Keeping Families Strong

Keeping Children Safe and Well
Division of Child Behavioral Health

10 Years of System of Care Implementation:

*Letting the Data Tell the Story*
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System of Care Values and Principles

VALUES:

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

Promoting Independence

Team Based

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Family Involvement

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Home, School & Community Based
DCBHS Objectives

*We want to keep kids...*

**At Home**
(with their families and not in out-of-home treatment settings)

**In School**
(in their regular school in their school district)

**Out of Trouble**
(not involved with the Juvenile Justice System or at risk of detention or incarceration)
DCBHS History

- Statewide implementation occurred over a six year period
- County level implementation occurred on a rolling basis
- Created the opportunity to test county level effects of implementation and cumulative effects statewide
- Statewide use of the Child Assessment of Needs and Strengths (CANS) Assessments
- 170,000 children enrolled (40,000 active) and database of more than 500,000 individual CANS assessments
1999
NJ wins a federal System of Care grant for Burlington County

2000
Governor approves plan to implement SOC statewide, known as the Children’s Initiative. NJ restructures the funding system that serves children to maximize federal funds through Rehab Option.

2001
Statewide CSA contract begins, providing utilization review, care coordination and statewide MIS. CANS tools implemented.

2002

2003

2004

2005

2006
NJ systematically implements local systems of care across 15 service areas. By 2006, all local service areas have a CMO, FSO, MRSS, and YCM

The Department of Children and Families becomes independent cabinet-level department.

Training and Technical Assistance Program is created
Children’s Initiative Concept Paper: Reform Agenda

• Increase Revenue And Expand Underfunded Services
• Increase Family Participation
• Establish Common Entry Point And Assessment Tools
• Create Utilization Management And Care Coordination System-wide
• Establish Care Management Organizations (CMOs) As Intensive Care Managers
• Create Structure For Ongoing Collaboration And Planning With Stakeholders
• Provide Training/Technical Assistance
• Re-align Existing Services And Programs To Operate As Participants In The New System of Care (SOC)
Children’s Initiative Concept Paper: Anticipated Outcomes

• Improved Emotional Stability
• Maintain Children In Communities
• Reduce Residential Lengths Of Stay
• Reduce Acute Hospital Admissions And Re-admissions
• More Stable Living Environments For Children
• Improve Educational And Social Functioning
• Reduced Criminal Activity For Children Involved In Care
Evaluation Project: Areas for Review

- Family Participation
- Overall Population Changes
- Acute Hospital System
- Juvenile Justice System
- Residential Care
- Community Services
- Fiscal Efficiency and Equity
- Overall Behavioral and Emotional Functioning
Family Satisfaction with Participation in Treatment has Substantially Improved

- 0% Satisfied
- 10% Not Satisfied
- 20% Neutral
- 30% No Response

The chart shows the percentage of satisfied, not satisfied, neutral, and no response for each year from 2004 to 2009.
Family Survey Shows Strong Cultural Competency of Staff
Demographics

- Review found a substantial shift in age at enrollment.
- Some shift in Race/Ethnicity, but attributable to County Demographics.
- In 2003 40% of newly enrolled children were under 14 years old, by 2010 that percentage had grown to 60%.
- Tends to indicate system of care has become more preventative.
Percentage of Children Under Age 14 at First Enrollment has Grown Significantly
Acute Inpatient System: Background

- Heavily used as a safety net for kids
- Particular focus of the SOC
- Established Mobile Crisis Response teams and greater access to services before hospitalization
- Closed last state psychiatric hospital for children in 2005
Annual Admissions Saw A Dramatic Shift from 1998-2003 Trend
Discharges Readmitted within 30 Days Reduced by More Than 50%
Acute Inpatient Impacts Overview

• 1998 to 2003: 24% increase in admissions
• 2003 to 2009: 4% decrease in admissions
• 2002 to 2009: 50% reduction in 30-day readmissions
• Given average costs per admission, NJ has averted approximately $40 million since 2004 in reduced inpatient stays.
Juvenile Justice Overview

• Key Target Population
• Overall Decreasing Juvenile Crime Rates And Implementation Of Juvenile Detention Alternatives Has Contributed To Lower Secure Care Populations
• Review County-by-County, via Regression Analysis of Pre- And Post-Implementation of Local System Of Care
Juvenile Justice Admissions

• Encouraging Results
• 9 counties had sufficient data for analysis (these 9 counties represented 85% of all admissions)
• 6 of 9 had a statistically significant decrease in admissions to juvenile justice programs, post-implementation and no counties saw any increase
• On average, 18 fewer children per month, more than 200 per year, were placed in juvenile justice programs, post-implementation in the 6 counties
Residential Care Overview

• Encompasses many types of services, from Therapeutic Foster Care to Hospital Alternatives
• Key focus of System of Care initiative in least restrictive setting
• Reducing inappropriate admissions and shortening lengths of stay were stated goals, particularly in institutional Residential Treatment Center (RTC) programs
Percentage of Children Receiving Residential Care Has Decreased As Community Alternatives are Made Available
Average CANS score at Admission to RTC Has Increased as Residential is Used More Appropriately
Average Improvement for ChildrenExiting RTC has Also Improved
Length of Stay in Residential Care has Moved Lower, but Without a Clear Trend
RTC Summary

- Average need level of youth entering RTC programs is higher (lower need youth are being successfully served in the community as an alternative to RTC).
- Length of stay has decreased
- Level of improvement of youth at discharge has increased.

Serving Youth with the Highest Level of Needs, Shorter Lengths of Stay, and Better Improvement: A Great Combination.
Access to In-Community Services

- Goal Of Initiative Is To Improve Access To Services, Particularly Community-based Services
- In 2000, NJ Served Approximately 7000 Children In Community-based Case Management, In-home And Day Treatment Programs
- In 2009 NJ Served 30,000 In Case Management, In-community And Day Treatment Programs, More Than A 500% Increase
Children Served in Community-Based Programs* has Grown by More than 500%

*2000/2001 data unavailable

Does not include outpatient services reimbursed through Medicaid
CMO Outcomes

• Youth receiving Care Management Organization (CMO) services have shown increased improvement.
• Improvement is measured by the youth’s improvement in the CANS assessment.
CMO Average Improvement Exiting Children has Grown as Programs Have Matured
Funding Better Matching Needs

• At the inception of the System of Care, an analysis was completed looking at the needs of each county as compared to the funding provided to each county.
• This same analysis was completed when NJ obtained an independent assessment of the Child Behavioral Health System of Care in 2005 (Conducted by the University of South Florida)
• DCBHS completed the same analysis in 2008.
• The results show that as our system of care has developed, we have been better able to match the funding to the needs of specific counties.
Figure 7.
Comparison of Original Estimated Spending per Capita and Need Index

- Total Children's Initiative Costs per Child in Poverty
- Need Level

Costs Per Capita
- Cape May: $456
- Essex: $520
- Atlantic: $447
- Camden: $889
- Mercer: $2,284
- Salem: $1,031
- Union: $1,192
- Hudson: $1,071
- Monmouth: $941
- Passaic: $1,010
- Burlington: $1,010
- Ocean: $691
- Bergen: $161
- Gloucester: $349
- Middlesex: $997
- Warren: $1,202
- Somerset: $939
- Morris: $973
- Sussex: $1,068
- Hunterdon: $1,493

Children = Ages 0 through 17
Figure 8.
Comparison of 2005 Consolidated Children’s Mental Health Spending per Capita and Need Index

Total Consolidated Costs per Child in Poverty

Need Level

Costs Per Capita

$0

$100

$200

$300

$400

$500

$600

$700

$800

$900

$1,000

$1,100

$1,200

$1,300

$1,400

Cape May

Camden

Mercer

Salem

Atlantic

Essex

Passaic

Warren

Hudson

Union

Gloucester

Monmouth

Sussex

Ocean

Burlington

Bergen

Middlesex

Somerset

Morris

Hunterdon

Children = Ages 0 through 17
Comparison of FY ‘08 Consolidated Per Capita (All Children under 18) Spending to Needs Index by County
Letting the Data Tell the Story

• System Of Care Has Effected Significant Changes As Anticipated
• Particular Effects On Secondary Systems (Acute Care/JJ) Were Seen
• Resource Efficiency And Equity Have Improved
• Family Participation Is Improved
• Residential Care Used More Appropriately And Effectively
• Funding (And Therefore Service Availability) Better Matches The Needs Of Each County.