2017-2018 REGION 4 TOP PRIORITIES WITH KEY STRATEGIES

Below are the three top priorities for **Region 4** for 2017-18

Priority 1: Children and Adolescent Beds

Increase the number of child and adolescent Behavioral Health (BH)/Addictive Diseases (AD)/Intellectual and Developmental Disabilities (IDD) inpatient and Crisis Stabilization Unit (CSU) beds.

Key Strategies:

1. Develop contracts with local hospitals for beds dedicated to child and adolescent Behavioral Health (BH)/Addictive Diseases (AD)/Intellectual and Developmental Disabilities (IDD) treatment. Small hospitals are closing at an alarming rate. Make the concept appealing by assisting the hospitals by providing technical or other support by helping with legwork involved in credentialing, privileging, CON and accreditation. (For example, ask Donalsonville how they did it.)

2. Collect data and develop performance improvement measures on the number of beds required and not available, the length of wait time until a bed is available, and the location of the bed when made available (how far from the child's home is the inpatient placement.

3. Create and fund local Crisis Stabilization Units (CSUs) to serve children and adolescents of all disabilities. Consider underutilized hospitals and private behavioral health providers (i.e., Turning Point).

4. Collaborate with other agencies who have a toe-in-the-water and already serve behavioral health (BH), addictive disease (AD), and intellectual and developmental disabilities (IDD) children and adolescents.

Priority 2: Rural Access

Improve the ease of access to outpatient treatment for Behavioral Health (BH), Addictive Diseases (AD), and Intellectual Developmental Disabilities (IDD) in rural areas.

Key Strategies:

1. Fund and recruit professional counselors to assess and treat individuals in a routine, reliable, and consistent basis in their local communities. Provide a well published schedule and send the same counselor to the site to maintain continuity of care and compliance.

2. Collect data for each individual served to include number of miles traveled, how much you paid someone to bring you for an initial appointment, and rate the convenience of the service location.

3. Insist that the Behavioral Health Assessments (BHAs) be simplified and only cover data that is required for reimbursement by funding sources, accreditation, or certification. The essential evidence that an individual is in need of services can be established in less than 15 minutes. Counselors should be allowed to do a down and dirty (short and efficient) BHA and come back within 30 days and complete it with other required pieces of data.

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Priority 3: Prevention/Early Intervention

Expand early intervention/education/prevention to identify at-risk children and adolescents for behavioral health, addictive diseases, and intellectual/developmental disabilities.

Key Strategies:

1. Collaborate with and utilize agencies, services, and programs already in the business of identifying at-risk families and youth such as Family Connections and Georgia Cares. Other agencies such as the Department of Family and Children Services (DFCS), Public Health, Juvenile Court, Babies Come First, pediatricians and school counselors already know which families are at-risk. Don't reinvent the wheel.
2. Allocate funding and recruit dedicated staff to serve at-risk families and youth. Utilize an ACT concept to wrap around at-risk youth and families.
3. Collect data on all aspects of early intervention, education, and prevention.
4. Create a billable service in such a way that the service may be reimbursable whether delivered in the home, community, or school.
5. Develop admission criteria for services that are broad and generous for the first 60 days, so that adequate assessment and planning can be established. (It takes a while to develop trust.)
6. Provide ongoing, persistent community education for families about early warning signs as well as how to access treatment.
7. Utilize TV, radio, count fairs, and newspapers in an ongoing, persistent, and constant basis to inform and encourage early treatment. This outreach should include colleges, technical schools, health fairs, and school organizations such as 4-H, FFA, and PTA.
8. Redirect monies from the complicated and expensive IFI team-process to early intervention and prevention services. This would ensure independent, self-reliant families early in the child's life and decrease the need for intensive intervention.