

Community Care for Behavioral Health and Developmental Disabilities Task Force



Final Report
July 2005
Bruce Cook, Chair

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1 Executive Summary

Vision Statement

The Community Care for Behavioral Health and Developmental Disabilities Task Force developed a vision statement that....

*Georgia will have the nation's **best** system of community care for behavioral health and developmental disabilities...the **best** care at the **best** cost!*

Process

An extensive data gathering phase was conducted to identify: major problems within Georgia's existing system, national best practices from industry experts and input from various advocate and stakeholder groups. Seven recommendations were presented as a consensus from the task force to the governor for implementation.

Seven Recommendations

1. Establish a fee for service CSB/provider system.
2. Require the use of evidence based/ best outcome practices.
3. Develop an open, competitive CSB/provider environment.
4. Establish greater accountability for outcomes and performance.
5. Provide appropriate utilization of the state hospital system and reinvest saved dollars into community care.
6. Establish a Single System of Care for children and adolescents.
7. Develop an effective intervention program for the MH/Ad needs of the adult offender population.

2 Introduction

In May 2005 Governor Sonny Perdue, via the Commission for a New Georgia, created the Community Care for Behavioral Health and Developmental Disabilities Task Force. The Task Force was charged to determine the current state of Georgia's public behavioral health and developmental disabilities delivery system and to develop a comprehensive, implementable plan for improvement. Two audits conducted by the Georgia Department of Audits on the MHDDAD Division of the Department of Human Resources and the Community Service Board delivery system indicated significant problems existed within the current system. The current system is complex and poses barriers that impede care for people with mental illnesses, addictive diseases and developmental disabilities. Problems with Georgia's community-based mental health system have evolved over a number of years. The Task Force was commissioned to develop concrete recommendations to solve the problems and to ensure that the needs of people in Georgia are effectively being met.

3 Membership

The Task Force was fortunate to have outstanding representation from both the private and public sector. The diversity of the group spanned age, gender, ethnicity and geography. The Task Force was comprised of the following:

Bruce Cook, Task Force Chair

CTB Publishing, LLC

Jim Beck,

Nationwide Insurance Co.

Lynette Bragg,

Governor's Council on Developmental Disabilities

Dr. Peter Buckley,

Medical College of Georgia

Becky Butler,

Annie E. Casey Foundation

Bob Fink,

Ridgeview Institute

Judy Fitzgerald,

Atlanta Business Leaders Initiatives

Ed Graves,

Governor's Council for MHMRSA

David Lushbaum,

NAMI Georgia

Anna McLaughlin,

Georgia Parent Support Network

Ann Parker, Ph.D.,

Waffle House

Sherry Jenkins-Tucker,

Georgia Mental Health Consumer Network

Carlis Williams,

Administration for Children & Families

In addition, consulting support was provided by:

Dr. Henry Harbin, *President's Commission on Mental Health*

Cookerly and Associates

Administrative support was provided by: Jerry Guthrie, Greg Maxey, and Tiffany Robertson.

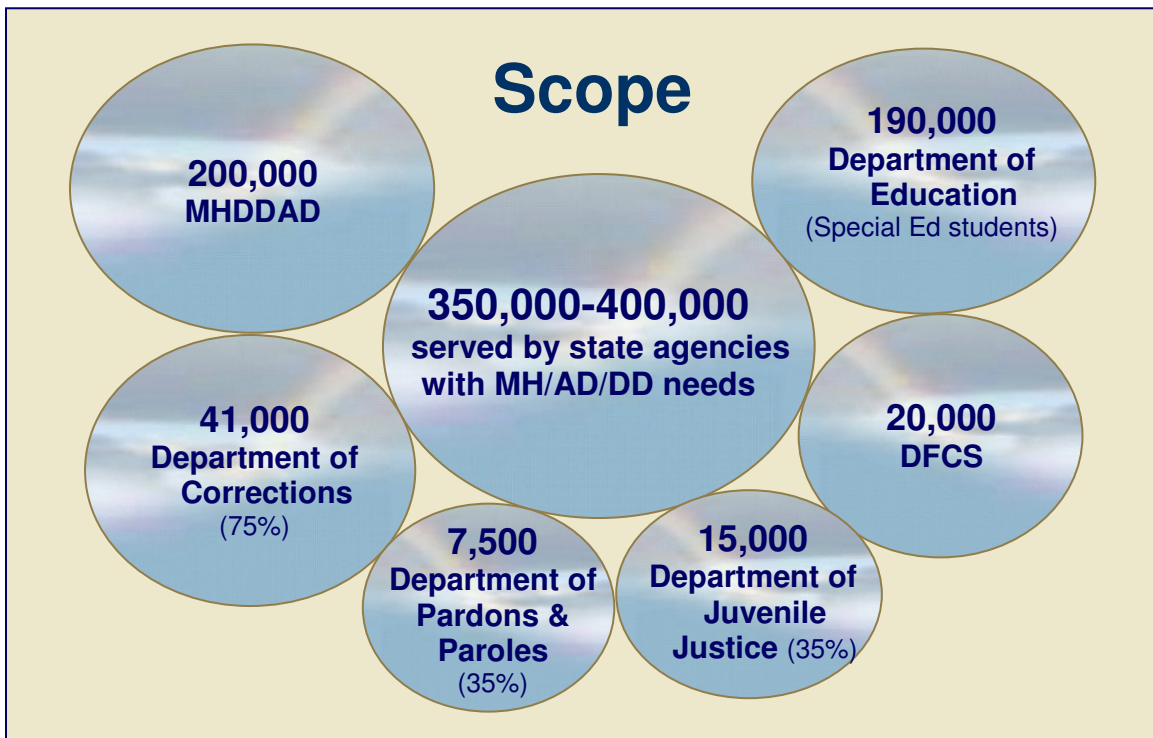
4 Vision

The State of Georgia will work toward a more effective and efficient public behavioral health and developmental disability system that values recovery, cultural competency, best outcome practices and accountability in addition to becoming more consumer/family-centered and comprehensive. We envision a future when everyone with a need has access to effective treatments and support that is essential for living, working, and learning. As mentioned, the Task Force established the following bold vision:

Georgia will have the nation's best system of community care for behavioral health and developmental disabilities...the best care at the best cost!

5 Scope

A number of state agencies currently provide mental health, addictive disease and developmental disabilities services to consumers. The following is an estimate of the number of individuals with behavioral health or developmental disabilities needs served each year through various Georgia government agencies.



6 Guiding Principles

For a task force to be successful, a shared set of guiding principles must be at the heart of the effort. The following six guiding principles were adopted by the task force.

- 1- **Recovery/self determination:** Service goals should emphasize the support needed to ensure consumers are able to live, work, learn and participate fully in their communities.
- 2- **Consumer driven:** Services should be driven by the unique needs and preferences of the consumers and families.
- 3- **Community-based comprehensive services:** Services should be delivered when and where consumers and families will most easily access them.
- 4- **Cultural competency:** Services offered should be responsive to the cultural context and characteristics of the population served.
- 5- **Best Outcome Practices:** Services provided should either be evidence-based practices with documented effectiveness or emerging best practices with planned effectiveness measures.
- 6- **Accountability:** Services are accountable to the consumers and taxpayers of Georgia and are to be carefully monitored and evaluated to ensure positive consumer outcomes.

7 Data Gathering Phase

In order to identify the facts and fully understand the current state of Georgia's public behavioral health and developmental disabilities delivery system the Task Force initiated a series of data gathering efforts.

- Visits to 7 Community Service Boards (CSBs) and 2 state hospitals
- Researched best practices research in 10 states
- Conducted public hearings for input and comment
- Meeting with CSB Association and members
- Meeting with Regional Planning Boards leadership
- Meeting with State Agencies: MHDDAD, DOE, DOC, DJJ, DCH, DPP
- Meeting with Department of Audits, CSB audit team
- Meeting with 3 national Administrative Service Organizations (ASOs)

8 Top 10 Problems

From the data gathering phase the following top ten problems of Georgia's existing system were identified.

1. Inequitable grant-in-aid funding model not related to population or service needs.

- Currently approximately \$500 million in state grant in aid is distributed throughout the existing CSB and provider system based upon historical funding amounts rather than population demographics or estimates of consumers in need. In addition each CSB has established independent budgets, spending levels and overhead costs for providing various services. The result is a significant variance in costs per consumer served between various CSBs. The following chart indicates the funding and cost discrepancies between two counties in metro Atlanta serving approximately the same number of consumers and a rural county in South Georgia.

County CSB	Budget	Consumers Served	Cost per consumer	Percent Increase
Cobb/Douglas CSB	\$25.9M	12,545	\$2,064	
Dekalb CSB	\$39.3M	12,000	\$3,275	+59%
Middle Flint CSB	\$15.8M	3,875	\$4,096	+98%

2. Inconsistent CSB quality for financial, business and treatment practices.

- State audits performed on seven CSBs indicated a number of problem areas dealing with cost/financial controls, reliable data and effective governance and oversight. However, visits to five additional CSBs by Task Force members failed to confirm that the problems cited in the audit were universal to every CSB. Therefore, it is fair to state that there a significant variance in the quality of operations in various CSBs in the following areas:

- i. Lack of cost/financial controls

- ii. Lack of effective systems and reliable data
- iii. Lack of governance and oversight

3. Over-utilization of state hospital system, high readmission and drop-out rates.

- The Georgia Mental Health GAP Analysis for 2005 indicated the following state hospital system utilization data:
 - i. A high, 96%, occupancy rate.
 - ii. Georgia provides three times the amount of hospital treatment service per capita compared to the national average.
 - iii. 40% of discharges from state hospitals fail to show up for follow-up appointments in local community settings.
 - iv. Readmission rates for discharges from state hospitals are 55% higher than the national average.

4. Lack of consistent, evidenced-based practices by CSBs/providers.

- Evidence-based treatment practices are not consistently utilized by CSBs and providers in the delivery of treatment services and options. One example is that only four of the 25 CSBs offer the highly effective Assertive Community Treatment Teams to consumers who need and could benefit from this type of intervention.

5. No unified system for children and adolescents.

- Currently, children and adolescents with behavioral health problems are served through individual “silo” agency programs (DFCS, DOE, MHDDAD, etc) which fail to interact with each and do not provide a single “case manager” perspective on the over-all needs of the child, adolescent and family. As a result too often children and adolescents do not receive the necessary behavioral health interventions that can lead to recovery.

6. No effective interventions for adult offenders.

- It is estimated that 75% of the adult offender population has an addictive disease. In addition, 20%-30% have a mental disease diagnosis. Without effective addictive disease interventions, national data indicates 2/3 of those released return to the prison population within 3 years and over 40% of those who return are for drug violations. In essence a “revolving door” system exists which continues to overload the prison system with no solution in sight.

7. Inadequate utilization management

- Currently, the utilization of individual treatment options is determined by CSBs and providers. Without a separation between provider and the utilization management function it is difficult to maintain objectivity in the over-all effectiveness and efficiency of service delivery. Private sector mental health systems have seen the benefit of separating the provision of services from the utilization management.

8. Inadequate accountability for outcomes by service providers.

- Currently, performance indicators among CSBs and providers tend to focus on process and intermediate outcomes rather than measuring the effectiveness of various treatment interventions against the over-all goals of recovery and improved behavior and functioning. In addition, consumers and families do not have the benefit of outcome data to help in the selection of various service providers.

9. Ineffective IT/MIS system.

- No data system exists to track utilization of individual consumer treatment interventions. In addition, no system exists for the MHDDAD Division to aggregate treatment, operational and financial data from CSBs and providers.

10. Inconsistent access system.

- Access to treatment options for consumers is provided through CSBs in various counties. In areas where the CSB access system is not well maintained there tends to be delays in consumers receiving timely treatment options. It is also difficult to provide other provider options to consumers outside the CSB network. In addition MHDDAD is unable to gather utilization data independent of CSB or provider involvement.

9 Recommendations

Utilizing the six guiding principles, the Task Force identified the following seven specific recommendations for solving the ten top problems and achieving the vision to become the **best system in the country**. To improve the quality of care and services, the Task Force recommends essentially transforming how behavioral health care and developmental disability services are delivered in Georgia. Transformation of the mental health system will eliminate disparities and provide early screening, assessment, and referral to services. In the transformed system, consumers and family members will have access to both timely and accurate information to promote learning, understanding, self-monitoring, and accountability. The seven recommendations are:

1. Establish a **fee for service** provider system
2. Require the use of **evidence based/best outcome** practices
3. Develop an **open, competitive** CSB/provider environment
4. Establish greater **accountability** for outcomes and performance
5. Provide **appropriate utilization** of the Georgia state hospital system and **reinvest** saved dollars into community care
6. Establish a **Single System of Care** for children and adolescents
7. Develop an **effective intervention** program for the MH/AD needs of the adult offender population

1. Establish a fee for service provider system by 1 July 06.

In a fee for service provider system providers are paid a single rate for treatment services provided to Medicaid and non-insured consumers. Thirty three states have already moved from a grant in aid model to a fee for service system providing Georgia with valuable data and information on how to transition to a fee for service system, avoid pitfalls in the transition process and achieve the desired and anticipated benefits, which are:

- Paying for services rather than programs.
- Equalize funding to all CSBs and providers.
- Insuring the delivery of best practice treatment services for consumers.

A key ingredient to a fee for service system is the use of an independent administrative service organization to provide the following functions;

- Utilization management and review
- IT/MIS data system
- Oversight of a state wide single point of entry for consumers

Implementation steps:

- Selection of an ASO to provide utilization management and review, IT/MIS system and claims payment and development of a single point of entry system by Fall 2005.
- A fee for service pilot program will be implemented October 2005-March 2006 in the Southeast MHDDAD region.
- During FY06 providers will be evaluated using new service rates allowing providers to prepare for fee for service as well as MHDDAD to realign its resources. Special areas of concern to be addressed are: fees to be paid, cash flow transition planning, reimbursement process and utilization of best practices.
- Full implementation for core services to occur by July 2006.

2. Require use of Evidence-based Practices and/or high outcome practices by all CSB/providers by 1 July 07.

- Only evidenced-based practices with well-documented outcomes as well as emerging best practices with promising, but less thoroughly documented outcomes will be used by CSB/providers after July 1, 2007. EBPs ensure the consumer the best opportunity to achieve recovery goals and to improve in behavioral objectives.
- Case management will be required as a best practice with each CSB/provider by July 2006. A case management system will provide a consumer/family friendly service with the same case manager providing a single point of contact as the consumer progresses through the various treatment options.

Implementation steps:

- A list of acceptable evidence-based practices and high outcome programs for all CSB/providers to be developed by July 2006.
- Training options will be provided for all CSB/providers for evidenced based practices and high outcome programs during 2006. The program will be focused on improving skills, knowledge, and attitudes of frontline service providers.

3. Develop an open, competitive CSB/provider environment.

A competitive CSB/provider environment enabling all CSB/providers to bid on opportunities for service within the state will begin during FY06. It is anticipated that a fully competitive environment will be in place no later than FY08. Contracts will focus on key outcome indicators. Failure to meet performance criteria will result in opening the service area up for competitive bids by other providers and CSBs.

Implementation steps:

- MHDDAD to develop a new CSB/provider contract to include specific performance and outcome criteria by 31 December 2005. Contracts should focus on key outcome indicators and seek to eliminate and minimize unnecessary regulatory paperwork and procedures.
- Competitive process for bids on opportunities by 1 July 2005.
- Fully competitive environment no later than FY 2008.

4. Establish a greater accountability for CSB/provider outcomes and performance

A key component in the behavioral health system is accountability for services delivered. There is an interest in greatly increasing the accountability of Georgia's provider network in which roles and responsibilities are defined, performance measured, and continuous quality improvements are made based upon results.

- Monthly recovery outcomes for all CSB/providers available online by 1 April 2006.
 - Establish clear state wide accountability measures to allow for consistent information
 - Performance outcomes available online for consumers and the general public
- The establishment of a quarterly high level accountability review process with MHDDAD and an enlarged Governor's Advisory Council to include Regional Board leadership by 1 January 2006.

Implementation steps:

- MHDDAD to develop agreed upon performance outcomes measure by 1 November 2005.
- A system for gathering and posting the performance outcomes to be developed by the ASO by 31 March 2006
- Form enlarged Governor's Advisory Council by 1 November 2005

5. Provide appropriate utilization of state hospital system and reinvest saved dollars in community care

With the advent of newer generation medications, the role of acute care hospitalization has moved to one of stabilization as a first step toward a “step-down” continuum of care within the community. Alternative community modes of stabilization such as Crisis Stabilization Units and med-surgical hospitals provide a better seamless system for the consumer and family, improve discharge planning for community services and are significantly less costly than the state hospital system. The state hospital system should become service of last resort.

- Develop a plan by 31 December 2005 for transitioning acute care admissions to additional Crisis Stabilization Units (CSUs) or local med-surgical hospitals.
 - One example of potential cost savings is found in an analysis of Cobb/Douglass CSB admissions for acute care stabilization. Approximately 2,000 admissions occurred in one year. Approximately 1,000 were made to the Cobb/Douglass CSU at a cost of \$1,764 per patient. The remaining 1,000 was made to the NW Regional Hospital for a cost of \$7,386 per patient. The cost differential is \$1 for CSU vs. \$4 for regional hospital-- for the same treatment.
 - The benefits for providing acute care treatment in the community are not only the cost savings of approximately \$1 to \$4, but easier discharge planning, greater family involvement and more likely consumer participation in “step-down” treatment options.
- Implement a plan to transition approximately 1,400 long-term care consumers to community settings by July 2006.
- Achieve a reduction in the average daily census in state hospitals and reinvest savings into community behavioral health services beginning FY 07. Targeted reinvested savings of approximately 20,000 acute care admissions per year are estimated at \$4,000/patient.

Implementation steps:

- Identify and/or make provisions for anticipated acute care admissions to Med Surgical and/or CSUs in each region by October 31, 2005
- No longer place acute care admissions to state hospitals beginning 1 November 2005.
- Develop alternative placement for approx. 1300-1500 DD and long term care patients by 31 Oct 05. Complete placements by 31 Dec 05.

6. Establish a state wide Single System of Care for children and adolescents

More than \$200 million is spent annually on a fragmented system of support for children and adolescents. There needs to be a coordinated effort between all child-serving agencies to provide single case management and seamless services for children and adolescents. Some of the barriers to these efforts have been changes in leadership, siloed funding and turf guarding among agencies. Systems of Care have proven to be successful with coordinating efforts of agencies and meeting the needs of children. This approach includes interagency collaboration, individualized treatment, cultural competence, community-based services, and accountability. The three key elements of an effective single system of care are: case manager accountability, non-duplicative services, and blended/braiding funding.

- Prior to September 1, 2005, establish an interagency task force of department heads, chaired by the Governor's Office to provide direction
- Develop a plan of implementation by October 31, 2005, which will ensure the implementation of Systems of Care at state, regional, and local levels throughout Georgia.

Implementation steps:

- Utilizing the Child and Adolescent Infrastructure Grant Executive Committee, composed of various state agencies, family members and stakeholders develop a plan of implementation by October 31, 2005 which will ensure the implementation of Systems of Care at state, regional, and local levels throughout Georgia.
- Prior to August 1, 2005 a meeting chaired by the Governor's Office with Commissioner Walker, Commissioner Murray and Superintendent Cox should occur to provide direction and input for the plan of implementation.

7. Develop an effective intervention program for the MH/AD needs of the adult offender population

An estimated 15-20% of this population has a mental illness and as many as 75% has an addictive disease. Lack of effective treatment leads to high recidivism rates (as high as 40%) for discharged offenders

- Establish a task force to develop and implement an effective intervention program by 31 October 2005

Implementation steps:

- The Governor's Office working with the Commission for a New Georgia should establish a new Task Force by October 31, 2005 to undertake the planning for an effective adult offender mental health/addictive disease intervention program for Georgia.