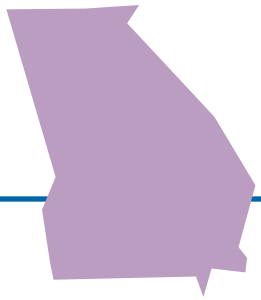

Spotlight on Georgia

January 2018

This brief highlights the major strategies, lessons learned, and outcomes from Georgia's experience from February 2010 to February 2016 with the quality demonstration funded by the Centers for Medicare & Medicaid Services (CMS) through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). For this demonstration, CMS awarded 10 grants that supported efforts in 18 States to identify effective, replicable strategies for enhancing the quality of health care for children. With funding from CMS, the Agency for Healthcare Research and Quality (AHRQ) led the evaluation of the program.

Georgia's Goals: Improve services for children with complex behavioral health needs by—

- Improving the quality of peer support provided to youth and caregivers.
- Refining care management entities to improve coordination across child-serving agencies.

Partner States: Maryland and Wyoming implemented similar projects and met quarterly with Georgia and the Center for Health Care Strategies to engage in peer learning through a quality collaborative.

Georgia established a certification process for youth and caregivers who provide peer support

Through peer support programs, youth with complex behavioral health needs and their caregivers: (1) provide emotional support to other youth and their families, (2) help them develop skills in self-empowerment and in taking an active role in their care, and (3) help them identify and connect with community resources. Georgia's goal was to develop a standardized peer support training and certification process to improve the consistency and quality of these services. With support from the CHIPRA quality demonstration, Georgia—

- **Developed two new training curricula** to prepare youth with behavioral health needs and their caregivers to provide peer support. The curricula included an initial training before certification and continuing education opportunities after certification. Georgia indicated that actively engaging youth and caregivers in curriculum development fostered their support for the curriculum and helped make the trainings both relevant and accessible. The State administered a test at the end of each training to identify youth and caregivers who met the qualifications for peer support certification. To guide improvements in curricula, the State also aggregated the test data to identify common gaps in the knowledge and skills of trained youth and caregivers.
- **Certified more than 100 caregivers** who completed peer support trainings. CHIPRA quality demonstration staff reported that certified caregivers developed new skills, including recognizing stressors in other caregivers and using communication techniques such as reflective listening. As of this writing, only caregivers who were certified by the State to provide peer support could be reimbursed by Medicaid for this service.[1]
- **Started training youth to provide peer support to other youth with complex behavioral health needs**. Youth who helped develop the curriculum and were interested in providing peer support often were still learning to manage their own behavioral health needs. Consequently, the State held workgroups on self-management and recovery for these individuals and gave them the opportunity to attend conferences on behavioral health supports before they began peer support training. CHIPRA quality demonstration staff indicated that participation in these activities was crucial in preparing youth to provide peer support. However, involvement with these activities significantly delayed the start of training, and only 18 youth were certified during the grant period.[1]
- **Provided training to new and existing family support organizations that employ many of the certified youth and caregivers and bill Medicaid for the services they provide.** Georgia found that the challenges faced by some of these organizations, such as youth and caregiver turnover and financial instability, were barriers to

providing high-quality support services. In response, the State offered these organizations training in writing grants, establishing a board of directors, retaining staff, setting up a 501(c)(3) nonprofit organization, and understanding Medicaid billing.

- **Disseminated lessons learned in peer support to other States.** Georgia presented at conferences and disseminated descriptions of its peer support programs to representatives from other States. Some of these representatives also observed Georgia's training sessions in order to inform the development of their own programs.

> "Whenever you bring parents together, it empowers them. It eliminates isolation and that hopeless feeling, and they become enthusiastic."
>
> — Georgia Family Advocate, June 2012

Georgia developed a quality improvement process for care management entities (CMEs)

CMEs use intensive care coordination to help orchestrate the many services needed by youth with complex behavioral health needs.[2] Through the demonstration, Georgia aimed to improve access to and the quality of services provided by the State's two CMEs. During the grant period, however, most youth served by the CMEs were transitioned from fee-for-service Medicaid to the State's Medicaid managed care program. Under this arrangement, the State's managed care organization (MCO) can choose whether to offer CME services. Moreover, the State's decision not to seek Federal approval for enhancements to its Medicaid program during the grant period also limited the State's ability to make changes to improve CMEs. Working within this context, Georgia narrowed the focus of its efforts and achieved the following:

- **Assessed services provided by CMEs.** Georgia contracted with a State university to describe the participants served by the CMEs and to estimate the use of behavioral health services by CME participants and how use changed over time.
- **Identified funding to sustain CME services.** During the grant period, the State identified funding for CMEs to serve youth who would otherwise be served in out-of-home care settings, such as residential treatment centers. However, the State was unable to identify funding for youth who did not qualify for out-of-home care but could benefit from CME services. Consequently, the CHIPRA quality demonstration staff and other CME stakeholders at child-serving agencies educated the State's sole MCO that serves youth in foster care on the CME model and encouraged the MCO to develop contracts with CMEs to serve the additional youth. The State used data on project outcomes to demonstrate to the MCO why the reimbursement rates for CMEs, typically higher than other care coordination rates, were worth the investment. In the final year of the grant, the MCO agreed to provide CME services, and Georgia developed a State Plan Amendment that included those services.[3]
- **Established an infrastructure for continuous quality improvement for CMEs.** The State started requiring CMEs to meet with quality improvement staff at a local university and State agencies to discuss the CMEs' performance and to identify strategies for improvement. To support these monthly discussions, the State also initiated quarterly reporting to CMEs. The reports included data on service quality and youth and family outcomes, such as school suspensions, involvement in the juvenile justice system, and participant satisfaction. As a result of these discussions and reports, Georgia reported that CMEs improved not only their process for collecting and recording quality data but also increased adherence to evidence-based practices for intensive care coordination.

Key demonstration takeaways

- Actively engaging youth and caregivers in designing the peer support trainings helped the State to create an accessible, comprehensive curriculum and to identify barriers to implementing quality peer support. However, youth needed their own training and support from the State before engaging in the curriculum development process.
- Georgia's new caregiver peer support training program helped caregivers develop skills needed to support other caregivers of children with complex behavioral health needs. The State also developed programs to help youth learn to manage their own conditions and support others, though the significant level of support required for youth may limit the sustainability and scalability of youth peer support programs.
- The State developed an infrastructure for improving CME quality. However, the State's ability to expand and improve CME services during the grant period was limited by external factors, including the administrative and financial changes underway in the State's Medicaid program.

Endnotes

1. As of Summer 2017, Georgia had trained and certified more than 130 caregivers and more than 40 youth.
2. CMEs follow the high-fidelity wraparound care–planning model outlined by the National Wraparound Initiative. For more information, visit http://nwi.pdx.edu/.
3. CMS approved the Medicaid State plan amendment in May 2017.

Continuing Efforts in Georgia

After Georgia's CHIPRA quality demonstration grant ended in February 2016, the State planned to—

- Hold additional caregiver and youth peer support trainings.
- Submit its State Plan Amendment, under which Georgia planned to expand access to CME services and sustain funding for peer support services. (CME and peer support services for parents and youth were approved by CMS in May 2017.)
- Continue encouraging CMEs to pursue quality improvement activities even though it did not plan to continue its formal quality improvement meetings or data feedback activities.

LEARN MORE

Georgia's CHIPRA quality demonstration experiences are described in more detail on the national evaluation Website available at **http://www.ahrq.gov/policymakers/chipra/demoeval/demostates/ga.html.**

The following products highlight Georgia's experiences—

- *Evaluation Highlight No. 6:* How are CHIPRA quality demonstration States working together to improve the quality of health care for children?
- *Evaluation Highlight No. 7:* How are CHIPRA quality demonstration States designing and implementing caregiver peer support programs?
- *Implementation Guide No. 1:* Engaging Stakeholders to Improve the Quality of Children's Health Care
- *Implementation Guide No. 2:* Designing Care Management Entities for Youth with Complex Behavioral Health Needs

The information in this brief draws on interviews conducted with staff at Georgia, CMEs, and family-advocacy organizations and review of project reports Georgia submitted to CMS.

The following staff from Mathematica Policy research contributed to data collection or the development of this summary: Grace Anglin and Adam Swinburn.