PROMISING PATH TO SUCCESS

System of Care
Expansion and Sustainability Grant
Project Period: 9/30/2015-9/30/2019
Children’s System of Care History

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

2000 - 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.

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).

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.

December 2014
Integration of Physical and Behavioral Health is piloted in Bergen and Mercer County with expected Statewide rollout.

July 2015
NJ wins a Federal SAMHSA Grant System of Care - Expansion and Sustainability

*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.
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
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
# System of Care Values and Principles

<table>
<thead>
<tr>
<th>Youth Guided &amp; Family Driven</th>
<th>Community Based</th>
<th>Culturally/Linguistically Competent</th>
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<tr>
<td>Strength Based</td>
<td>Family Involvement</td>
<td>Individualized</td>
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<td>Unconditional Care</td>
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<td>Promoting Independence</td>
<td>Cost Effective</td>
<td>Team Based</td>
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<td></td>
<td>Comprehensive</td>
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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.
Language Is Important

Client Case Placement

No
Language Is Important

Language of CSOC
- Children, youth, young adult
- Parents, caregivers
- Treatment
- Engagement
- Transition
- Missing

Not the Language of CSOC
- Clients, Case, Consumer
- Mom and Dad
- Placement
- Motivated
- Close, Terminate
- Runaway
Project Highlights

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

ROI Analysis of the CSOC Expansion

21-42 months

Baseline ROI Analysis and Refine Analysis Plans

Months 13-20

Prepare Data for ROI Analysis

Months 7-12

Develop ROI Analysis Plan

Months 1-6
Strategies for Sustainability and Wide Scale Adoption

1. Training, Coaching & Implementation Monitoring
   - Six Core Strategies
   - The Nurtured Heart Approach

2. Super User Groups to sustain fidelity to these trauma informed practices

3. Research
   - Return on Investment (ROI) Study
Six Core Strategies To Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint

1. Leadership toward organizational change
2. The use of data to inform practice
3. Workforce development
4. Full inclusion of individuals and families
5. The use of seclusion and restraint reduction tools, which include the environment of care and use of sensory modulation
6. Rigorous debriefing after events in which seclusion and restraint might have been used
Out of Home Treatment

Authorizations (which provide access to out of home care) is reduced due to more access and availability of community resources.
Behavioral Health Youth in Out of Home Treatment Settings
2010 - September 2015

Note: Data does not include DD only children.
Behavioral Health:

- Intensive Residential Treatment Services (IRTS)
- Psych Community Homes (PCH)
- Specialty Beds (SPEC)
- Residential Treatment Centers (RTC)
- Group Homes (GH)
- Treatment Homes (TH)

*Intensities of Service (IOS): Levels of OOH treatment based on intensity, frequency, and duration of treatment.
The Nurtured Heart Approach

The 3 Stands

1. **Absolutely No!** – Refuse to energize negativity
   
   Our attention is the ultimate prize

2. **Absolutely Yes!** – Super-energize success
   
   Active, Experiential, Proactive & Creative Recognitions

3. **Absolutely Clear!** – Set clear limits & consequences
   
   The power of proactive clarity and resets
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
- Family Support Organization (peer partner)
- 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)
Thank You

Merci

Gracias