

New Jersey Behavioral Health
System of Care:
Training for MLTSS
Managed Care Organizations (MCOs)
Part 1

Presented by:
Department of Human Services

Day 1—Systems Focus

I. Introduction and Welcome

Presenters:

Mollie Greene, DMHAS

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GOALS AND OBJECTIVES

Goal of Behavioral Health (BH) Training

- To understand the State mental health and addictions system
- To have access to tools and resources required to effectively manage BH services for Managed Long-Term Services and Supports (MLTSS) members

Objectives of BH Training

- Understand the role of the Managed Care Organizations (MCO) Care Managers in BH care for MLTSS members
- Understand the role of the MCO CM in coordinating MLTSS covered and non-covered BH services
- Provide a set of tools to assist in planning and assessing appropriate level of care for MLTSS members needing BH services
- Provide case studies that offer participants an opportunity to explore practical applications of information presented

THE COMPREHENSIVE MEDICAID WAIVER AND BEHAVIORAL HEALTH

Comprehensive Medicaid Waiver Highlights

- Model for reform and innovation
- Streamlines program administration and operation
- Preserves eligibility and enrollment
- Eliminate emergency room (ER) co-pays
- Enhances and coordinates services to specialty populations
- Rewards efficiency in care
- **Integrates behavioral health and primary care**
- The full waiver application and final terms and conditions can be found online at:

www.state.nj.us/humanservices/dmahs/home/waiver.html

What Does the Comprehensive Medicaid Waiver Mean for BH Services?

- Development of innovative delivery systems, including initiatives to promote integrated physical health (PH) - BH care
- Support for community alternatives to institutional placement
- Braiding of NJ FamilyCare, federal Block Grant and state-only funding streams
- Opportunities for rate rebalancing
- Increased focus on consumers with developmental disabilities and consumers with co-occurring BH and PH conditions
- No-risk model or Administrative Services Organization (ASO) transition to risk-based model or Managed Behavioral Health Organization (MBHO) for adult consumers – “BH carve-out”
- Full-risk integrated managed care model for adult consumers in waiver programs or meeting nursing facility (NF) level of care through MLTSS – “BH carve-in”

Access to BH Services Under MLTSS in the Comprehensive Medicaid Waiver

- The State will utilize its existing MCOs to manage Medicaid BH services for the MLTSS-eligible members residing in Home and Community Based Services (HCBS) or Nursing Facilities (NFs)
- The State will establish specific criteria for the provision and coordination of BH services
- Providing and coordinating the BH services for this population is critical to maintaining these individuals in the least restrictive and most integrated setting appropriate to their needs

Access to BH Services Under MLTSS in the Comprehensive Waiver

- All MCOs are required to establish care management and care coordination for each MLTSS eligible member
- The State has established minimum qualifications for Care Managers
 - MCOs must provide integrated case management for all MLTSS, including acute care and BH
 - The State will ensure that each MCO assigns a Care Manager for every member enrolled in MLTSS

Access to BH Services Under MLTSS in the Comprehensive Medicaid Waiver

- MCOs are required to establish an MLTSS BH administrator position whose responsibilities will include:
 - “...developing, implementing and coordinating BH services and settings that can meet the needs of the MLTSS Members with BH needs” (MCO contract 9.9.1)

Access to BH Services Under MLTSS in the Comprehensive Medicaid Waiver

- For all MLTSS individuals the need for BH services shall be assessed and provided in collaboration with the member, the member's family and all others involved in the member's care, including other agencies or systems
 - Services shall be accessible and provided by competent staff members who are adequately trained and supervised
 - The strengths and needs of the member and his/her family shall determine the types and intensity of services
 - Services should be provided in a manner that respects the member's and family's cultural heritage and appropriately utilizes natural supports in the member's community

BH Stakeholder Involvement in MLTSS

- Representatives from the BH provider community and advocacy agencies participate in the MLTSS Steering Committee and participated in the MLTSS Work Group
- Staff from DMHAS have been involved in the work group and MLTSS Steering Committee

ADULT BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION (ASO)

Functions of the Adult ASO as Outlined in the Special Terms and Conditions

- 24/7 Call Center
- Member services
- Screening and assessment
- Prior authorization
- Network management
- Utilization management, including level of care determination and continuing care review
- Care management
- Medical management
- Care coordination
- Quality management
- Information technology
- Data submission and reporting requirements
- Financial management, including claims processing and payment
- Development of care models and service arrays for consumers with intellectual and developmental disabilities; non-SNP dual eligible (Medicare and Medicaid), and Medicaid expansion populations
- Coordination with the MCOs regarding high-utilizing consumers and consumers screened with BH/medical conditions

Stakeholder Involvement In the Adult ASO

- DMHAS, in partnership with NJ FamilyCare, developed a stakeholder input process to:
 - Inform the Department of Human Services' values and vision regarding the design and implementation of an ASO/MBHO
 - Elicit broad stakeholder input regarding the design and development of the various components of the ASO/ MBHO
 - Initiate a targeted workgroup process to inform more detailed level components of the ASO/MBHO
 - Identify leveraging opportunities under Health Care Reform to support a transformed system
- The final Steering Committee report and recommendations were posted in June 2012 at [http://www.state.nj.us/humanservices/dmhs/home/mbho/Stakeholder final report june15 2012.pdf](http://www.state.nj.us/humanservices/dmhs/home/mbho/Stakeholder%20final%20report%20june15%202012.pdf)

THE CASE FOR INTEGRATED CARE

The Case for Integrated Care

- Historically, BH care under Medicaid FFS has been fragmented, with an over-reliance on institutional, rather than community-based care
- Consumers traditionally receive care through MCOs with limited or no formal protocols for coordination of care between medical and behavioral health delivery systems
- Approximately two-thirds of NJ FamilyCare's highest cost adult beneficiaries have mental illness (MI) and one-fifth have both MI and a substance use disorder (SUD)

The Case for Integrated Care

- National studies estimate that during a one-year period up to 30% of the US adult population meets criteria for one or more MH problems, particularly mood (19%), anxiety (11%), and substance use (25%)
- MH problems are 2 to 3 times more common in patients with chronic medical illnesses such as diabetes, arthritis, chronic pain, headache, back and neck problems and heart disease
- Left untreated, MH problems are associated with considerable functional impairment, poor adherence to treatment, adverse health behaviors that complicate physical health problems and excess healthcare costs
- Most MH treatment is provided in primary care settings, and the percentage provided solely in these settings is rapidly growing

CURRENT FEE-FOR-SERVICE BH SYSTEM OF CARE

Current Fee-For-Service (FFS) BH System of Care

- NJ FamilyCare Expansion
- Covered benefits and populations
- State-only contracted services

NJ FAMILYCARE EXPANSION

Expansion Under the Federal Health Care Law

- The NJ FamilyCare Expansion under the new Federal Health Care law requires that parents, single adults and childless couples, ages 19 to 64, with incomes under 133% FPL, receive an Alternative Benefits Plan (ABP)
 - Qualified single adults, childless couples and parents receive NJ FamilyCare Plan ABP package effective 1/1/2014
 - Recipients in General Assistance Medicaid were moved into managed care from Program Status Code (PSC) 761 to PSC 762 effective 1/1/14
 - NJ FamilyCare childless adults were moved from PSC 763 to PSC 762 effective 1/1/14
 - Parents in PSC 380 were moved from Plan D to Plan ABP effective 1/1/14

Expansion Under the Federal Health Care Law

- Open enrollment for this new NJ FamilyCare expansion began October 1, 2013, with an effective date of 1/1/14
 - Applications continue to be accepted
- Childless adults and parents found eligible for Plan ABP beginning 1/1/14 received an enrollment letter
 - The letter explains the benefit package as well as an opportunity for a disability review based on special health care needs

NJ FamilyCare Summary

Newly Eligible Populations

- Parents and Caretaker Relatives
- Single Adults and Childless Couples

Increased Income Limits

- 133% of the Federal Poverty Level for most NJ Residents (\$15,282 for an individual.; \$25,975 for a family of 3)
- Increased Limits for Children and Pregnant Women

Federal Share of Benefits

- January 2014: 100%
- January 2017: 95%
- January 2018: 94%
- January 2019: 93%
- January 2020: 90%

Timetable

- Oct. 2013 – Applications begin
- Jan. 2014 – New benefits begin for an estimated 300,000 new Medicaid beneficiaries

Benefit Plan

- The Alternative Benefit Plan (ABP) needs to meet Mental Health Parity and Addiction Equity Act (MHPAEA) requirements
- Plan D or General Assistance parents or childless adults have been transferred to Plan ABP effective 1/1/2014 and receive a richer benefit than they had before 1/1/2014

MHPAEA in ACA

- On October 3rd, 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was signed into law
- This Federal law requires group health insurance plans (those with more than 50 insured employees) that offer coverage for mental illness and substance use disorders to provide those benefits in no more restrictive way than all other medical and surgical procedures covered by the plan
- Within the ACA, States that are implementing Medicaid Expansion need to provide the 10 Essential Health Benefits (EHBs) in the ABP that includes mental health and substance use services

BH Services in the ABP

BH services currently in the State Medicaid Plan

- Targeted Case Management (ICMS)
- Community Support Services (7/14)
- Behavioral Health Home (1/14)
- MH Outpatient
- SUD Outpatient (limited)
- Adult Mental Health Rehabilitation (group homes)
- Inpatient psychiatric services
- Opioid Treatment Services
- Psychiatrist, Psychologist or APN
- Partial Care/Hospitalization
- Medical Detox
- PACT



Additional BH services to be covered in the ABP

- *Non-medical detox
- SUD partial care
- SUD IOP
- SUD Outpatient
- *SUD short term residential
- Psychiatric Emergency Services/Affiliated Emergency Services



*Subject to IMD exclusion
SUD - Substance Use Disorder

MLTSS BH COVERAGE THROUGH THE MCOS

BH Services Covered by MCOs Under MLTSS

- MCO contract & MLTSS BH Services Dictionary
 - Acute Partial Hospitalization
 - Adult MH Rehabilitation (AMHR)/ community residential programs (e.g. group homes and supervised apartment settings)
 - Behavioral Health Home (BHH)
 - BH Independent Practitioner (Psychiatrists, Psychologists, Advanced Practice Nurses)

BH Services Covered by MCOs Under MLTSS

- Opioid Treatment Services (medication assisted treatment)
- Outpatient MH Clinic/Hospital Services
- Partial Care
- Private Psychiatric Stand-Alone Hospital/Acute Care Psychiatric Inpatient Unit in an Acute Care Hospital
- Psychiatric Partial Hospitalization

NOTE: Program in Assertive Community Treatment (**PACT**) and Targeted Case Management (**TCM**) are not covered by MCOs, but MCOs are required to coordinate these services for MLTSS members, as needed

BH Services *Coordinated by* MCOs Under the MLTSS

- **Crisis Intervention:**
 - Early Intervention Support Services (EISS)
 - Designated Screening Center (DSC)/Affiliated Emergency Services (AES)
 - Statewide Clinical Outreach Program for the Elderly (S-COPE)
 - Statewide Clinical Consultation and Training (SCCAT)
- **Intermediate and Long-Term Psychiatric Inpatient Services:**
 - State hospitals
 - County hospitals
- **Special Care Nursing Facility (SNF)**
- **Psychiatric Residential Services:**
 - Supportive Housing and Residential Intensive Support Teams (RIST)

BH Services *Coordinated by* MCOs Under the MLTSS

- **Program of Assertive Community Treatment (PACT)**
- **Integrated Care Management Services (ICMS)**
- **Substance Use Disorder (SUD) Outpatient:**
 - Intensive Outpatient (IOP)
 - Outpatient (OP)
 - Partial Care (PC)
- **SUD Residential:**
 - Non-Hospital Detoxification
 - Short Term Residential
 - Long Term Residential
 - Halfway House

BH Services *Coordinated by* MCOs Under the MLTSS

- **Peer Support Services:**
 - Self Help Centers
 - Peer Wellness Coaches
 - Self Help Meetings
 - Warmline
- **Other Support Services:**
 - Supported Employment/ Supported Education
 - Intensive Family Support Services (IFSS)
 - Projects of Assistance in Transition From Homelessness (PATH) & other homeless resources
 - Hotline
 - Hopeline

- **Prevention Services**

OTHER WAIVER INITIATIVES

Other Waiver Initiatives

- CSOC initiatives:
 - Autism Spectrum Disorders (ASD)
 - Severely Emotionally Disturbed (SED)
 - Developmentally Disabled/Intellectually Disabled/Mentally Ill (DD/ID/MI)

MLTSS PROVIDER ENROLLMENT

MLTSS BH Provider Enrollment

- The expectations for network adequacy are the same for BH providers in MLTSS
- The expectation for MLTSS is that the MCO has at least two providers of each service in each county
- “The contractor shall develop a BH network delivery system that acknowledges and supports principles of wellness and recovery,” including but not limited to the use of peer supports and a culturally competent provider network (MCO contract section 9.9.3)

Day 1—Systems Focus

II. Overview of the State BH System

Presenters:

Roger Borichewski, DMHAS

Mollie Greene, DMHAS

MERGER OF MENTAL HEALTH AND ADDICTION SERVICES

Merger of the Divisions of Mental Health Services and Addiction Services

- The SFY 2011 budget merged of the Division of Mental Health Services and the Division of Addiction Services into the Division of Mental Health and Addiction Services (DMHAS)
- Nationally, and in NJ, the incidence of co-occurring disorders is 40% - 60%, although prevalence estimates range dramatically
- Often those with co-occurring disorders can not find treatment in either the addiction or mental health networks
- The merger was an attempt to break down silos and enable the new division to design and implement a system that provides a continuum of prevention, early intervention, treatment and recovery supports for people with substance use, co-occurring and mental health disorders

MISSION, VISION AND VALUES

DMHAS Mission

- DMHAS, in partnership with consumers, family members, providers and other stakeholders, promotes wellness and recovery for individuals managing a mental illness, substance use disorder or co-occurring disorder through a continuum of prevention, early intervention, treatment and recovery services delivered by a culturally competent and well trained workforce.

DMHAS Vision

- DMHAS envisions an integrated mental health and substance abuse service system that provides a continuum of prevention, treatment and recovery supports to residents of New Jersey who have, or are at risk of, mental health, addictions or co-occurring disorders.
- At any point of entry, the service system will provide access to appropriate and effective person-centered, culturally-competent services delivered by a welcoming and well trained work force.
- Consumers will be given the tools to achieve wellness and recovery, a sense of personal responsibility and a meaningful role in the community.

DMHAS Values

- DMHAS' work is driven by its values. Staff within the Division value:
 - consumers' dignity, and believe that services should be person-centered and person-directed;
 - the strength of consumers, their families and friends because it serves as a foundation for recovery;
 - the commitment of its partner agencies to professionalism, diversity, hope and positive outcomes;
 - evidence-based practices that show consumer-informed and peer-led services improve and enhance the prevention and treatment continuum;
 - the public trust and believe that it is essential to provide effective and transparent services, and
 - a culturally diverse workforce.

Wellness and Recovery Model

- Treatment of mental illness embraces the notion of wellness and recovery, believing that persons with mental illness can lead full lives and be contributing members of society
- Core components of recovery according to the Federal Substance Abuse and Mental Health Services Administration:
 - Hope
 - Non-linear
 - Strength-based
 - Peer support
 - Self-direction
 - Responsibility
 - Holistic
 - Individualized and person-centered
 - Empowerment
 - Respect

Trauma Informed Care

- DMHAS is moving towards a trauma informed system of care, in which all services will consider whether individuals have experienced trauma and will intervene to ameliorate its effects
- Services will:
 - Include individuals and their supporters in the planning, design, implementation and monitoring of best and promising trauma practices
 - Incorporate knowledge about trauma in all aspect deliveries
 - Be welcoming, hospitable and engaging
 - Minimize re-victimization

THE STATE BEHAVIORAL HEALTH PROVIDER NETWORK

DHS Office of Licensing (OOL)

- The Office of Licensing is the licensing and regulatory authority of the Department of Human Services
- OOL regulates programs serving persons with mental illness and substance use disorders, as well as developmental disabilities and traumatic brain injuries
- Through its licensing and regulatory process, the OOL supports the provision of a safe environment in which consumers receive services appropriately
- OOL consists of various operating units: Developmental Disabilities Licensing, Mental Health Licensing, and Substance Abuse Licensing
 - Developmental disabilities licensing:
<http://www.state.nj.us/humanservices/ool/licensing/>
 - Mental health licensing regulations:
http://www.state.nj.us/humanservices/ool/documents/10_190_MHLicensing.pdf
 - Substance abuse licensing regulations:
<http://www.state.nj.us/humanservices/das/information/licregs/regulations/>

Purchasing Services

- DMHAS purchases BH treatment services directly with provider agencies through a variety of means:
 - Cost-reimbursement MH contracts
 - Slot-funded SUD contracts
 - Fee-for-Service (FFS) SUD contracts
 - DMHAS procures services not covered in the State Plan for low-income consumers and for individuals not covered under Medicaid

Cost Reimbursement MH Contracts

- State Hospitals
- STCF Units in local hospitals
- Psychiatric Screening Centers
- Crisis Diversion Programs
- Early Intervention and Support
- Deaf Enhanced Screening & STCF
- Addiction Recovery and Prevention Programs
- Community Residential Programs
- Outpatient Programs
- Supported Education
- Partial Care/Hospital
- Homeless Services
- Case Management
- Legal Assistance
- Justice Involved Services
- Supportive Employment
- Family Support Programs
- Consumer Self Help Centers
- Specialty Programs
- Cultural Competence Training Centers
 - PACT
 - RIST
 - IOTSS
 - IOC
 - SCCAT (DDD)
 - S-COPE (Elderly)

Slot-Funded SUD Contracts

- DMHAS purchases substance abuse treatment beds/slots via contracts with community-based organizations
- Services are funded through federal SAPT Block Grant and State funds, including:
 - Outpatient
 - Intensive Outpatient
 - Partial Care
 - Halfway House
 - Detoxification
 - Short Term Residential
 - Long Term Residential
- Special Populations under SAPT Block Grant
 - Women’s set-aside
 - Deaf, Hard of Hearing & Disabled
 - HIV
- Special Populations under State Resources
 - Child Welfare Reform Plan (women and men)
 - Medication Assisted Treatment Initiative (MATI)

FFS SUD Contracts

- DMHAS operates a network of licensed treatment facilities contracted to provide SUD treatment through FFS reimbursement method
- A full continuum of substance abuse services are offered through eight FFS initiatives

Scope of the SUD FFS Network

- Currently, 139 licensed substance abuse treatment facilities operating across 285 separate sites serve consumers in New Jersey through the DMHAS FFS Initiatives Network
- Approximately \$39.42 million is managed through the FFS initiatives to support substance use disorder treatment and enhancement services
- Approximately 17,460 unduplicated individuals served annually through DMHAS FFS initiatives

DMHAS FFS Initiatives

- Driving Under the Influence (DUII)
- Drug Court Initiative (DCI)
- MAP – State Parole Board (SPB)
- MAP – Department of Corrections (DOC)
- Medication Assisted Treatment Initiative (MATI)
- Screening, Brief Intervention & Referral to Treatment (SBIRT) – Mercer County only
- South Jersey Initiative (SJI)
- Recovery and Rebuilding Initiative (began November 2013)

DMHAS RATE SETTING ACTIVITIES

DMHAS Rate Setting Activities

- DMHAS engaged Myers and Stauffer (M&S), a national CPA firm, to conduct a rate analysis for DMHAS services
- Objectives:
 - Support transition from current multiple contracting methodologies – cost-reimbursement, slot utilization, and FFS – to a uniform FFS methodology
 - Develop a fee schedule that is reflective of the costs incurred in providing the services
 - Encourage cost efficiencies through new payment system
 - Provide equity in rates or “like rates for like services”
 - Maintain/increase access to services statewide

Methodology

- M&S is using the following data sources:
 - Comprehensive cost and unit data collection exercise with a sample of providers – completed fall of 2013
 - Existing FFS rates paid by commercial payers and Medicaid, where applicable
 - Detailed analysis of current spending (mental health and addictions cost reimbursement and slot contracts, SUD FFS contracts, Medicaid spending on BH conditions)
 - Rates in other states (with most similarity to NJ demographics and in relative proximity)



The Goal is to establish rates that will fairly compensate New Jersey community agencies for the costs incurred in the services they provide

Stakeholder Involvement

- DMHAS has committed to transparency throughout the rate-setting process and stakeholders' input has been actively solicited
 - Provider kickoff meeting held May 2013
 - Stakeholder Steering Committee Fiscal Workgroup convened in July 2013 prior to implementation of cost survey and in March 2014 concurrent with practice groups
 - Practice groups convened in December 2013 and March 2014 to review and comment on service-specific cost assumptions and models
 - Consumer and family advocates included in these groups

Implementation

- Preliminary rate schedules to be delivered to DMHAS in late spring of 2014
- M&S to complete fiscal impact analyses at the program, provider, state, and federal level
- Final rates must be approved by the NJ Office of Management and Budget prior to implementation
- A subset of services will remain under contract reimbursement

Day 1—Systems Focus

III. BH System of Care—MLTSS MCO-Covered Services

Presenters:

Roger Borichewski, DMHAS

Mollie Greene, DMHAS

Robert Eilers, DMHAS

ACUTE CARE PSYCHIATRIC INPATIENT

Acute Care Psychiatric Inpatient

- DMHAS funds and/or manages services to provide care to individuals who are in need of inpatient care
- Inpatient services are available to individuals who are voluntarily or involuntarily admitted

Short Term Care Facilities (STCF)

- Acute care adult psychiatric units in a general hospital for the short term admission of individuals who meet the legal standards for commitment and require intensive treatment
- All admissions to STCF's must be referred through an emergency or designated screening center
- STCF's are designated by DMHAS to serve a specific geographic area, usually a county

Deaf Enhanced STCF

- All persons who are deaf and hard of hearing will be served on an equal basis at all DMHAS funded programs
- A deaf enhanced STCF has more experience and training in communication with individuals who are deaf and hard or hearing
- The individual who is deaf or hard of hearing has the option of receiving service at the nearest STCF or electing to be transferred to a deaf enhanced STCF

Voluntary Inpatient Psychiatric Units

- Located in general community hospitals throughout New Jersey
 - Note: Not all hospitals offer this specialty
 - No voluntary admissions to State psychiatric hospitals
- Regulated by the N.J. Department of Health at N.J.A.C. 8:43G-26
- Required to provide:
 - Individual, group and family therapy
 - Psychotropic medications
 - Rehabilitative services
 - Psychological services (e.g. testing)
 - Recreational therapy
- Provide care to individuals who are in need of inpatient care (e.g. severe depressive symptoms) and are agreeable to consenting to treatment

Involuntary/Civil Psychiatric Commitment

- Assessment Criteria for Involuntary Commitment
 - Person has a mental illness that causes him/her to be dangerous to:
 - Self
 - Others
 - Property

AND

- Unwilling to voluntarily be admitted to appropriate treatment

AND

- Other less restrictive available means of treatment/stabilization are inappropriate

Involuntary/Civil Psychiatric Commitment

- Assessment shall designate:
 1. Inpatient treatment for the person if he/she is immediately or imminently dangerous or if outpatient treatment is deemed inadequate to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future; and
 2. Outpatient treatment for the person when outpatient treatment is deemed sufficient to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future
- NOTE: Medication shall not be involuntarily administered in an outpatient setting

Involuntary/Civil Psychiatric Commitment

- Commitment Routes

- Public (Screening) Route:

- Certified Screener completes screening document
 - Psychiatrist completes screening certificate
 - Patient is legally committed for up to 72 hours from completion of certificate

- “Alternate” Route:

- Application completed by family or hospital administrator
 - Psychiatrist completes clinical certificate
 - Another physician completes 2nd clinical certificate
 - Judge signs commitment order
 - Patient is committed for up to 20 days

Involuntary Outpatient Commitment

- Involuntary outpatient commitment programs provide comprehensive outpatient services, coordination and a referral system that addresses the needs of individuals committed to outpatient treatment, including:
 - 1) Consumer-inclusive treatment planning and development
 - 2) Treatment plan adherence support
 - 3) Assessment of dangerousness and clinical progress
 - 4) Arrangements for transportation to court hearings, evaluation, and programs
 - 5) Provision of or direct linkage to ongoing clinical and support services as identified in each consumer's Wellness Recovery Action Plan (WRAP) and any Psychiatric Advance Directive (PAD)
 - 6) Capacity to interface with the court system, including but not limited to, the committing judge, the county adjuster's office and the lawyers involved in the process

CRISIS DIVERSION PROGRAM

Crisis Diversion Program

- An intensive case management program designed to reduce unnecessary psychiatric hospitalizations
- Crisis diversion programs focus on assisting individuals in identifying and obtaining treatment goals, and providing support and linkages to the services that an individual needs to stay in their own environment and in the community

COMMUNITY RESIDENTIAL PROGRAMS

Community Residential Programs

- A program for adults with mental illness in community residences owned or leased by the provider or through service agreements providing support and encouragement in the development of life skills required to sustain successful living within the community
- Consumers live in the most normalized, least restrictive environment possible to promote individual growth and safety
- Programming focuses on empowering the consumer's use of generic community supports to meet physical, psychological and social needs to promote an improved quality of life and emotional well being

PARTIAL CARE SERVICES

Partial Care

- Partial Care includes:
 - Acute Partial Hospitalization
 - Partial Care Hospitalization
 - Partial Care

Partial Care Services

- Partial Care services are designed to assist individuals with severe mental illness to achieve community integration through valued living, learning, working, and social roles and to prevent hospitalization and relapse
- The role of Partial Care is to facilitate consumer integration into the community
- This balance between recovery and clinical services is accomplished through the provision of individualized, comprehensive, non-residential, structured programming

Partial Care Services (continued)

- Specific services include:
 - Psychiatric services
 - Counseling
 - Skill development
 - Case management
 - Psychoeducation
 - Pre-vocational
 - Social and leisure services
- Available on an hourly basis for up to 5 hours per day at least five times per week
- The primary treatment modality is group

MH OUTPATIENT SERVICES

Outpatient Programs (OP)

- Services provided to consumers with a mental illness but excluding substance abuse and developmental disability (unless accompanied by treatable symptoms of mental illness)
- Periodic therapy, counseling and supportive services are generally provided at the provider agency for relatively brief sessions (between 30 minutes and 2 hours)

Independent Practitioners

- Psychiatrists
- Advanced Practice Nurses (APN)
- Psychologists
- Independent psychiatrists, APNs and psychologists, who are licensed by their Board, can treat patients as Medicaid providers for a negotiated fee

MEDICATION ASSISTED TREATMENT

What is Medication Assisted Treatment?

- Medication Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders
- There are several new medications that provide evidence-based treatment for specific substance use disorders and other older medications that are also used in MAT
- Despite the scientific evidence that treatment works, many with substance use disorders have not had access to MAT

Goals for Pharmacotherapy

- Prevention or reduction of withdrawal symptoms
- Prevention or reduction of drug craving
- Prevention of relapse
- Restoration to or toward normalcy of any physiological function disrupted by drug addiction

Medications for Maintaining Abstinence

- Buprenorphine (Suboxone, Subutex, Zubsolv) - opioid dependence
- Methadone - opioid dependence
- Naltrexone (Revia, Vivitrol) - alcohol, opioid dependence (usually as injectable depot)
- Acamprosate (Campral) - alcohol dependence
- Disulfiram (Antibuse) - alcohol dependence

Medications for Detoxification

- Benzodiazepines
 - Alcohol detoxification
- Benzodiazepines and phenobarbital
 - Benzodiazepines detoxification
- Buprenorphine, methadone and clonidine
 - Opiate detoxification
- Other therapies (used off label with more limited evidence of effectiveness)
 - Dopamine agonists, modafinil and propranolol (for cocaine/stimulants detoxification)
 - Oral THC, lithium, nefazodone, and buspirone (for cannabis withdrawal)

Methadone for Opioid Dependence

- Methadone is only prescribed/dispensed for maintenance treatment at licensed Opioid Treatment Programs (OTPs)
- OTPs can also provide buprenorphine and other medications
- OTPs must:
 - Meet Federal regulations
 - Be approved by SAMHSA
 - Be licensed by the Drug Enforcement Agency
 - Be licensed by the State of NJ and have DMHAS State Opioid Treatment Authority (SOTA) oversight
 - Receive accreditation by JCAHO, or CARF, or COA
 - Provide medical services (physical evaluations, labs, urine drug screens, etc.) and substance use counseling sessions, with frequency of counseling based on phase system

Office-Based MAT to Treat Opioid Dependence

- Buprenorphine can be prescribed by office-based physicians who have DATA 2000 Waived Certification
 - Approved by FDA in October, 2002
 - Long-acting partial opioid agonist
 - Delivered sublingually
 - Can be taken once a day or less frequently
- Clients need counseling and supports.
- Physicians encouraged to use the Prescription Monitoring Program (PMP)

Emergency Care: Naloxone

- Naloxone is an opioid antagonist used to counter the effects of an opiate overdose and reverse life-threatening effects (CNS and respiratory system depression)
- Most commonly used intravenously for fastest action by paramedics and medical professionals, but trained bystanders who have naloxone can administer it intra-nasally
- All individuals who are administered naloxone must be transported to the hospital following the injection because it is short-acting
- DHS/DMHAS plans to have training provided to lay persons (consumers, peers, family, friends etc.) to use naloxone in overdose emergencies in accordance with the Overdose Prevention Act
- The Act provides legal protection and immunity from liability for medical professionals prescribing naloxone and for individuals administering it in overdose emergencies

BEHAVIORAL HEALTH HOMES

Behavioral Health Homes

- A Behavioral Health Home (BHH) utilizes a defined set of services to integrate care and promote health and wellness
- A BHH service provides and or coordinates primary and specialty medical care with behavioral health care
- The services also include coordination or delivery of supports services needed to maintain health and promotes health and wellness by empowering individuals to participate in their own care and management of chronic disease

Behavioral Health Homes

- Eligible consumers – SMI and at risk of increased utilization of medical and behavioral health care services
- Eligible providers must:
 - Be licensed mental health agencies
 - Complete a Learning Community
 - Be certified by DMHAS
 - Be accredited within 2 years
- NJ will implement county by county
 - Bergen County – June/July 2014
 - Mercer County – Fall 2014
 - Subsequent counties will follow contingent on the outcomes of these first two counties
- NJ is also in the process of designing a BHH for individuals with a substance use disorder