ensuring that children are able to recover from their trauma and

return to regular school functioning. HWC is about "approaching kids with 'challenging behaviors' with a lens of compassion, not punishment."

When a child is exposed to a traumatic event, they are connected to a law enforcement officer, who observes the child and makes a HWC referral which includes the child's name, age, school they attend and words, "Handle with Care." The first responder connects with the school system/teaching staff and personnel. From there, the child is connected with school counselors/social workers/or nurses, and these providers refer children to mental health providers as needed. If no additional support is deemed necessary, the child continues to be observed and continues with regular classroom activity.

Judge Michael Key led the first Georgia HWC implementation in Troup County, and Chatham County launched HWC in 2021. HWC implementation requires partnerships among police jurisdictions, EMS, fire departments, and school systems. There is a lot of interest in implementing the program in other parts of the state. HWC is nationally implemented at the state level in 24 states, including six southern states (Florida, Kentucky, Maryland, Tennessee, Virginia, and West Virginia).

Resilient Georgia has plans to roll out HWC programs statewide, but resources are still needed to do so. HWC materials are free, but funding is needed to support program staff and administrative costs. A full application has been drafted in partnership between the Criminal Justice Coordinating Council, Georgia Center for Child Advocacy (GACCA), and Georgia Family Connection Partnership. The plan includes a multidisciplinary expert advisory panel; two full time statewide implementation positions housed at GACCA; mini grant implementation program; training and communication plan buildout; and data and evaluation plan buildout. The projected annual cost is $400-450k per year, which includes 2 FTEs housed at GACCA, a mini grant program, and administrative costs.

Georgia Mental Health Access in Pediatrics (GMAP)

Presentation from Josephine Mhende, DrPHc, MPH, Program Manager, GA Mental Health Access in Pediatrics (GMAP), Center of Excellence for Children's Behavioral Health, Georgia Health Policy Center, Georgia State University

The Georgia Mental Health Access in Pediatrics (GMAP) program, funded by the Human Resources and Services Administration (HRSA), is dedicated to increasing pediatric providers' comfort and knowledge to treat and manage mild-to-moderate behavioral health concerns in day-to-day practice. The focus population is primary care providers in Georgia who serve children ages 0-21, and currently the program is being implemented in DBHDD Regions 3, 4, and 5. The program partners include the Center of Excellence for Children's Behavioral Health at Georgia State University, the Georgia Chapter of the American Academy of Pediatrics, Augusta University Medical College of GA (this partner helps with ensuring that the program reaches rural areas), DBHDD (who is the primary grant recipient), Children's Health Care of Atlanta (CHOA), and Mindworks Georgia (formerly IDT). Mindworks' membership includes representation from all state agencies as well as other agencies and

stakeholders who support the public behavioral health system in Georgia and is responsible for designing and implementing an integrated behavioral health system of care for children.

The number of children aged 0-21 with a treatable behavioral health issue in Georgia is increasing, with up to half of children in Georgia not being able to receive the treatment they need; as such, GMAP was created to increase pediatricians' expertise in addressing children's behavioral health issues. Pediatric providers who enroll in GMAP have access to ECHOs, teleconsultation with behavioral health experts, and a variety of other specialized resources. The program components, which are presented in an informational video,[7] include provider education (recent topics have included anxiety, depression, eating disorders, ACEs, and learning disabilities); provider-to-provider teleconsultation advice lines that allow physicians to speak with behavioral health experts; and a resource directory with care coordination and referrals for behavioral and mental health disorders.[8]

GMAP has three main goals. The first goal is to implement ECHO trainings to increase the number of pediatric primary care providers in Georgia who are trained to screen, treat, or refer children affected by behavioral disorders, especially those living in rural and underserved areas. The second goal is to provide support to the pediatric primary care workforce in Georgia through access to regional pediatric mental health teams providing behavioral health consultations, referral information, and care coordination (i.e., via the teleconsultation advice line). The third goal is to consolidate and expand disparate resource and referral databases to build and sustain a comprehensive on-line resource of behavioral health providers in Georgia.

So far, the reach of Project ECHO provider education program components has been skewed more to urban than rural providers, but the GMAP team is working to engage more providers in rural areas. Additionally, most of the advice line provider participants have been located in Region 3, and there has not been as much activity in Regions 4 and 5; GA-AAP is working to reach these regions. So far, the top reason for teleconsultation calls is medication management. Over 400 calls have been made thus far, and 114 providers are enrolled.

Future work for GMAP includes learning from providers about what Project ECHO topics they'd like to see, and how GMAP can support the enrolled provider network. Additionally, GMAP would like to lift up the family voice, and include highlights and perspectives from families to learn about their lived experiences through GMAP. Finally, the program is working towards sustainability beyond the HRSA funding years. Sustainability efforts will include sharing progress data with stakeholders to engage more partners; expanding the teleconsultation line to be able to serve more providers; and adding GMAP sites to all regions.

Medicaid and Children's Mental Health: New Rate Study Content and Potential Impact

Presentation from Wendy Tiegreen, Director, Office of Medicaid Coordination and Health System Innovation, Georgia Department of Behavioral Health and Developmental Disabilities

[7] https://vimeo.com/823425906?share=copy
[8] https://gacoeonline.gsu.edu/gmap/

DBHDD and DCH jointly conducted a provider rate study throughout 2022-2023 to learn more about the Medicaid fee-for-service reimbursement model. The study excludes CMO rates, PRTF rates, and other standalone practitioner rates. It includes CSBs, Assertive Community Treatment (ACT) providers, Peer Support providers (CPSs), Intensive Family Intervention (IFI) providers, and some Crisis Stabilization Unit (CSU) services. The result is an actuarially-sound rate study, which is required by CMS.

The last rate study was conducted in 2008, and therefore this current study is well overdue. Current provider wages are based on labor statistics from 2007. Since then, there has been a continued behavioral health workforce crisis. For context, HB 911 (Appropriations Bill FY23) gave DBHDD the funds to complete a study of Medicaid Rehabilitation Option which it manages with DCH. The partners in this study include DCH and Deloitte, a certified Medicaid actuary. As part of Georgia's ARPA spending, which is to be processed before March 31st, 2025, DCH/DBHDD released a plan to CMS to call for implementing rate increases with relief funds provided to state for providers. The desired release was January 2024; however, we are not there yet, because CMS countered with required rate study expectations – which DCH and DBHDD are now in the process of completing.

The rate study was complete in June 2023, and findings are posted on the DBHDD website. Several steps are still in process to carry out the rate increases, including leadership endorsement; DCH board notice, hearing, and approval; CMS submission and approval; and IT modifications. Additionally, the state needs to create a sustainability plan for CMS to ensure that the funding will continue beyond the distribution of ARPA funds. The elements that were reported included staff wages, employee-related expenses, staffing patterns, productivity adjustments, administrative costs, and program support costs. The rate methodology decisions included information about group rates, telehealth assumptions, CSU rates, and wage trends. The fiscal impact summary determined that the state needs to significantly improve practitioner salaries based on national rates to recover workforce vacancies.

Next steps include projecting the ARPA funds, executive and legislative considerations, CMS review and acceptance, as well as technical implementation.

All presentation speakers offered recommendations around increasing access to behavioral health services using community models of care. The full set of recommendations are included in the recommendations section of this report.

November 16, 2023

Integrated Children's Mental Health – National and State Perspectives

Addressing child and adolescent behavioral health has become increasingly imperative in the wake of the COVID-19 pandemic. Federal action at the congressional and administrative levels has begun to address barriers in access to insurance coverage for behavioral health services, particularly for those who qualify for Medicaid and the Children's Health Insurance Program (CHIP). State-level action is necessary to remove barriers for access to substance use treatment across all levels of need.

Presentations from Anne Dwyer, Esq., Associate Research Professor, Georgetown University McCourt School of Public Policy's Center for Children and Families; and Kimberly Johnson, Director of Willowbrooke Counseling Center, Tanner Medical Center

The Center for Children and Families (CCF) is a policy and research center dedicated to promoting access to high-quality and comprehensive health coverage for children and families, with a focus on policy development related to Medicaid and the Children's Health Insurance Program (CHIP). In her presentation, Ms. Dwyer provided a landscape overview about recent federal Medicaid and CHIP actions, with a focus on youth mental health. She also touched on Medicaid unwinding, which has large implications for children's access to health care, including mental health care.

When talking about mental health care, one must discuss Medicaid. Medicaid is a joint federal and state program, and it is the largest payer of behavioral health services in the U.S. Medicaid and CHIP cover 50% of U.S. children, and 40% of children in Georgia. According to the Centers for Medicare and Medicaid Services (CMS), as of 2020, nearly a third of children ages 3-17 who were enrolled in Medicaid or CHIP had a mental, emotional, developmental, or behavioral health problem. However, just because a child has a mental or behavioral health need as well as Medicaid or CHIP coverage, it does not mean they have easy access to mental health care. CMS has reported that of the children who receive mental health care, 35% report it was "very" or "somewhat" difficult to obtain.

Even before the pandemic, access to behavioral health care was an issue, and now behavioral health care needs have been exacerbated by COVID. National groups, such as the American Academy of Pediatrics, have declared child and adolescent mental health a national emergency, and the Centers for Disease Control (CDC) placed an advisory around the increase in child and adolescent behavioral health issues. In 2021, data from the CDC showed that 60% of female students and 70% LGBT+ students experienced persistent feelings of sadness and hopelessness.

Federal action towards increasing access to behavioral health services via Medicaid and CHIP has happened via congressional action and administrative action. Congress has passed several bills over the last three years that included policies related to mental and behavioral health. There has also been administrative action through rulemaking, informational bulletins, and action plans.

American Rescue Plan Act (ARPA) was passed by Congress in 2021, which provided three years of enhanced funding for Medicaid to provide community-based services, including behavioral health services. This includes Medicaid community-based mobile crisis intervention services option, as well as home and community-based services. Notably, the funding will sunset after 5 years, and funds to be used toward home and community-based services must be used by March 31st, 2025. Many states, including Georgia, are planning on using these funds to support child and adolescent mental and behavioral health. For example, there are plans to provide in-home behavioral health aids for children under 21 with Autism. This funding was initially set to expire in 2024 but was extended into 2025.

In addition to ARPA, the Bipartisan Safer Communities Act was passed by Congress, which includes support for Medicaid and CHIP behavioral health services. The largest part of this initiative is funding towards the expansion of Medicaid Certified Community Behavioral Health Clinic (CCBHCs) demonstration. About 22% of CCBHC clients are children, and there are standards of care by which every CCBHC must follow. Every two years, two new states can join the CCBHC demonstration. Georgia is one of the states that is already authorized to adopt the CCBHC model. In addition to the CCBHC expansion, the Safer Communities Act also includes provisions around improving access to Medicaid telehealth services, Medicaid and CHIP funding for school-based services, and increased Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program oversight and transparency. To date, CMS has released many new resources and guidance around implementing school-based services and EPSDT benefits (which is the essential coverage protection for children on Medicaid to receive screening and intervention services they need, including services for behavioral health). A congressional report on the Act is due by June 2024, and the Government Accountability Office will submit a report in June 2025 about the implementation of EPSDT and compliance of state Medicaid Programs. To learn more about the Safer Communities Act, there are resources on the CCF's website.

After the passage of the Safer Communities Act, the Consolidated Appropriations Act of 2023 was passed. This includes behavioral health provisions for CHIP and Medicaid, including two new provisions around youth in juvenile settings. The new provisions are around ensuring that youth in juvenile institutions receive appropriate EPSDT benefits, including behavioral health screenings and interventions around the time of their release. Additionally, states will be given the option to allow youth being released from juvenile settings to be covered by CHIP and Medicaid. These provisions will go into effect January 1, 2025. In July 2025, CHIP and FFS Managed Care plans will be required to provide public provider directories, including information about the specialty of the provider, whether they accept Medicaid patients, their cultural and linguistic capabilities, and whether they provide services via telehealth. The Act also includes guidance on the continuum of crisis services, and a report on maternal mental health.

In addition to the bills that have been passed into law, there has also been congressional committee action in the House and Senate. The House passed the Support for Patients and Communities Reauthorization Act, which passed out of the Energy and Commerce Committee, which extends provisions around requiring state Medicaid agencies to release substance use disorder and mental health data. The Senate Finance Committee passed the Better Mental Health Care, Lower Drug Cost, and Extenders Act. The next steps for these proposed bills are still unfolding; updates are regularly posted on the CCF's website (https://ccf.georgetown.edu/).

The administration has also taken action towards improving access to behavioral health care. In August 2022, CMS released two bulletins that touched on youth mental health. The first included general guidance on Medicaid and CHIP covering behavioral health services for children and youth. The guidance reiterated that some behavioral health services can be provided to youth without a diagnosis. CMS also released informational bulletin on school-based behavioral health, providing a checklist on how to enhance care provided in schools. Other guidance has been released, such as guidance around ARPA spending and providing

crisis services. In July, CMS released a Mental Health and Substance Use Disorder Action Plan, which includes promoting behavioral health parity and coordination of treatment, improving engagement in care, providing services in nontraditional settings, and improving the quality of care by implementation of evidence-based practices.

Formal rulemaking has also happened via administrative action, such as enhanced requirements around health quality measures starting in 2024. This includes a core set of health care measures that need to be provided via Medicaid and CHIP. CMS has released two proposed rules around access to managed care via Medicaid or CHIP, which includes developing wait time standards, including a maximum wait time of 10 days for behavioral health treatment follow-up. At the end of September, there will be a comment process for how to enforce behavioral health parity for youth.

The unwinding of Medicaid coverage for children will have implications for access to care. In 2020, congress passed the Families First Coronavirus Response Act, which required states to maintain coverage for all those enrolled in Medicaid during the Public Health Emergency (PHE). Now that the PHE has been lifted and the Act is unwinding, an estimated 3.9M children will lose coverage despite still qualifying for it. As unwinding unfolds, there are huge consequences for children. In Georgia alone, 15,000 children have already been unenrolled; a large portion is due to procedural reasons. Approximately 3 in 4 children who will be unenrolled are still eligible.

Explainers, issue briefs, and blogs on information presented today are on CCF's website (https://ccf.georgetown.edu/). They also have a state data hub with state-specific information that allows comparison of health care trends and information between states.

Ms. Johnson is an LPC and director of outpatient services at Willowbrooke Counseling Center. Her presentation focused on how to increase access to care for adolescents and families who have substance-related needs. She shared her background, which provides insight into her perception of barriers that exist in access to behavioral health care. Her first job in behavioral health was at a child and adolescent residential treatment facility. She became passionate about the work and the children and teams she worked with, and then moved to a position to become a therapist. She worked for a CSB for 12 years, and worked with children, adolescents, and adults, with behavioral health and substance use needs. For the past 10 years, she has worked for Tanner Medical Center, a private non-for-profit hospital, which provides services at every level of care. There is a 92-bed inpatient facility, including dedicated beds for adolescents. They have inpatient and outpatient treatment programs, including their Regain Program, which is a substance use intensive outpatient program for working professionals. There is also a robust school-based counseling program.

Willowbrooke's policies and guidelines are provided by DBHDD, as well as guidelines related to being a hospital, but because of contracts with DBHDD, there are additional standards for their services. These standards present barriers for individuals and families seeking treatment. Occasionally, rules they need to follow lead to risks that outweigh the intended benefits.

In Georgia, 6.75% of youth report having used drugs in the last month, and 7.20% reported using alcohol (National Center for Drug Abuse Statistics). Moreover, 11.09% have used

marijuana in the last year, and 2.63% report that they have misused pain relievers. These percentages are lower than the national average, however, Georgia ranks 49/51 (including D.C.) when it comes to access to behavioral health care (Mental Health of America).

The barrier Ms. Johnson will primarily focus on is related to Subject 111-8-9.-13, which are rules and regulations for drug abuse treatment and education programs (a blanket rule that includes both). Particularly, this rule includes guidance on what is required on initial assessment, STD and TB testing, and who can conduct these tests. The TB test needs to be conducted by a medical provider, and it can be done at the time of admission into substance use services if there is a qualified provider at the time of intake. However, the individual seeking services must return within a 48-to-72-hour window after the test is performed, or the process needs to start over again. The policy was created knowing that when there is a delay from when the person was motivated to get treatment, this may affect whether they will return for treatment within a 48-to-72-hour window.

The second requirement is around STD testing, which is vaguely worded. The accreditation to perform this test comes from the Drug Abuse Treatment and Education Program, which serves as the body to verify that all individuals have received the test before they can receive treatment. Bloodwork is needed for the STD testing, and if a medical professional is available, they can do it without needing a referral. But many places do not have a lab on-site and need to refer and hope that an individual will show up and return for treatment. Also, conversations with families around this is uncomfortable, presenting another barrier.

There are different levels of care for adolescent drug abuse treatment per the American Society of Addiction Medicine (ASAM). Level 1 includes outpatient treatment, Level 2 includes intensive outpatient/partial hospitalization, Level 3 includes residential/inpatient treatment, and Level 4 includes intensive inpatient treatment. Level 1 and prevention/early intervention services can be provided in-person or via telehealth. The regulations for TB and STD testing apply to all levels of treatment; however, it only applies to those who are seeking substance use treatment, not other behavioral health treatment.

There are inconsistencies in standards of care based on insurance payer types. For example, private payers do not have to follow as strict requirements as those who have Medicaid (through DBHDD or managed care) or are uninsured must follow for treatment.

Ms. Johnson closed out her presentation with recommendations to remove existing barriers in accessing substance abuse treatment among children and adolescents, which are included in the recommendations section of this report.

The DBHDD Provider Network

Wendy Tiegreen, Director, Office of Medicaid Coordination and Health System Innovation, Georgia Department of Behavioral Health and Developmental Disabilities

Within DBHDD's community behavioral health provider network, there are three primary categories for behavioral health (encompassing of mental health and addiction, including SUD treatment and recovery support). It is a tiered system.

Tier 1 providers are Comprehensive Community Providers (CCPs) and include Community Service Boards (CSBs). They are quasi-governmental and comprehensive in nature as far as how they are defined and their funding structure. Each CSB (Tier 1 provider) functions as the "safety net" for DBHDD's target population. Right now, the population is the uninsured or those covered under the Medicaid rehab option. The rehab option is just one category in Georgia (there are dozens); it is a comprehensive behavioral health service array, which is jointly managed with DCH. It includes psychiatric assessment to peer support; addictive disease recovery support services; etc. – flexible nontraditional and traditional services. DBHDD also serves as support for the under-insured. The first federal parity law passed in 2008, and the second passed with the ACA; however, parity processes are still being ironed out, and there are different levels of package comprehensiveness among insurance companies. Therefore, when children and young people need a service that isn't covered by their insurance, DBHDD will come into play as a wraparound service. To be a Tier 1 provider, they need to provide services for children and youth, and they need to provide both mental health and addiction services. In all cases possible, providers also cover crisis stabilization and recovery support – either 1) psychiatric rehabilitation or peer support program; or 2) assertive community treatment, community support team, or intensive case management. There is a set of standards and key performance indicators (KPIs) for each tier, monitored on an annual basis. For Tier 1, the standards include:

1. Be a public entity that receives state (e.g., structural support) funds from DBHDD to serve the target and eligible populations;
2. Be the Safety Net for individuals identified by DBHDD or the provider as high risk and vulnerable;
3. Serve children, adolescents, emerging adults, and adults;
4. Have Electronic Information Systems capability;
5. Competently serve individuals with co-occurring Behavioral Health and Developmental Disabilities;
6. Competently serve individuals with Mental Health needs and Substance Use Disorders;
7. Provide all of the services in the core benefit package plus designated specialty services;
8. Have an active Board of Directors;
9. Provide accessible services for deaf and hard of hearing individuals; and
10. Serve as the clinical home for individuals enrolled in services. The CCP functions as a clinical home for an individual's behavioral health needs.

Tier 2 providers are Community Medicaid Providers (CMPs) who only serve Medicaid covered individuals. DBHDD does not have enough state money to pay for a large array of providers; therefore, they have a small group of providers who go through a vigorous screening process who provide core services for the Medicaid population through the DBHDD rehab option. The standards for these providers include:

1. A provider that serves children, adolescents, emerging adults, and/or adults;

2. A provider that competently serves individuals with mental health, SUDs, and co-occurring issues;
3. A provider that has the capacity and infrastructure to provide all of the services in the core benefit package;
4. A provider that provides accessible services for individuals who are deaf and hard of hearing; and
5. A provider that provides culturally and linguistically competent services.

Tier 3 providers are Specialty Service Providers. They provide at least one specialty service out of several service types, including: Intensive Family Intervention (IFI); Mental Health/Addiction Clubhouses; Addiction Services; Psychosocial Rehabilitation; Supported Employment; Assertive Community Treatment; Intensive Case Management; Residential Treatment; and Peer Services. These are specialty-type only providers. Specialty Providers can be a Tier 3 provider plus a Tier 1 or a Tier 2 provider.

Behavioral Health Reform and Innovation Commission

Subcommittee on Children and Adolescents

Recommendation Priorities

The Child and Adolescent Subcommittee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action.

1. Encourage Georgia Community Service Boards to adopt the Certified Community Behavioral Health Center (CCBHC) model that is designed to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age - including developmentally appropriate care for children and youth.
2. Expand the Apex program to more schools throughout Georgia. In addition, provide and expand access for telemental health access in schools and consider expanding the Apex program reach to rural areas by use of telemental health as part of a plan to expand School-Based Behavioral Health services.
3. Expand and plan for future funding of Georgia Mental Health Access in Pediatrics (GMAP) programs.
4. Address maternal mental health issues as a leading cause of maternal deaths by developing a comprehensive plan that includes existing and promising practices (e.g., PEACE for Moms; Northeast Ga Medical Center; Healthy Moms-Healthy Babies; Barkin Index of Maternal Functioning).
5. Develop a comprehension plan to provide Dialectical Behavioral Training (DBT), Mental Health First Aid (MHFA) Training, NAMI Ending the Silence Training, and trauma-informed training for educators and other professionals who work with children and adolescents as part of a plan to expand School-Based Behavioral Health services.
6. Modify the current TB Symptom Screen requirement per DCH rule to allow non-medical professionals who are qualified to complete substance use assessments (e.g., Addiction Certification or Licensure) for intake of children and adolescents who need substance abuse treatment. Eliminate the requirement for prevention/early intervention, Level 1 (Outpatient), or Level 2 (Intensive Outpatient/Partial Hospitalization) treatment modalities because these children and adolescents run a much lower risk of spreading illness amongst others. This modification would accelerate the assessment and therefore treatment of children and adolescents with substance abuse issues without compromising the health of others.
7. Support Certified Peer Specialists (CPS) expansion and create a map of existing CPS resources.
8. Address the provider licensing issues that cause delays and negatively impact the mental health workforce.
9. Increase the number of Crisis Stabilization Units that provide outpatient treatment for children and adolescents.

10. Provide flexible spending rates for Psychiatric Residential Treatment Facilities (PRTF) and Child Caring Institutions (CCI) that will allow intensive and child-centered services and management for a wider spectrum of needs.
11. Establish higher pay rates for Behavioral Health providers who work with children and adolescents.
12. Require CMOs to reimburse obstetric and pediatric providers for maternal mental health screenings and referrals from the prenatal to postpartum period.

The Child and Adolescent Subcommittee identified the following recommendations as priorities needing additional study for future consideration.

1. Even when children and adolescents have Medicaid and CHIP coverage, access to mental health services is difficult and needs to be addressed by developing more access points.
2. Georgia should implement the in-house behavioral health aids program for children under the age of 21 with autism.
3. Conduct a study in Georgia to determine the use of CMS school-based services and EPSDT benefits to identify and address gaps in service provision.
4. Georgia should work to get the 15,000 unenrolled children back into Medicaid coverage.
5. Increase the number of Community Medicaid Providers (CMPs) through a mental health workforce improvement plan that includes an increase in CMP pay.
6. Address maternal mental health by adding the Psychiatry Access Services program so obstetricians/health care providers can consult with a psychiatrist in real-time for recommendations for medications, interventions, psychiatric care, etc.
7. Study how to expand Handle with Care to more school districts.

A full list of recommendations is included in Appendix A of this report.

More detailed notes from each of the 2023 Presentations can be made available upon request. Please contact Dr. Ann DiGirolamo (adigirolamo@gsu.edu).

Appendix A: BHRIC Children and Adolescents Subcommittee Full Recommendations List (2023)

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations	Alignment with 2022 Recommendation?	2023 Legislative Alignment
Behavioral Health Services and Resources - DBHDD	Create a database of Certified Peer Specialists within the state, with the goal of understanding where gaps in services and strengths may exist.			X			
Behavioral Health Services and Resources - DBHDD	Promote Certified Peer Specialist workforce development by increasing and standardizing compensation and creating full-time positions.		X	X	X	Appendix Recommendation- Expand the Certified Peer Support Specialist program and increase compensation.	House & Senate FY24 budget note 63.3 ($277K, DBHDD): "Increase funds to increase salaries for forensic peer mentors." Disregarded by Governor.
Behavioral Health Services and Resources - DBHDD	Clarify services provided and populations served through existing Crisis Stabilization Units, with a focus on identifying those that address substance use and/or comorbid mental health and substance use challenges.			X	X		
Behavioral Health Services and Resources - DBHDD	Encourage all Community Service Boards to adopt Certified Community Behavioral Health Clinic (CCBHC) models so that their services that align with integrated health models and standards of care.			X	X	Priority Recommendation 7, develop and support strategies to expand the state's capacity to provide access to endorsed programs.	
Behavioral Health Services and Resources - DBHDD	Continue to address behavioral health and developmental disabilities workforce challenges, including reviewing and implementing recommendations from the recent rate studies.		X	X		Priority Recommendation 1, increase the mental health and substance abuse treatment provider pay.	House & Senate FY24 budget note 62.10 ($0, DBHDD): "Begin implementation of the 2022-2023 provider rate study pending approval by Centers for Medicare and Medicaid Services." Disregarded by Governor. HB 520, Section 3, line 183-192: "[DBHDD] shall conduct a comprehensive study of the public behavioral health workforce in the state ... Such study shall include review of staffing levels, salaries, vacancy rates, and a comparison to private practice salaries and salaries of public behavioral health workforce staff members in surrounding states." BILL DID NOT PASS.
Behavioral Health Services and Resources - DBHDD	Continue progress on the development and implementation of MATCH and connections with the Local Interagency Planning Teams (LIPTs).			X	X		Gov. issued Executive Order on 9.1.23 to allow data sharing between executive state agencies.
Behavioral Health Services and Resources - DBHDD	Implement the new procurement of managed care, utilizing guidance from the recent white paper from DBHDD/DCH/Governor's Office, and encourage active DBHDD involvement in the CMO procurement process.			X			
Mental Health Issues for Unhoused and Foster Children	Establish a small and short-term workgroup to create a strategic plan around young adults who are aging out of state custody and have a dual diagnosis with both mental health and developmental disabilities. This population has been steadily growing over the past five (5) years, yet there are limited placement and long-term resources available. This workgroup should be established as part of Mindworks, and the group's recommendations should be communicated to the Behavioral Health Coordinating Council.	X		X			

Mental Health Issues for Unhoused and Foster Children	Emphasize community engagement and collaboration, including to determine what services are needed and where they should be provided. a. Revitalize the MATCH committee and Student Attendance and School Climate Committee (SASCC) for community-based and multidisciplinary solutions. b. Prioritize the delivery of timely services in-home or in-field where appropriate, as well as crisis services. c. Use data to enhance collaborative efforts and improve outcomes.	X		X	X	Priority Recommendation 7, develop and support strategies to expand the state's capacity to provide access to endorsed programs.	House & Senate budget FY24 budget note 68.5 ($1M, DBHDD) "Increase funds for the Multi-Agency Treatment for Children (MATCH) teams to support collaboration across state agencies to meet the treatment needs of children". DISREGARDED IN GOVERNER'S BUDGET. Gov. issued Executive Order on 9.1.23 to allow data sharing between executive state agencies.
Mental Health Issues for Unhoused and Foster Children	Georgia should leverage funding opportunities to build a larger, highly qualified workforce and increase access to care. a. Prioritize efforts to leverage the Families First Prevention Services Act (FFPSA), enacted as part of Public Law (P.L.) 115—123. b. Increase funding and reimbursement rates for case management, PRTFs/CCIs, Medicaid, and other necessary services. c. Adopt policies to make reimbursement for providers more reliable and timely. d. Explore new sources of funding.	X	X	X	X	Priority Recommendation 1, increase the mental health and substance abuse treatment provider pay. Priority Recommendation 4, re-evaluate Medicaid reimbursement rates for ASD. While this recommendation is specific to ASD there is a reoccurring recommendation to address reimbursement rates and restrictions across multiple services. See also Priority Recommendation 11 and 12. Future Consideration Priority 3 (Study how to close the gap in the continuum of care of mental health and substance abuse services and treatment that exists between Amerigroup, Georgia Families 360, CareSource, Peach State, and DBHDD.)	House & Senate FY24 budget notes 94.17, 95.14, 96.4 ($200K, DCH): "Increase funds to increase reimbursement rates for developmental and behavioral screening and testing." Retained in Governor-approved budget. House & Senate FY24 budget note 62.10 ($0, DBHDD): "Begin implementation of the 2022-2023 provider rate study pending approval by Centers for Medicare and Medicaid Services." Disregarded by Governor. HB 520, Section 17, lines 905-906, 927-931: "On and after January 1, 2024, the department shall ensure that the Medicaid program includes:"…"The provision of specialized therapeutic foster services for persons under the age of 21 years and, when appropriate, their caregivers and family of origin, to enable a recipient to manage and work toward resolution of emotional, behavioral, or psychiatric problems and to support reunification with his or her family of origin in a highly supportive, individualized, and flexible home setting." BILL DID NOT PASS.
Mental Health Issues for Unhoused and Foster Children	Increased and flexible spending rates for Psychiatric Residential Treatment Facilities (PRTF) and Child Caring Institutes (CCI) that allow for intensive and creative programming (as mentioned above) to better serve this population. This would also assist in reducing the state custody 'hoteling' challenge since more PRTFs and CCIs would be likely to accept these youth.		X	X	X	Priority Recommendation 5, increase the capacity of C&A Substance Abuse Intensive outpatient Programs. Priority Future Consideration 6 (Study reimbursement options for room and board when residential placement is necessary for children's behavioral health treatment.)	

Mental Health Issues for Unhoused and Foster Children	Allow Psychologists, Psychiatrists, LCSWs, LPCs, and LMFTs as participating providers in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check Program so that they can screen, diagnose, and start treatment for children 0-26 without having to seek prior authorization or require a diagnosis for treatment. This would better allow for co-location of physical and behavioral health services. Currently, behavioral health providers have to complete comprehensive assessments and intakes in order to bill insurance providers, which can be lengthy and cumbersome. This allows for quicker access to care. Right now, EPSDT is only authorized by Pediatricians.			X	X		HB 520, Section 17, lines 905-906, 911-913: "On and after January 1, 2024, the department shall ensure that the Medicaid program includes:"…"Reimbursement for services provided by licensed professional counselors, licensed marriage and family therapists, and certified peer support specialists in federally qualified health centers, as defined in 42 U.S.C. Section 1905(l)(2)(B);" BILL DID NOT PASS.
Mental Health Issues for Unhoused and Foster Children	Support preventative mental health strategy which includes stable, healthy housing; mental and physical health supports; positive learning environments; education; and workforce development to prevent mental health challenges that lead to these disastrous outcomes which includes generational poverty.		X	X	X		
Mental Health Issues for Unhoused and Foster Children	Make funding for services easier to access by reforming state contracting procedures: a. Awardees should be notified of approval prior to the start date of the contract as to properly prepare for program; b. Release funds in a timely manner to providers (State often makes payments months late); c. Fund administrative oversight (indirect expenses); and d. Fund at 100% of programming costs which decreases the burden on the provider to run the programs and fundraise to cover the gap of actual costs.		X	X			
Mental Health Issues for Unhoused and Foster Children	By increasing the timeliness of approvals and access to services, Medicaid wait lists and service wait times are shortened. Set the bar for expectations of approval times.			X			
Mental Health Issues for Unhoused and Foster Children	Allow for in-home services and require collaborations and partnerships to form so that utilization of space and infrastructure which is already built into their home communities (e.g., YMCAs, community centers, libraries, schools, etc.) with proper safeguards will increase access to services.			X	X	Priority Recommendation 7, develop and support strategies to expand the state's capacity to provide access to endorsed programs.	
Mental Health Issues for Unhoused and Foster Children	Emphasize family choice and community engagement whereby the family should help identify their needs in partnership with the provider so that location, dates/times, and how to best deliver services focuses on supporting the family in the best way possible.				X	Priority Recommendation 7, develop and support strategies to expand the state's capacity to provide access to endorsed programs.	
Mental Health Issues for Unhoused and Foster Children	More training opportunities that are cost-covered for specialized modalities such as Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavior Therapy (DBT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). These therapies are not widely utilized throughout Georgia yet have solid efficacy with youth and young adults in child welfare.		X	X	X		
Mental Health Issues for Unhoused and Foster Children	Leverage the Multi-Agency Treatment for Children (MATCH) committee to support and implement BHRIC strategies around this work and population.			X	X		House & Senate budget FY24 budget note 68.5 ($1M, DBHDD) "Increase funds for the Multi-Agency Treatment for Children (MATCH) teams to support collaboration across state agencies to meet the treatment needs of children".

Mental Health Issues for Unhoused and Foster Children	There needs to be intentional focus on the Families First Prevention Services Act (FFPSA), specifically utilizing Title IV-E funding (which can be use for prevention strategies) to create more opportunities for reunification. FFPSA allows for both youth and caregivers to receive necessary treatment in order to achieve needed outcomes so that reunification can occur. Currently, DFCS is working on a clearinghouse for approved modalities; however, there needs to be more urgency around this process and more creative strategies permitted inside the clearinghouse such as High Fidelity Wraparound and the like.		X	X	X	Future Consideration Priority 3 (Study how to close the gap in the continuum of care of mental health and substance abuse services and treatment that exists between Amerigroup, Georgia Families 360, CareSource, Peach State, and DBHDD.)	HB 520, Section 17, lines 905-906, 927-931: "On and after January 1, 2024, the department shall ensure that the Medicaid program includes:"…"The provision of specialized therapeutic foster services for persons under the age of 21 years and, when appropriate, their caregivers and family of origin, to enable a recipient to manage and work toward resolution of emotional, behavioral, or psychiatric problems and to support reunification with his or her family of origin in a highly supportive, individualized, and flexible home setting." BILL DID NOT PASS.
Mental Health Issues for Unhoused and Foster Children	Georgia should expand prevention efforts that nurture protective factors (like housing stability, supportive school environments, and healthy families) for every child and identify mental and behavioral health challenges before they become crises. a. Expand School-Based Mental and Behavioral Health (SBBH) services to every child who needs them in every public school. b. Expand coverage of the Trauma Impact Rule to apply to children experiencing homelessness. c. Open Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to Licensed Clinical Social Workers (LCSWs) and Licensed Professional Counselors (LPCs). d. Create new tools for DFCS to help children avoid foster care or stabilize them when they enter care. e. Reform Transitional Living Programming for children in foster care. f. Adopt a strategic plan for transition-age youth with mental health and developmental disabilities. g. Assess and meet the individual needs of children. h. Expand housing supports for low-income children and families.		X	X		Priority Recommendation 2, seek 1115 waiver to allow a portion of Medicaid funding to be used to address social determinants of health. Future Consideration Priority 1 (Study how to close the gap in the continuum of care of mental health and substance abuse services and treatment that exists between Amerigroup, Georgia Families 360, CareSource, Peach State, and DBHDD.)	HB 520, Section 17, lines 905-906, 927-931: "On and after January 1, 2024, the department shall ensure that the Medicaid program includes:"…"The provision of specialized therapeutic foster services for persons under the age of 21 years and, when appropriate, their caregivers and family of origin, to enable a recipient to manage and work toward resolution of emotional, behavioral, or psychiatric problems and to support reunification with his or her family of origin in a highly supportive, individualized, and flexible home setting." BILL DID NOT PASS.
Maternal and Infant Mental Health	Prioritize expansion of the occupational therapy workforce to increase accessibility.	X	X	X	X		HB 520, Section 19, line 1040-1042: "The board is authorized to provide for the repayment of student loans held by recipients in consideration of the recipient performing services as a mental health or substance use professional in accordance with subparagraph (a)(1)(c) of this Code section." BILL DID NOT PASS.
Maternal and Infant Mental Health	Coordinate efforts across the BHRIC and state departments to establish a subcommittee to make recommendations for improving maternal mental health in Georgia (e.g., formalize the Perinatal Mental Health Taskforce through BHRIC or state departments).	X		X			
Maternal and Infant Mental Health	Require CMOs to reimburse obstetric and pediatric providers for maternal mental health screenings and referrals from the prenatal to postpartum period.	X		X	X		
Maternal and Infant Mental Health	Expand provisions of HB 146, which mandates 3 weeks paid parental leave for postpartum caregivers, to include individuals who have experienced a pregnancy loss.	X	X	X			

Maternal and Infant Mental Health	Promote access to maternal mental health services in broader settings by supporting and expanding the following: Collaborative care for postpartum patients, either through consultation or embedded mental health service models. Ensure that pediatricians and obstetric care providers are aware that maternal suicide rates peak at 6-9 months postpartum, and thus collaborative care during this timeframe is essential. Embedding non-specialist providers (e.g., nurse navigators, social workers, and peer support specialists) into the provision of care/task-sharing in primary care settings. Use of technology to provide maternal mental health services (e.g., telemedicine, interactive case review such as ECHO, and AI-driven teletherapy and coaching). Expand and find ways to sustain Mental Health Access programs (e.g., PEACE for Moms).		X	X	X		
Maternal and Infant Mental Health	Prioritize dissemination of existing low/no cost health resources in rural areas and expand access to expand access to FQHC and CSBs by establishing outreach programs.			X	X		
Maternal and Infant Mental Health	Incorporate in-house mental health providers to mitigate bottlenecks from positive maternal mental health screens to referral and treatment.			X	X		
Maternal and Infant Mental Health	Establish a comprehensive statewide universal screening system for perinatal mood and anxiety disorders (e.g., the Barkin Index of Maternal Health).			X	X		
Maternal and Infant Mental Health	Develop and implement processes resulting in more home medical visits for caregivers and pregnant people.		X	X	X		
Maternal and Infant Mental Health	Address maternal health by adding Psychiatry Access Services program so obstetrician/health care provider can consult with a psychiatrist in real-time for recommendations for medications, interventions, psychiatric care, etc.		X		X		
Maternal and Infant Mental Health	Expand the existing Certified Peer Specialist credential to include Perinatal Mental Health and reduce restrictions.			X	X		
School Based Behavioral Health	Modernization or update to the health standards and health education in the state of Georgia.	X		X	X		
School Based Behavioral Health	DCH: Submit an SPA to allow claims and policy changes to ensure all provider types can be reimbursed for services delivered in school settings. Expand coverage to include full range of providers in Georgia; currently only LCSW professionals can bill; need to expand (e.g., school psychologists, LMFTs).	X	X	X	X		
School Based Behavioral Health	General Assembly: Allocate funding in the budget to continue improving the ratios of school counselors, social workers, and psychologists in K-12 congruent with national standards.		X	X	X		
School Based Behavioral Health	Ensure school staff, administrators, mental health counselors, and school counselors are trained in mental health first aid.		X	X	X	Appendix Recommendation- continue funding for the Mental Health Training Initiatives for educators.	

School Based Behavioral Health	Create a funded position allocated for a fully trained but not necessarily clinically credentialled professional in every school to increase the number of proactive intentional staff who are designated for the coordination of mental health resources and services.		X	X	X		
School Based Behavioral Health	State agency to establish a portfolio of clinical mental health providers that are vetted and couple that with incentives or requirements for formal MOU's to be put in place so that clinical services are accessible by every school and every student.		X	X	X		
School Based Behavioral Health	Provide wraparound support for families of students experiencing mental health challenges.				X		
School Based Behavioral Health	Provide more grants for mental health counselors at schools.		X	X		Appendix Recommendation - Explore opportunities for more funding/grants.	
School Based Behavioral Health	Provide more grants for school nurses.		X	X		Appendix Recommendation - Explore opportunities for more funding/grants.	
School Based Behavioral Health	Make Dialectical Skills Group (DSG) facilitator trainings (2 days of training) available to every middle/high school, college, and university in Georgia. Georgia's RESA's and University Colleges of Education are possible delivery models.		X	X	X		
School Based Behavioral Health	Fund a train-the-trainer model of DSG facilitator training to make scaling the provision of these skills highly reliable and efficient. Georgia's RESA's and University Colleges of Education are possible delivery models.		X	X	X		
School Based Behavioral Health	Make tele-mental health services available in all K-12 schools.		X	X	X	Appendix Recommendation-Schools should explore the use of telehealth for medical and mental health services.	
School Based Behavioral Health	General Assembly: Continue to fund and expand Apex (including adequate program support). Funding can support Technical Assistance and Evaluation efforts as well as programmatic efforts.		X	X			
School Based Behavioral Health	General Assembly: Fund increase for DBHDD and Medicaid BH provider rates		X	X		Priority Recommendation 1, increase the mental health and substance abuse treatment provider pay. Priority Recommendation 4, re-evaluate Medicaid reimbursement rates for ASD. While this recommendation is specific to ASD there is a reoccurring recommendation to address reimbursement rates and restrictions across multiple services. See also Priority Recommendation 11 and 12.	House & Senate FY24 budget notes 94.17, 95.14, 96.4 ($200K, DCH): "Increase funds to increase reimbursement rates for developmental and behavioral screening and testing." Retained in Governor-approved budget. House & Senate FY24 budget note 62.10 ($0, DBHDD): "Begin implementation of the 2022-2023 provider rate study pending approval by Centers for Medicare and Medicaid Services." Disregarded by Governor.
School Based Behavioral Health	General Assembly/Philanthropy: Fund a comprehensive study of Peer Support opportunities in SBBH programming.		X	X		Appendix Recommendation - Expand the Certified Student Peer Support program	
School Based Behavioral Health	State Agency/School District: Leverage telehealth to increase access to SBBH supports and services, particularly in rural school districts.		X	X	X	Appendix Recommendation-Schools should explore the use of telehealth for medical and mental health services.	

Children and Community Mental Health	Support Integrated Behavioral Health (IBH) in primary care settings by: a)Encouraging and/or incentivizing agencies to embed behavioral health providers in their practice. b)Requiring insurance payers to reimburse for the IBH CPT codes 99484, 99492, 99493, 99494.	X	X	X	X	Priority Recommendation 4, re-evaluate Medicaid reimbursement rates for ASD. While this recommendation is specific to ASD there is a reoccurring recommendation to address reimbursement rates and restrictions across multiple services. See also Priority Recommendation 11 and 12.	House & Senate FY24 budget notes 94.17, 95.14, 96.4 ($200K, DCH): "Increase funds to increase reimbursement rates for developmental and behavioral screening and testing." Retained in Governor-approved budget. HB 520, Section 17, line 911-912: "[The Medicaid program includes] reimbursement for services provided by licensed professional counselors, licensed marriage and family therapists, and certified peer support specialists in federally qualified health centers" BILL DID NOT PASS.
Children and Community Mental Health	Improve communication between primary care and behavioral health providers by: a)Requiring bidirectional communication between primary care providers and mental health providers. b)Establishing a method of secure communication between schools and primary care providers. c)Require pharmacies to put brand and generic names on prescription bottles. This allows patients to recall and discuss medications more easily. Not all generic medications are equal; for example, some methylphenidates are immediate vs. delayed release.	X			X		
Children and Community Mental Health	Increase coverage and reimbursement for mental health conditions through implementation of mental health parity.		X	X	X		
Children and Community Mental Health	Establish stricter requirements for insurance payers around networks and accountability.			X			
Children and Community Mental Health	Establish formularies for: a) Behavioral health medications b) Liquid and chewable options when available c) Limiting prior authorizations			X	X		
Children and Community Mental Health	Remove administrative barriers to access by: a) Streamlining the enrollment of mental health providers with payers. b) Considering ways to allow district, regional, or state level approval for individual physician services in schools that are located in rural/underserved areas (e.g., contracts with individual physicians). c). Encouraging CSBs to adopt CCBHC models.			X	X		
Children and Community Mental Health	Invest in collaborations, coalitions, and programs that focus on prevention.		X				
Children and Community Mental Health	Identify resources and ways to fund statewide Handle with Care program implementation		X	X	X		

Children and Community Mental Health	Continue expanding and building sustainable funding for the Georgia Mental Health Access in Pediatrics (GMAP) Program. a) Identify key topics of interest for providers. b) Lift up family voice through GMAP. c) Expand through a data driven process, sharing information with stakeholders and increasing services and sites throughout the state. d) Explore ways to increase reach and accessibility of GMAP ECHO for providers in Georgia, particularly those in Southeast GA (e.g., timing of sessions, etc.) e) Consider expanding GMAP connections with residential psychiatric facilities for children in Georgia as a resource. f) Continue to identify ways to incorporate integrated Behavioral Health into primary care through GMAP (e.g., teleconsultations).		X		X	Future Priority Consideration 4 (Study how to sustain the Georgia Pediatric Psychiatry Consultation and Access Program (GaPPCAP) and Georgia Mental Health Access in Pediatrics (GMAP) that provides training for primary care professionals in identifying and treating mild to moderate behavioral health conditions in children in primary care practices or school-based health programs.)	Gov. issued Executive Order on 9.1.23 to allow data sharing between executive state agencies
Children and Community Mental Health	Increase the reimbursement rates and annual salaries for the behavioral health workforce.		X	X		Priority Recommendation 1, increase the mental health and substance abuse treatment provider pay. Priority Recommendation 4, re-evaluate Medicaid reimbursement rates for ASD. While this recommendation is specific to ASD there is a reoccurring recommendation to address reimbursement rates and restrictions across multiple services. See also Priority Recommendation 11 and 12.	House & Senate FY24 budget notes 94.17, 95.14, 96.4 ($200K, DCH): "Increase funds to increase reimbursement rates for developmental and behavioral screening and testing." Retained in Governor-approved budget. House & Senate FY24 budget note 62.10 ($0, DBHDD): "Begin implementation of the 2022-2023 provider rate study pending approval by Centers for Medicare and Medicaid Services." Disregarded by Governor. HB 520, Section 17, line 917-925: "Reevaluation and updating of Medicaid reimbursement rates for autism spectrum disorder diagnostic assessments and services ..." BILL DID NOT PASS. HB 520, Section 17, line 911-912: "[The Medicaid program includes] reimbursement for services provided by licensed professional counselors, licensed marriage and family therapists, and certified peer support specialists in federally qualified health centers" BILL DID NOT PASS.
Children and Community Mental Health	Expand the capacity of Crisis Stabilization Units by increasing the number of beds and available staffing.		X	X		Appendix Recommendation - expand the number of CSUs to cover more regions	HB 520, Section 6, line 278-282:"Such study shall also include a review of the continuum of crisis services to determine if changes can be made in other points on the continuum that could relieve capacity needs on inpatient behavioral health beds, including examining the need for non-crisis resources, such as psychiatric respite beds and other resources and services to all for interventions before a crisis occurs" BILL DID NOT PASS.

Children and Community Mental Health	Continue supporting and expanding Georgia Mental Health Access in Pediatrics (GMAP) program in similar access lines for physicians to receive mental health consultation.			X	X	Future Priority Consideration 4 (Study how to sustain the Georgia Pediatric Psychiatry Consultation and Access Program (GaPPCAP) and Georgia Mental Health Access in Pediatrics (GMAP) that provides training for primary care professionals in identifying and treating mild to moderate behavioral health conditions in children in primary care practices or school-based health programs.)	
Children and Community Mental Health	Increase funding and support for school-based health centers.		X	X	X		
Integrated Children's Mental	In the wake of Medicaid unwinding, provide support and resources for families to ensure that children who are eligible for Medicaid remain enrolled and to prevent procedural disenrollment.	X		X	X		
Integrated Children's Mental	Modify the current TB Symptom Screen requirement per DCH rule to allow non-medical professionals who are qualified to complete substance use assessments (e.g., Addiction Certification or Licensure) for intake of individuals who are seeking substance abuse treatment. In particular, eliminate the requirement for those seeking prevention/early intervention, Level 1 (Outpatient), or Level 2 (Intensive Outpatient/Partial Hospitalization) treatment modalities, as these individuals run a lower risk of spreading illness amongst other patients. This modification would accelerate the assessment and therefore treatment of individuals with substance abuse issues without compromising the health of others.			X	X		
Integrated Children's Mental	Eliminate the STD screening requirement per DCH rule for intake of individuals seeking substance abuse treatment, unless "clinically indicated." In particular, eliminate the requirement for those seeking prevention/early intervention, Level 1 (Outpatient), or Level 2 (Intensive Outpatient/Partial Hospitalization) treatment modalities, as these individuals run a lower risk of spreading illness amongst other patients.			X	X		
Integrated Children's Mental	Even when children and adolescents have Medicaid and CHIP coverage, access to mental health services is difficult and needs to be addressed by developing more access points.		X	X	X	Priority Recommendation 12, The Department of Community Health (DCH) should be strongly encouraged to consider reimbursement for 90791 for Medicaid patients in Georgia.	
Integrated Children's Mental	Georgia should implement the in-house behavioral health aids program for children under the age of 21 with autism.		X	X	X	Future Priority Consideration 2, Study how to create incentives to open more residential treatment facilities and crisis stabilization units for acute ASD funded by a combination of federal and state funds and reimbursements from Medicaid and insurance carriers.	
Integrated Children's Mental	Conduct a study in Georgia to determine the use of CMS school-based services and EPSDT benefits.		X	X			
Integrated Children's Mental	Georgia should work to get the 15,000 unenrolled children back into Medicaid coverage.			X	X		

Integrated Children's Mental	Increase the number of Community Medicaid Providers (CMPs) through a mental health workforce improvement plan that includes an increase in CMP pay.		X	X	X		HB 520, Section 3, line 183-192: "[DBHDD] shall conduct a comprehensive study of the public behavioral health workforce in the state ... Such study shall include review of staffing levels, salaries, vacancy rates, and a comparison to private practice salaries and salaries of public behavioral health workforce staff members in surrounding states." BILL DID NOT PASS.

Georgia Behavioral Health Reform and Innovation Commission

Appendix B: Subcommittee on Involuntary Commitment

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on Involuntary Commitment

2023 Annual Report

<u>Chair</u>

Judge Sarah Harris

<u>Members</u>

Justice Michael Boggs

Judge Bedelia Hargrove

Judge Stephen Kelley

Dr. Karen Bailey

Nora Lott Haynes

Dr. Dejuan White

December 2023

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former-Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact of behavioral health issues on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas including the Subcommittee on Involuntary Commitment chaired by Judge Sarah Harris (2023).

During 2023, the Subcommittee on Involuntary Commitment held one public meeting on topics Assisted Outpatient Treatment (AOT), Interaction and Impact of Persons with Serious and Persistent Mental Illness, and Intensive and Sustained Engagement and Treatment Program (INSET).

List of Presenters to the BHRIC Subcommittee on Involuntary Commitment 2023

BHRIC Subcommittee on Involuntary Commitment **Justice Michael Boggs, Judge Bedelia Hargrove, Judge Stephen Kelley, Dr. Karen Bailey, Nora Lott Haynes, Dr. DeJuan White**
Support to the BHRIC Subcommittee on Involuntary Commitment

Presenters to the BHRIC Subcommittee on Involuntary Commitment 2023		
Date	**Topic**	**Presenter**
Date	Topic	**Presenter** Presenter's Title
July 19, 2023	Update on Assisted Outpatient Treatment (AOT) and Status of Action on Previous Committee Recommendations	**Judge Sarah S. Harris** Chair of BHRIC Subcommittee on Involuntary Commitment
	Interaction and Impact of Persons with Serious and Persistent Mental Illness	**Julia Fisher Strauss, JD** Associate General Counsel *Department of Aging Services, Department of Human Services* **Carlton Coleman** Public Guardianship Office Section Manager *Department of Aging Services, Department of Human Services*
	Intensive and Sustained Engagement and Treatment Program (INSET)	**Kim Jones** Executive Director *NAMI*

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Recommendation Priorities

The Involuntary Commitment Subcommittee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action.

TRANSPORTATION

As a part of the Mental Health Parity Act, the Georgia legislature implemented a provision to provide law enforcement additional options to transport persons immediately to an emergency receiving facility when the individual has not been engaged in committing a criminal offense, and law enforcement does not have a signed 1013 document or a Probate Court order to apprehend. Such transport can only be made following consultation with and consent by a physician, as defined by law. (O.C.G.A. § 37-3-42(a)(2) and O.C.G.A. § 37-7-42(a)(2))

Concerns have been raised as to the effective implementation of this statute; therefore, a study was undertaken to determine the utilization of the transport provision and any barriers to its use. The obstacles relating to use of the transport provision were consistently identified in the numerous interviews with law enforcement from around the state and the resultant survey.

The most frequently identified barriers to use of the transportation statute were: lack of clarity on the process and its use; lack of specific protocols for process implementation and difficulty developing local processes; lack of specific training in the process and co-training for law enforcement and mental health partners; and, concerns about liability risks related to using the process. Law enforcement agencies and CSB's who used the new transport provision were more likely to have co-responder units and identified coordinated protocols.

Based upon these results, the Involuntary Commitment Subcommittee makes the following recommendations:

1. Relating to the involuntary transportation provision:

a. It is recommended that DBHDD, in collaboration with law enforcement representatives, develop model transport forms and model protocol guidelines for transport pursuant to O.C.G.A. § 37-3-42(a)(2) and O.C.G.A. § 37-7-42(a)(2).

b. It is recommended that a co-training program model and materials be developed for law enforcement and mental health providers who provide consultations as well as those in emergency receiving facilities. The study identified the need for education and training to understand the shared language, liability issues, and procedures when issues arise in transport.

c. It is recommended that the Georgia Health Policy Center be engaged to continue the work in this area and assist in creation of a comprehensive training program for transportation.

2. An issue relating to use of the transportation process identified by both law enforcement and mental health providers was a lack of clarity and understanding as to liability, particularly when use of force might be required. There was also a lack of understanding as to the definition of "physician" as it is used in the statute. The 2022 amendment to O.C.G.A.§ 37-3-4 and O.C.G.A. § 37-7-5 added "transport" to the immunity from liability for actions taken in good faith compliance with the transport, admission and discharge provisions of Chapter 3 and Chapter 7 of Title 37.

a. It is recommended that O.C.G.A. § 37-3-42(a)(2) and O.C.G.A. § 37-7-42(a)(2) be amended to specifically reference back to O.C.G.A.§ 37-3-4 and O.C.G.A. § 37-7-5 to clarify liability concerns for law enforcement.

b. It is also recommended that O.C.G.A. § 37-3-42(a)(2) and O.C.G.A. § 37-7-42(a)(2) be amended to clarify the definition of physician in paragraph (2) as follows:
(ii) the peace officer has consulted either in-person or via telephone or telehealth with a physician, ***as defined*** *in Code Section 37-3-41****(d) and delete (b) to eliminate confusion***

3. The Involuntary Commitment Subcommittee recognizes that in Georgia, the transport of individuals via a signed 1013 form or Order to Apprehend falls to law enforcement. At least 12 states have been identified as developing alternatives to law enforcement transport and in 22 states EMS services can transport individuals to crisis treatment. Transport by law enforcement is a burden to an already understaffed system and can be stigmatizing to those being transported. Transportation in the state may not be a one-size-fits-all solution due to distances to emergency receiving facilities, the available resources within a county area, and funding.

a. It is recommended that a continued study be conducted of alternative transportation options for use during crisis intervention when directed by a 1013 form or Order to Apprehend. It is further recommended that the study include an extensive environmental scan of policies and practices related to transport used in other states, including evidence-based and -informed interventions. In addition to reviewing transportation alternatives, the study should also examine the methods used by other states to determine where a person is sent for crisis intervention, how it is determined, and who makes the determination.

b. It is also recommended that DBHDD expand its initial transportation Pilot project to encompass a more diverse area that may include both rural counties with smaller populations and a larger county with more urban areas.

DEPARTMENT OF HUMAN SERVICES – DIVISION OF AGING AND PUBLIC GUARDIANSHIP OFFICE

The Subcommittee heard testimony of the growth in the number of individuals who suffer from serious and persistent mental illness who are carried on the caseload of the Division of Aging and Public Guardianship Office. Many of these individuals are the most difficult to place and have gone untreated for long periods of time. Many have never applied for disability nor any other type of financial assistance. The Division of Aging often needs support and guidance from DBHDD and there is not a streamlined process for communication between the agencies to troubleshot difficult cases.

1. It is recommended that strategies be implemented to improve communication and collaboration between the Division of Aging, the Public Guardianship Office and DBHDD, including cross-agency training to understand the roles and limitations of each agency.
2. It is recommended that DBHDD establish a liaison to work and coordinate with the Division of Aging and the Public Guardianship Office for guidance and direction and to troubleshoot complex cases.

ASSISTED OUTPATIENT TREATMENT

Although the Assisted Outpatient Treatment Program (AOT) established by the Mental Health Parity Act is still in its infancy, three of the grant programs are running successfully and close to participant capacity. However, the program continues to face many challenges, including workforce obstacles, comprehensive understanding of AOT, and training. Definitions and understanding of AOT seem to vary greatly among clinicians inside and outside of the program.

1. It is recommended that funding continue for 5 pilot projects across the state.
2. It is recommended that a study be conducted to build an additional AOT Pilot project specifically in conjunction with misdemeanor diversion.
3. It is recommended that targeted training be developed for all CSB's and treatment providers, educating about the use of assisted outpatient treatment.
4. Given that AOT Pilots are at different stages of implementation with each AOT site operating in accordance with local needs and resources, it is recommended that a study be conducted to understand AOT Pilot site implementation including how each utilizes funding to support staffing and operations.

CERTIFIED PEER SPECIALISTS

As part of their evaluation of the Assisted Outpatient Treatment (AOT) programs, the Subcommittee sought to identify factors relating to obtaining applicants for the position of Certified Peer Specialist, a critical role in AOT. The Subcommittee, with the assistance of Carol Carabello, Director of Adult Mental Health at DBHDD, sought information concerning the use of

Certified Peer Specialists (CPS) and tracking of how many certified peers are currently in the work force. DBHDD indicated that there is not a database to track the number of CPSs presently working; however, DBHDD is developing a database that will be able to track this information and aid in linking CPSs to available employment opportunities.

Although peer specialists complete their training ready for credentialling as a CPS, many would also benefit from general employment readiness skills. An amendment to the training contract for CPSs that specifies the addition of material in both administrative and soft skills would be useful to support CPS employability and career success.

Difficulties were also identified in the processes that allow for review of certain criminal offense histories for CPSs seeking employment with a state agency, with timeliness of processing being identified as a key concern.

Finally, stagnant pay and Medicaid reimbursement rates for CPSs were also identified as areas of concern.

1. The committee supports DBHDD in the build out of a database to track CSP employment in the public and private sector and to enhance support for employment opportunities for CPSs.
2. It is recommended that DBHDD implement a revision to the procedure for review of the process for allowance of certain offense histories in an individual's Criminal History Record when they are seeking agency employment. Pre-emptively offering the individual an opportunity to begin the waiver process during or near the end of the certification training would allow opportunities for hire without the individual having to wait for employment and would prevent agencies from losing good candidates to other employment due to processing delays.
3. It is recommended that the contract for the CPS training be revised to include enhancement of administrative and soft skills that increase CPS employability and workplace success.
4. The Subcommittee refers to the Work Force Study committee the issue of pay and Medicaid reimbursement rates for Certified Peer Specialist.

Involuntary Commitment Subcommittee Appendix

- Involuntary Transport Study, Georgia Health Policy Center, GSU
- Transportation in Behavioral Health Crisis Services: 2022 NRI Analytics Improving Behavioral Health April 3, 2023
- 2022 Statewide Probate Court Mental Health Filings, Judicial Council of Georgia, Administrative Office of the Courts
- Certified Peer Specialist Data, Carol Carabello, LCSW, MPA, Dir. Office of Adult Mental Health DBHDD
- Input from Certified Peer Specialist
- State mental health Agency Peer Specialist Workforce, 2022 NRI Analytics Improving Behavioral Health, December, 2022
- DHS Georgia Department of Aging Services – Public Guardianship Office – Placement slides.

Georgia Behavioral Health Reform and Innovation Commission

Appendix C: Subcommittee on Hospital and Short-term Care Facilities

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on

Hospital and Short-Term Care Facilities

2023 Annual Report

Chair

Dr. Brenda Fitzgerald

Members

Dr. Mark Johnson

Senator Brain Strickland

Dr. Michael Robert Yochelson

Kim Jones

Senator Kim Jackson

Donna Hyland

Commissioner Candice Broce

Commissioner Christopher Nunn

November, 2023

Report prepared with assistance from Resilient Georgia

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former-Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas including the Subcommittee on Hospital and Short-Term Care Facilities chaired by Dr. Brenda Fitzgerald (4 Years as Chair).

During 2023, the Subcommittee on Hospital and Short-Term Care Facilities held 5 public meetings on topics related to mental and behavioral health (MBH) care access including bed shortages, innovative MBH practices that other states have implemented, Georgia MBH workforce barriers and facilitators, and subject matter experts that work with specific populations experiencing MBH access issues.

List of Presenters to the BHRIC Subcommittee on

Hospital and Short-Term Care Facilities 2023

BHRIC Subcommittee on Hospital and Short-Term Care Facilities **Dr. Brenda Fitzgerald, Commissioner Candice Broce, Donna Hyland, Senator Kim Jackson, Dr. Mark Johnson, Kim Jones, Commissioner Christopher Nunn, Senator Brian Strickland, Dr. Michael Robert Yochelson,**
Support to the BHRIC Subcommittee on Hospital and Short-Term Care Facilities Dr. Emily Anne Vall, Roland Behm
Presenters to the BHRIC Subcommittee on Hospital and Short-Term Care Facilities ***2023***

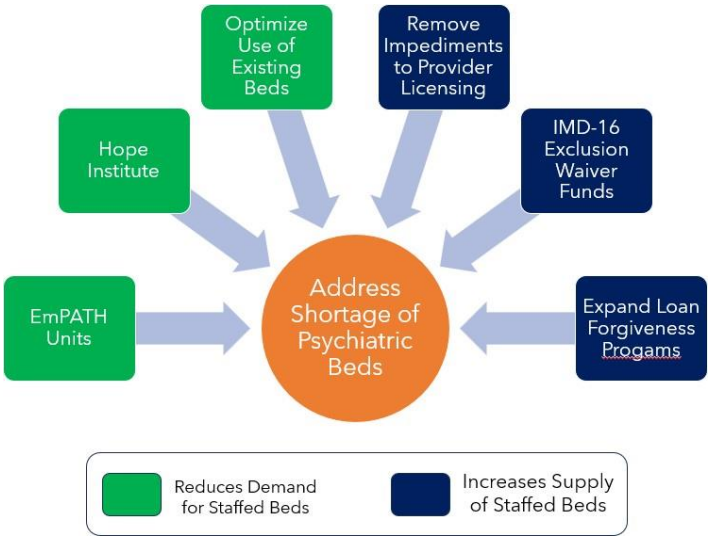
Date	Topic	Presenter
April 27, 2023	Increase your Capacity and Do More Good	**Clint Brooks, Bill Bott, Blake Shaw, and Sean Toole** The Change and Innovation Agency
July 27, 2023	Motherhood Beyond Bars: Supporting Infants and Mothers Impacted by the Criminal Justice System	**Amy Ard** Executive Director *Motherhood Behind Bars*
	Georgia's Infant Toddler Court Program	**Renee S. Johnson, MPA** Executive Directors, Mindworks GA – Center of Excellence for Children's Behavioral Health *Georgia Health Policy Center, GSU*
August 24, 2023	Expanding Outpatient Treatment of Suicidal Crises and Reducing Trauma of Behavioral Health Emergency Department Admissions	**David A. Jobes, Ph.D., ABPP** Professor of Psychology and Associate Director of Clinical Training **John N. Constantino, MD** Chief of *Behavioral and Mental Health at Children's Healthcare of Atlanta* **Scott Zeller, MD** Vice President for *Vituity Acute Psychiatry*
September 28, 2023	Increasing Provider Enrollment to Improve Patient Access for Mental and Behavioral Health Services	**Christina Lennon** Chief Strategy and Innovation Officer *Wellroot Family Services* **Cindy Levi**

		Chief Executive Officer *Avita Community Partners* **Cindy Simpson** Consultant *Murphy Harpst, Wellroot*
	The Effect of Certificate of Need Laws on Georgia Healthcare	**Kyle Wingfield** President and CEO *Georgia Public Policy Foundation* **Chris Denson** Director of Policy and Research *Georgia Public Policy Foundation*
October 26, 2023	Findings from GA DBHDD Bed Capacity Study and Strategic Plan	**Daniel Harlan** Managing Director *Alvarez and Marsal Consulting*
	Georgia Hospital Association's Review of Recommendations provided to the House CON Study Committee	**Anna Adams** Executive Vice President Georgia Hospital Association
	National Scan of Legislation Related to School Mental Health	**Angela Kimball** Senior Vice President of Advocacy & Public Policy *Inseparable*
	National Perspective on Best Practices & Research on School-Based Mental Health	**Dr. Sharon Hoover** Professor at the University of Maryland School of Medicine, Division of Child, and Adolescent Psychiatry
	Impact of Mental Health Services in Schools, Especially for High-Risk Students	**Sarah Broome** Principal, SG Strategies *Schmidt Futures Innovation Fellow*

The 2023 recommendations of the Hospital and Short-Term Care Facilities Subcommittee of the Georgia Behavioral Health Reform and Innovation Commission center around the need to address the shortage of fully-staffed psychiatric beds in the state. The recommendations fall into two categories: increase the supply of beds and decrease the demand.

As illustrated in the graphic, EmPATH units, Hope Institute suicide interventions, removing impediments to Medicaid provider enrollment, use of an IMD-16 waiver, expanding loan forgiveness programs, and optimizing use of existing beds can be combined to address the shortage of psychiatric beds in Georgia. Each of the six elements reinforces the others, and each recommendation also stands on its own.

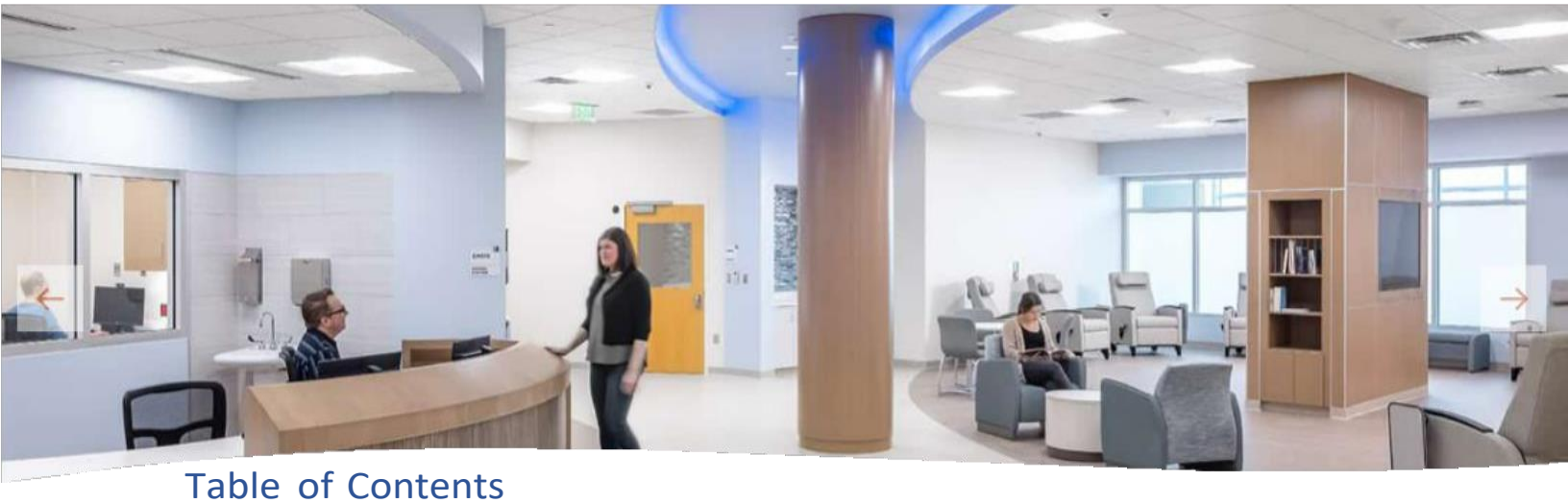
1. **EmPATH units** reduce demand for psychiatric beds in Georgia by co-locating the units next to emergency departments (EDs) and beginning treatment within hours. Approximately 75% of EmPATH unit patients are discharged back to the community in less than 24 hours, in lieu of facing psychiatric boarding in EDs and transfer to psychiatric beds.
2. **Optimizing use of existing psychiatric beds** among Georgia's community service board reduces demand for new psychiatric beds in Georgia by enabling better usage of the existing beds. Many CSBs' bed usage rates are significantly below the optimal 85% rate.
3. **Removing impediments to provider licensing** expands the supply of fully staffed psychiatric beds in Georgia by enabling additional competent and sufficient behavioral healthcare providers to staff new and existing psychiatric beds.
4. **Obtaining the IMD-16 exclusion waiver** expands the supply of fully staffed psychiatric beds by enabling another funding source. Once a waiver is received, a state may use Medicaid funds, including the federal match (approximately 66% in Georgia), to pay for inpatient services at hospital or residential facilities. DCH should be encouraged to submit this waiver, however cost is a huge component. Therefore it is also recommended that funding be identified.
5. **Expanding loan repayment programs** expands the supply of fully staffed psychiatric beds by encouraging behavioral healthcare providers to move to, or remain in, Georgia to offer services to those in need of behavioral healthcare services.



Recommendations

Hospital and Short-Term Care Facilities Subcommittee of the Behavioral Health Reform and Innovation Commission

Brenda Fitzgerald, M.D. (Chair)



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Introduction

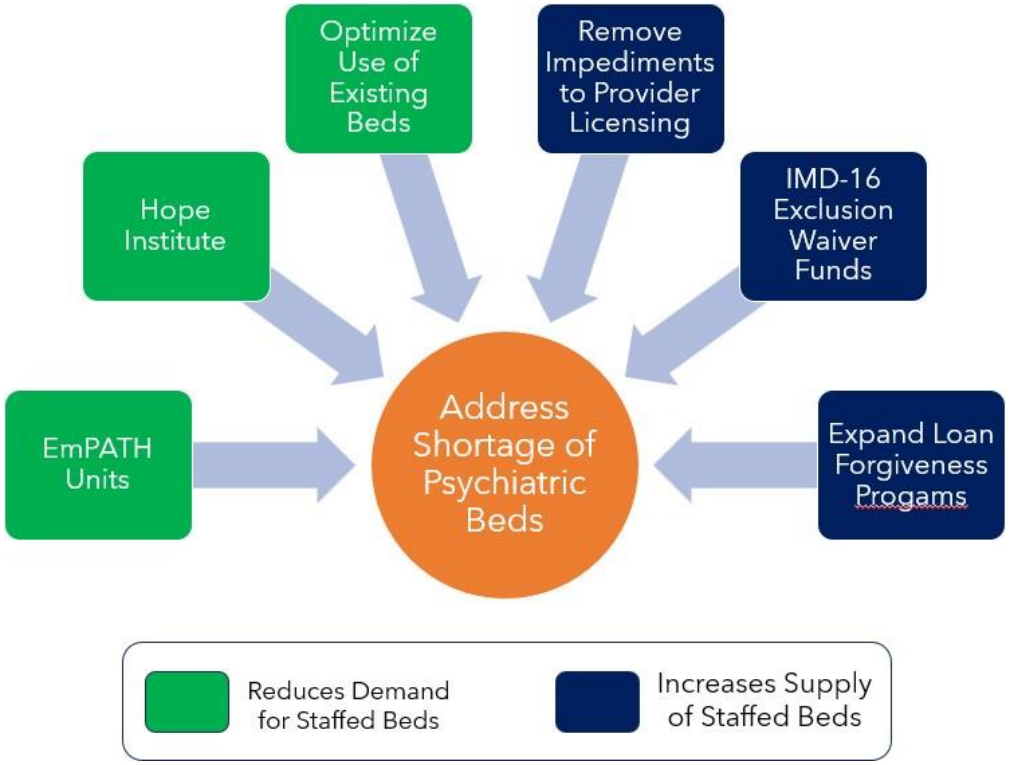
In 2019, House Bill 514 created the Georgia Behavioral Health Reform and Innovation Commission (BHRIC). The commission was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. BHRIC has several subcommittees, including the Hospital and Short-Term Care Facilities (Access) subcommittee.

This document lists recommendations of the Access subcommittee for consideration as we move into the 2024 legislative session. The recommendations are preceded by brief summaries of the issues supporting the recommendations. More extensive information on each of the issues comprise the remainder of the documents.

This document has two categories of recommendations.

1. The first is a reiteration of the recommendation from our initial report to **build a trauma informed knowledge base statewide** by implementing a virtual statewide trauma-informed training for all state employees similar to the Georgia Department of Administrative Services deployed the Human Trafficking Training Program.
2. The second category are a series of actions to **address the shortage of psychiatric beds** in Georgia, both by increasing the supply of staffed psychiatric beds and by decreasing bed demand.

As shown in the graphic below, EmPATH units, Hope Institute suicide interventions, removing impediments to Medicaid provider enrollment, use of an IMD-16 waiver, expanding loan forgiveness programs, and optimizing use of existing beds can be combined to address the shortage of psychiatric beds in Georgia. Each of the six elements reinforces the others.



Addressing the Shortage of Psychiatric Beds in Georgia

One of the great pressures on short term inpatient and ED facilities is that there are not enough residential beds, which has dire consequences for the entire system of short term and acute care. For children and adolescents, it has been estimated that approximately half of Georgia's Psychiatric Residential Treatment Facility (PRTF) beds are occupied by out-of-state children, which results in short-term and ED facilities being occupied by patients who should be in PRTFs. This results in overestimation of the number of additional inpatient beds needed and a false assumption that the number of residential beds in GA are available to GA residents.

There is also a community-wide quality concern for acute inpatient psychiatric units for children and adolescents, and the observation that Georgia foster children as a group are disproportionately denied access to acute inpatient psychiatric care (in comparison to their governmentally-insured counterparts who live with their biological parents) by for-profit hospitals.

RECOMMENDATIONS

1. Inpatient Unit Quality Concerns: Identify a team of subject matter experts to create a strategic plan to address and assess quality measures for acute inpatient psychiatric beds for children.

a. This should include identifying innovative strategies that high performing organizations have put in place that may be replicated, and a plan for quality control and improvement for all patient populations no matter the payor type.
b. Work with stakeholders and subject matter experts from across the state to ensure that there is a method of assurance that foster children (in comparison to other governmentally insured children) are not discriminated against in gaining access to in-patient facilities.

2. Displacement of GA PRTF access by out-of-state residents: Convene PRTF providers in Georgia to clarify the financial pressures and incentives that result in the preferential occupancy of non-Georgia residents. Once clarity is well documented, this information should be presented to BHRIC for further action and recommendations.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) conducted a bed study to review crisis stabilization and inpatient facilities funded by DBHDD that serve two discrete populations: (1) uninsured adults and children and adolescents receiving behavioral health crisis services; and (2) adults involved in the criminal justice system receiving forensic behavioral health services.

Findings from the bed study:

- Georgia has an acute near-term need for additional community-based behavioral health crisis beds for adults. The DBHDD bed study projects that Georgia will need five new facilities (i.e., behavioral health crisis centers) by 2025 to meet near-term demand.
- Georgia also has an acute near- and long-term need for additional forensic state hospital beds, with a gap of 199 beds projected by 2025.
- The projected near-term needs may be mitigated by diversion measures that allow individuals in crisis to be stabilized without admission to a facility.
- The SFY25 cost of implementing the study recommendations is $118.1 million.

RECOMMENDATIONS

1. Work with the private sector to maximize access for all Georgians.
    a. Direct the Department of Community Health (DCH) submit the IMD-16 waiver request for mental health and substance use treatment to CMS. The submission was required to be done by December 31, 2022, per the Georgia Mental Health Parity Act (HB 1013). To date, it has not been submitted.
    b. Currently Georgia pays the entire cost of psychiatric beds. Once a waiver is received, Georgia can use Medicaid funds, including the FFP (approximately 66% in Georgia), to pay for inpatient services at hospital or residential facilities, even if the facilities have more than 16 beds.
2. Utilize EmPATH units to reduce demand for community-based behavioral health crisis beds. In a study:
    a. Inpatient psychiatric admissions dropped from 57% of patients in the psych ED to 27% of patients in the EmPATH unit, significantly reducing demand for inpatient beds and overall costs.

b. The 30-day rate of psych patients returning to the ED dropped by 25%, and outpatient follow-up of patients improved by 60%.

3. Utilize the Hope Institute model of suicide intervention to reduce demand for community-based behavioral health crisis beds.
    a. The Hope Institute model significantly reduces both psychiatric boarding at the ED and demand for psychiatric beds. While approximately 1 in 8 persons admitted to the ED are experiencing a behavioral health crisis, approximately 80% of persons who are suicidal can be diverted to an outpatient Hope Institute intervention. This frees up those ED and psychiatric beds that would otherwise be occupied by patients experiencing suicidal crises.
4. Expand the behavioral healthcare workforce to by adopting financial incentives, including student loan forgiveness programs for various types of behavioral health professionals, and by eliminating impediments to the Medicaid provider enrollment processes.

Enabling Widespread Adoption and Use of EmPATH Units

EmPATH units are physical environments designed for acute psychiatric patients to receive assessment and evaluation in a therapeutic and least restrictive setting, regardless of a patient's ability to pay. Complementing the emergency department, the units provide a calm and comforting environment for patients, allowing movement and, more importantly, human interaction that is vital in the first 24 hours of treatment, something often not available in the emergency department.

EmPATH units streamline emergency department assessment of the health needs of mental health consumers and quickly transitions them out of emergency departments into a calming space that allows for the rapid assessment, support of behavioral health needs, and linkage to other services.

South Carolina implemented a grant program this year (2023) that used $35 million to fund the creation of 13 EmPATH units across the state, in return for a commitment to operate the units in accordance with the EmPATH model for a minimum of three years.

RECOMMENDATIONS

1. Fund one or more grant programs like South Carolina's program to establish EmPATH units at emergency departments in Georgia.
2. Direct the Department of Behavioral Health and Developmental Disabilities to develop and implement the EmPATH grant program(s). As part of its work, DBHDD shall seek input from relevant agencies, organizations, and programs, including organizations representing persons with lived experience of behavioral health crises.

Bringing EmPATH Units to Rural Georgia

Rural Georgians face unique challenges when attempting to receive effective treatment for serious mental illness and mental health conditions. There may be multiple barriers to care faced by individuals in rural areas, including:

- Accessibility –Rural hospital closures have resulted in rural Georgians having to travel longer distances to receive behavioral health services. Rural Georgians are less likely to be insured for mental health services or any healthcare services.
- Availability – Chronic shortages of mental health professionals exist, and mental health providers are more likely to practice in urban centers.
- Affordability – Some rural residents may not be able to afford the cost of health insurance or the cost of out-of-pocket care if they lack health insurance.

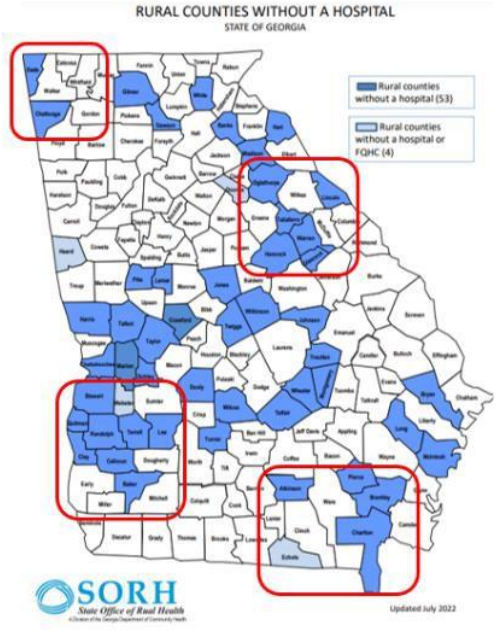
Further, while the prevalence of mental illness in rural and metropolitan areas is generally similar, there are some differences. For example, the suicide rate is nearly twice as great in the most rural areas of the U.S. compared to the most urban areas.

Georgia should encourage the establishment of EmPATH units in rural counties with hospitals, especially those located in proximity to rural counties that do not have hospitals (see graphic),

The presence of nearby EmPATH units helps ensure that emergency transports, including sheriff 's department vehicles, find themselves on far fewer multiple hour roundtrips to transport patients to places with crisis behavioral healthcare, during which time their community is left without an ambulance and sheriff department resources.

RECOMMENDATION

1. Reform the CON law, as necessary, to encourage and enable the development of EmPATH units.
2. Enable payment systems so EmPATH units can be used by all Georgians including those covered by state funds.



Expanding Georgia's Behavioral Health Workforce

There are two primary elements causing Georgians' lack of access to behavioral health professionals: actual and artificial workforce shortages:

1. The **actual shortage** is the difference between overall demand and supply of behavioral health care professionals.
2. The **artificial shortage** is the difference between the overall number of behavioral health care professionals in Georgia and the number of those professionals that are in-network with insurers or Medicaid managed care organizations.

As to the actual shortage, 150 of Georgia's 159 counties are considered mental health professional shortage areas. Some 77 counties have no full-time psychiatrists; 76 have no licensed psychologists; 52 have no licensed social workers; and 60 have no pediatricians.

As to the artificial shortage, a 2017 study by McKinsey & Co found that 21% of health plans included less than one-fourth of available providers, another 20% included fewer than 40% of available providers, and 21% of plans included fewer than one-third of available hospitals. In Georgia, only 53% of Georgia psychiatrists accept Medicaid clients.

Recommendations:

- Provide robust oversight and enforcement of parity obligations to, among other matters, eliminate reimbursement rate disparities between providers of mental health/substance use disorder care and medical/surgical care
- Establish and enforce network adequacy requirements, including requirements that payer networks include a minimum percentage of available providers and verify provider directory accuracy (e.g., eliminate "phantom" providers from directories).
- Remove impediments to the use of telehealth services to enable broader and more efficient use of patient and provider time and make full use of the additional provider capacity provided by interstate compacts.
- Develop Georgia specific loan-forgiveness legislation for behavioral healthcare professionals based on model legislation set out in **Appendix A.**
- Expand training in evidence-based therapies to better diagnose, treat, and manage child and adult mental health challenges.
    - Encourage and facilitate the REACH Institute's mental and behavioral health training opportunities for primary care providers in under resourced areas of Georgia by providing physician and clinician training scholarships, and
    - Work with organizations across the state to host, promote and implement such trainings.

Removing Impediments to Medicaid BH Provider Enrollment

There are many Georgia behavioral healthcare providers that could be Medicaid providers, including providers serving DBHDD; however, the existing provider enrollment processes are cumbersome, time-consuming, and dissuade providers from applying to serve Medicaid clients. A study by the Carl Vinson Institute found approximately 60 steps in the existing provider enrollment process. Private sources of funding may be used to hire one or more professional service firms to partner with relevant state agencies to restructure the enrollment process.

RECOMMENDATIONS:

1. Review the provider enrollment process and consider eliminating steps that are not required by the Centers for Medicare and Medicaid Services' "Medicaid Provider Enrollment Compendium."
2. List the steps in the provider enrollment process, inform applicants of where they stand in the process, and include contact information and/or a chat function to enable providers to ask questions.

3. Adopt continuous rolling enrollment; or consider more open enrollment periods – monthly, bimonthly, quarterly.
4. Review and revise existing deadlines in the process that result in closure of applications and require a provider to begin the process anew.
5. Develop alternatives to requiring a provider to show a 1–3-year contractual relationship with an insurance company or a government agency for the delivery of behavioral health services, including considering a 1–3-year provisional core provider status and allowing philanthropic funding to be considered in lieu of service contracts.

Region	CSB	Occupancy Rate
1	Avita Community Partners	55%
1	Highland Rivers -- 69%	69%
2	Advantage Behavioral Health	55%
2	Serenity Behavioral Health	69%
2	River Edge	63%
3	Fulton County	133%
3	DeKalb CSB	61%
3	View Point Health	53%
4	Aspire Behavioral Health (Albany)	87%
4	Georgia Pines	83%
4	Behavioral Health Services of South Georgia	91%
5	CSB of Middle Geogia	86%
5	Pineland Area CSB	52%
5	Unison Behavioral Health (Satilla CSB)	81%
5	Gateway CSB	79%
6	Pathways	74%
6	McIntosh Trail	57%
6	New Horizons CSB	48%
6	Middle Flint	41%

6. Eliminate duplicative documentation requirements for applicants by (A) establishing a digital portal to hold all documents for each applicant and (B) utilizing information already on file for existing providers seeking to expand their services for DBHDD.
7. Revise existing accreditation requirements (a copy of a three-year minimum accreditation certificate and survey report for Community Behavioral Health Services) to allow provisional approval for agencies who have other programs accredited and are contracted for services by other state agencies.
8. Allow Drug Abuse Treatment and Education Program (DATEP) licensure to commence after receiving a Medicaid number.
9. Enable Medicaid reimbursement of Family First Prevention Services Act focused on mental health services including Functional Family Therapy (FFT) and Multi-systemic Therapy (MST).

Note: In the absence of any increase in Medicaid reimbursement rates, these procedural "fixes" will have a minimal impact on increasing the number of Medicaid providers in Georgia. If reimbursement rates remain unchanged, Geogia risks losing providers currently serving Georgia Medicaid enrollees. Georgia-based providers can elect not to serve Georgia Medicaid enrollees. Further, Georgia is party to several interstate compacts that allow Georgia providers to offer their services via telehealth to persons in other compact states with higher reimbursement rates.

Optimizing Use of Existing Psychiatric Beds

The 159 counties in Georgia are served by community service boards (CSBs), most of which serve multiple counties. Each of the CSBs has psychiatric beds for use by Georgia's safety net population.

Using data from the DBHDD bed study, the table shows occupancy rates for psychiatric beds for each CSB by region. According to Alvarez & Marsal, the authors of the bed study, the optimal occupancy rate for psychiatric beds is 85%.

The occupancy rates for some CSBs are in excess of the optimal rate. For a significant number of CSBs, the occupancy rates are below the optimal rate, including some with occupancy rates below 65%.

The bed study states that the projected need "assumes that Georgia can meet optimal occupancy (85%) for all of its existing facilities; if this is not achieved, the number of needed additional beds and facilities will be greater."

RECOMMENDATION:

1. Develop and implement processes to optimize intra- and inter-region access to existing CSB psychiatric beds.

Addressing the Shortage of Psychiatric Beds

DBHDD Bed Study (Continued)

In August 2023, the Department of Behavioral Health and Developmental Disabilities (DBHDD) published a study addressing the number of behavioral health crisis and forensic beds available to the agency in Georgia. The study focuses on crisis stabilization and inpatient facilities funded by DBHDD that serve two discrete populations:

1. Uninsured adults and children and adolescents (C&A) receiving behavioral health crisis services; and
2. Adults involved in the criminal justice system receiving forensic behavioral health services.

DBHDD supports a broad statewide system in which behavioral health crisis and forensic beds are one component of various inter-related services.

Study Recommendations

- Georgia has an acute near-term need for additional community-based behavioral health crisis beds for adults. The model developed by a DBHDD contractor assisting in the bed study projects that Georgia will need five new facilities (i.e., behavioral health crisis centers) by 2025 to meet near-term demand. Georgia will need an additional facility by 2027 and two more by 2032, for a total of eight new facilities over a ten-year period.
    - The projected near-term need may be mitigated by diversion measures that allow individuals in crisis to be stabilized without admission to a facility, such as via GCAL, Mobile Crisis, EmPATH units, and Hope Institute outpatient suicide intervention.
    - This projection assumes that Georgia will staff its existing facilities in such a way that they attain optimal occupancy rates (i.e., make the most efficient use of their existing bed capacity). Georgia will need to maximize its current bed capacity by addressing workforce challenges to meet the demand projected in the model.
- Georgia also has an acute near- and long-term need for additional forensic state hospital beds, with a gap of 199 beds projected by 2025. This projected need is supported by the state's growing forensic waitlist. While this need can be met by

building new facilities, it may also be mitigated by increasing resources to reevaluate individuals on the forensic admissions waitlist, expanding jail-based competency restoration programs, and / or increasing utilization of forensic step-down facilities, such as Community Integration Homes and Forensic Apartments.

Enable Federal Funding to Access Existing Psychiatric Beds

The Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds.

The IMD payment exclusion was intended to leave states with the primary responsibility for financing inpatient behavioral health services. However, the lack of federal funding limits access to needed inpatient services and contributes to high levels of unmet need.

The exclusion is one of the very few examples of Medicaid law prohibiting the use of federal financial participation (FFP) for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services.

The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21 and has long been a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health services.

Section 1115 Waivers and SB 610

The Centers for Medicare and Medicaid Services (CMS) encourages states to submit requests seeking to waive the IMD exclusion for inpatient care for adult mental health and substance use disorder treatment and serious emotional disorder for children.

More than 30 states have received IMD-16 exclusion waivers Once a waiver is received, a state may use Medicaid funds, including the FFP (approximately 66% in Georgia), to pay for inpatient services at hospital or residential facilities, even if the facilities have more than 16 beds.

SB 610, enacted in 2022, contains the following provision:

> No later than December 31, 2022, [DCH] shall submit a waiver request to the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services to authorize private institutions for mental disease (IMDs) to qualify for Medicaid reimbursement for mental health and substance use disorder treatment.

Recommendation

- To date, DCH has not submitted the required waiver request. This may be in part to the cost, and it is the recommendation of this subcommittee that funds are identified to help with this.

EmPATH Units Reduce Trauma and Demand for Psychiatric Beds

EmPATH units are physical environments designed for acute psychiatric patients to receive assessment and evaluation in a therapeutic and least restrictive setting. Complementing the emergency department, the units provide a calm and comforting environment for patients,

allowing movement and, more importantly, human interaction that is vital in the first 24 hours of treatment, something often not available in the emergency department.

EmPATH units streamline emergency department assessment of the health needs of mental health consumers and quickly transitions them out of emergency departments into a calming space that allows for the rapid assessment, support of behavioral health needs, and linkage to other services.

While emergency departments provide vital and necessary care, their bustling environments do not feel calming to a person experiencing a mental health crisis. EmPATH units are an innovative approach to emergency mental health care, designed to guide people safely through a current crisis while building skills that will support them through future challenges.

EmPATH Units and Reducing Demand for Psychiatric Beds

EmPATH units significantly reduce demand for psychiatric beds. As one study found:

- ED length of stay dropped from an average of 16 hours to 5 hours when patients were transferred to an EmPATH unit.
- Inpatient psychiatric admissions dropped from 57% of patients in the psych ED to 27% of patients in the EmPATH unit, significantly reducing demand for inpatient beds and overall costs.
- The 30-day rate of psych patients returning to the ED dropped by 25%, and outpatient follow-up of patients improved by 60%, from 39% to 63%.

EmPATH Unit Advantages

- Prevent unnecessary admissions — frees up inpatient beds for those most in need and, in turn, reduces payer denials.
- Offers more compassionate care — though these units serve high-risk populations, less than 1% of patients require restraint, sedation, or other coercive treatments.
- Improved emergency department throughput — reduces boarding for participating hospitals, freeing up beds to improve throughput and reduce the number of left-without-being-seen patients.
- Increases Patient and provider satisfaction — caring for patients in a supportive setting apart from the emergency department speeds recovery and reduces the likelihood of aggressive behavior toward staff.

EmPATH Unit Elements

- Rapid evaluation and comprehensive treatment planning by a psychiatrist or psychiatric prescribing provider
    - *Early assessments improve outcomes. The combination of a prompt assessment and treatment with a supportive, healing environment can lead to impressive results, especially in safety and symptom relief. EmPATH units report the use of physical restraints and/or forced medications in less than 1% of patients, even when the majority of patients are on involuntary psychiatric holds.*
- Constant observation and re-evaluation

- Ligature safe—bathrooms, door handles, etc.
- Large, open milieu with fold-flat recliner chairs with a minimum of 80 sq. ft. total per client, including 40 sq. ft. around each chair.
    - *Rather than individual beds or rooms, in this short-term outpatient program each patient is provided their own recliner or 'sleeper' chair, which can be positioned upwards for joining in socialization or group therapy, or folded flat if one wishes to take a nap. Recliners are arranged to maximize personal space, and there is also ample room on the unit for those patients who wish to walk about, pace or meditate; some units even feature a safe outdoor retreat. Stations with snacks, beverages, and linens are accessible to patients without needing to involve the staff. There are opportunities to read books or periodicals, watch TV, play board games, or chat privately with a therapist or peer support counselor.*
- Open nursing station with intermingling of staff and clients to facilitate socialization, discussion, interaction, and therapy.
    - *All staff are intermingled with the patients on the milieu — there is no glass-enclosed 'fishbowl' nursing station. Nurses, social workers, therapists, and peer support counselors are always available and close by. Because of this of this set-up, any patient having difficulties or escalating symptoms can be quickly assisted in a supportive and non-coercive way. Unlocked enclosed areas are available should an individual need temporary privacy to decompress.*
- Voluntary calming rooms with elimination of locked seclusion rooms or restraints

Some might question why patients would be all together in the milieu rather than the more traditional emergency psychiatry strategy of individual rooms. For a person in crisis, human interaction can be very beneficial.

EmPATH Units by the Numbers

Treatment Times

- Treatment at an EmPATH unit is initiated within one hour of arrival.
- The great majority of psychiatric emergencies, like other medical emergencies, can be resolved in less than 24 hours with prompt, appropriate intervention.
- Patients typically get better within 14–18 hours. The goal of an EmPATH unit is to keep stays shorter than 24 hours.

Length of Stays; Inpatient Admissions; and Return Rates

- ED length of stay dropped from an average of 16 hours to 5 hours when patients were transferred to an EmPATH unit.
- Inpatient psychiatric admissions dropped from 57% of patients in the psych ED to 27% of patients in the EmPATH unit, significantly reducing demand for inpatient beds and overall costs.
- The 30-day rate of psych patients returning to the ED dropped by 25%, and outpatient follow-up of patients improved by 60%.

Seclusion and Restraint Usage

- Use of seclusion and restraint in EmPATH units is low, even though most patients are on psychiatric holds. The rate is less than 1%, which is significantly less than the approximate 14% rate in traditional psychiatric EDs.

Outpatient Suicide Interventions (Hope Institute Model)

In late October 2023, Children's Healthcare of Atlanta (CHOA) launched an innovative suicide intervention based on the Hope Institute model described below. At launch, the CHOA suicide intervention can treat approximately 1,000 patients a year.

The Hope Institute suicide intervention model provides short-term crisis intervention and stabilization for individuals experiencing suicidal ideation. The Hope Institute model, the Collaborative Assessment and Management of Suicidality (CAMS) promotes the acquisition of skills that comprise key objectives of dialectical behavioral therapy—a leading intervention for the resolution and prevention of suicidal behavior--while safely supporting clients through the process of crisis recovery.

Clients can visit a Hope Institute location or opt to be treated via telehealth, sometimes multiple times per week based on need, and the average length of treatment is 6-8 weeks.

The Hope Institute model provides more effective, less traumatic, and less costly treatment for suicidal persons who would otherwise be treated in emergency departments and subsequently hospitalized.

The Hope Institute model significantly reduces both psychiatric boarding at the ED and demand for psychiatric beds. Approximately 1 in 8 persons who present to the ED are experiencing a behavioral health crisis; among these half are suicidal, and among those presenting for suicidality up to 80% are appropriate for diversion or transfer to an outpatient Hope Institute intervention. This frees up ED beds that would otherwise be occupied by patients experiencing suicidal crises, accelerates the process of recovery, and directly addresses the root causes of suicidal behavior in ways that may dramatically reduce the risk of future recurrence.

Enabling Greater Participation at CSB Board Meetings

The 22 community service boards (CSBs) service the 159 counties in Georgia, with many CSBs serving multiple counties. The current legislative requirement of holding in-person board meetings within the Open Meetings Act impairs the ability to have the necessary quorum at monthly board meetings. For example, one CSB has a 15-member board covering a 12 county area. One-third of the board members are elected officials. In-person attendance at board meetings, as required by existing legislation, poses challenges – e.g., some board members must drive 1.5 to 2 hours for a board meeting. In addition, the public rarely attends and comments at the board meetings to the travel required to appear in person.

As many of the CSB board members are comprised of elected officials, law enforcement, etc., attendance at board meetings takes them away from their communities. Consequently, board members have resigned due to their inability to be out of their community for a whole day.

Set out in **Appendix B** is a proposed amendment to the Georgia Open Meetings Act that would allow CSB board meeting – including public comment – to be held via conference call or video call.

Appendix A

Model Legislation

NEW SECTION: (Insert reference to OCGA law(s) being amended)

(a) The department shall distribute funds to eligible institutions, as described in subsection (c), that sponsor clinical behavioral health training programs, as described in subsection (b), for the purpose of increasing the number of training positions within such clinical behavioral health training programs at each eligible institution that receives funding from the department.

(b) Clinical behavioral health training programs shall consist of the following types of training for the following types of trainees:

(1) Residency training for physicians specializing in psychiatry or any subspecialty of psychiatry;

(2) Residency training for physicians specializing in addiction medicine;

(3) Clinical training for psychologists;

(4) Clinical training for social workers;

(5) Clinical training for professional counselors;

(6) Clinical training for marriage and family therapists;

(7) Clinical training for addiction counselors;

(8) Clinical training for psychiatric advance practice nurses; and

(9) Any other type of clinical training of behavioral health clinicians deemed relevant and applicable by the department.

(c) Eligible institutions shall include hospitals, schools, or consortiums located in the state that sponsor and maintain primary organizational and financial responsibility for clinical behavioral health training programs in the state and which are accountable to an accrediting organization recognized by the United States Department of Education, the Federal Centers for Medicare and Medicaid Services, or another national body that reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the department.

(d) The department shall establish criteria for approving and distributing funds under subsection (a) and evaluate the following factors when establishing such criteria and reviewing and prioritizing applications for such funds:

(1) The current supply of each provider type identified in subsection (b) throughout the state, to the extent it is practicable for the department to determine such supply;

(2) The current demand for services furnished by each provider type identified in subsection (b) throughout the state, to the extent it is practicable for the department to

determine such demand;

(3) The anticipated future supply of each provider type identified in subsection (b), to the extent it is practicable for the department to determine such future supply;

(4) The current aggregate number of training positions for each provider type identified in subsection (b) at eligible institutions that sponsor clinical behavioral health training programs;

(5) The percentage of trainees who successfully complete the type or types of behavioral health clinical training programs for which the eligible institution is seeking funding under subsection (a); and

(6) Other factors the department deems relevant and practicable.

(e) The funds distributed under subsection (a) for clinical behavioral health training programs shall consist of appropriations by the Legislature and federal medical assistance matching funds, if applicable.

(f) The department shall:

(1) Seek new federal medical assistance matching funding to contribute to the funds distributed under subsection (a); or

(2) Seek increased federal medical assistance funding within any existing arrangement under which federal medical assistance matching funding contributes to state funding of clinical behavioral health training programs.

(g) Applications to receive funding under subsection (a) must be submitted to the department by an eligible entity and must be received on a timeline determined by the department and such applications shall be in the form and manner determined by the department.

(h) Funds distributed under subsection (a) shall not be used to displace current funding from federal or state sources.

NEW SECTION: (Insert reference to OCGA law(s) being amended)

(a) The department shall establish and administer the Behavioral Health Provider Student Loan Repayment Program that shall provide for the repayment of a portion of the eligible qualifying loan expenses of program participants for each period of service that meet the requirements of this section.

(b) Behavioral health providers eligible for loan repayment under subsection (a) shall consist of:

(1) Physicians who specialize in psychiatry or any subspecialty of psychiatry;

(2) Physicians who specialize in addiction medicine;

(3) Psychologists;

(4) Social workers;

(5) Professional counselors;

(6) Marriage and family therapists;

(7) Addiction counselors;

(8) Psychiatric advance practice nurses; and

(9) Any other behavioral health provider deemed relevant and applicable by the department.

(c) To qualify for the loan repayment described in subsection (a), eligible behavioral health providers described in subsection (b) shall:

(1) Be residents of this state;

(2) Agree to meet the requirements described in subsection (e);

(3) Agree to have their student loan debt verified by the department for the purposes of determining the prioritization of applicants described in subsection (g);

(4) Agree to have their billing records inspected by the department for the purposes of determining if they are meeting the requirements described in subsection (e) and for the purposes of satisfying the requirements of subsection (h); and

(5) Have no history of disciplinary actions or sanctions by the relevant licensing or certifying provider board;

(d) Program participants shall enter into a written contract with the department that specifies the total amount of eligible student loan expenses that may be redeemed by the department if the requirements described in subsection (e) are met.

(e) Behavioral health providers described in subsection (b) will receive loan repayment under subsection (a) for any qualifying year, not to exceed six years in total loan repayment, in the following amounts, under the following terms:

(1) $10,000 for a year in which the provider can demonstrate to the department through billing records that at least 25 percent of the provider's patients or clients were Medicaid recipients and for which payment was furnished by the state's medical assistance program and not by other means;

(2) $10,000 for a year in which the department can verify that the provider was a full-time contract employee providing behavioral health services at a facility or practice for which the department can verify that at least 25 percent of the facility or practice's patients or clients were Medicaid recipients and for which payment was furnished by the state's medical assistance program and not by other means;

(3) $25,000 for a year in which the provider can demonstrate to the department through billing records that at least 50 percent of the provider's patients or clients were Medicaid recipients and for which payment was furnished by the state's medical assistance

program and not by other means;

(4) $25,000 for a year in which the department can verify that the provider was a full-time contract employee providing behavioral health services at a facility or practice for which the department can verify that at least 50 percent of the facility or practice's patients or clients were Medicaid recipients and for which payment was furnished by the state's medical assistance program and not by other means;

(5) After the first year in which the provider meets the requirements of paragraph (1), (2), (3), or (4), or any combination of such paragraphs for a third consecutive year, the provider shall receive $20,000 towards loan repayment in addition to whichever amount the provider is entitled to for meeting the requirements of paragraph (1), (2), (3), or (4) for that year, provided that a provider may only qualify for repayment under this paragraph one time; and

(6) If a provider meets the requirements of paragraph (1), (2), (3), or (4), or any combination of such paragraphs for a sixth consecutive year, the provider shall receive $50,000 towards loan repayment in addition to whichever amount the provider is entitled to for meeting the requirements of paragraph (1), (2), (3), or (4) for that year.

(f) A behavioral health provider described in subsection (b) shall receive not more than $220,000 in total loan repayment under subsection (a) and shall not receive more payment than the total amount of student loan debt owed by the provider as of the date the application is submitted.

(g) The department shall evaluate the following factors for the purposes of prioritizing and approving applications from the eligible behavioral health providers described in subsection (b) for loan repayment under subsection (a):

(1) The total amount of student loan debt currently owed by a provider submitting an application;

(2) The current supply of each provider type identified in subsection (b) throughout the state, to the extent it is practicable for the department to determine such supply;

(3) The current demand for services furnished by each provider type identified in subsection (b) throughout the state, to the extent it is practicable for the department to determine such demand;

(4) The current participation rate in the medical assistance program of each provider type identified in subsection (b), to the extent it is practicable for the department to determine such participation rate;

(5) Whether the provider attended in-state institutions of higher education; and

(6) Other factors the department determines are relevant, applicable, and practicable.

(h) The department shall ensure, through examining billing records, that at least fifty percent of all applications approved are for providers who would not have met the Medicaid patient or client thresholds described in any of paragraphs (1), (2), (3), or (4) of subsection

(e) during the previous three calendar years.

(i) To qualify for repayment under subsection (a) a loan may be a government or commercial loan for the actual costs paid for tuition and reasonable education and living expenses relating to the obtaining of a degree for use as a behavioral health provider identified in subsection (b).

(j) A behavioral health provider described in subsection (b) that is currently participating in any other state or federal loan repayment program is not eligible for loan repayment under subsection (a), provided that for the purposes of this section the federal Public Service Loan Forgiveness Program established under subsection (m) of Section 455 of the Higher Education Act of 1965 (20 U.S.C. 1087e(m)) shall not be construed as a federal loan repayment program.

Appendix B

Model Legislation Language

Amendment to O.C.G.A. Sec. 50-14-1 to allow for telephonic CSB board meetings. Subsection (f) provides that "an agency with state-wide jurisdiction or committee of such agency shall be authorized to conduct meetings by teleconference, provided that any such meeting is conducted in compliance with this chapter."

Note: If the "state-wide jurisdiction" limitation in this subsection was broadened, we believe that would satisfy the parties involved.

Georgia Behavioral Health Reform and Innovation Commission

Appendix D: Mental Health Courts and Corrections

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on

Mental Health Courts and Corrections

2023 Annual Report

<u>Chair</u>
Chief Justice Michael Boggs

<u>Members</u>
Sheriff Andy Hester
Judge Brenda Weaver
Judge Kathleen Gosselin
Stan Cooper
Commissioner Michael Nail

December 2023

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former-Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas including the Subcommittee on Mental Health Courts and Corrections chaired by Justice Michael Boggs (2020-2023).

During 2023, the Subcommittee on Mental Health Courts and Corrections held one public meeting on legislative and administrative updates regarding 2022 recommendations and Familiar Faces.

To further the work of the subcommittee Commissioner Tanner formed the Advisory Committee on Forensic Competency to work under the purview of Mental Health Courts and Corrections subcommittee. This report includes the work and recommendations of the advisory committee supported by the Mental Health Courts and Corrections subcommittee.

List of Presenters to the BHRIC Subcommittee on Mental Health Courts and Corrections 2023

BHRIC Subcommittee on Mental Health Courts and Corrections **Sheriff Andy Hester, Judge Brenda Weaver, Judge Kathleen Gosselin, Stan Cooper, Commissioner Michael Nail**		
Support to the BHRIC Subcommittee on Mental Health Courts and Corrections		
Presenters to the BHRIC Subcommittee on Mental Health Courts and Corrections 2023		
Date	**Topic**	**Presenter**
Date	Topic	**Presenter** Presenter's Title
August 11, 2023	Recap – HB 520/ Familiar Faces Recommendations	**Chief Justice Michael Boggs**
	Administrative Action and Updates	**Commissioner Kevin Tanner** Department of Behavioral Health and Developmental Disabilities
	Discussion and Strategy/Select Recommendations	**Chief Justice Michael Boggs**

Mental Health Courts and Corrections Advisory Committee on Forensic Competency

2023 Annual Report

Chair

Judge Kathlene Gosselin

Members

Judge Phillip Jackson

Judge Michael Key

Judge Penny Haas Freeseman

Judge Victoria Darrisaw

Judge Patsy Porter

Judge Eric Brewton

Judge Sarah Harris

Judge Kenya Johnson

Chris Van Rossem

ADA Nikia Smith Sellers

Dr. Emile Risby

Dr. Julie Oliver

Dr. Kiana Wright

DA Herb Cranford

Brandon Bullard

December 2023

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The commission created five subcommittees in order to review these focus areas including the Subcommittee on Mental Health Courts which formed the Forensic Competency Advisory committee chaired by Judge Kathlene Gosselin (2023).

List of Presenters to the Mental Health Courts and

Corrections Advisory Committee on

Forensic Competency 2023

Forensic Competency Advisory Committee.

Judge Phillip Jackson Judge Michael Key, Judge Penny Haas Freeseman, Judge Victoria Darrisaw, Judge Patsy Porter, Judge Eric Brewton, Judge Sarah Harris Judge Kenya Johnson, Chris Van Rossem, ADA Nikia Smith Sellers, Dr. Emile Risby Dr. Julie Oliver, Dr. Kiana Wright, DA Herb Cranford, Brandon Bullard

Support to the Forensic Competency Advisory Committee

Presenters to the Forensic Competency Advisory Committee 2023

Date	Topic	Presenter
Date	Topic	**Presenter** Presenter's Title
May 22, 2023	Workforce Challenges & Study and Bed Study	**Commissioner Kevin Tanner** *Department of Behavioral Health and Developmental Disabilities*
	Current State of Forensic Services	**Dr. Emile Risby,** Chief Medical Officer and Director of Hospital Services *Department of Behavioral Health and Developmental Disabilities*
	Prison Forensic Peer Program	**Carol Caraballo** Director of Adult Mental Health *Department of Behavioral Health and Developmental Disabilities*
	Jail In-Reach Pilots	**Carol Caraballo** Director of Adult Mental Health *Department of Behavioral Health and Developmental Disabilities*
	Georgia Work and National View	**Dr. Debra Pinals** Professor, *University of Michigan*
August 30, 2023	Evaluation Process Updates	**Dr. Emile Risby,** Chief Medical Officer and Director of Hospital Services *Department of Behavioral Health and Developmental Disabilities*

	Early Judicial Intervention	**Marilyn Leake** Senior Policy Analyst *The Counsel of State Governments*
October 4, 2023	Outpatient Evaluation and Restoration	**Marilyn Leake** Senior Policy Analyst *The Counsel of State Governments*
	Tennessee Forensic Evaluation Practices	**Dr. Jeff Feix** Executive Director, Office of Forensic and Juvenile Court Services

		Tennessee Department of Mental Health and Substance Abuse Services
	Texas Initiative: Eliminate the Wait	**Dr. Julie Oliver,** State Forensic Director *Department of Behavioral Health and Developmental Disabilities*
November 15, 2023	In-Person Tour of Georgia Regional Hospital – Atlanta	N/A

Recommendation Priorities

The Forensic Competency Advisory Committee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action.

1. **Jail Based Restoration, Outpatient and Inpatient Restoration**
    a. The general consensus among the committee was that jail-based restoration needs to be included in the statute so that it is clear there are three options: outpatient, jail based, and inpatient.
    b. The outpatient section of the statute should be reviewed/modified to allow DBHDD to recommend this as an initial option where applicable. Judges, as they have the final say so for bond, will still have to make the final determination. Jail-based restoration needs to fall under "in-patient" so as to allow DBHDD to move defendants to the appropriate facility.
    c. The committee and DBHDD will explore policies concerning involuntarily administering medication in jails and detention centers, and contact the Sheriff's Association on this point.

2. **Develop a study committee to conduct an environmental scan to identify evidence-based and evidence–informed practices other states utilizing for the following:**
    a. defining and implementing jail-based, outpatient restoration programs,
    b. diverting individuals with low-level criminal offenses (e.g., misdemeanors) from state hospitals,
    c. addressing gaps in legislation to explore options for people with IDD or dementia.

3. **Education Needed for Judges, Attorneys and Community Stakeholders (including CSBs)**
    a. Eliminate the Wait document is being adapted to Georgia to be used as a reference tool and possible bench card for various classes of judges.
    b. DBHDD has prepared a brochure for judges to hand to defendants.
    c. DBHDD has prepared a document for judges to include in their files concerning questions / considerations of competency.
    d. Any other materials that could be used to spread awareness and understanding of the overarching goal of competency restoration and competency courts/dockets will be explored.

4. **Evaluation of Restoration**
    a. The committee recommends more community resources, but at this time recognizes the funds and the staff / personnel are not available to meet the needs. In particular, this

conversation focused mainly on misdemeanors and the need to have more diversion and community resources to divert individuals charged with misdemeanor offenses out of the criminal justice system before they become a part of the competency evaluation and restoration path at DBHDD. Some of the committee members will be exploring options and/or pilot projects to connect defendants to local resources that could allow them to be treated and released from jails.

b. DBHDD doctors informed the committee on a hospital site visit that primary concerns are staff shortages and diverting low level offenders out of the evaluation/restoration path that there is not a large population of individuals that are being missed that could otherwise be treated as outpatients, so no policy changes are needed at this time.

5. Consideration of Differentiating the Difference between Misdemeanors and Felonies

a. There was discussion about policies needed for streamlining misdemeanors to divert them from the forensic process. The statute could address early intervention for misdemeanor/low level charges as discussed in # 3 a& b above.

6. Two Other Communities of Individuals to be Considered:

a. We intend to continue to explore options for defendants that are developmentally disabled or have dementia. These individuals are currently not included in the code for involuntary commitment.

Georgia Behavioral Health Reform and Innovation Commission

Appendix E: Subcommittee on Workforce and System Development

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on Workforce and System Development

2023 Annual Report

Chair

Representative Mary Margaret Oliver

Members

Cindy Levi

Dr. Nicoleta Serban

Wayne Senfeld

Sallie Coke

December 2023

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The commission created six subcommittees in order to review these focus areas including the Subcommittee on Workforce and System Development chaired by Representative Mary Margaret Oliver (2020-2023).

During 2023, the Subcommittee on Workforce and System Development held one public meeting on the topics of workforce innovation and data sharing.

This report includes a summary of the subcommittees' public meeting and its recommendations.

List of Presenters to the BHRIC Subcommittee on Workforce and System Development 2023

BHRIC Subcommittee on Workforce and System Development **Cindy Levi, Dr. Nicoleta Serban, Polly McKinney, Wayne Senfeld, Sallie Coke, Renee Johnson**
Support to the BHRIC Subcommittee on Workforce and System Development

Presenters to the BHRIC Subcommittee on Workforce and System Development 2023

Date	Topic	Presenter
Date	Topic	**Presenter** Presenter's Title
October 24, 2023	Deloitte Workforce Study	**Will Arnold** Deloitte Consulting
	Executive order on Data Sharing	**Elizabeth Holcomb** Director, *Office of Health Strategy and Coordination* **Kanti Chalasani** Division Director, Georgia Data Analytics Center – *Governor's Office of Planning and Budget*

Summary of Presentations to Subcommittee

October 24, 2023

Department of Behavioral Health and Developmental Disabilities Workforce Innovations Report: Preliminary Findings

Will Arnold, Managing Director – GPS, Deloitte

The Subcommittee heard from Will Arnold, Managing Director with Deloitte Consulting. Mr. Arnold presented the findings of the Workforce Innovation report Deloitte prepared for Commissioner Tanner and the Department of Behavioral Health and Developmental Disabilities (DBHDD). The guiding objective of the report is to identify strategies needed to strengthen the workforce recruitment, retention and experience of DBHDD professionals. Deloitte used DBHDD workforce goals of workforce diversification, enhanced employee experience, high return on investment, and positioning DBHDD as a career destination to inform the recommendations.

There was a four-stage approach to compose the report, a current state assessment and compensation study. Followed by data gathering and an environmental scan which included scanning more than one hundred public, private, health, and educational entities for workforce best practices. They then facilitated a breakthrough lab with various public and private sector leaders to collaborate on innovative workforce solutions. Lastly, data and information collected through these processes was prioritized into recommendations and action items.

The report found that DBHDD is in immediate need of workforce innovation. Recruitment, retention, care delivery, and below market compensation were identified as key workforce sustainability challenges. It was found that on average DBHDD salaries are 19% below national market median data. Additionally, the agency is experiencing a 57% turnover rate amongst millennial employees and 29% of their employees are eligible for early retirement within 5 years. This coupled with long recruitment times, limited professional development opportunities, and administrative burdens for delivering care puts DBHDD at risk of being unable to maintain its current workforce.

Deloitte identified a path forward via implementation of 19 recommendations which have been prioritized into short-term (within the year), medium-term(1-2 years), and long-term (2+ years) categories based on urgency of need, time and resources impact on workforce.

Of the 19 recommendations 11 of them were categorized as short-term goals to consider implementing within the year. Two of which are out-of-state license reciprocity and salary market adjustments. A full list of the report's recommendations can be found in the appendix of this report.

Data Sharing

Elizabeth Holcomb, Director, Office of Health Strategy and Coordination (OHSC), Governor Office of Planning and Budget

Kanti Chalasani, Division Director, Georgia Data Analytics Center (GDAC), Governor's Office of Planning and Budget

On September 9, 2023 Governor Kemp issued an Executive Order (EO), ordering the Georgia Data Analytic Center (GDAC) to facilitate data-sharing between executive state agencies. The Subcommittee heard an update on the status of the EO rollout from Elizabeth Holcomb, Director of the Office of Health Strategy and Coordination (OHSC) and Dr. Kanti Chasalasani, Director of GDAC. Dr. Kanti shared with the Subcommittee that GDAC is in the process of creating a data request template for state agencies in an effort to streamline the request process. GDAC is also creating a uniform data-sharing agreement that at the time of the hearing was under review with a tentative publish date of January 2024.

The Subcommittee Chair and members thank Governor Kemp for issuing the EO and Dr. Kanti and Director Holcomb for their efforts in managing the rollout. As the data-sharing process continues to be evaluated and established the Subcommittee Chair suggests that guidelines be put in place for timelines and deadlines when a question of conflict arises. Currently, if a data-sharing conflict arises it is sent to the Governor's office for review with no determined deadline for a final decision. The Subcommittee also noted that there may be a need to further review the language of the agencies able to participate so that it may include the Board of Regents and allow universities access to data-sharing.

Recommendation Priorities

The Workforce and System Development Subcommittee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action.

1. Implement Recommendations from the Behavioral Health Workforce Rate Study

The Behavioral Health Workforce is facing several sustainability challenges, one of which is below-market compensation rates. The Deloitte Compensation Analysis found that on average the Department of Behavioral Health and Developmental Disabilities (DBHDD) salaries are 19% below the national market data. When looking at specific job codes it was reported that on average DBHDD minimums for Psychiatrists, Forensic Psychiatrists, and Physicians salaries are 24% below market median. Currently, there are upwards of 75 counties in the state that do not have a full-time psychiatrist, 52 counties without a licensed social worker, and 60 without pediatricians. With 29% of employees becoming eligible for early retirement within the next 5 years and 57% turnover rate amongst the millennial generation, DHBDD will not be able to sustain and grow its current workforce if it is unable to offer competitive salary rates.

The Workforce and Systems Development Subcommittee recommends the State allocate funds in the budget to implement salary market adjustments.

2. Increasing Medicaid Reimbursement Rates as findings in the DCH Reimbursement Rate Study Indicate

In 2021 the Governor's office released a Mental Health Reform Action plan which noted that Georgia has some of the lowest reimbursement rates in the country[1]. To address this barrier the Department of Community Health (DCH) completed a reimbursement rate study in 2022, to compare Georgia's reimbursement rates to other states. As a result of this study, the DCH has identified and put forward to be approved updated reimbursement rates for the Comprehensive Supports (COMP), Elderly and Disabled, and Independent Care (ICWP) waiver programs.

The Workforce and Systems Development Subcommittee recommends an increase of Medicaid reimbursement rates as the DCH reimbursement rate study indicates.

3. Out-of-State License Reciprocity

The issue of licensure was presented to the Subcommittee during 2022 committee testimony and has continued to be a barrier to addressing the Behavioral Health workforce shortage. This barrier was further identified in the 2023 Deloitte Workforce Innovations

[1] Accenture. (2021, December 2). *Mental Health Reform Action Plan.* Prepared by Accenture for the Georgia Governor's Office of Health Strategy and Coordination.

Report for the Department of Behavioral Health and Developmental Disabilities (DBHDD). Within that report out-of-state reciprocity was noted as a top recommendation that could be done within the year and have an immediate impact on expanding the workforce. Similarly, the 2023 Senate Study Committee on Expanding Georgia's Workforce recommendations included enhancing and expanding licensing reciprocity in high-demand fields as a top legislative recommendation. The National Alliance on Mental Illness (NAMI) reported that states with restrictive scope of practice limitations on average have a 30% rate of unmet mental healthcare needs among adults. There are currently 39 states that have enacted some form of licensure reciprocity for mental health clinicians (PSYPACT). License reciprocity removes unnecessary barriers and encourages healthcare providers from other states to practice in Georgia.

The Workforce and Systems Development Subcommittee recommends environmental scan be done to assess Georgias alignment with the 39 states that have enacted license reciprocity. The Subcommittee further recommends the State enact legislation to allow for out of state reciprocity.

4. Enhancing Opportunities for Foreign Trained Behavioral Health Professionals

The state of Georgia is continuing to increase in ethnic and racial diversity, which also increases the need for culturally competent and equitable health services/providers. Furthermore, Georgia's population has shown an exponential increase in foreign-born people who now reside in the state, contributing to 10% of Georgia's population. In addition to facing a behavioral health workforce shortage, fewer minority and foreign-born behavioral health providers are accessible and readily available to serve these communities. There is a need for Foreign Trained Behavioral Health Professionals, however, there are barriers that may impede this process. Other states have reduced these barriers through temporary licensure, the creation of task force, and pathways for Foreign Trained Behavioral Health Professionals for making licensure easier to navigate, obtain, and use. Other activities that may support this work include establishing culturally competent divisions within state agencies such as DBHDD, creating incentive programs, implementing National CLAS Standards, improving coordination between agencies and programs, and culturally responsive crisis services.

The Workforce and Systems Development Subcommittee Recommends changes to Georgia's licensing practices to reflect cultural competencies, and create a pathway for foreign trained behavioral health professionals to establish a license in Georgia.

The Georgia Secretary of State (SOS) must recognize that there is a national movement to ease the transfer of mental health licenses from other states and foreign countries by taking legislative steps to make licensures more consistent nationally. The issue of licensure is one of bipartisan support that the entire General Assembly recognizes needs to happen to

address workforce shortages in high-demand fields. During the 2023 Legislative Session, Rep. Katie Dempsey introduced HB 839 the Social Work Licensure Compact Act to ease the transfer of license for clinical social workers. While HB 520, an omnibus mental health bill introduced during the 2023 legislative session by Representatives Todd Jones and Mary Marget Oliver, sought to modernize and streamline the state's licensure processes. Each year the General Assembly continues to recognize the importance of easing licensure and removing unnecessary obstacles.

5. Create Career Pathways

The Subcommittee recognizes the importance of investing and developing the current and incoming talent to establish the Behavioral Health workforce as a career destination. As reported in the 2023 Deloitte Workforce Innovations Report the Department of Beha vioral Health and Developmental Disabilities (DBHDD) is facing workforce sustainability challenges with recruitment and retention. The landscape assessment identified increased market competition, limited professional development opportunities and rural recruitment as factors for this. Additionally, 20% of the national healthcare workforce has left the field since the start of the COVID-19 pandemic, and an additional 20% reported leaving due to workload and burnout[2]. Georgia is not unique in its healthcare workforce shortage. The National Governors Association for Best Practices (NGA Center) created a learning collaborative of 23 states that shared and collaborated on policy recommendations and best practices for recruitment and retention. Among the recommendations and best practices statewide cross-agency coordination, funding healthcare workforce initiatives, career pathways, strengthening the rural and behavioral workforce were key focuses. States within the collaborative such as West Virginia, invested in scholarship and loan repayment with in-state service obligations. These state investments also included a designated Rural Track Program in any specialty accredited by the Accreditation Council for Graduate Medical Education, the first of its kind. Oklahoma invested Medicaid dollars into their Certified Community Behavioral Health Clinics (CCBHC) creating 600 new jobs. In conjunction with this investment, they have created several career ladders for easy-to-use career mapping to retain the workforce.

The Workforce and Systems Development Subcommittee recommends that DBHDD create clear and enticing career paths for current and future employees. The agency should look to adopt models such as the Health Workforce Initiative, Mental & Behavioral Health Career Pathways as an easy-to-use career mapping tool[3]. The subcommittee further recommends the agency create pathways to invest in professional development through continuing education that will allow individuals to grow within the agency. To create a pipeline for the future workforce the subcommittee recommends cross-agency collaboration to fund,

[2] "Association between social media use and depression among U.S. young adults during the COVID-19 pandemic," *EClinicalMedicine* 2021,

[3] "Mental and Behavioral Health Career Pathways," California Health Workforce Alliance

promote, and incentives educational programs for the Behavioral Workforce such as dual-enrollment programs.

6. Increase Psychiatric Residency Programs

Georgia has a mental health workforce shortage. The low number of psychiatrists in Georgia is a large contributing factor to access issues. Georgia has fewer psychiatric residency programs than neighboring states and data suggests that psychiatrists are mo re likely to practice in the state where their residency training is located.

The Workforce and Systems Development Subcommittee recommends a pathway to increase residency programs in the state, and funding pathways that serve promising.

7. Loan Repayment Assistance Program for Mental Health and Substance Use Disorder Professionals

HB 1013 called for the creation of a service cancelable loan program for students enrolled in any degree program for mental health and substance use professionals, which will be administered by the Georgia Student Finance Commission. This program creates an incentive for students to enter degree programs to become mental health and substance use professionals by awarding loans to students which can later be repaid through service once they are licensed and practicing in the field. Based on the subcommittees review of other states programs and related workforce data and it would be worthwhile for Georgia to incentivize its current workforce to practice in mental health professional shortage areas through a loan repayment assistance program for individuals who are no longer students but actively practicing in the workforce as a licensed mental health or substance use professional.

Participants in the program would receive loan repayment assistance that is conditioned on five consecutive years of service in a facility with a Health Professional Shortage Area (HPSA) designation that serves the Medicaid and PeachCare for Kids population. This loan repayment program would be administered of the Georgia Board of Healthcare Workforce. The concept of a loan repayment program has been discussed previously with HB 1013, but new language is necessary to ensure such loan assistance can be offer ed to licensed professionals in addition to the service cancelable loan program available to eligible students.

The Workforce and Systems Development Subcommittee recommends the establishment of loan repayment assistance programs for individuals who are practicing as a license mental health or substance use professional, conditional on five consecutive years of services in a facility with a HPSA designation that serves both Medicaid and Peachcare for Kids.

Georgia Behavioral Health Reform and Innovation Commission

Appendix F: Department of Behavioral Health and Developmental Disabilities Workforce Innovations Report: Preliminary Results

Deloitte.

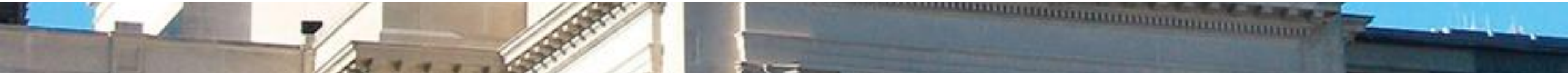
D·B·H·D·D

Department of Behavioral Health & Developmental Disabilities

Workforce Innovations Report: Preliminary Findings

August 31, 2023

D·B·H·D·D



What We're Driving Towards

"Hope won. Countless Georgians will know that we have heard their despair and frustration. We have set Georgia on a path to lifting up and reforming a failed mental health care system."

- House Speaker David Ralston on the unanimous 2022 vote in both the House and Senate on comprehensive mental health legislation

DBHDD Mission Statement:

*"To lead an **accountable and effective continuum of care** to support Georgians with **behavioral health challenges, and intellectual and developmental disabilities** in a dynamic health care environment"*

DBHDD Goals:

Workforce Diversification: Expand the rural and 'non-traditional' workforce demographics, accommodating population segments that require flexible work models and bolstering academic pipelines.

Enhanced Employee Experience: Create an employee-centric work environment that prioritizes well-being and connection, market-leading total rewards, and modernized care delivery models.

High Return on Investment: Make smart, high-value investments in DBHDD's workforce to increases accessibility and availability of quality mental health care for all Georgians.

DBHDD as a Career Destination: Define and realize DBHDD's employer value proposition that considers career pathing and opportunities for development.

Engagement Overview: Where We've Been

The data and recommendations included in this presentation are a culmination of research, data gathering, and analysis completed to help DBHDD design and build a sustainable and impactful workforce strategy.

Current State Assessment and Compensation Study

- Analyzed 105 job codes, turnover data, and conducted interviews and focus groups.

Environmental Scan and Data Gathering

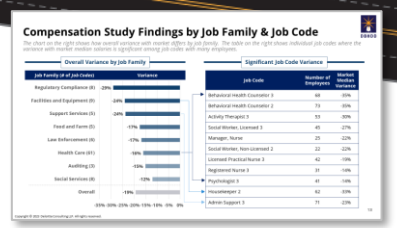
- Scanned 100+ public, private, health, and educational entities for workforce best practices.

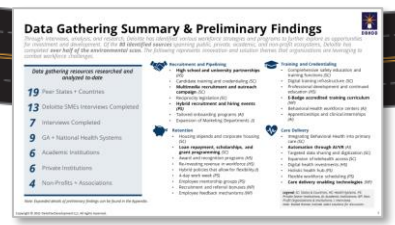
Breakthrough Lab: Solution Design

- Facilitated a lab with 16 public and private sector leaders to design innovative workforce solutions.

Recommendations and Driving Change

- Reviewed and prioritized recommendations, developed action plans and overall roadmap.





Our Guiding Objective: To identify the strategies needed to strengthen the workforce recruitment, retention, and experience of DBHDD professionals, and ultimately strengthen Georgians' access to mental health care.

DBHDD's Immediate Need for Workforce Innovation

DBHDD challenges and below-market compensation pose an immediate risk in maintaining its current workforce and sustaining the workforce of the future in alignment to its future state workforce goals.

Workforce Sustainability Challenges…

Recruitment

- Rural Workforce Recruiting
- Long Recruitment Times
- Increased Market Competition

Retention

- Limited Professional Development Opportunities
- Noncompetitive Compensation
- Disconnected from Leadership

Care Delivery

- Administrative Burden
- Reliance on Paper
- Meeting Continued Education Requirements

57%
Millennial Turnover Rate

29%
Employees Eligible for Early Retirement within 5 Years

66%
Employees Generation X or older

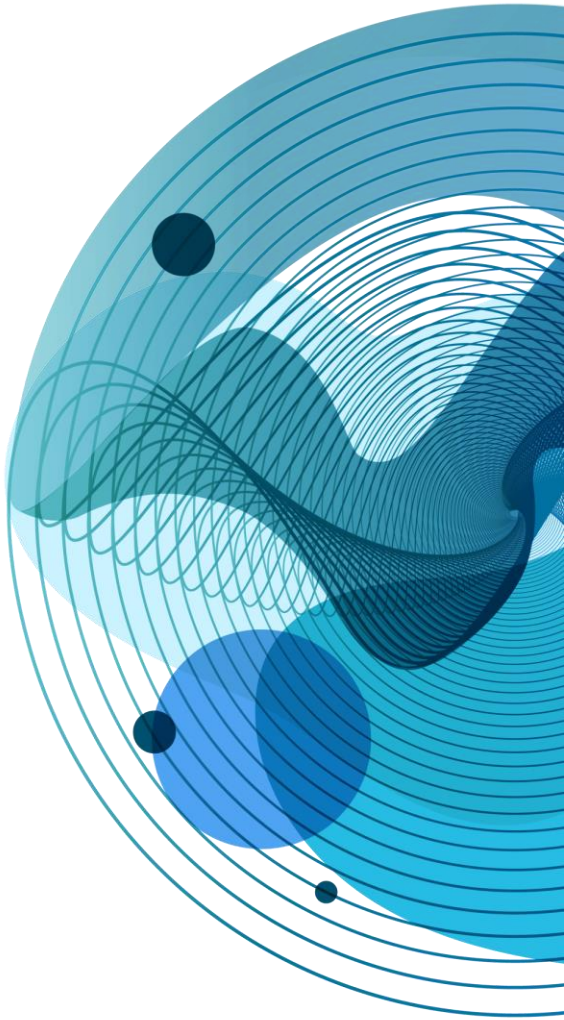
…Coupled With Below-Market Compensation

- On average, DBHDD **salaries are *19% below* national market median data.**
- On average, **salaries in the Statewide Distribution Structure (SWD)** – job codes A to T – **are *25% below* national market median data.**
- On average, the **DBHDD minimums for Psychiatrists, Forensic Psychiatrists, and Physicians** (Board Certified and Eligible) **are *24% below* market median salaries.**

Job Code	No. of Employees	Market Median Variance
Behavioral Health Counselor 2	73	-35%
Social Worker, Licensed 3	45	-27%
Psychologist 3	41	-14%
Housekeeper 2	62	-33%

Table: *Select job codes where the variance with market median salaries is significant among job codes with many employees.*

Workforce Innovation:
Path Forward for DBHDD's Future



Workforce Recommendations Summary

*DBHDD is considering for implementation **19 recommendations**, which fall into one of following three categories based on urgency of need, time and resources required, and impact on the workforce.*

1

Short-Term

<1 year

Examples include:

- Career Marketing Campaign
- Process Optimization and Automation
- Career Pathway Programming
- Out-of-State License Reciprocity
- Salary Market Adjustments

2

Medium-Term

1-2 years

Examples include:

- Expansion of Telehealth Services
- Expansion of Partnerships with Law Enforcement and Community Groups
- Dependent and Education Stipends
- Internship Programs

3

Long-Term

2+ years

Examples include:

- Employee Housing
- Behavioral Health Ecosystem Workforce Development
- Create and Expand Practicum Sites

Select Short-Term Recommendations Details

***11 short-term recommendations** were developed for implementation over the next **12 months**, including the select recommendations below.*

Short-Term Recommendations	Description
Career Marketing Campaign	Develop marketing materials to present **DBHDD as a career destination**, highlighting career paths, benefits, and employee testimonials. Includes **partnerships with camps, high schools, and junior colleges** to distribute materials with the aim of expanding the candidate pipeline.
Process Optimization and Automation	Re-evaluate processes and policies across DBHDD to **reduce administrative burden** and **streamline processes**, such as time-to-hire, through the reduction of paperwork, the introduction of **automation**, and the **integration of GenAI** and other technology where applicable.
Career Pathway Programming	Create an **integrated career path solution** to help employees plan out career trajectory, leveraging both an **on-site career centers** to increase visibility and an **online portal** to view career paths, milestones, and required/recommended trainings and credentialling; explore opportunities to offer **on-site courses to upskill employees**.
Out-of-State License Reciprocity	Update state legislation to **expand the existing workforce** by establishing **seamless licensure transfer** for qualified healthcare professionals and evaluate opportunities to increase the reach of existing workforce through **expanding the scope of practice** through tiered licensure.
Salary Market Adjustments	**Adjust the existing and new salaries** of selected job positions to **increase DBHDD competitiveness** in the marketplace based on the results of the compensation study.

Call to Action

DBHDD can take action now to pave the way for transformative advancements that will reshape the future of behavioral health across Georgia.

Identify strategic partnerships combining state, employer, education, and philanthropy in an ecosystem of support **to champion behavioral health workforce development.**

Confirm owners, governance structures, and updated **resources** for each solution.

Measure and track outcomes to confirm progress and identify ongoing changes to continuously improve efficacy of the strategy.

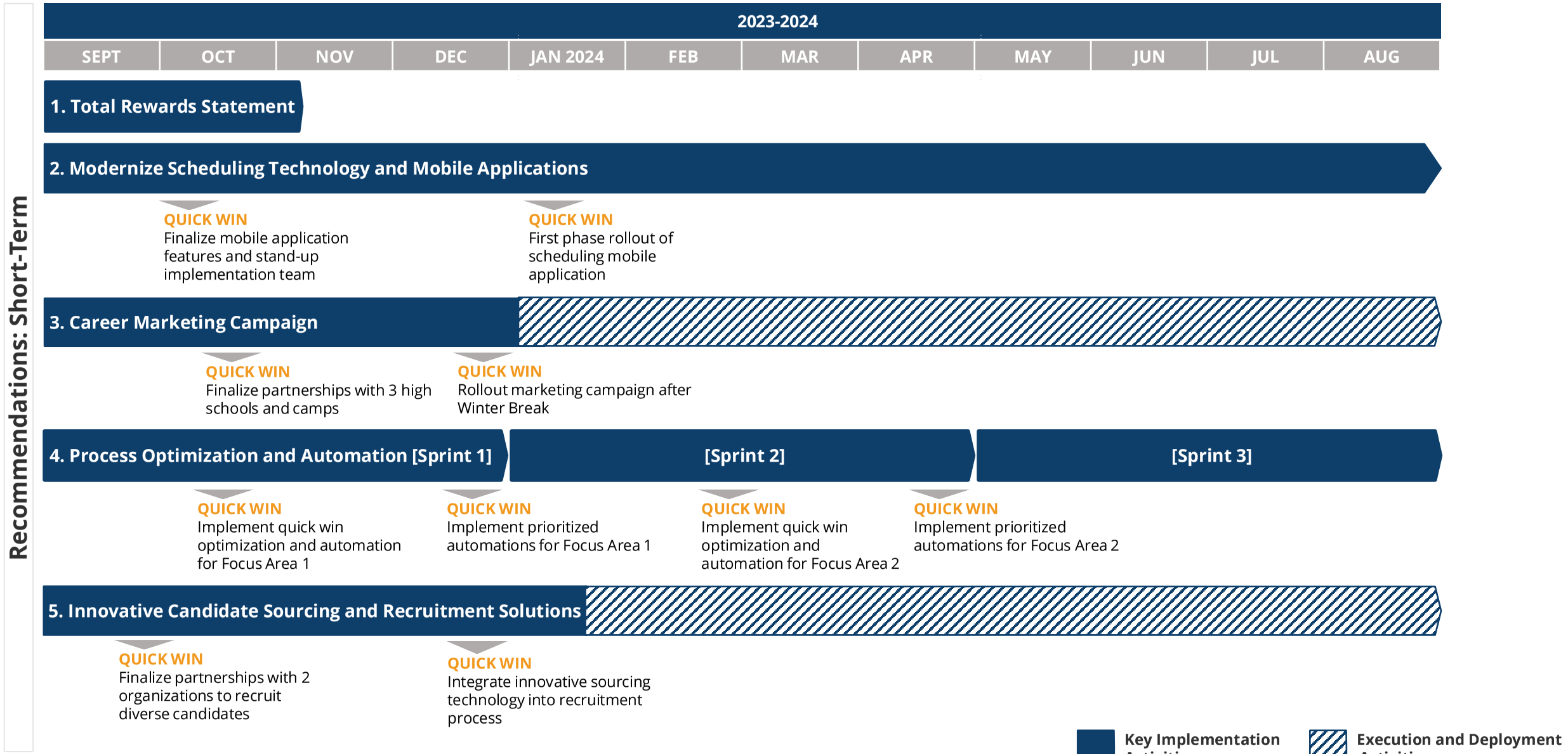
Anticipated Outcomes: Improved services, better patient outcomes, and a stronger and more resilient behavioral health workforce

Recommendations Summary: Short-Term [< 1 year]

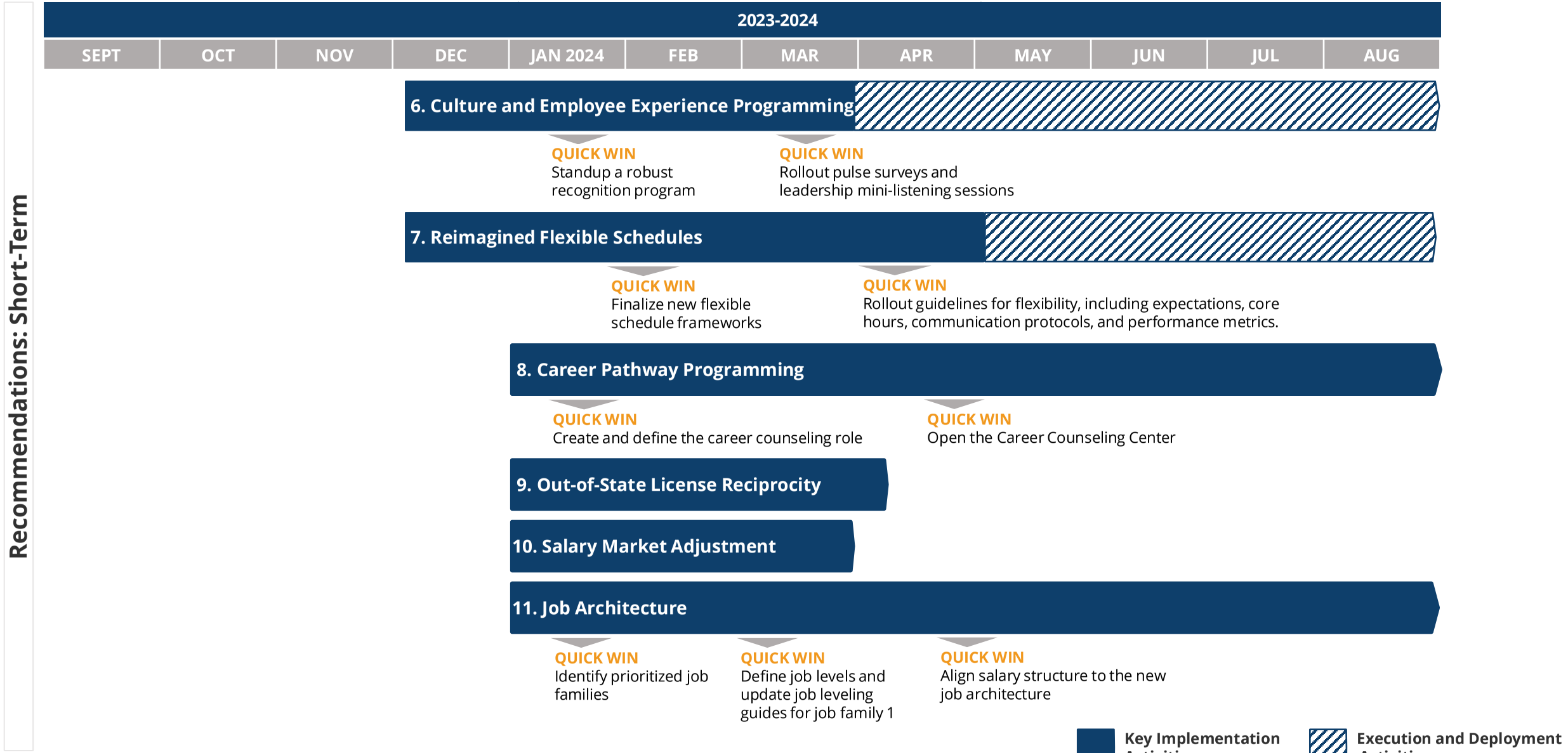
*DBHDD is considering the following recommendations for implementation in the next **12 months**.*

Strategic Approach		Description
1	**Total Rewards Statement**	Publish and distribute individual employees' total rewards statements that detail comprehensive benefits, including long-term financial incentives, and develop an employee communication and education campaign to highlight the impact of these benefits to drive awareness
2	**Modernized Scheduling Technology and Mobile Applications**	Enhance existing DBHDD scheduling rollout by introducing a mobile scheduling application to allow employees to easily access their schedules anytime, anywhere along with submitting time off requests, adjusting preferences for specific weeks/months, and swapping shifts.
3	**Career Marketing Campaign**	Develop and disseminate internal and external marketing materials to present DBHDD as a career destination, illustrating a variety of potential career paths that promote DBHDD's unique benefits, and display employee testimonials. Partner with camps, high schools, healthcare systems, career centers, and nonprofits to distribute these materials – while integrating mental health education and career programming – with the aim of expanding the candidate pipeline. Leverage interactive channels such as Podcasts, job shadowing, and internal internships for dynamic engagement to generate interest in a career at DBHDD.
4	**Process Optimization and Automation**	Re-evaluate processes and policies across DBHDD to reduce administrative burden and streamline processes, such as time-to-hire, through the reduction of paperwork, introduction of automation, and the integration of GenAI and technology where applicable to reduce time-consuming administrative and duplicative tasks.
5	**Innovative Candidate Sourcing and Recruitment Solutions**	Expand candidate pipeline to include diverse workforce segments such as carefully screened formerly incarcerated individuals, individuals with disabilities, veterans, and immigrant populations through partnerships with external organizations. Build relationships with advocacy groups to reach these populations, disseminate career marketing materials, and explore partnerships with external organizations (including academic institutions) to streamline hiring. Explore innovative candidate sourcing and recruitment solutions which leverage technology to identify and contact candidates in an expanded target candidate pool.
6	**Culture and Employee Experience Programming**	Design and execute a comprehensive engagement and culture strategy to include monetary and non-monetary recognition programs, tenure or milestone awards/celebrations. Institute employee engagement activities such as stay interviews, listening sessions, engagement surveys, and official and unofficial feedback mechanisms to further develop employee experience programming.
7	**Reimagined Flexible Schedules**	Redesign schedules to incorporate flexible, part-time, and contract employees for traditionally full-time roles, broadening the candidate pool and enhancing employee scheduling flexibility. Integrate these new flexible schedules and staffing into the implementation of the digital scheduling platform to empower effective management of employee availability.
8	**Career Pathway Programming**	Create integrated career path solution to help employees plan out career trajectory, leveraging both an on-site career centers to increase visibility and an online portal to view career paths, milestones, and required/recommended trainings and credentialling to furnish employees with a well-defined route for professional growth and promotion.
9	**Out-of-State License Reciprocity**	Update State legislation to expand the existing workforce by establishing seamless licensure transfer for qualified healthcare professionals and evaluate opportunities to increase the reach of existing workforce through expanding the scope of practice through tiered licensure.
10	**Salary Market Adjustments**	Adjust the existing and new salaries of selected job positions to increase DBHDD competitiveness in the marketplace based on the results of the compensation study, reassigning affected jobs to the appropriate pay grade internally to reflect the alignment with external market.
11	**Job Architecture Transformation**	Transform the current job architecture to create clear, more delineated career paths for each role that illustrate position-specific requirements including education, experience, licensure, credentials, and training, etc., needed to get to the next level in the organization. Increase the number of levels available for growth opportunities and include position mapping so that employees see the trajectory that a certain position will put them on as they climb a career path ladder at DBHDD.

Short-Term Recommendations: Roadmap (1 of 2)



Short-Term Recommendations: Roadmap (2 of 2)



Recommendations Summary: Medium- and Long-Term

DBHDD is considering the following recommendations for implementation ***in the next 24 months and beyond****.*

Medium-Term [1-2 Years]

Strategic Approach		Description
12	**Expansion of Telehealth Services**	Expand telehealth services to increase access to care and modernize care delivery, leveraging high school campuses as publicly accessible sites for remote telehealth services.
13	**Expansion of Partnerships with Law Enforcement and Community Groups**	Strengthen partnerships with law enforcement and community groups through therapist ride alongs with law enforcement and other community partners to increase community awareness and improve law enforcement outcomes.
14	**Dependent and Education Stipends**	Develop dependent care programs to aid employees in maintaining a healthy work-life balance, reducing caregiving stress, and allowing employees to fully engage at work; additional educational stipends provide upskilling and training to explore career advancement opportunities.
15	**Employee Referral Bonus**	Offer a one-time bonus to employees that refer candidates that are hired and work a minimum six months.
16	**Internship Programs**	Formalize additional internship programs for clinical and non-clinical roles to create sustainable workforce pipelines directly aligned with DBHDD roles.

Long-Term [2+ Years]

Strategic Approach		Description
17	**Employee Housing**	Develop employee housing near hospitals to address the housing needs of employees.
18	**Behavioral Health Ecosystem Workforce Development**	Create a program for the general public that trains, educates, and equips individuals to pursue behavioral health employment regardless of employer.
19	**Create and Expand Practicum Sites**	Increase practicum site capacity through creating nurse apprenticeship programs, expanding residency programs/rotations, and establishing a designated teaching hospital.

Compensation Study Methodology

The following summarizes the compensation study area of focus and approach.

Job Title Coverage

105	8	38%	67%
Number of job titles benchmarked	Number of job families	Percent of job titles	Percent of DBHDD employees

Survey Data Compilation & Analysis

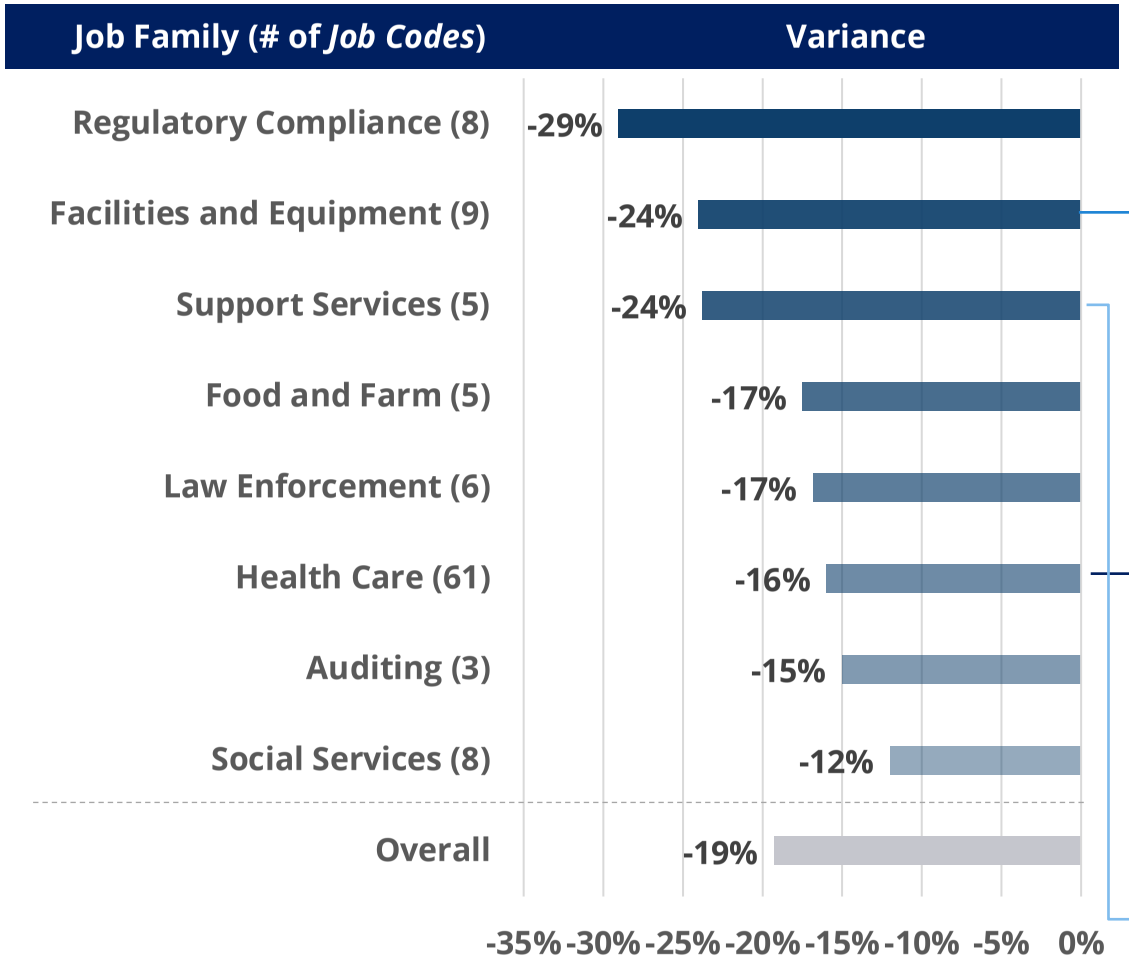
- With DBHDD input, confirmed matches to market based on positions' primary duties and responsibilities
- Compiled 25th, 50th and 75th percentile national market data from multiple surveys representing similarly-sized and type of health care providers
- Compared the market data to BDHDD incumbent salaries and salary grades in the State of Georgia salary structures used to maintain BDHDD salaries

DRAFT

Compensation Study Findings by Job Family & Job Code

The chart on the right shows how overall variance with market differs by job family. The table on the right shows individual job codes where the variance with market median salaries is significant among job codes with many employees.

Overall Variance by Job Family



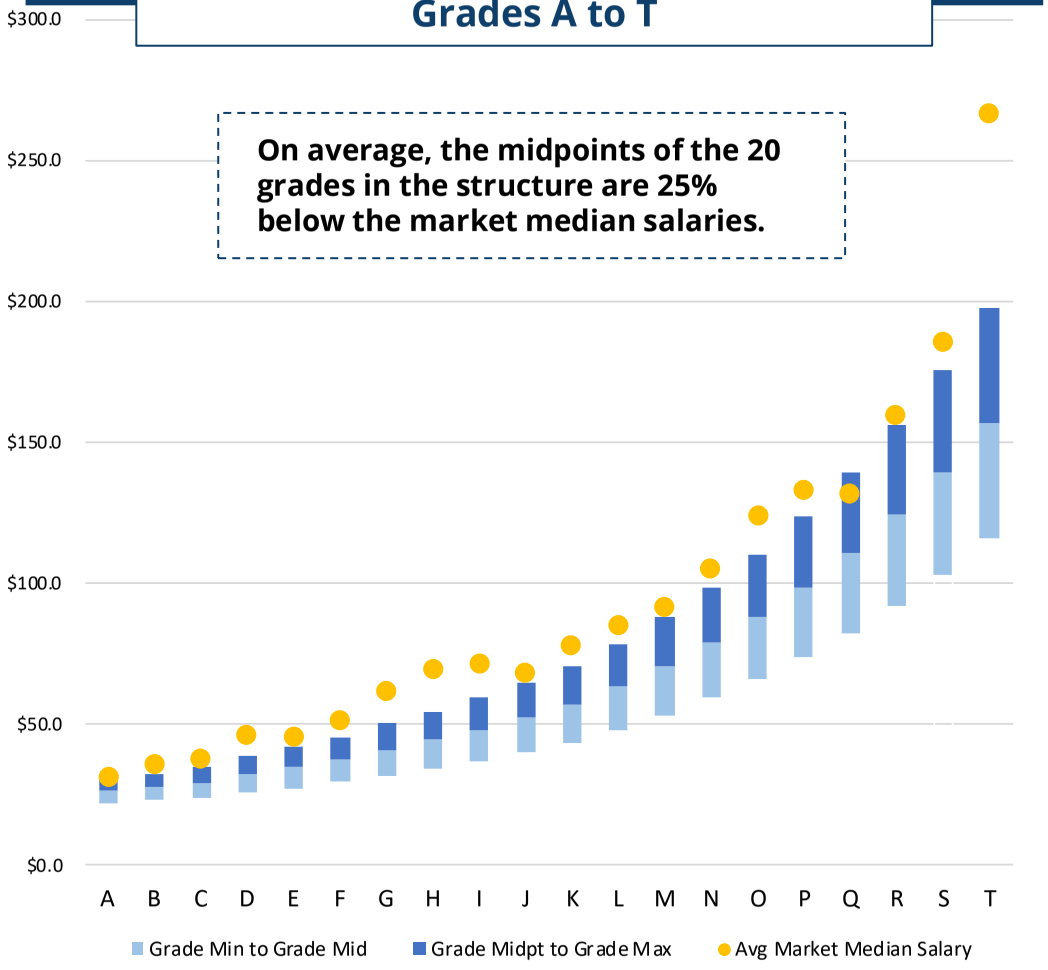
Significant Variance by Job Code

Job Code	Number of Employees	Market Median Variance
Behavioral Health Counselor 3	68	-35%
Behavioral Health Counselor 2	73	-35%
Activity Therapist 3	53	-30%
Social Worker, Licensed 3	45	-27%
Manager, Nurse	25	-22%
Social Worker, Non-Licensed 2	22	-22%
Licensed Practical Nurse 3	42	-19%
Registered Nurse 3	31	-14%
Psychologist 3	41	-14%
Housekeeper 2	62	-33%
Admin Support 3	71	-23%

Compensation Study Findings by Salary Grade

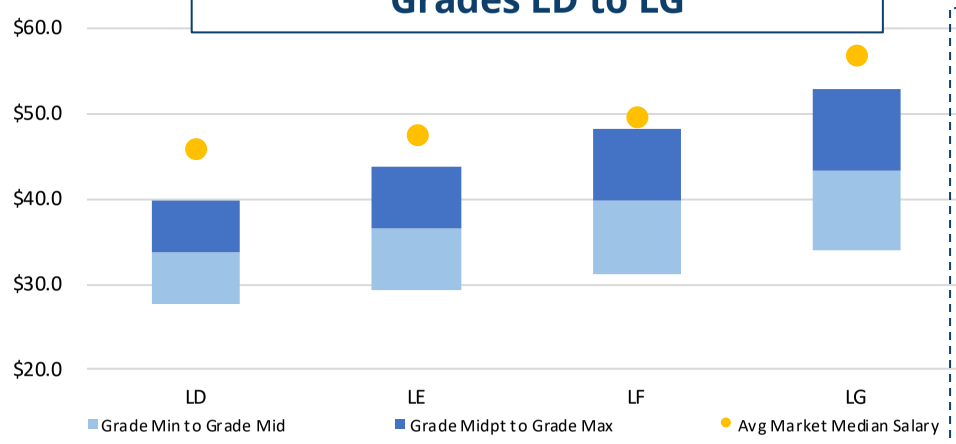
The job codes benchmarked are aligned to the Statewide Distribution, Law Enforcement, Psychiatrist and Physician salary grades. The SWD and LAW midpoints and the Psychiatrist and Physician minimums (effective July 1, 2023) have been compared to the market median salaries.

Statewide Distribution (SWD) Structure: Grades A to T



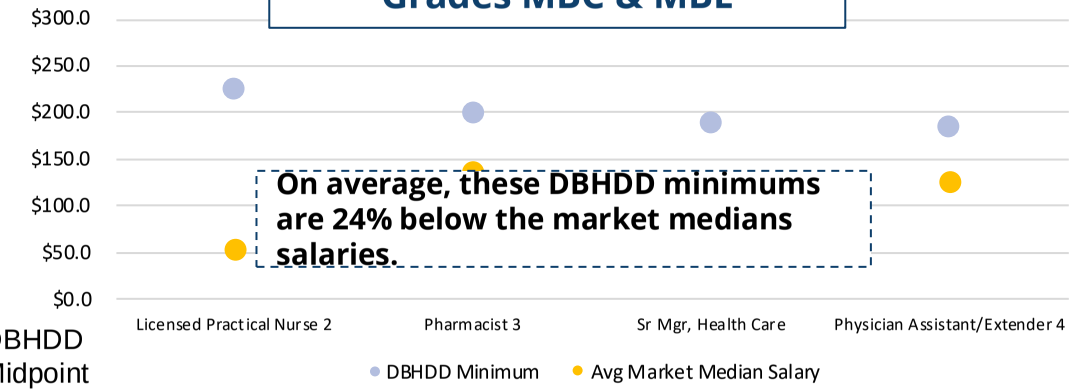
On average, the midpoints of the 20 grades in the structure are 25% below the market median salaries.

Law Enforcement (LAW) Structure: Grades LD to LG

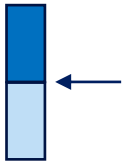


There are 17 total Law Enforcement grades. On average, the midpoints of the 4 grades into which benchmark jobs are aligned are 14% below the market median salaries.

Psychiatrists & Physicians: Grades MBC & MBE



On average, these DBHDD minimums are 24% below the market medians salaries.



DBHDD Midpoint

Market Adjustment Alternatives

As the previous slides show, DBHDD employee salaries and the structures used to maintain DBHDD salaries generally fall below market.

BDHDD could increase the salaries of individual employees or reassign position to a different salary grade to enhance alignment to the market data. Most organizations establish a market target for pay along with a targeted range around their market target – e.g., individual salaries within plus or minus 15% of the market median salary, salary grade midpoints within plus or minus 10% of the market median salary, etc.

Alternative I: *Maintains position salary grade assignments but increase the salaries of 2,245 individual employees that fall below the market median. The following shows the estimated cost of these salary increases at varying levels relative to the market median salaries. These costs exclude associated benefit costs.*

25% of market median	50% of market median	100% of market median
$5.7 million	**$11.4 million**	**$22.8 million**
Avg Employee Salary Increase: 5%	***Avg Employee Salary Increase: 10%***	***Avg Employee Salary Increase: 20%***

BDHDD will need to determine its budget for market adjustments and the positions where employee salary adjustments are most critical (e.g., positions involved in direct patient care within their hospitals).

Alternative II: *Change positions' salary grade assignments among the 105 positions benchmarked based on market and increase the salaries of 427 employees that fall below the position's new salary grade minimum. The following shows the estimated cost of these salary increases; this value excludes associated benefit costs.*

Increases to the Minimums of Updated Market-based Salary Grades
$2.95 million
Avg Employee Salary Increase: 12%

BDHDD will likely need to adjust the salary grades of select non-benchmarked positions relative to the benchmarked positions.