



Spotlight on New Jersey

Strategies to Support Youth With Serious Behavioral Health Needs Through a Care Management Entity Approach

By Taylor Hendricks

In Burlington County, New Jersey, two state-contracted, private nonprofit agencies – Partners for Kids and Families¹ and the Family Support Organization (FSO) of Burlington County² – are partnering through a unique collaborative model to help youth and families address behavioral health issues and create long-term plans for recovery.

Partners for Kids and Families was established in 2001 through grant funding from the Substance Abuse and Mental Health Services Administration's Children's Mental Health Initiative, and initially focused on serving multi-system involved children.³ The organization is among the first of New Jersey's 15 care management organizations, and has been providing comprehensive support for children and youth with complex behavioral health needs for over 10 years. In the summer of 2013, it also began serving children and youth with developmental disabilities and substance abuse issues. FSO of Burlington County is staffed by parents who have cared for a child or youth with behavioral health issues and who work directly with parents and/or caregivers. Together, these two organizations are partnering to deliver services via a care management entity (CME) approach, an innovative way to meet the needs of high-risk children and youth.⁴

CME Basics and New Jersey Specifics

What are CMEs?

CMEs – referred to as care management *organizations* in New Jersey – evolved out of the movement over the past two decades to develop coordinated systems of care for children and youth with serious behavioral health needs and their families. These entities follow system of care values, which means their work is youth- and family-driven, team-based, collaborative, individualized, and outcomes-based. Typical CME services include:

1. Creation and facilitation of a child and family team (CFT);

¹ For more information about Partners for Kids and Families, visit: <http://www.burlingtoncme.org/>.

² For more information about Burlington County's Family Support Organization, visit: <http://www.fsoburlco.org/>.

³ Children's Mental Health Network. "Burlington Partnership." <http://www.cmhnetwork.org/alumni/map/new-jersey/burlington-partnership>.

⁴ "Care Management Entities: A Primer." Center for Health Care Strategies. March 2011. Available at: <http://www.chcs.org/resource/care-management-entities-a-primer/>.



2. Intensive care coordination using the Wraparound approach;⁵
3. Linkage to peer supports and crisis response/intervention; and
4. Referrals to natural supports and home- and community-based services.

CMEs are also responsible for data collection and reporting, and managing utilization of services and quality outcomes.

New Jersey's CMEs

New Jersey's CMEs are part of the Children's System of Care,⁶ a statewide delivery system designed for children and youth with complex behavioral health needs, developmental disabilities, and/or substance abuse issues. Each county in the state has a CME and FSO that collaborate to support families affected by a child or youth's behavioral health challenges. New Jersey prioritizes family involvement in its CME model, and the FSO plays an integral role in establishing and sustaining family engagement.

Like most CMEs, Burlington County's uses multiple funding streams to provide the full array of services. About 75 percent of Partners for Kids and Families' budget comes from Medicaid and the remainder is covered by state contract funds. Intensive care coordination services provided by the CME are covered as targeted case management in New Jersey's Medicaid State Plan Amendment. The state also has a new 1115 Medicaid waiver, which, once implemented, will allow youth with complex behavioral health needs to receive three additional services – transitioning life skills, non-medical transportation, and youth support training. New Jersey is also piloting a developmental disability/mental illness waiver program, which allows for: case/care management; individual supports; natural supports training; intensive in-community habilitation; respite; non-medical transportation; and interpreter services for eligible children, youth, and their families.⁷ In New Jersey, children and families who are not eligible for Medicaid can access CME services through a state Medicaid “look-alike” plan – so no family is excluded based on income.

FSOs are county-based, private, nonprofit, 501(c)(3) organizations, which were originally established under New Jersey's statewide family organization until they met the business infrastructure expectations set by the state to become independent organizations. New Jersey's FSOs are funded by the state through Medicaid administrative dollars and state contract funds.

⁵ “What is wraparound?” *Wraparound Basics*. National Wraparound Initiative. Available at: <http://nwi.pdx.edu/wraparoundbasics.shtml#whatiswraparound>.

⁶ For more information about New Jersey's Children's System of Care, visit: <http://www.nj.gov/dcf/about/divisions/dcsc/>.

⁷ D. Simons, S. Pires, T. Hendricks, & J. Lipper. *Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State and Community Profiles*. Center for Health Care Strategies. July 2014. Available at: <http://www.chcs.org/resource/intensive-care-coordination-using-high-quality-wraparound-children-serious-behavioral-health-needs-state-community-profiles/>.



From Referral to Transition: How Does the CME Approach Work?

While CMEs typically adhere to similar values and provide a core set of services, they have diverse operational processes. Partners for Kids and Families executive director Michael Dallahan, FSO executive director Deborah Kennedy, and their colleagues described how the process works in Burlington County:

1. *Prior to Referral*

In New Jersey, a statewide administrative services organization, called a contracted services administrator (CSA) is responsible for triaging the needs of youth and families who connect with the Children's System of Care.⁸ The CSA is staffed by clinicians who determine whether a youth meets the level of care criteria (moderate or high) to refer them and their family to the county care management organization or to other services.^{9,10} Families, child welfare and juvenile justice caseworkers, behavioral health clinicians, and others, can call the CSA to access services for youth and families.

2. *Referral to CME*

Once a CSA clinician determines that a youth meets the necessary level of care criteria, the youth is referred to Partners for Kids and Families and is assigned a care manager. The parent/caregiver is referred to the FSO and assigned a family support partner. These referrals are processed via New Jersey's Child Youth Behavioral Health Electronic Record (CYBER), which was developed and is owned by the state.

CYBER, which allows all system partners to document their work in a single record, is used statewide by CMEs, mobile response, residential, in-home, and some outpatient providers. The CSA is also required to use it as part of its contract. Individual records on CYBER encompass treatment plans, assessments, progress notes, and more. The system also interfaces with New Jersey's Medicaid Management Information System (MMIS), Medicaid eligibility database, and the statewide automated child welfare information system (SACWIS).

3. *Initial Meeting*

Within 72 hours of the referral, the care manager and family support partner meet with the youth and family members. During this initial meeting, families are oriented to the Wraparound process and its underlying values.^{11,12} The care manager and family support partner begin

⁸ New Jersey's current contracted services administrator is called PerformCare, <http://www.performcarenj.org/>.

⁹ NJ CSOC Service Guidelines for children/youth with moderate-level needs: <http://www.performcarenj.org/pdf/provider/clinicalcriteria/cmo-moderate.pdf>.

¹⁰ NJ CSOC Service Guidelines for children/youth with high-level needs: <http://www.performcarenj.org/pdf/provider/clinicalcriteria/cmo-high.pdf>.

¹¹ E. Bruns and J. Walker. "Phases and Activities of the Wraparound Process: Building Agreement About a Practice Model." *Wraparound Practice* (Chapter 4a.1). National Wraparound Initiative. Available at: [http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-\(phases-and-activities\).pdf](http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf).



identifying the youth's and family's strengths and needs and determine who should participate on the CFT. The CFT includes the youth and his/her caregiver(s), formal supports (e.g., therapist, child welfare case manager, probation officer), and natural supports (e.g., basketball coach, clergy, friend). The goal is for a CFT to be split 50-50 between formal and natural supports, though natural supports, which are integral to successful outcomes, can be more challenging to identify. The family support partner is particularly critical in gaining the trust and buy-in of families.

4. *Crisis and Individualized Service Plans*

Within seven days of the referral, the CFT works together to develop a crisis plan¹³ that outlines the youth and family's definition of a crisis; risks or triggers; and strengths and available resources. Within 30 days, the CFT develops an individualized service plan (ISP),¹⁴ which outlines the youth and family's goals, strengths, needs, and strategies for recovery. The ISP guides the work of the team and is updated at least every 90 days to reflect evolving needs.

5. *Ongoing Engagement*

Following the initial 30-day engagement period, the care manager and family support partner work with the youth and family to achieve the goals of the ISP and move toward transition. A care manager must have *at least* three contacts per month with members of the CFT, with the frequency determined by the youth and family's needs. A parent support partner must see a parent every 21 days at minimum during a child and family's involvement with the CME. Care managers, care manager supervisors, and the director of operations share a rotating on-call schedule to ensure access to help for families who may experience a crisis during after-work hours.

6. *Transition*

The average length of involvement for a youth with the CME in Burlington County is between six to 18 months, depending on the level of need. Ideally, transition out of the CME occurs when the youth and his/her family has developed a sustainable plan and a network of natural supports. Sometimes a family may move out of Burlington County or opt out of CME services. Regardless of the circumstances for transition, Partners for Kids and Families provides the youth and family with information on how to access services in the future, including referrals if necessary. The FSO also offers ongoing support groups and trainings for parents and caregivers.

¹² E. Bruns and J. Walker. "Ten Principles of the Wraparound Process." *The Principles of Wraparound* (Chapter 2.1). National Wraparound Initiative. Available at: <http://www.nwi.pdx.edu/NWI-book/Chapters/SECTION-2.pdf>.

¹³ For more information on crisis plan development in the wraparound process, see: the National Wraparound Initiative's Phases and Activities of the Wraparound Process (pg. 11). Available at: <http://www.nwi.pdx.edu/pdf/PhaseActivWAProcess.pdf>.

¹⁴ For more information on individualized service plan (or 'plan of care') development in the wraparound process, see: the National Wraparound Initiative's Phases and Activities of the Wraparound Process (pg. 9). Available at: <http://www.nwi.pdx.edu/pdf/PhaseActivWAProcess.pdf>.



State Activity and Federal Support for CMEs

New Jersey is one of a number of states using the CME model in its approach to providing care coordination for children and youth with serious behavioral health needs. The Center for Health Care Strategies is working with three of these states – Georgia, Maryland, and Wyoming – in a quality improvement collaborative funded by the Centers for Medicare & Medicaid Services (CMS) to implement or expand the CME approach.¹⁵ Though CMEs across the country share many common elements, like systems of care, they are unique to the environments in which they operate and the children and families they serve.

CMS supports the CME approach to care for children and youth with behavioral health needs and the core services these entities provide, including intensive care coordination using Wraparound and family and youth peer supports.¹⁶ States and communities interested in exploring this approach can learn from the experiences of existing programs using intensive care coordination with high-quality Wraparound¹⁷ to determine what might work in their own local contexts.

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¹⁵ For more information on *Care Management Entities for Children with Serious Behavioral Health Needs: A CHIPRA Quality Improvement Collaborative*, visit: <http://www.chcs.org/project/care-management-entities-for-children-with-serious-behavioral-health-needs-a-chipra-quality-improvement-collaborative/>.

¹⁶ 5/7/13 Informational Bulletin on Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions. <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf>.

¹⁷ D. Simons, et al., op cit.