



Children's System of Care

White Paper on Critical Workforce Issues

Introduction

New Jersey has built a Children's System of Care (CSOC) for children and adolescents with emotional, behavioral and developmental challenges that is rightly recognized as a national leader for excellence. The tremendous success the system has achieved has brought with it great challenges, as growth and expansion have the system nearly at capacity. The integrity of many of the programs that make up the CSOC is becoming compromised due to rising caseloads, the inability to recruit appropriately trained and certified staff, and reduced rates of reimbursement that do not fully cover the costs of care for many of the programs in the continuum of care. In recent years, both intellectual and developmental disability (I/DD) services and substance use services have been transferred to the CSOC, exacerbating the quality, workforce and funding issues that were already in evidence.

The CSOC is a truly interconnected system with a single point of entry provided by the Contracted Services Administrator (CSA), PerformCare. If one piece of the system falters, it has detrimental effects on the other parts of the system. This is true for programs from outpatient mental health and substance use treatment, to partial care, to residential programs that are critical to the system being able to provide the appropriate level of care when needed.

Strengths of the CSOC

Outcomes for children and youth served by the CSOC have been very positive. The strong models at the core of the system have enabled it to successfully take on new populations, despite the continued need for clinical services for these populations to be fully developed. The exceptional work of the Care Management Organizations (CMOs), Family Support Organizations (FSOs) and Mobile Response and Stabilization Services (MRSS) has led to maintaining more and more children and youth in the community, not only decreasing inpatient stays and residential care, but contributing greatly to the very significant reduction of the juvenile justice census, keeping youth in the community who previously would have been in institutional facilities. The recently instituted use of MRSS staff for every resource family placement is showing signs that it will meet or exceed expectations for reducing multiple placements. The core programs of the CSOC continue to expand their scope and reach; however, the issues facing the system must be addressed in order to maintain the level of quality and success the system has achieved.

The Issues

Issues that need to be addressed in order to sustain the CSOC and maintain a high level of quality care are outlined below, followed by the recommendations of the New Jersey Association of Mental Health and Addiction Agencies' (NJAMHAA's) Children's Practice Group.

No COLAs in a Decade

Community-based providers have not received a of cost of living adjustments (COLA) from the State since 2008. In a FY 2015 report from the New Jersey Department of Children and Families, *NJDCF Workforce: Preliminary Highlights*, the critical need to maintain a skilled workforce is described along with the costs of high turnover. The report also provides the starting salaries for various staffing levels, which are, on average, \$10,000 to \$15,000 more than the starting salaries that community providers are able to offer. Professionals will continue to leave for similar, yet higher paying positions with the State or educational institutions, or abandon the field for other, more lucrative opportunities.

Unstable Workforce

The inability to recruit and retain quality staff contributes greatly to a lack of continuity of care, often disrupting progress that has been made by a child and/or family and resulting in the loss of gains made. The difficulty providers have in retaining experienced staff not only directly impacts the individuals served, but also negatively affects an entire agency, as knowledge, relationships and supervisory capacity are lost. The success of those served is reliant on a stable workforce.

Unpredictable Censuses

In addition to high staff turnover, the highly unpredictable size of the population to be served by various programs makes managing staff difficult for providers, including keeping to regulatory staffing ratios. Staff in many programs are being stretched to their limits to accommodate rises in population, in part because inadequate rates make it fiscally impossible to hire new staff when it is as likely that the population will decrease as suddenly as it increased.

Residential Programs: Occupancy rates in residential programs vary, but have consistently reached lows of 65% for substance use treatment beds. Bed utilization, needs assessments, innovative program models and best practices, particularly for those with co-occurring disorders, need to be fully researched and new models implemented that permit programs to sustain their bed capacity while best serving children and youth with proper lengths of stays. Many specialty treatment home models exist that need to be explored.

CMOs: The monthly rate for CMOs was raised effective August 1, 2017 from \$550 to \$775. The Legislature and Governor recognized that the arbitrarily reduced rate of \$550 was leading to unacceptable caseloads and the inability of care managers to provide all that they would ideally like to for both their high need and moderate need children, youth and families. CMOs anticipate being able to hire and retain a more stable workforce, though the adequacy of the increase remains to be evaluated, as advocates had requested an increase to \$850.

MRSS: Mobile Response programs must adhere to DCF expectations that they “will hire 1 Mobile Crisis FTE for every 5 dispatches per month and 1 Mobile Crisis Supervisor for every 6 Mobile Crisis FTE. Should [agencies] see an increase and/or decrease in census, [they] can adjust [their] budget and staff based on anticipated revenues and census trends.”

Shortages of Qualified Staff for Special Populations

Services for the youth with I/DDs lag behind those for other populations in the CSOC. There is insufficient capacity to serve this population, which raises concerns about care coordination and the

quality of care. The scarcity of Applied Behavior Analysis (ABA) credentialed staff leaves little room to ensure quality standards. This, too, is largely due to rates too low to attract and retain staff. Additionally, finding staff to serve rural areas has been highly challenging as qualified staff are unwilling to drive long distances without reimbursement for either time or mileage. As this is not a reimbursable service, services in these areas have been suffering. The population in need of substance use treatment faces workforce shortage problems similar to those of the I/DD population. A qualified workforce must be built to properly serve both populations.

Having qualified staff also means that training is a priority. Certain required trainings, such as Positive Behavior Supports, are offered through CSOC and the Boggs Developmental Disabilities Training School but are only offered quarterly in each region. Per-diem staff are unable to travel the distances required to complete this training during the required time frames.

As serving youth with I/DDs is still relatively new in the human services field, community and four year colleges do not have comprehensive curriculum for education on this population. Quality service provision could be higher if students were graduating with more training in this part of the field.

The Critical Need for Adequate Rates

In all of these programs, rates must be sufficient to support a stable workforce amidst fluctuating censuses. It is incomprehensible that contracts, regulations and oversight bodies would expect programs to adjust staffing on a monthly basis based on the most recent census that cannot predict the upcoming census. This is a flawed business model – programs can neither hire and train nor lay off staff quickly enough to make such a model fiscally viable, and such fluctuation in the hiring and reduction of staff does not address agency and community needs as they occur.

Before the recent rate increase for CMOs, caseloads for CMO care managers trended upward directly as a result of the inadequacy of rates. Other programs continue to be similarly stretched. Rates for residential programs are inadequate to cover all costs even if 100% capacity were maintained. When rate increases have occurred, inflationary factors are consistently absent, which leads to the erosion of sufficiency over time.

As they relate to I/DD Intensive In-Home Supports, the rates of reimbursement do not support staff's ability to attend the CSOC required trainings, as training is not a reimbursable item. The high demand for Board Certified Behavior Analysts (BCBAs), combined with the highly competitive rates offered by the Department of Education, has made hiring BCBAs extremely difficult for community-based providers. Additionally, the CSOC requirement for staff to be present at Child and Family Team meetings – while certainly a best practice – becomes unreasonable for per-diem staff who will not be reimbursed for their time.

Recommendations

The enormous growth, including expansion populations (I/DD and SU), without increased resources/rates is leading to an erosion of the CSOC success and difficulties in maintaining service capacity throughout the continuum of care. In order to sustain the system and its strengths, the New Jersey Association of Mental Health and Addiction Agencies recommends the following:

Rates

- Review the current rates for Board Certified Behavior Analysts and increase them to be on the

same level as other credentialed professionals.

- Compensate IIH Behavioral and Family Support Services staff for time and travel costs for team meetings, as well as other travel and training costs.
- As the fee-for-service (FFS) oversight process moves forward with a comprehensive study of the adequacy of reimbursement rates, and the impact of FFS on consumer access, quality and continuity of care for adult services, the oversight should be expanded to include all Children's System of Care fee-for-service rates.
- A formula for upward adjustments of rates and contracts that is tied to an inflationary index must be established to prevent erosion of their adequacy to cover actual costs of care.

Utilization Management

- Bed utilization, needs assessments, innovative program models and best practices, particularly for serving youth with co-occurring disorders, need to be fully researched and new models implemented to enable programs to sustain their bed capacities while best serving children and youth with proper lengths of stays. Many specialty treatment home models exist that need to be explored.

I/DD Workforce Training

- Establish additional training avenue(s) for I/DD in-home staff which are available more frequently and/or on-line.
- Collaborate with New Jersey schools of social work, and counseling and psychology programs to increase clinical and case management training for serving the I/DD population.