Expanding Access to Children's Behavioral Health Services

Lessons Learned in New Jersey

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Key Points

System of Care Building Blocks

Factors that Impact Design

Leadership Strategies

Stakeholder Engagement

Data Integration

Individualized Care Plan

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PerformCare is a full-service managed behavioral health care organization (MBHO) that supports individuals and providers through programs in both the public and private sectors.

Founded in 1994 by a group of leading behavioral health providers, PerformCare is a member of Amerihealth Caritas Family of Companies, one of the largest Medicaid managed care organizations in the United States.

PerformCare is NCQA Accredited.

PerformCare New Jersey

As the Administrative Service Organization (ASO) for the State of New Jersey's Division of Children's System of Care (CSOC) since 2009, PerformCare New Jersey utilizes ***significant expertise and integrated technologies*** to register, authorize, and coordinate services for children, youth, and young adults who are experiencing emotional and behavioral challenges, are developmentally and intellectually disabled or need certain substance abuse treatment services.

NJ's Foundation - Values and Principles

Child Centered & Family Driven Community Based Culturally Competent		
Strengths Based Unconditional Care Promoting Independence	Family Involvement Collaborative Cost Effective Comprehensive	Individualized Home, School & Community Based Team Based

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Children's System of Care Vision

To help youth succeed…

At home

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

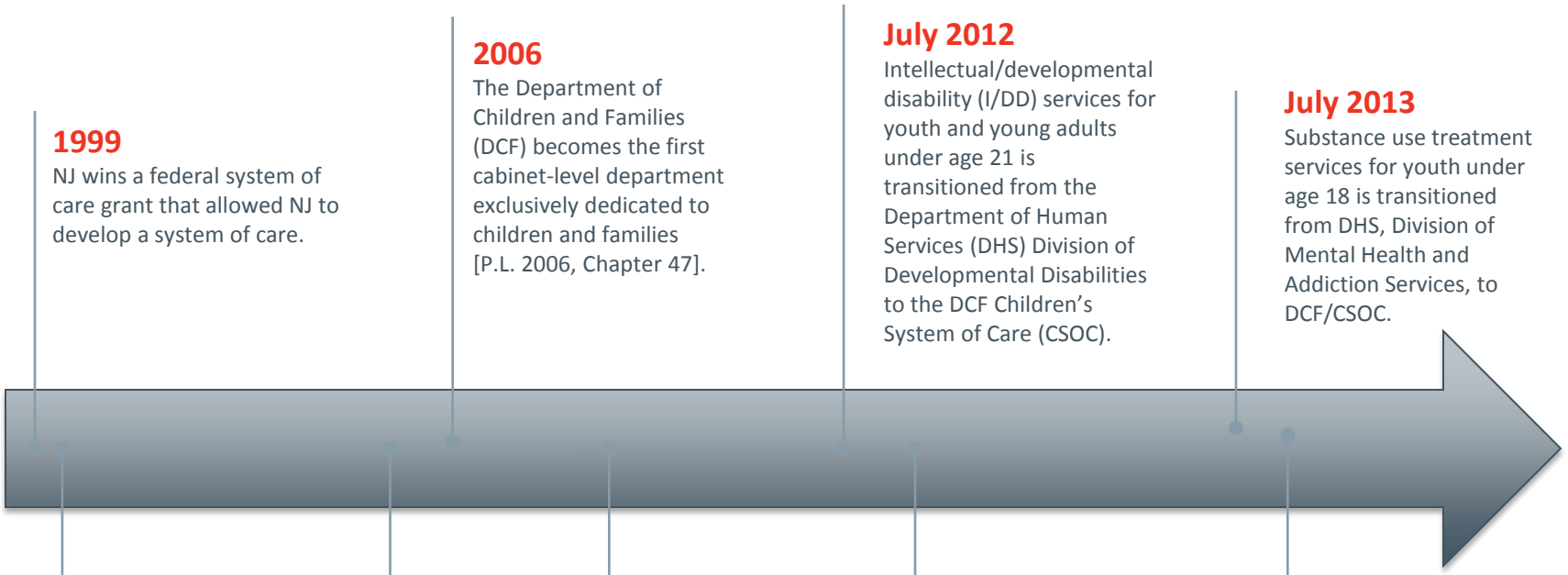
At school

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.

NJ Children's System of Care History



1999
NJ wins a federal system of care grant that allowed NJ to develop a system of care.

2001
NJ restructures the funding system that serves children. Through Medicaid and the contracted system administrator, children no longer need to enter the child welfare system to receive behavioral health care services.

2005
Closed State Psychiatric Hospital For Children

2006
The Department of Children and Families (DCF) becomes the first cabinet-level department exclusively dedicated to children and families [P.L. 2006, Chapter 47].

2007 – 2012
The number of youth in out-of-state behavioral health care goes from more than 300 to three.*

July 2012
Intellectual/developmental disability (I/DD) services for youth and young adults under age 21 is transitioned from the Department of Human Services (DHS) Division of Developmental Disabilities to the DCF Children's System of Care (CSOC).

May 2013
Unification of care management, under CMO, is completed statewide.

July 2013
Substance use treatment services for youth under age 18 is transitioned from DHS, Division of Mental Health and Addiction Services, to DCF/CSOC.

November 2014
Behavioral Health Home Pilot

***How did NJ 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.**

Source-State of NJ Division of Children's System of Care PowerPoint

Who's Integrated?

The NJ Children's System of Care serves:

- **Behavioral health:** Youth with moderate to severe needs, entire NJ population (over 45,000 youth in the last fiscal year).
- **Child welfare:** Youth with child welfare involvement and a treatment need.
- **Developmental disabilities:** Youth eligible for services based on regulatory definition of functional impairment (over 17,000 youth).
- **Substance use:** Youth who are underinsured and have a treatment need (1143).
- **Housing:** Young adults experiencing homelessness (573).

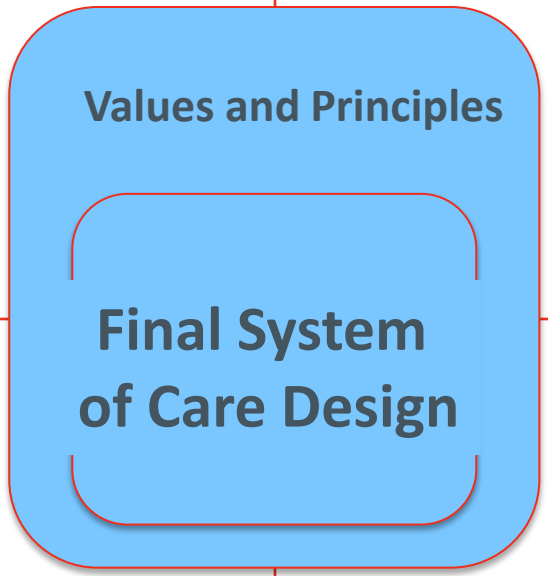
Factors that Impact Design*

Financing

- Title XIX funding:
  - —Rehabilitation option.
  - —Targeted case management.
- Child welfare.
- Juvenile justice.
- 1915 like (i) or (c).
- 1115 waiver.
- CHIP/SCHIP.
- State funds.

Environment

- Political.
- Perspectives of leaders.
- Lawsuits and settlements.
- Crisis and tragedy.
- Mandates.
- Community will.
- Economy.



Priorities

- Serve more children.
- Evidence Based-Practices
- Care management.
- System coordination.
- Reduce institutional care.
- Particular populations.

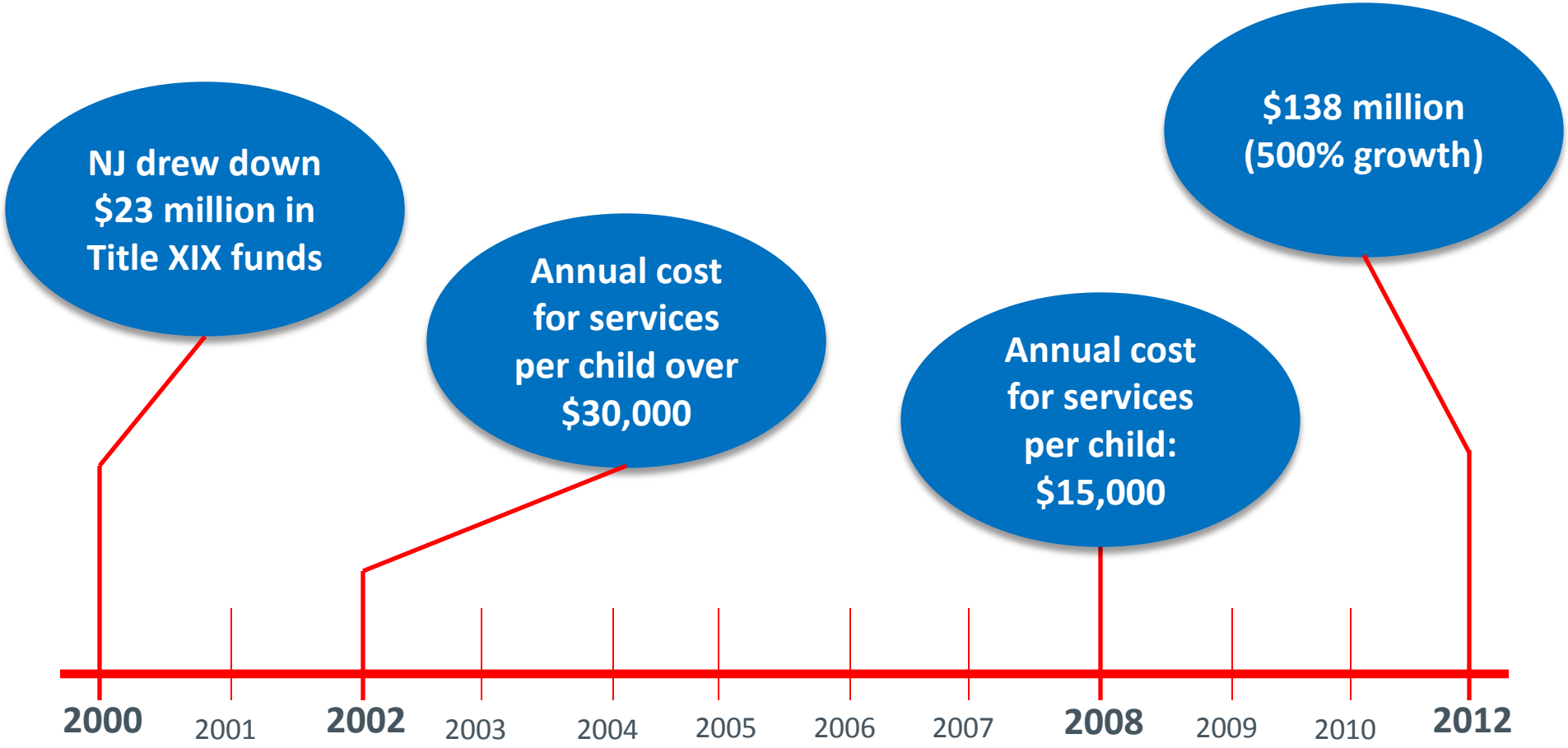
Structure

- Government.
- State vs. county.
- Existing reality.
- Envisioned ideal.
- Medicaid agency.
- Locus of control.
- Leadership structure.

Source-State of NJ Division of Children's System of Care PowerPoint

System Sustainability

State sought to maximize federal revenue to support system growth and maximize resource efficiency.



Federal Funds Expended

Administrative Service Organization

The ASO's Role as a Partner with the State

Role of State	Role of PerformCare
Vision/policy for system of care	Access to Care: 24/7/365 single point of contact for families
Setting data collection priorities	Developing/enhancing electronic medical record
Using data to refine service array	Data collection and reporting
Contract management and service line manager	Provider training, communication, technical support
Rate setting, new services (via notice of funds availability), funding priorities	Leverage braided and blended funding streams to maximize services and availability of Federal Funding Participation (FFP)
Defining new service and population rules, requirements, and criteria, ensuring compliance with statutes and regulations	Rapidly implementation ensuring capacity for new services/populations

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Leadership Strategies

How do you handle uncertainty, ambiguity and rapid change?

Understand and communicate the vision of where we are going.
Recall the vision when things get murky.

Be transparent to families, providers, staff and state, giving current status and acknowledging challenges.

Share and report progress regularly.

Develop partnerships with family, and with advocacy and provider groups and organizations.

Be flexible and acknowledge what we don't know yet.

Stakeholder Engagement

For providers, advocates, youth and families:

New service populations have different expectations for accessing services.

Recognize and respect cultural and attitudinal differences in seeking health care and services.

Build a fair, equitable service model to access services based on level of need.

Encourage dialogue and feedback with key stakeholders and recognize contributions.

Family Culture and Engagement

Address system change and worries early on with families

- Behavioral health: will the system forget about us?
- Developmental disabilities: do you really understand what we need?
- Substance abuse: will it be more difficult to access services?

Establish stakeholder groups

- State-stakeholder group.
- ASO-family leader group.

Be in front of families frequently

Provider Culture

Manage provider expectations.

Slow but steady change — especially around contracting.

Have providers who embrace system change present in many provider orientations to address concerns and provide "on-the-ground" advice to quell fears about immense change.

Find subject matter experts to guide the work (local and national) — many are more than willing.

Be prepared for workforce challenges – develop comprehensive training for all system partners through a university contract.

Communication

Make the most of technology: website, family portal and notifications within the electronic record.

Close communication between state and ASO: co-located staff.

Acknowledge when there is no answer (yet) rather than generating false expectations.

Know who is responsible for what messaging.

Be consistent.

The squeaky wheel problem: let complaints inform, but let data drive practice changes.

Data Integration: Challenges

Agreeing up front on what really matters.

Common definitions are needed to crosswalk services and data sets.

Technical questions: how do we get the file?

Privacy concerns: who owns the data, and what can be seen or shared?

Set priorities for Day 1 reports.

Data Integration: Strategies

Get the right people in the room: content experts, decision makers (all sides), data analysts and IT.

Recognize that “the perfect is the enemy of the good.” Having some kind of data decision points early is critical in fine tuning.

Specialized data collection: expanded modules for CANS tools, Level of Care Indicator (LOCI) and custom family support application.

Build reporting functions to capture discrete data for service penetration and utilization, and track braided funding of unique youth populations.

Individualized Care Plan

- Key component of any intensive care management model.
- Serves as the roadmap for everyone involved in the youth's care.
- Ensures all services are aligned and rendered and are ***driven by the child-family team process.***
- Care manager oversees the process and intervenes should a youth have difficulty accessing care.
- ASO and providers ***share an integrated IT platform*** which ensures timely access to and sharing of information.
- All assessments, crisis plans, authorizations and outcome measurement tools would be housed in this shared platform.

A System of Care That Works

"Access to the Right Care at the Right Time"

- Care Management
- Outpatient Services
- Family Support Services & Organizations
- Intellectual/Developmental Disability Eligibility & Services
- Substance Use Treatment Services
- Partial Care Partial Hospital
- Residential Treatment Adolescent Housing Hub
- Mobile Response and Stabilization Services Human Trafficking Emergency Services

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Care is the Heart of Our Work