

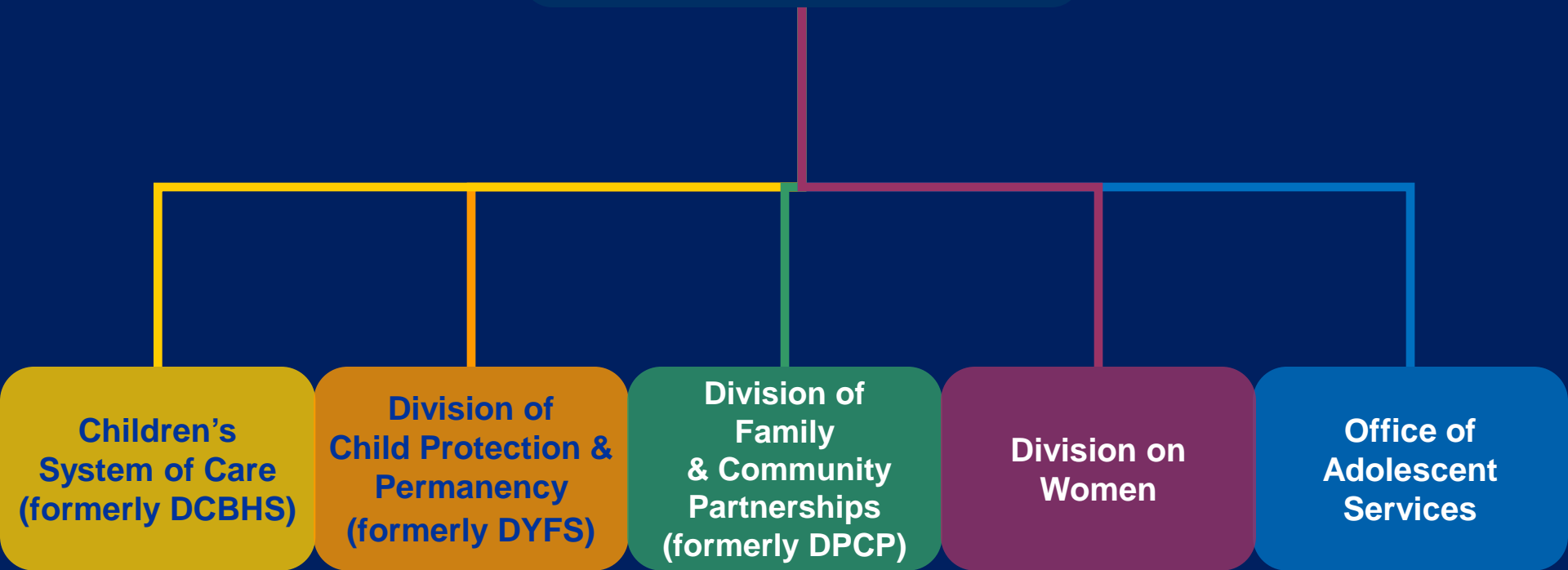
Trust, Transfer, Transition, Integration, Transformation

How the NJ Children's System of Care
Assumed Responsibility for Adolescent
Substance Use Treatment

New Jersey Department of Children and Families
Children's System of Care
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New Jersey Department of Children and Families

Commissioner



Children's System of Care Objectives

To help youth succeed...



At Home

Successfully living with their families and reducing the need for out-of-home treatment settings.



In School

Successfully attending the least restrictive and most appropriate school setting close to home.



In the Community

Successfully participating in the community and becoming independent, productive and law-abiding citizens.

Children's System of Care Values and Principles

Child Centered & Family Driven Community Based Culturally Competent

Strength Based

Unconditional Care

Promoting Independence

Family Involvement

Collaborative

Cost Effective

Comprehensive

Individualized

Home, School &
Community Based

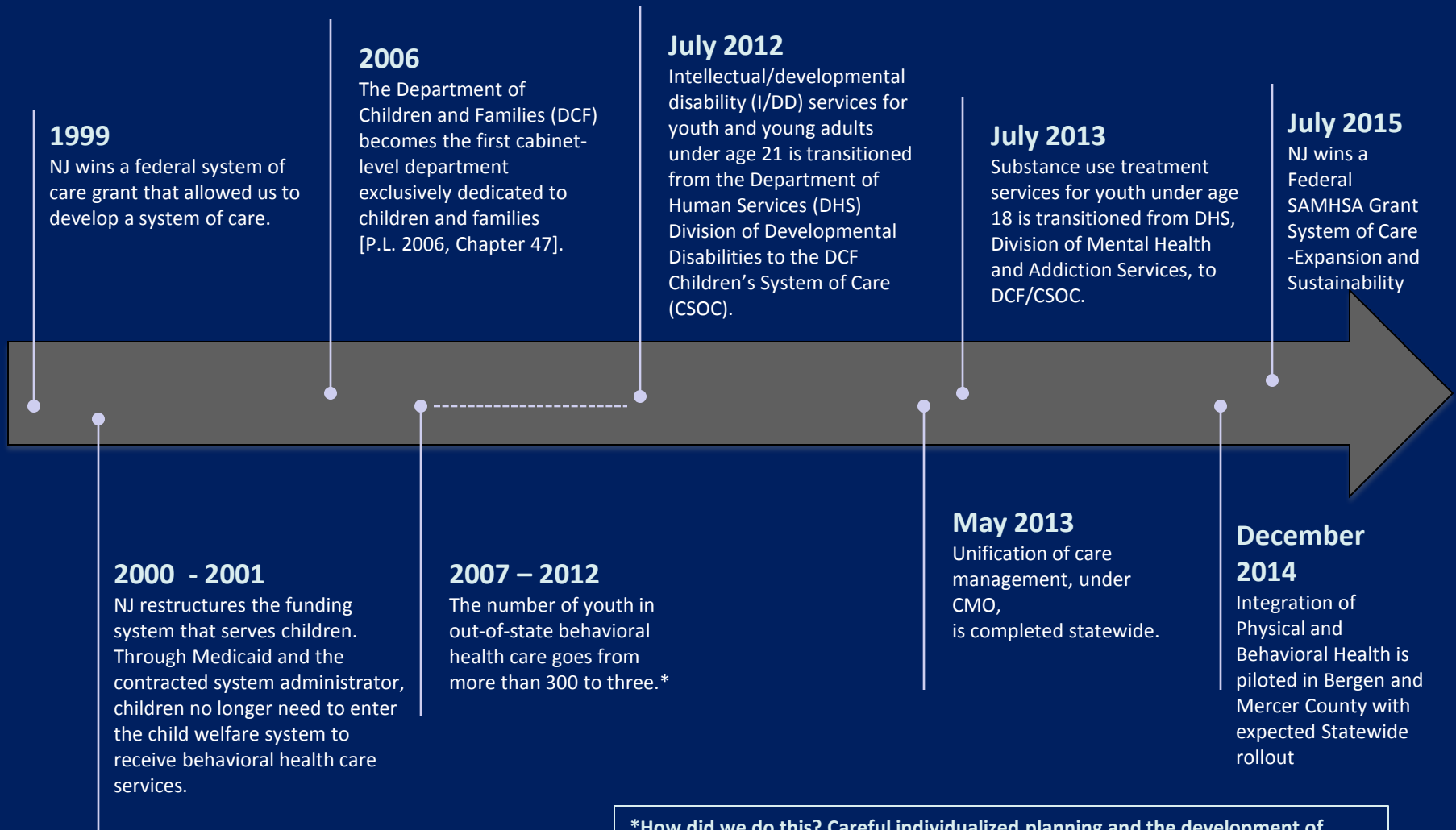
Team Based

Summary of Children's Initiative Concept Paper

In summary, the Children's Initiative concept operates on the following abiding principles:

- The system for delivering care to children must be restructured and expanded
- There should be a single point of entry and a common screening tool for all troubled children
- Greater emphasis must be placed on providing services to children in the most natural setting, at home or in their communities, if possible
- Families must play a more active role in planning for their children
- Non-risk-based care and utilization management methodologies must be used to coordinate financing and delivery of services

Children's System of Care History



***How did we do this? Careful individualized planning and the development of in-state options (based on research about what kids need) using resources that were previously going out of state.**

Financing

Title XIX Funding
 -Rehab Option
 -Targeted Case Mgt
 Child Welfare
 Juvenile Justice
 1915 like (i) or (c)
 1115 Waiver
 CHIP/SCHIP
 State Funds

Priorities

Increase Access to Care
 EBPs
 Care Management
 System Coordination
 Reduce Institutional Care
 Particular Populations

CSOC Values &

**Final
System
of Care
Design**

Principles

Environment

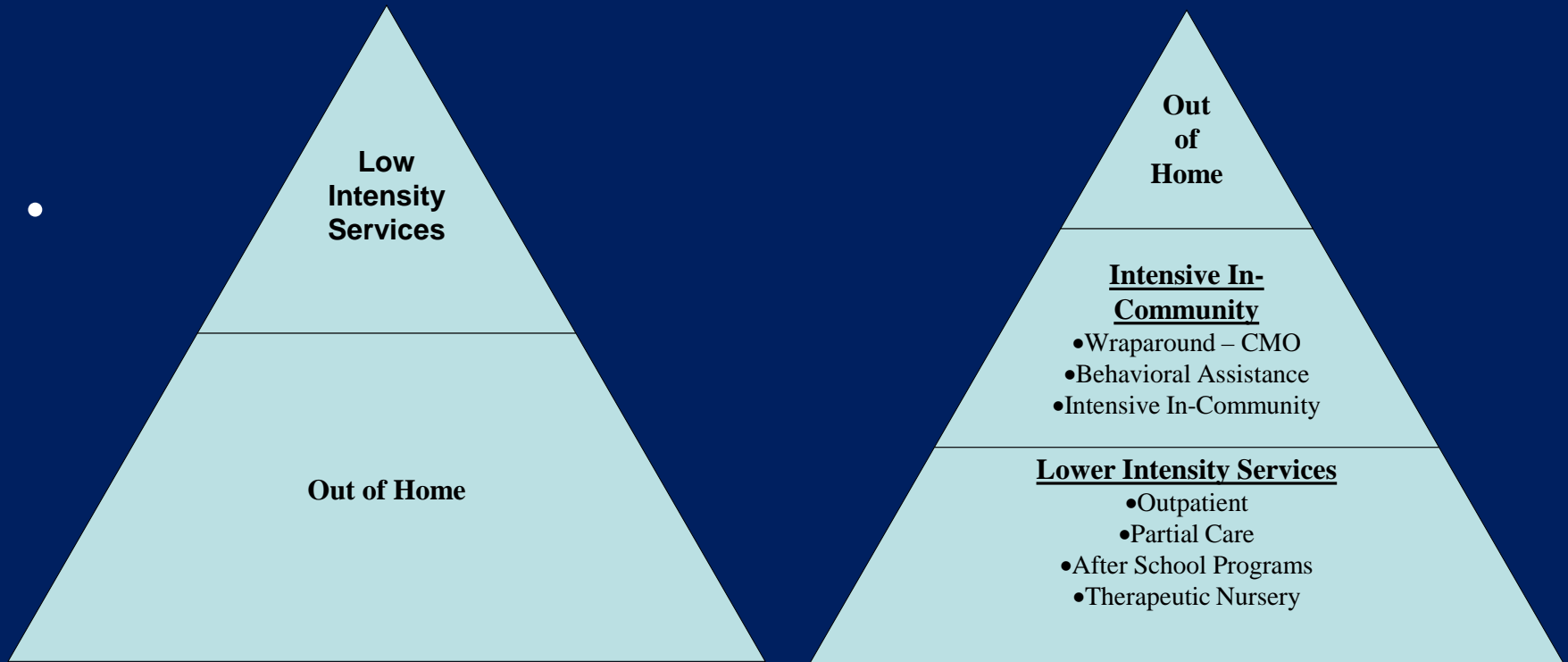
Political
 Perspectives of Leaders
 Lawsuits/Settlements
 Crisis/Tragedy
 Mandates
 Community Will
 Economy

Structure

Government
 State vs. County
 Existing Reality
 Envisioned Ideal
 Medicaid Agency
 Locus of Control
 Leadership Structure

Factors That impact Design

Overuse of Deep-End Services



Language Is Important



Language of CSOC

- Children, youth, young adults
- Parents, caregivers
- Treatment
- Engagement
- Transition
- Missing
- Not clients, case, consumers
- Not Mom and Dad
- Not Placement
- Not motivated
- Close, terminate
- Runaway

What We Have Learned

- The system of care model works
 - Less children in institutional care
 - Less children accessing inpatient treatment
 - Closure of state child psychiatric hospital and RTCs
 - Very few children in out-of-state facilities
 - Children in out of home care have more intense needs than prior to the system of care development
 - Wraparound works
 - Less youth in detention centers – many reasons, not necessarily because of the system of care
- Federal funding support under Title XIX

Children's Interagency Coordinating Council CIACC

- CIACC Data Dashboards
- Education Partnerships
- Increase in participation in local CIACC's

Key System Components

Contracted System Administrator

- **PerformCare is the single portal for access to care available 24/7/365**

Care Management Organization

- **Utilizes a wraparound model to serve youth and families with complex needs**

Mobile Response & Stabilization Services

- **Crisis response and planning available 24/7/365**

Family Support Organization

- **Family-led support and advocacy for parents/caregivers and youth**

Key System Components

Intensive In-Community

- Flexible, multi-purpose, in-home/community clinical support for parents/caregivers and youth with behavioral and emotional disturbances who are receiving care management, MRSS, or out-of-home services

Out of Home

- Full continuum of treatment services based on clinical need

DD-IH and Family Support Services

- Supports, services, resources, and other assistance designed to maintain and enhance the quality of life of a young person with intellectual/developmental disability and his or her family, including respite services and assistive technology

Substance Use Treatment Services

- Outpatient, out of home, detox treatment services (limited), co-occurring services

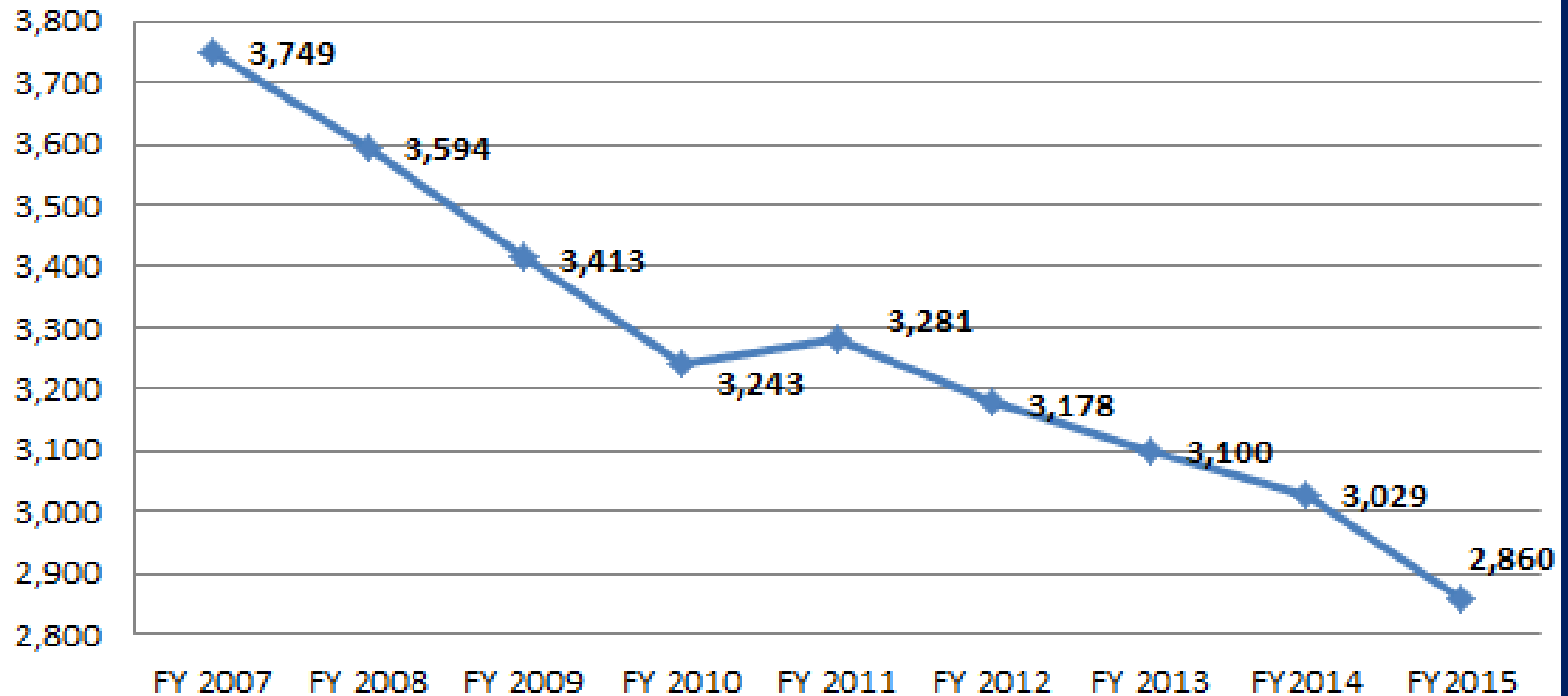
Traditional Services

- Partial Care, Partial Hospitalization, Inpatient, and Outpatient services

Out of Home Treatment

Authorizations (which provide access to out of home care) is reduced due to more access and availability of community resources

OOH Authorizations-Unique Youth



Child Family Team

Child Family Team (CFT)

A team of family members, professionals, and significant community residents identified by the family and organized by the care management organization to design and oversee implementation of the Individual Service Plan.

CFT members should include, but are not limited to, the following individuals:

- **Child/Youth/Young Adult**
- **Parent(s)/Legal Guardian**
- **Care Management Organization**
- **Natural supports as identified and selected by youth and family**
- **Treating Providers (in-home, out-of-home, etc.)**
- **Educational Professionals**
- **Probation Officer (if applicable)**
- **Child Protection & Permanency (CP&P)
(if applicable)**



Behavioral Health Home (BHH)



What it is:

- CMOs are the designated BHH for Children in NJ
- Enhancement to the Child Family Team to bring medical expertise to the table

What it is not:

- Not a physical site

CSOC Substance Use Treatment Services

Available Services:

- *Assessment*
- *Outpatient (OP)*
- *Intensive Outpatient (IOP)*
- *Partial Care (PC)*
- *Long-Term Residential (LT-RTC)**
- *Short-Term Residential (ST-RTC)**
- *Detoxification*

All service authorizations are based on clinical justification.

***Qualifies for co-occurring enhancement services**

Co-Morbidity in Children and Adults

Cost Driver	Children	Adults
Behavioral Health	↑	
Physical Health		↑

- Co-Morbidity is not as high in Children as in Adults
 - 1/3 of Children with Behavioral Health have chronic conditions
 - 2/3 of Adults with Mental Illness have chronic conditions
- CMS will only approve those State Plan Amendments (SPA) that cover both children and adults (lifespan)
- Assisting children and their families manage a chronic illness will reduce significant costs related to physical healthcare in adults

Promising Path to Success (PPS) Project Highlights

- Six Core Strategies
- Nurtured Heart Approach
- Youth Partnership
- Return on Investment

PPS What We Hope to Accomplish

- ✧ Reduce the percentage of youth in the system of care who require multiple episodes of Out of Home (OOH) treatment
- ✧ Reduce the percentage of youth who re-enter treatment after discharge from an initial treatment episode
- ✧ Reduce the average length of stay for youth in OOH treatment from 11.5 to 9 months
- ✧ Analyze and understand the impact of each type of system involvement to aid in making resource allocation decisions

Promising Path to Success Rollout- 5 Phases in 4 Years

Phase 1

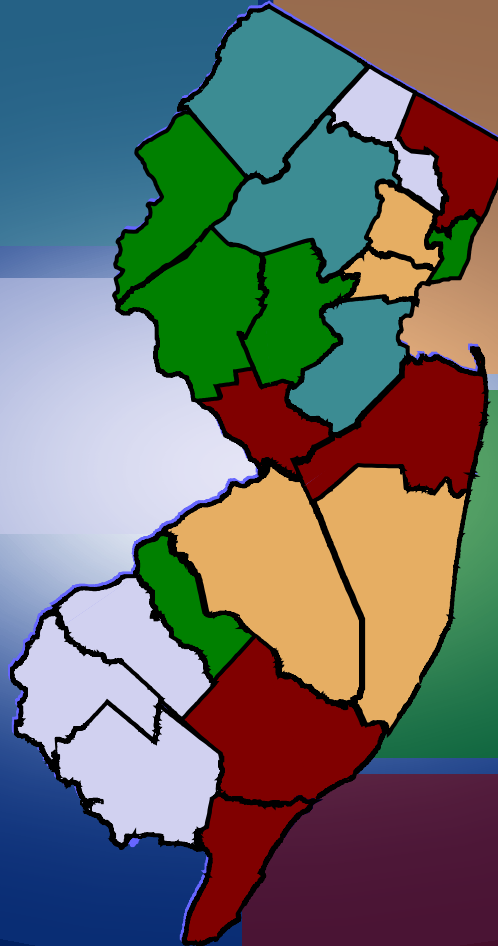
November 2015

- Morris and Sussex
- Middlesex

Phase 2

October 2016

- Cumberland, Gloucester, Salem
- Passaic



Phase 3

June 2017

- Burlington
- Essex
- Ocean
- Union

Phase 4

March 2018

- Hunterdon, Somerset, Warren
- Hudson
- Camden

Phase 5

December 2018

- Atlantic and Cape May
- Bergen
- Monmouth
- Mercer

Key Components of Each Phase

Kick Off

- Local Kick Offs

Training

- Six Core Strategies (6CS) for OOH, CMO, FSO, MRSS & CIACC Leadership
- Nurtured Heart Approach (NHA) for OOH, CMO & FSO staff

Sustainability

- Coaching for OOH on 6CS implementation
- Nurtured Heart Approach (NHA) Super User Group

HOW DOES NJ'S CHILDREN'S SYSTEM OF CARE MODEL IMPACT THE YOUTH WE SERVE?

- ✓ *Nationally recognized model for Statewide Children's System of Care*
- ✓ *Less children in institutional care*
- ✓ *Less children accessing inpatient treatment*
- ✓ *Closure of state child psychiatric hospital and RTC's*
- ✓ *Less children in out-of-state facilities*
- ✓ *Children in out of home care have more intense needs than prior to the system of care development*
- ✓ *Wraparound model works!!*
- ✓ *Less youth in detention centers*

SU Transition

- 1) Governor Signs Order for Integration
- 2) Extensive Discussion/Negotiation/Information
- 3) Sharing with the “Sending Division”
- 4) Stakeholder Groups
- 5) Provider Training/EHR
- 6) CMO Inclusion
- 7) Rate Increase and Adjustment
- 8) Movement to Convert OOH Programs to Co-Occurring
- 9) On-going R&D

Stakeholder Group

Provided **system partners** an opportunity to understand each other;

Provided **community partners** an opportunity to understand potential changes;

Provided **treatment providers** an opportunity to foresee their own destiny;

Represented by:

Families

Service Recipients

Care Management Organization (CMO)

Outpatient Providers (OPD)

Out of Home Treatment Providers (OOH)

Existing Division (DMHAS)

Receiving Division (CSOC)

Advocates

Access

- The most important goal: Easy access for youth and families;
- Routinely, all access to System of Care (SOC) services are routed through our Contracted Systems Administrator (CSA);
- Historically, access to substance use services occurred through direct contact with provider agencies;
- It was clear that we needed to adopt and maintain the direct access process;
- This required the System of Care to adjust its process;
- Therefore, we blended the process by which youth accessed services through DMHAS and the process by which youth access services thru CSOC;

Evaluation

- We maintain the use of the LOCI (Level of Care Index) which correlates with ASAM Criteria.
- CSOC also integrated the NJ System of Care CANS instrument and Bio-Psychosocial evaluation (BPS).
- Agencies may also use a standardized SU assessment tool.
- Agencies are now required to complete these tools in order to receive an Intensity of Service (IOS) disposition and a service authorization through our CSA.
- This authorization process was implemented in order to maintain good data and served as a precursor to these agencies becoming Fee for Service (FFS) providers.
- The CSA will issue a 30 day presumptive authorization to give providers the time to complete the evaluative processes

Funding

- Initially, when the substance use contracts transitioned to CSOC, they remained as cost reimbursement;
- The vision was to convert contracts to Fee for Service (FFS);
- At this juncture, CSOC converted all the OOH contracts to co-occurring FFS contracts.

The Child Family Team Drives the Treatment

Services

Outpatient (OP)

Intensive Outpatient (IOP)

Partial Care (PC)

Long Term OOH (LT)

Short Term OOH (ST)

Co-Occurring RTC (CO RTC)

Withdrawal Management (WM)

Service Delivery

- The authorization is the conduit for youth to receive services and for agencies to get paid through what was still a cost reimbursement system.
- The authorization also opens the electronic record, which is closely governed by the 42 CFR Part 2, to the agency. This allows the agencies to complete treatment plans and to request continued care and/or transition youth to another intensity of services within our system of care.
- All treatment plans require approval by credentialed care coordinators at the CSA.
- Treatment plans are completed cyclical and are reviewed by dually licensed clinicians at the CSA for continued care.
- All treatment plans include the CANS and the LOCI.
- All planning is done under the driving auspices of the Child Family Team.

Meetings

All of the above were accomplished through regular meetings with the providers, NJ System of Care staff and the CSA.

Our goal has been to reach consensus in order to address the needs of our youth most efficiently, using tried interventions.

Inherited Agencies

- Initially, all agencies (both Outpatient and OOH) were transitioned as-is.
- They maintained their traditional structure and intervention.
- Two out-of-home agencies opted out of the transfer at the outset,
- One agency left the fold after two years as they were bought out by a private agency.
- At this juncture, all of the outpatient agencies remain and continue their practices.

Agencies–Outpatient

- The major change for the outpatient providers is that they adopted the System of Care Bio Psychosocial (BPS) evaluation and the treatment planning models.
- Continue to use the LOCI.
- Have been able to provide BPS evaluations as a new revenue path.
- Overtime, we converted all the IOP slots into a “time bank” with the OP slots.
- This afforded the agencies and youth the opportunity to participate in treatment based on a clinical review as well as their ability to commit to a set number of sessions per week. This appears to be a more efficient use of resources.
- The outpatient providers continue to operate on a cost reimbursement basis.

Agencies-OOH

- CSOC was able to develop a limited number of co-occurring out of home treatment programs with intensive behavioral health interventions. This was a major step towards true integration of care.
- The remaining OOH agencies functioned on a cost reimbursement basis and as primary substance use program until July 1, 2015.
- In July 2015 and after many meetings, trainings, and contract alterations, CSOC successfully converted all OOH substance use provider agencies to co-occurring programs with an increased per diem rate and a set of standardized contract deliverables.

Agencies-OOH (cont')

- Transitioning these programs to a co-occurring model meant that these agencies were being supported to expand their staff by hiring licensed behavioral health clinicians (including dually licensed clinicians) and engage psychiatry and nursing as a routine part of their work.
- Allied therapies were added;
- CSOC developed market based rates on the Medicaid platform, which is congruent to the rest of our system's processes.
- In some instances, the rates were raised two or three times.
- It has been a challenge for these agencies to become integrated from a programmatic, clinical, and process point of view. However, we succeeded.

Treatment

- Simultaneous to the transfer and ultimately, the transition to the System of Care, we developed a co-occurring substance use and behavioral health trauma based model of treatment.
- It seemed clear to us (based on our years of experience), that youth using some form of substance were also experiencing behavioral health and emotional challenges.
- The greater majority of the youth coming for substance use treatment were referred not only for their “use”, but because of their presenting overt behaviors.

Treatment (Cont')

- Initially, we were able to convert one existing RTC's substance use program into a co-occurring program that would provide a braided, integrated set of interventions for youth.
- This agency hired a well-known consultant who developed a trauma based substance use program for their youth. This program is always full and has been a great success. The agency says that based solely on the youth they have in their larger RTC, they could fill the program two times over.
- As this program only served males, we developed two five-bed co-occurring programs for girls in the community.
- Achieved thru an RFP.
- These programs have been open for nearly two years and after a trial time to bring them up, they are usually functioning at capacity. We are currently releasing an RFP to develop 50 more of these intensive co-occurring beds that will be embedded in RTCs.

Withdrawal Management (WM)

While the initial transfer of programs did not include any medical detox resources, as a result of the Hurricane Sandy (in Fall 2012), funding became available to develop a small program for up to six youth.

Curiously, and with great concern, these beds were never used to their capacity. We recently moved this program to a more central location and utilization has grown significantly.

Linkage to the System of Care

One of the few data points we were able to gain before the transfer, was that youth who had been in one of the OOH programs and were also connected to one of the System of Care's Care Management Organizations had better outcomes in the community.

As a result of that fact, we have begun to attach all youth going into an program with a Care Manager upon the youth's admission to an OOH program with the intent of the youth being able to be transitioned back into the community with a Plan of Care developed by a Child Family Team and in developing a strong community plan.

Successes

We are able to provide better in-depth care and treatment for youth who are presenting with behavioral health challenges and who are using some form of substance.

We are in a better position to educate our youth and families through the System of Care infrastructure which has the ability to provide an array of interventions that allow for a wraparound approach.

Concerns

We are not using all our resources during a time of grave concern in which we see youth suffering and not accessing services.

Into the future....

*We should identify our goals moving forward such as

- 1) Operating at full capacity
- 2) Substance Use Consultants in every county
- 3) Continue to refine clinical care
- 4) Treatment Plan Redesign

For more information...

Children's System of Care

<http://www.state.nj.us/dcf/families/csc/>

PerformCare Member Services:

877-652-7624

www.performcarenj.org

