Integrating New Populations in an Existing System of Care: New Jersey’s Experience

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

Commissioner

Division of Children’s System of Care
formerly DCBHS

Division of Child Protection and Permanency
formerly DYFS

Division of Family and Community Partnerships
formerly DPCP

Division on Women

Office of Adolescent Services
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.
Children’s System of Care History

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

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].

FY 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.

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).

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.

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

*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.
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.
- EBPs.
- 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.

CSOC values and principles

Final system of care design
NJ Children’s System of Care

Reasons for Integration of Developmental Disability Services and Substance Use Services

- Synchronized service coordination and elimination of duplicated services.
- Support sustainable communities and balanced resource coordination.
- Bring all children’s services into a single department.
- Further current progress and achievement of strategic objectives of the Department of Children and Families.
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).
Operationally What Happened?

• Transfer of demographic information and special DD code
• Transfer of 4,000 authorizations of children receiving a service
• Care management reconfigured
• Back room assistance from state staff
• Location of available slots for services unknown
• Applications to determine eligibility for developmental disability services
• Summer camp applications and qualified camps
• Emergency out of home placement
• Immediate lesson learned
Workforce Challenges

- Identified new competencies needed for staff.
- Sought feedback and learned from the “experts” for developing tools and business products.
- Conducted comprehensive statewide training for all system partners through university contract (at no cost to participants).
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.
Communication

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

• Close communication between state and CSA: 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.
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.
  - CSA-family leader group.

- Be in front of families frequently.
Provider Culture

• Manage provider expectations.

• Slow but steady change — especially around contracting.

• Have existing system of care providers present in many new 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.

• For substance abuse, learning that key value is “holding on” to the youth while they have them, and requiring an authorization process that doesn’t delay admission to level of care.
Data Integration: Challenges

• Agreeing up front on what really matters.
• Common definitions are needed to crosswalk definitions and data sets.
• Technical questions: how do we get the file?
• Privacy concerns: who owns the data, and what can be seen or shared?
• Setting priorities.
Data Integration: Strategies

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

- Ongoing access until data transition is finished (may take far longer than expected).

- 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, 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.

- Integrate new populations and services within existing reporting formats to monitor key functions (for example, tier reporting by call center service request and then by population).
Quality Improvement

• Delineate performance measures for new modules and tools.

• Design new assessments to assess level-of-care service needs and measure outcomes over time.

• Select measures that address strength-based outcomes that are realistic and attainable.

• Test pilot newly designed assessments and refine based on experience.

• Aggregate findings about new youth characteristics and needs for policy planning and new or expanded service delivery.
Privacy

How do you handle release of information in an integrated electronic record system?

• Design an integrated release of information that permits providers to disclose information to the CSA, and for the CSA to re-disclose to providers for treatment referral of youth, in compliance with 42 CFR.

• Address requirements for 42 CFR confidentiality by designing new, expanded release-to-disclose form.

• Develop new consent processes for developmentally disabled young adults and their families who are unable to provide consent or who require special assistance to access services.
Lessons Learned: Silver Linings

“We don’t know what we don’t know...”
But also: “We’ve done this before.”

Developing IT simultaneous to implementation required temporary manual processes for almost every new element. This proved to be an asset in the long run, as this manual stage became a way to test assumptions and refine tools before hard-coding them into the system.
For More Information

Children’s System of Care
www.state.nj.us/dcf/families/csc/

PerformCare
www.performcarenj.org