

Children's Initiative

Concept Paper

I. Introduction

Background

Children's advocates have long identified a need for fundamental structural reform of New Jersey's System of Care for children with emotional and behavioral disturbances and their families. Like virtually every other state, a number of child-serving systems, each with its own mandates, perspective, and priorities, have responsibility to serve these children. Children and families enter DHS services through many different doors (child welfare, mental health, juvenile justice, education and the courts), often with similar needs for behavioral health and other community support services. The access route generally defines the problem and the services available. This, in turn, tends to define treatment goals and objectives based on the mandates and priorities of the specific child-serving system. The available services within these systems are then organized as programs, requiring children to fit the program's structure rather than structured to meet the individual needs of the child and family.

Each child serving system has had ongoing difficulties accessing services from the others, and has developed separate, overlapping systems, offering many parallel and duplicative services. Efforts to bridge these gaps between parallel systems have been only partially successful. Services from parallel systems are coordinated by County Case Assessment Resource Teams (CARTs) on an ad hoc, case-by-case basis with mixed results that are highly dependent on the ability of individual case managers and families to overcome the inherent barriers of a segmented service system. CART's generally come into the situation too late, and with too little authority and inadequate resources to support needed levels of service intensity and integration.

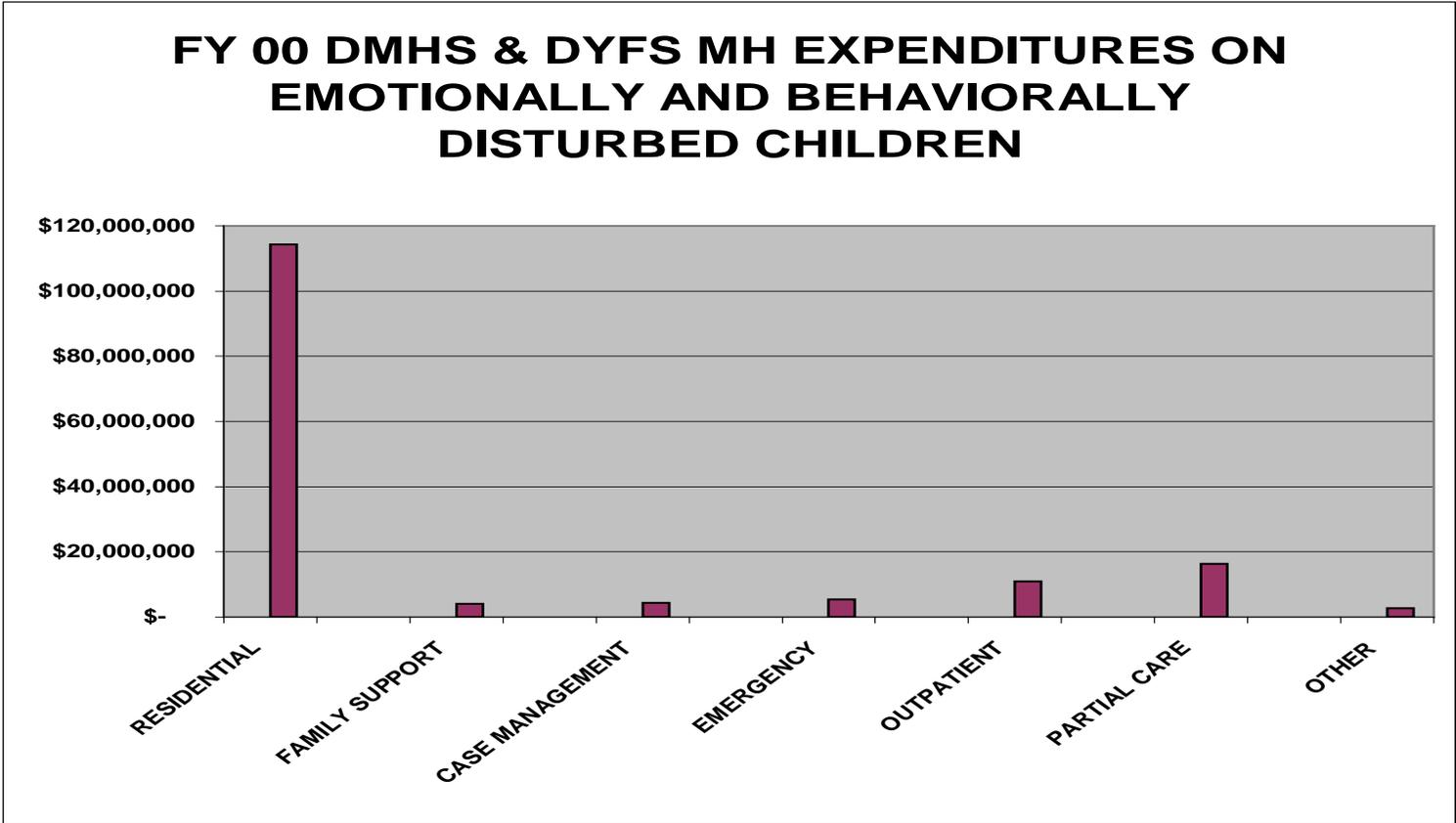
Children and families can receive uncoordinated and duplicative services from a variety of child-serving entities without effective resolution of common issues. Under the worst circumstances, the child's ties to family, school and community are severed.

These are problems related primarily to structure and financing. New Jersey has strong individual programs and providers that deliver excellent services. Many providers are nationally recognized for innovation, clinical competence and commitment to children and families. Funding, however, has not matched the level of need; most resources go to facility-based services, located outside the communities in which children and families live. This is a major reason families, too often, are unable to participate fully in the treatment their children receive. A much smaller proportion of resources go to community-based services. (See Chart One.) New Jersey has developed innovative home-based services that complement an extensive system of low intensity outpatient

services within communities. Community-based services, however, generally lack the resources to address the needs of high-risk children and families with complex needs.

All child-serving systems acknowledge the fragmentation of the current service system, the paucity of high-intensity community-based services, and the absence of meaningful collaboration between facility-based and community-based services. All child-serving systems similarly acknowledge the need for higher levels of service coordination and integration at the community level.

CHART 1



Vision and Purpose

The New Jersey Department of Human Services has concluded that fundamental structural reform is essential to support children and adolescents in achieving their highest potential, while living in a safe and permanent home and attending local schools. The Department's vision for this structural reform includes maintaining and strengthening whenever possible the ties between children, families, and communities.

The Children's Initiative will build on strengths of existing services and develop a more effective system of care, responsive to this objective.

A common screening and assessment process used across the various DHS child-serving entities will be the basis for determining service needs. Children and families need comprehensive, culturally competent services based on plans tailored to their individual needs with child-centered and strength-based goals. These services will be coordinated and integrated at the community level, and available across child-serving systems in a timely manner, regardless of the specific door through which children and families enter. Services will be accessible and organized to build on family and community strengths.

These services will be financed through flexible funding mechanisms and provided within an integrated system of care accountable to outcomes directly related to the well being of children and families. Information will be available and shared across child-serving systems.

The Department believes that better outcomes are possible for children and families and the system reform envisioned through the Children's Initiative will ensure that:

- Children have improved emotional stability
- Children are more likely to remain in their communities.
- Residential lengths of stay are reduced.
- Acute psychiatric hospital re-admissions are reduced.
- Families and caretakers provide more stable living environments for children.
- Children are likely to improve in educational performance and overall social functioning.
- Fewer crimes are committed by youth involved with services.

Budget

Governor Whitman's Fiscal Year 2001 budget will contain approximately \$39 million dollars in a combination of new state and federal funds for the Children's Initiative.

These new funds will be **combined with \$167 million dollars** identified in the State Fiscal Year 2000 budget for services to children and youth with emotional and behavioral disturbances to develop an integrated **funding pool of \$206 million dollars** for the Children's Initiative. DHS anticipates the investment of additional state and federal funds over the course of this multi-year initiative with the pool of available funds totaling approximately \$280 million dollars by the end of the five- year implementation period. The Initiative will be managed at the Department level and reflect a partnership among the Divisions of Medical Assistance and Health Services, Youth and Family Services and Mental Health Services.

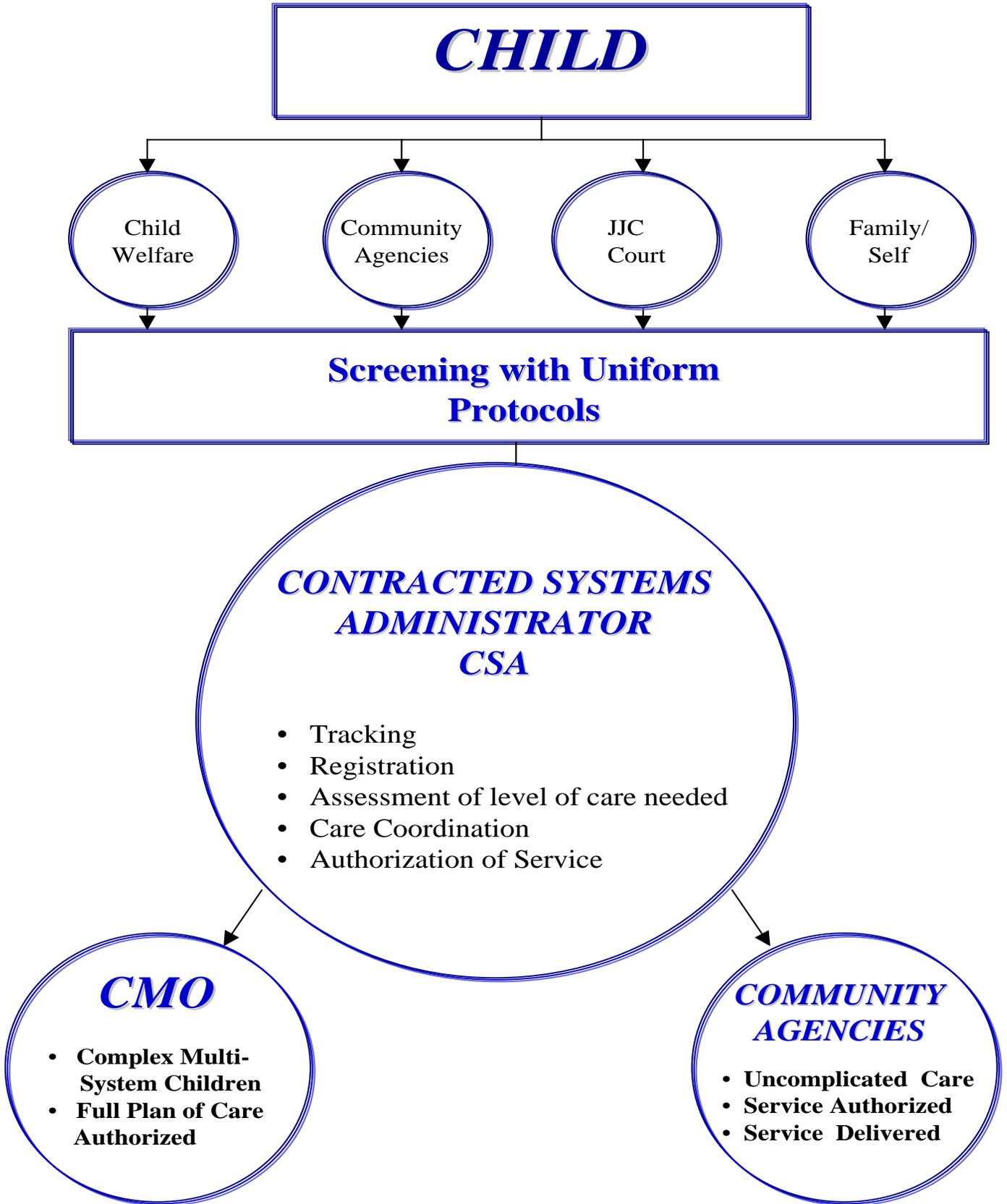
	<i>CURRENT EXPENDITURES</i>			<i>PROPOSED FUNDING</i>		<i>TOTAL</i>
	<i>FY'2000</i>			<i>FY'2001</i>		<i>FY'2001</i>
	<i>(DYES)</i>	<i>(DMHS)</i>	<i>(DMAHS)</i>	<i>TOTAL</i>	<i>New Funding FY'2001</i>	<i>Pooled Funding Current and New</i>
State	\$86.2M	\$21.7M	\$6.6M	\$114.5M	\$10M	
Federal/Title 19	\$14.8M	\$5.6M	\$2.6M	\$23.0M	\$29M	
Federal/Title 4E	\$16.0M			\$16.0M		
Support by Other Funds		\$13.5M		\$13.5M		
TOTAL	\$117.0M	\$40.8M	\$9.2M	\$167M	\$39M	\$206M

II. New Jersey Reform Agenda

For the past year, the Department of Human Services has reviewed the status and needs of the New Jersey System of Care for Children and Families, and studied reform initiatives in other states. From this work, the Department has developed a reform agenda consistent with New Jersey's longstanding commitment to core principles and values, and the Governor's Vision for the reform of children's services. The Department will proceed incrementally over a three to five year period to transition this reform agenda into a new system, building on current system strengths to develop the capacity for system management consistent with available resources. It will also require a commitment to change on the part of all system stakeholders. The elements of the DHS reform agenda will:

- **Focus on children, adolescents and young adults with emotional and behavioral disturbances and their families. Young adults are defined as individuals ages 18-21 transitioning from the children's system.**
- **Increase revenue and expand under-funded services while controlling growth** to assure development of an organized system of innovative providers with services and settings that match population needs.
- **Increase family participation in service planning and system development through family-run organizations.**
- **Establish common screening and assessment tools and a single process for entry into the system.**
- **Install utilization management methodologies that assure rapid access to services and care coordination** to ensure comprehensive treatment planning, active family involvement, clinical innovation, and provider accountability to treatment goals and objectives through a **Contracted System Administrator (CSA)**. **There will be no incentive for the CSA to restrict care for children and youth.**
- **Develop community-based Care Management Organizations (CMOs)**, a new type of entity, that will be accountable for identifying, organizing and, over time, purchasing local services and community resources for children requiring the most intensive services.
- **Establish the organizational structure for ongoing collaborative planning and system management among all child-serving systems** to assure effective integration of policy, resources, and procedures to support an organized system of care for children and families.

- **Provide training and consultation** to ensure full family participation, build provider capacity and ensure the development and delivery of quality services.
- **Re-align services and programs operated directly by the DHS** to operate as accountable participants in the new system of care while continuing to be operated by DHS. Potentially, the role and mission of these programs and facilities will change so that the service system will operate as a managed continuum. This continuum will include long-term inpatient psychiatric hospitalization and residential treatment at Arthur Brisbane Child Treatment Center, residential care at the Woodbridge Diagnostic, Ewing and Vineland Residential Treatment Centers as well as service planning and case management provided by the Divisions of Youth and Family Services and Mental Health Services.



Target Population

The Children's System of Care will address all children with emotional and behavioral disturbances and their families across DHS child-serving systems, including children eligible for child welfare, mental health and/or Medicaid services ages 0-18 and youth 18-21 transitioning to the adult system. Child and family need will dictate the services received and the intensity of care coordination.

Many children and families have stable living arrangements, with easily identified needs. Their involvement with a child-serving system will likely be brief, and they will be quickly and directly referred to service providers. This segment of the target population will be tracked to facilitate early identification of more complex issues requiring a more intense service and greater care coordination. Tracking will also establish individual case files in a centralized database.

It will also provide focus on those children whose emotional and behavioral disturbances, while not yet as persistent as the most seriously involved children, nevertheless require increasingly complex treatment and a greater degree of care coordination.

Other children and families have serious emotional or behavioral disturbances and multiple system involvement. Many of these children are in, or at imminent risk for, placement outside their home or community. The Children's Initiative will provide comprehensive, intersystem assessment, treatment planning, and community-based care management for the most seriously involved children and youth through the Care Management Organizations.

Principles and Values

The Children's Initiative is grounded in New Jersey's long-standing commitment to core principles for organizing and delivering services for children and families that support the dignity and integrity of children, families, and the communities in which they live. These principles and values have driven the ongoing development of existing community-based approaches to service delivery, and continue to drive this reform agenda. Those core principles include:

- **Services will be child-centered and strength-based**

The Children's Initiative is designed to break down barriers between child-serving systems. It is not a Mental Health Initiative; not a DYFS Initiative, not a Medicaid Initiative; not a Juvenile Justice Initiative. It is a Children's Initiative and addresses the whole child in all aspects of family and community life, focusing on strengths that support community living and healthy social development for children and families.

- **All services and functions will be family-focused and family-friendly**

The Initiative will engage families as active participants at all levels of planning, organization, and service delivery to build on family strengths and assure the family perspective throughout the entire process of system planning and implementation. All services will be designed to meet family needs for accessibility and will be respectful of family rights and responsibilities.

- **Services will be community-based and culturally competent**

Child and family needs and strengths are defined culturally. To be effective, all services must address cultural diversity at the community and family level and deliver care consistent with community strengths and values.

- **All services and functions will be outcomes accountable.**

The Children's Initiative will not simply expand services, though more services will be provided and are certainly needed. The system of care will be accountable for organizing, coordinating, and delivering services that result in improved outcomes for children, families, and communities, in targeted DHS policy areas of:

- ◆ Permanency of placement and living arrangements
- ◆ Community Safety
- ◆ Mental health

History of National System Reform

Reforming the structure and financing of children's services has been ongoing throughout the nation over the past decade. Many states have taken advantage of increased availability and flexibility in federal funding streams to expand services. States have used a variety of system reform strategies including private sector managed care technologies, operational changes within state or county government, and community-based systems of care that link clinical services with community resources and family-to-family support. Nationally, reform of Children's Services is clearly a work in progress. Evidence from other states demonstrates that expanded revenue without management of growth results in increased services but not necessarily improved access or capacity in critical areas. Without management of service development, revenue enhancement can simply expand some types of services without filling service gaps or promoting better service coordination and outcomes.

Other states have borrowed managed care strategies from the private sector managed care industry. While managed care gate keeping and utilization management methodologies can organize segmented service systems, they have often presented impenetrable obstacles for children with intense service needs.

Additionally, when these technologies are applied within the mental health system alone rather than across systems, children's long-term needs are often shifted from the mental health system to the child welfare system. Additionally, private sector managed care companies are not embedded in the local communities in which children and families live. This makes it difficult to focus on developing the natural community supports and partnerships with families necessary to support community living and placement stability. Over fifty local systems of care are operating in 35 states. Designed to serve children with intense, multi-system service needs, they have achieved the following successes:

- maintained children in their own homes and communities
- enabled families and caregivers to provide more stable living environments for children
- improved educational performance and overall social functioning
- decreased the number of crimes committed by youth involved with services
- reduced the length of stay and number of placements in residential treatment
- reduced acute psychiatric hospital admissions and readmissions

The challenge is to link these systems of care with other system reform strategies to ensure a unified approach for all children with varying degrees of emotional and behavioral disturbances.

Finally, states have tried to re-engineer state government functions to mirror managed care organizations. State governments, however, have found that outsourcing critical system management functions to outside vendors and improving planning and contract management capability within state government is more effective.

The Children's Initiative includes components to expand services and manage growth, to ensure that all care is coordinated and appropriate and to ensure that locally organized systems of care through caremanagement organizations are in place for children and families with the most intensive service needs. To support structural reform of service organization, management, and delivery, the Children's Initiative will require the following system components:

System Requirements

1. Family Support Organizations

The role of parents and other family members and substitute caregivers in individual service planning and development of the system of care will be enhanced including new roles for parents in training and evaluation processes.

Family Support Organizations will be identified to provide Family-to-Family support to all children and families receiving services. DHS will provide technical assistance in conjunction with the New Jersey Parents Caucus and the National Federation of Families for the development of Family Support Organizations. Their services will be available on a voluntary basis to all children and families who receive services. The Family Support Organizations will be particularly involved with plans developed for children and families with complex issues, needing care coordination and community-based care management.

This support may include:

- Help and information
- Guidance and support
- Advocacy to ensure service access and delivery
- Participation in treatment planning and care management.

2. A State-wide Contracted System Administrator (CSA)

Although DHS will retain all service dollars and full authority and management responsibility for all operations, a number of critical administrative functions for the Children's System of Care will be developed, installed and operated by a Contracted System Administrator (CSA) serving as an agent of DHS policy and authority. The CSA will be procured through a competitive bidding process and contracted to provide comprehensive services that support planning, implementation, management and development of the Children's System of Care, including:

- Organization and management of access/entry services and procedures, crisis management services, assessments and treatment planning.
- Tracking and monitoring service outcomes by establishing individual case files in a centralized database.
- Organization and implementation of care coordination, service authorization and utilization management services for children and families with complex needs and multiple service requirements.
- Identification and referral of children and families for community-based care management.
- Administrative support, technical assistance, and performance monitoring for local Care Management Organizations.
- Monitoring, tracking, and reporting key process and outcome indicators to ensure quality and improve performance.
- Interface with other DHS Management Information Systems.

Specifications and performance requirements for CSA functions are under development by DHS. The CSA will be procured through a competitive RFP process and contracted to provide comprehensive services through a single vendor. The procurement process will include clear specifications for CSA functions consistent with its role as an arm of the DHS Children’s Initiative. The CSA will be held accountable to defined performance standards for management effectiveness based on desired outcomes for children and families. The CSA contract will not be risk bearing. The CSA will have no financial incentive to limit access to appropriate levels of care. The CSA will be required to incorporate on an on-going basis stakeholder input on the criteria used to make service authorization and level of care decisions.

Entities with a demonstrated organizational capacity to provide these administrative functions statewide are eligible.

3. An Organized Provider Continuum of Expanded Services

The Children’s Initiative will work closely with providers for development of a defined set of services consistent with population needs and DHS policy objectives. The following list delineates which services from the continuum will be added to the Medicaid program as EPSDT rehabilitation services. Medicaid requirements for rehabilitation services allow services to be provided in any location and supervision by any appropriate professional. Over time, the array of services will be expanded to include, minimally:

	CURRENT MEDICAID SVS.	NEW MEDICAID SVS.
◆ Assessment (Screening, Evaluation & Diagnostic Services)		X
◆ Mobile Crisis/Emergency Services		X
◆ Out-of-Home Crisis Stabilization Services		X
◆ Acute Inpatient Hospital Services	X	
◆ Residential Treatment Center Care	X - Some	
◆ Group Home Care		X
◆ Treatment Homes/Therapeutic Foster Care		X
◆ Intensive Face-to-Face Care Management		X
◆ Outpatient Treatment	X	
◆ Partial Care	X	
◆ Intensive In-Home Services		X
◆ Behavioral Assistance		X
◆ Wraparound Services		X
◆ Family-to-Family Support		X

System reform will require adjustments by the provider community. **Providers** of services to children and youth with emotional and behavioral disturbances **will need to function as part of an integrated system.** Substantial changes in patterns of utilization and types of services are envisioned over time, including:

- Development of common screening protocols and comprehensive assessment procedures for all critical domains of child and caretaker status and functioning.
- Expansion or development of services that enhance crisis response and management capability, such as mobile crisis and new out-of-home crisis settings.
- Expanded capacity for services delivered in-home or at other off-site locations.
- Individualized plans of care that address a child and family's treatment and social support needs from acute care through transition services and community support.
- Integration of residential care with community-based services.
- Partnership with families and other substitute caregivers in service planning and system development.

Providers will need to be organized geographically to assure ongoing links between facility-based and community-based services and to ensure the availability of the full continuum of care to support community-based care management. Locally based services are important in order for children to maintain ties to their families and communities. All providers will be accountable to outcomes consistent with treatment planning and objectives as monitored by the Contracted System Administrator and/or Care Management Organizations.

Management capacity for this new system of care will be gradually enhanced including the incremental introduction of new procedures for administrative oversight, contract management and reimbursement. The Department acknowledges the essential role of providers as partners in this change process and their need to maintain clinical integrity and business viability. DHS will support provider transition into the new system. **Initially, current service providers will continue to contract directly with DHS.** Gradually, working with the provider community, the Department will realign our methods of contracting and reimbursement to support the purchase of individualized plans of care once needed data is available to make this a viable shift.

These developments will require substantial input and ongoing feedback from providers and family members, with ongoing training, consultation, and technical assistance. DHS will offer a number of venues to assure early and ongoing involvement of providers in the implementation and operation of the new Children's Initiative System of Care.

4. Community-based Care Management Organizations (CMO's)

Care management Organizations, a new type of entity, will identify, organize, deliver, and coordinate services and community resources for children with multiple service needs across child-serving systems, whose ties to family and community are at risk. CMO's are specifically designed to develop the organizational structure and care management processes needed to address these complex and multi-system issues. The CMO is responsible and accountable for the design and implementation of interdisciplinary Individual Service Plans (ISP's) that address needs and maintain the child's connection to family and community. CMO's are supported by a flexible funding process among participating child systems and will authorize all services delivered under an ISP with goals that incorporate clinical needs and permanency planning. Providers delivering services within the ISP will be directly accountable to the CMO for service utilization and quality of care.

To be a CMO, organizations will have to demonstrate commitment and capacity to organize an effective system of care at the community level that builds on strengths and effectively addresses needs. They will have to identify and develop natural social supports and community resources, as well as the professional services needed to support them.

CMO's are not traditional providers, and their business is not intake and referral to existing services within their own organization. CMO's are organized to identify and organize family and community resources and coordinate them with a wide array of interdisciplinary and intersystem services. An Individual Service Plan is more than a collection of services. It integrates services with family strengths and natural support systems to achieve common goals. The CMO will also arrange for a face-to-face care manager to work with the child and family to develop and implement the ISP. The CMO structure and business models must be designed around this capacity.

As business entities contracted with DHS, CMOs are the single point of organizational accountability for developing the system of care needed to deliver desired outcomes for children with emotional and behavioral disturbances, whose ties to home and community are threatened. Providers may reconfigure and create independent business structures as CMOs, but, as CMOs, their governance, organizational structure, and functional capability must clearly reflect the capacity needed to deliver the services and outcomes described above. In order to ensure that there is no appearance of conflict the Department may decide to propose limits on the amount of business that can be purchased or arranged by the CMO from any of its related or parent agencies.

CMO's will be contracted to organize and develop community capacity for managing and delivering services to targeted children and families. CMOs will:

- Identify, organize, and work with a network of local services and community resources that build on family and community strengths and natural supports and meet the defined clinical and social needs of children and their families as specified by DHS. Over time, the CMOs may directly purchase services and supports from providers and other community resources.

- Provide comprehensive, intersystem, strength-based assessment, treatment planning, and intensive care management for children and families that support community living, using locally organized services and resources.
- Develop individual plans of care that fully involve families, community resources, and child-serving systems in the organization and delivery of care to achieve common objectives.
- Accept DHS referrals on a “no eject/ no reject” basis.
- Have governance and management structures and processes that reflect community interests and culture.
- Implement individualized plans of care with fiscal accountability under budgets linked to projected need and utilization.

Community-based Care Management Organizations will be procured through a competitive RFP process. The CMO Procurement process will provide core requirements for structure and function, with ample latitude for clinical innovation and flexibility to achieve desired outcomes for children and families. The DHS will require the CMO’s network of professional services include any willing and qualified provider (i.e. providers eligible to receive DHS contract funds and/or Medicaid reimbursement). The key to determining an organization’s capability as a CMO, will be how clinical services are integrated with natural community supports and a child and family’s strengths. Wraparound Milwaukee and Children Come First from Dane County Wisconsin, Kids Oneida in New York as well as Sonoma, Santa Barbara and San Mateo County in California are well-known initiatives that use this system of care management. They have successfully produced positive changes in community living status and overall functioning for children with emotional and behavioral disturbances and their families.

A fiscally viable CMO minimally needs a population base of approximately 350,000 people or 50,000 children. At this point, the DHS anticipates phasing in up to 15 CMOs across the state.

As locally based Care Management Organizations are introduced, the use of child family teams (CFT) will be expanded under the direction of the CMO. As the CFT process continues to grow, the CART structure will be gradually phased out. The County Interagency Coordinating Councils (CIACCs) will continue to exist and play an advisory and planning role.

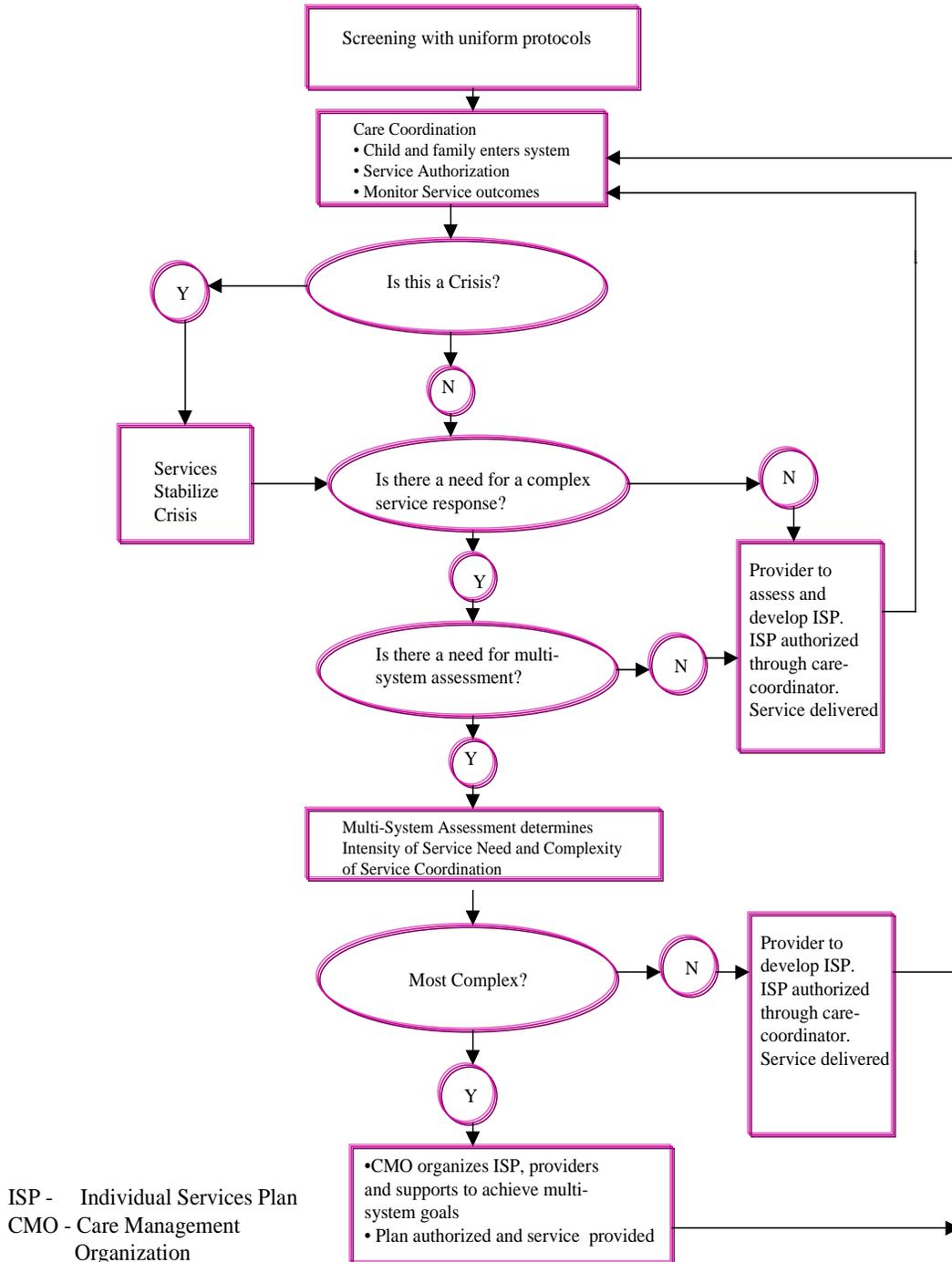
III. *Child and Family Flow*

By establishing the components to operate this new System of Care, the Children's Initiative should result in a more accessible, better integrated, individualized and more accountable system of care for children and families that will provide:

- **Focus on comprehensive needs of the child and family**
- **Timely, family-friendly access to services**
- **Consistent, comprehensive screening for risk and clinical need.**
- **Immediate and effective response to crises.**
- **Rapid referral to direct service for uncomplicated cases.**
- **Coordination of care for children and families with complex needs for multiple services.**
- **Comprehensive community-based care management for children and families with multiple system involvement at risk for placement outside the home or community.**
- **Management and coordination of information needed to support treatment planning and service delivery.**
- **Monitoring of critical indicators of quality to assure accountability to desired outcomes and objectives.**

Children and families will move through the system as follows:

SYSTEM OF CARE THE CHILDREN'S INITIATIVE - CLIENT FLOW CHART



1. Access Screening, Crisis Management, and Referral

Children and families will continue to enter the system of care through a variety of doors. They may be **referred from one of the child serving systems** (Mental Health, DYFS, JJC, the Courts, Education, or Substance Abuse). They may **directly access a provider or crisis management service**. Alternatively, they may directly seek help and referral through the telephone-based access service established by the Children's Initiative to operate on a full-time, real-time basis by the Contracted System Administrator (CSA).

Children and families will be screened by all providers at the point of access for risk and clinical need using common, consistent procedures and tools across all access points, regardless of the access route. The development of screening tools and procedures for use across child-serving systems has begun and will include input from providers and families. The purpose of access screening is to assure children and families:

- **Receive rapid response to crisis and risk as the first and foremost priority.**
- Access appropriate services as quickly as possible.
- Are assisted in planning and coordinating multiple services when needs are complex.
- Are offered family-to-family support for accessing and utilizing services.

Results of this screening will provide the basis for design and implementation of individualized treatment plans. A **Contracted System Administrator (CSA)** will gather and organize information from all access points and establish an individual file for each child and family in a centralized database. The CSA will monitor and coordinate referrals to appropriate levels of care including crisis management through facilities or mobile services.

Depending on levels of risk and complexity of need as indicated by screening at the point of access, children and families may:

- Be immediately triaged for crisis management and continued assessment.
- Remain with, or be referred to, an individual provider for delivery of indicated services.
- Be assigned a CSA care coordinator for organization of treatment planning and service delivery.
- Be assigned to a Care Management Organization for development of an individualized service plan.

The CSA will provide information to families regarding the availability of the **Family Support Organization** for ongoing family-to-family support and assistance in service access and delivery, as needed and desired by the family. The CSA will ensure that families whose children have intense, multi-system needs are referred to the Family Support Organization.

2. Assessment and Care Coordination

Children and families with relatively uncomplicated needs that can be met by a single service provider will be referred for direct service to a provider of their choice (or continue with the provider initiating the request for service authorization) within the continuum of licensed/certified, eligible providers. That provider will perform an assessment that addresses needs and strengths and results in an individualized treatment plan with clear objectives. Treatment plans consisting primarily of individual, group or family therapy will be registered with the CSA and presumptively authorized up to a specified number of units of service (current thinking is up to 20). This segment of the target population will be tracked to monitor service outcomes and to facilitate early identification of more complex issues requiring a more intense service and greater care coordination. Services beyond the specified number of units will be subject to review of a more comprehensive treatment plan by the Contracted Systems Administrator.

Children and families with more complicated needs, characterized by high levels of risk and/or clinical complexity, requiring multiple services will also be assigned a **CSA care coordinator** to work closely with the child and family to develop an integrated treatment plan. The care coordinator will:

- Identify, organize and coordinate assessments based on a common protocol as indicated by initial screening for risk and clinical needs.
- Coordinate involvement of family-to-family support in treatment planning through a family-run organization.
- Design and authorize service packages based on assessment results.
- Manage information and monitor service progress.
- Assist in problem solving as identified by the family.
- Identify candidates for Care management through the community Care Management Organization.

3. Community-based Care Management

Families with multiple system involvement and children with serious emotional and behavioral health needs in, or at imminent risk for, placement outside the home and community are candidates for community-based care management delivered by contracted **Care Management Organizations (CMO)**. The CSA Care Coordinators using DHS screening criteria and standards, currently under development, will identify eligible children and families. Initial selection of children for enrollment in a designated Care Management Organization will be done in consultation with DHS.

The CMO will design, organize and implement a single, integrated plan of care that incorporates interdisciplinary clinical services with family and community resources. The plan of care will be implemented under the direction and authority of a child and family team, organized and facilitated by a CMO Care Manager. Care managers will be individuals at the masters level with extensive experience with children with emotional and behavioral disturbances and their families who are involved with multiple child-serving systems. For children with the most intensive needs the care manager to child ratio is expected to be 1:10. This is the ratio recommended by the federal Center for Mental Health Services. The Child and Family Team may include representatives from all involved child-serving systems, as well as key providers, family members, and community residents. All services will be delivered and monitored under the authority of that team, and accountable to outcomes endorsed by the family.

CMO Plans of Care will be registered with the CSA. **The CSA will authorize service plans as a total package, so that it will not be necessary to obtain separate authorization for each service within the plan.** The CSA will monitor Plan of Care implementation for quality and outcomes.

4. Ongoing Information Management and System Support

The CSA will install systems for gathering, coordinating, organizing and distributing information needed for management at all administrative and clinical levels. The CSA will also interface with other DHS management information systems. The CSA will monitor and report on all critical process and outcome indicators for system of care functions, and all system of care components. Information will be distributed to system of care participants as an ongoing quality improvement process.

IV. DHS Management

The Department of Human Services will retain full responsibility and authority for system of care design, implementation, and management. By its very nature, the Children's Initiative will necessitate a cross-divisional, coordinated DHS approach, requiring ongoing reform of policy and reorganization of resources.

This reform process will be managed by:

- An Executive Oversight Board, Chaired by the Commissioner of Human Services including critical policy and decision-makers among child serving systems for ongoing adjustment of policy and reorganization of resources.
- A Stakeholder Implementation Advisory Committee of involved and affected stakeholders for ongoing input.
- The DHS will establish a Children’s Initiative Management Team that reports directly to the Deputy Commissioner of DHS. The team will include full time staff directly accountable to the project and dedicated staff from participating divisions and departments as liaisons for system of care design and implementation.

The DHS Children’s Initiative Management Team will be directly responsible for:

- System of Care design and performance specifications.
- Needs-based planning for system capacity and performance expectations.
- Procurement of CMOs and Contracted System Administrator.
- Contract management of CMOs and Contracted System Administrator.
- Development of Family Support Organizations.
- Confirmation of children and families initially selected for CMO case management.
- Oversight of System of Care operations.
- Identification of issues requiring modification of DHS policy reforms and resource reorganization.

DHS will gradually enhance its ability to manage this new system of care through the incremental introduction of changed or new administrative requirements. The Department acknowledges the essential role of providers as partners in this change process and their need to maintain clinical integrity and business viability. DHS will support provider transition into the new system.

V. *Financing*

Financing Strategies

The Children’s Initiative calls for pooling resources currently supporting many DHS children’s programs and managing those resources so that services are expanded and can be tailored to the individual child. The Initiative will increase

the amount of federal funds for which the state is eligible under Medicaid. The DHS 2001 budget will contain approximately \$39 million in a combination of new state and federal revenue. These new funds will be combined with \$167 million dollars identified in the State fiscal Year 2000 budget for services to children and youth with emotional and behavioral disturbances to develop an integrated funding pool of \$206 million dollars.

Exploration of New Payment Methods

The Children's Initiative will begin application of care management principles and methodologies to the organization, coordination, and delivery of child welfare and child mental health services. New procedures for contract management and reimbursement for this new system of care will be introduced incrementally. The Department acknowledges the essential role of providers as partners in this change process and their need to maintain business viability. DHS will support provider transition into the new system. **Initially, current service providers will continue to contract directly with DHS.** Gradually, working with the provider community, the Department will realign our methods of contracting and reimbursement to support the purchase of individualized plans of care once needed data is available to make this a viable shift.

This shift may include exploring the use of case rates to allow for more flexibility for CMOs and to align fiscal incentives for providers with DHS policy objectives to improve the quality of services. Implementation of the Children's Initiative will provide cost and utilization data that will allow accurate and fair rate setting. This rate-setting process for case rates will occur over the first three years of implementation, and will not be used until consistent and reliable information of projected utilization and costs is available. These new methodologies will be gradually introduced in conjunction with training and technical assistance.

VI. *Implementation Plan*

The Department will phase-in the Children's Initiative System of Care over a three to five year period. Initially, system reform efforts and service expansion will focus on children with the most complex needs involved with multiple systems, especially those children whose emotional and behavioral disturbances require increasingly intense service responses placing them at-risk for multi-system involvement and placement outside the home and community. The development of Care Management Organizations (CMO) to address this population will begin in several counties during the first year, expanding throughout the state in years two and three. Increasing CMO service capacity on a gradual basis is important because CMO's will go beyond organizing a treatment response to clinical needs. They will build community capacity through developing and organizing natural helping networks to support community living for children and their families or caretakers.

The Contracted System Administrator (CSA) implementation priorities for the first year will be to develop an operational infrastructure and database to organize services for the child-serving systems partners including child welfare, mental health and juvenile justice. This includes establishing procedures to ensure that the service needs of children requiring multiple services or involved with multiple systems are met. This also includes establishing operational relationships with the CMOs. Providers will be oriented to the new system and gradually brought into the care coordination and utilization management process towards the end of the first year of the CSA contract.

Next Steps for Planning and Start-up

- Concept Paper Publication – Early Winter 2000
- Regional Public Forums – February 2000
- Formal Input – Until March 15, 2000
- Stakeholder Implementation Advisory Committee - Ongoing
- CSA Bid Process Announced – Spring 2000; Start-Up Late Fall - 2000
- CMO RFPs Issued – Late Spring 2000; Start-Up Late Fall 2000
- Service Expansion – Fall 2000

The State views the publication of this Concept Paper as the beginning of an interactive process for public input. The Department will also conduct regional public forums to provide interested individuals and organizations an opportunity to share their perspectives, concerns and ideas with the State regarding the development of the Children's Initiative. Public comments and participation in these forums will be crucial to the development of a system that will be responsive to the needs of those it serves.

Comments on this Concept Paper may be sent to:

**Michele K. Guhl, Commissioner
NJ Department of Human Services
240 West State Street
PO Box 700
Trenton, New Jersey 08625**

Comments will be accepted up to March 15, 2000.

BACKGROUND INFORMATION

Current Utilization Patterns for Children

Within the Department of Human Services, the Divisions of Mental Health Services (DMHS) and Youth and Family Services (DYFS) have primary responsibility for providing services to children with emotional and behavioral disorders. The following Table provides information on the current utilization patterns for DMHS and DYFS services. The numbers do not represent unduplicated counts.

CHILDREN WITH EMOTIONAL AND BEHAVIORAL DISTURBANCES

1. Children in various residential placement for emotional and behavioral disturbances*

	<i>DYFS</i>	<i>DMHS</i>	<i>MEDICAID</i>	<i>TOTAL</i>
Residential Treatment Ctrs.	887			
Group Homes	369			
Treatment Homes	465	18		
Psychiatric Community Residences		276		
Out-of-State Psychiatric Hospital			20	
TOTALS	1721	294	20	2035

* Slots available, not necessarily children

2. What types of children are in residential services?

34% - at least one psychiatric hospitalization
 61% - Court ordered
 7% - Last placement Juvenile Justice Commission

3. Children admitted to Psychiatric Hospitals

Children Crisis Intervention	
Service CSIS Units	3572
Arthur Brisbane	66

* Children referred to Brisbane after an admission in and CCIS

4. Children with emotional and behavioral disturbance receiving community based services*

Partial Care	3204
Youth Casemanagement	2693
Wrap-around Services	900
TOTAL	6797