New Jersey Mental Health Planning Council (MHPC)
Meeting Minutes

April 13, 2011

Notices to announce the date, time and location of this meeting were sent out to the following news outlets: *Newark Star-Ledger*, *Asbury Park Press*, *The Times* (Trenton), *Bergen Record*, *The Press* (Pleasantville), and the *Courier-Post* (Cherry Hill)

Attendees:

Jacob Bucher	Winifred Chain	Lisa Negron
Helen Williams	Damyanti Aurora	Leah Barhash
Angela Romano-Lucky	Patricia Dana	Gregory Karlin
Herbert Kaldany	Robin Nighland	Jim Romer
Phillip Lubitz	Angel Gambone (Phone)	Marilyn Goldstein (Phone)
Joseph Gutstein (Phone)	J. Michael Jones (Phone)	

DHS, DAS, DCBHS & DDD Staff:

Roxanne Kennedy	Julie Caliwan	Robert Eilers, MD
Deborah Klasky		

Guests:

Louann Lukens	Michael Ippoliti	Mary Ditri (Phone)

I. Administrative Issues/Correspondence/Review of Previous Minutes and Subcommittee Minutes
   a. The Council reviewed and approved the Meeting Minutes from March 9, 2011 with no corrections or additions.
   b. The Council received the Wellness and Recovery Transformation Action Plan Review Subcommittee Minutes from March 9, 2011.

II. Update regarding the merger between DAS and DMHS - Marie Verna (MV) attended the DMHS and DAS Merger Forum Committee meeting
   a. There were Provider Forums where providers presented their concerns regarding licensing, regulations and work force development.
   b. Reviewed information collected from the eight consumer/family forums and a report is being developed that will be given to Kevin Martone for review.
   c. The consumer survey results have not yet been released but may be available for the meeting next week.
   d. Marie will present to the Merger Committee the following issues from the Planning Council:
      i. The merger of the Planning Council and DAS Planning Committees
      ii. Adolescents involvement

iii. Future planning documents of the merged Divisions like the Wellness and Recovery Transformation Action Plan

III. Announcements

a. The Red Mill Museum in Clinton NJ will be doing an exhibit regarding the history of the treatment of mental illness in NJ from May 15 through the end of July. Phil will bring flyers when available.

b. The directions for the submission of the Community Mental Health Block Grant for 2012-2013 and are open for public comment for 60 days. Roxanne will email them to the Council.

i. The Block Grant proposes to cover a period of 21 months and submission will be required by September 1, 2011.

ii. Application will be made in April 2013 for a period of 2 years.

iii. Joint submission is requested for mental health and addiction services that includes services for children and adolescents.

iv. There will be meetings and planning among DAS, DCBHS and DMHS to plan for submission.

c. The Annual COMHCO conference is on Saturday, April 16, 2011

d. April is National Minority Health Month

e. The NAMI-Mercer annual fund raising walk will be held at Ryder on Saturday, May 21, 2011. For more information, please go to the NAMI-NJ website.

f. We need to clap about the good things that are happening in our life!!!

g. DMHS received the Employment Development Initiative Grant through NASMHPD and SAMHSA. The goals of this Grant are to train Supported Employment/Education and IMR Facilitators in the Wellness Coaching Model. In addition, it will provide Wellness Coaches to Peers in Leadership roles.

h. Lisa Negron reported that the Regional SCAC meeting, there may be somewhere down the line licensing that might include self help centers. Lisa would like the Planning Council to be aware of this and perhaps advocate as necessary.

i. The IOC Committee met on 4/12/2011 and will meet monthly with two subcommittees, one regarding court procedures and the other regarding screening and training. There are four members of the Planning Council on the Committee –Angela Romano-Lucky, Phil Lubitz, S. Robin Weiss, and Jim Romer. These members were asked to report back to the Planning Council about the developments of the IOC Committee.

j. There is a new process for the designation of screening centers and there will be three counties per year that will be rebid. Jim Romer expressed concern regarding the RFP for screening as it did not fully address children's issues that could leave gaps for children and adolescents in screening. To address this issue, a suggestion was made to invite DCBHS, John Verney and Roger Borichewski to the Planning council to discuss RFP issues. Question by Joseph Gutstein: Aren't children supposed to be seen by Mobile Repose to avoid screening? JR- A: Yes, but mobile response does not intervene if child is threatening suicide. They have to go to the ER.

IV. Information regarding the primary and Behavioral Healthcare Task Force- Dr. Robert Eilers, Medical Director

a. The Integration of Primary and Behavioral Healthcare Task Force is in the final stages of putting together a report of their activities and recommendations that will be sent to the DHS Commissioner for review prior to publication.
b. Activities of this Task force have included visits to Federally Qualified Healthcare Centers (FQHC), looking at literature, participating in conferences, speaking to consumers and providers, surveys, and meeting with the Primary Care Association (PCA), the provider organization of the FQHCs.
c. The PCA has a project funded by the Nicholson Foundation to provide behavioral health care services through two FQHCs, one in Newark and one in Lakewood. They screen for mental health issues and substance abuse issues and provide treatment. These FQHCs will be a resource going forward.
d. The Patient Protection and Affordable Care Act is being contested in Congress so we are not sure how much it will change before it is implemented but this will impact funding for prevention and other services.
e. In the State, there is an Accountable Care Organization that has recently been legislated and will impact services
f. The Medical Global Waiver would facilitate more integration of behavioral health services
g. Mental Health Parity will also affect services that will be available.
h. DMHS is working on an opportunity with the Department of Health and Senior Services (DHSS). Currently DHSS is involved in a consortium of providers involved in chronic care i.e. diabetes, obesity, infections disease and there are resources available to provide care but they do not address behavioral health issues. DMHS also spoke with DHSS about the increased morbidity rate among mental health consumers and we are trying to work to have better services that are integrated for the mental health and substance abuse consumers.
i. Substance abuse and smoking are contributing factors to health both in the general population as well as the mentally ill populations. Smoking cessation efforts have been curtailed due to funding
j. Goals of the Integration of Primary and Behavioral Healthcare Task Force:
    i. Integration of Primary and Behavioral Health Care
    ii. Prevention and health promotion
    iii. Consumer management of health needs.
    iv. Obtaining surveillance data on morbidity and mortality by collecting outcomes. Currently, both locally and nationally, we do not have good data regarding health indicators related to morbidity issues in the States. There are surveys and tools available that cold be tied into our mental health system that would allow DMHS to track health indicators for mental health consumers.
k. Continue to look at mortality related to smoking, antipsychotic use and feel as though we haven't done enough to address these issues. In the State hospitals we have developed a metabolic tracking form that needs to be completed to monitor metabolic syndrome that tracks waist circumference, lipids, BMI, weight, vital signs, blood glucose. The psychiatrists in the State hospital need to be aware of this and are required to look at these indicators. These health indicators need to

be addressed in the community as well. Regulations may need to be in place in order to have providers monitor for metabolic syndrome.

l. Questions/comments and answers:
    i. Marie Verna (MV) commented: There was a scan of providers to see what the obstacles are to best practices regarding the integration health and behavioral healthcare.
    ii. Q- Joseph Gutstein (JG): The Acute Care Task Force STCF Regulation Work Group tried to get information included about the integration of physical and behavioral healthcare in regulations. Will the task force include specific information regarding data collection and reporting to determine the impact on consumer morbidity and mortality and if so, will there be a timeline for implementation? A: The reports will mention data to be obtained but probably not a timeline. IT resources are limited and collecting relevant data will involve DHSS and Medicaid so there will need to be coordination to be able to collect data in a more integrated and effective way.
    iii. Julie Caliwan (JC): Is the Task Force looking at different structures and the need to change the service system? Are there things that are working in other States? A: Yes, the National Council for Behavioral Healthcare has been very active in talking about how to change the structure in States to be effective. For example, in Tennessee there was a large CMHC that became a FQHC that completely integrated behavioral and physical healthcare. There is the Four Quadrant Model to determine the consumer needs and the best setting to address their needs. There is the Chronic Disease Model that includes Wellness Coaching and self care skills. Dr. Eilers is going to a conference to discuss what is happening in other States and barriers. In NJ, Care Plus had a federal grant to integrate services but regulations have been a barrier. DMHS and DHSS are working together to find ways to streamline licensing for providers to be able to integrate care.
    iv. Phil Lubitz (PL): The atypical antipsychotic mediations are being moved to managed care. Consumer's access to the more expensive antipsychotic meds will still be available. This brings an opportunity to monitor the use of the atypical antipsychotic that are more expensive to the less expensive ones through the Medicaid database. Also, there is a Medicaid database that will be able to be used to cross monitor who is on antipsychotic and people with metabolic syndrome. A: Joe Parks, Medical Director in Missouri presented to NASMHPD Medical Directors information he collected regarding metabolic syndrome and medical use with data from Medicaid that includes lab testing and other interventions from mental health clinics. They worked together to give feedback through the Electronic Health Record (HER) to ensure that people are getting monitored more carefully.
    v. Herbert Kaldany (HK) In the Department of Corrections there has had EHRs for 5 years and monitors each inmate for Metabolic Syndrome who is receiving antipsychotic and information is sent to the treating physician.

We are able to look at data to determine if the antipsychotic increases metabolic syndrome or is it the illness itself. Also, the HIV population is what we modeled on because it is a population that has a high mental health services need. This effort blended physical and mental health services nicely to bring together structures that can guide best practices. Herb suggested that DMHS should look at their model of integration.

vi. Jim Romer (JR): The health issues of individuals in boarding homes and RCFS are sometimes neglected and present in screening services with psychosis related to their medical conditions. Do we need to file an incident report with DMHS? A: We would take a look at it but this should also be reported to DCA since they regulate the RHCFs and licensed boarding homes.

vii. JG: When someone isn't following ADA APA protocol, is that reportable? A: Yes but it is a standard of care and could be debated. HK added that it is considered the standard in care in general however; metabolic syndrome is probably going to be phased out since these indicators are well known to cause heart problems and diabetes. Mental health issues need to be thought of as more globally so the standard of care can help mental health consumers.

viii. MV: When will the report of the Task Force be published? A: Hopefully within the next few months.

ix. JG: The 10 x 10 Wellness campaign was re-launched last year.

x. JB: CSP has a relationship with University of Chicago and has been conducting health fairs in the self help centers in New Brunswick for data. A: Yes and there are Wellness Committees that have been recently formed at each State hospital.

xi. PL: With the budget shortfalls in smoking cessation, are there smoking cessation medications and other resources available in State hospitals? A: State hospitals are not directly affected. Quit Centers were used for staff initially but not currently. Counseling and medication assisted therapies are available for consumers in the State hospitals.

xii. PL: Are there tobacco replacements therapies available in Screening Centers? MV: A report came out yesterday addressing this. JR: Most hospitals don't allow smoking so they are usually available.

V. Older adult and aging services at DMHS, Dr. Robert Eilers and Deborah Klasky, Psychiatric APN

a. DMHS realizes we have an aging population and their physical and mental health issues need to be addressed.

b. There is a wider need for behavioral health services for older adults so Debbie is chairing a committee of those within DMHS who are working with services for older adults to deal with inpatient as well as community treatment issues for older adults.

c. Since Centralized Admissions inception, we have found that there are a lot of people who are referred to State hospitals who can go to nursing homes and

specialty care nursing homes. There are 144 behavioral health-specialized care nursing home beds but they are usually occupied and seldom vacant.

d. DMHS is looking to help community providers with behavioral health issues to avoid inpatient settings.
e. Debbie Klasky is a psychiatric advanced nursing practitioner who monitors the PASRR process in NJ at the DMHS (handouts provided)
    i. PASRR means Pre Admission Screening and Resident Review
    ii. In 1987 the federal government mandated each state have a PASRR program. The PASRR program in NJ is a collaborative process between Medicaid, DHSS, DMHS and DDD. Through a Memorandum of Understanding, Medicaid has designated DHSS to administer PASRR services.
    iii. All Medicaid certified nursing facilities may not admit an individual with serious mental illness, mental retardation or a related condition unless the individual has been properly screened, evaluated and found to be appropriate for nursing facility placement.
    iv. The intent of PASRR is to protect individuals with serious mental illness and/or mental retardation from inappropriate placement in a nursing facility.
    v. Anyone being referred to a nursing home receives a Level 1A Screening Tool to determine if they have a serious mental illness or a developmental disability regardless of the payment source. This is done by the referring agency.
    vi. If someone is determined to be positive on a Level 1A tool, a psychiatrist or APN completes a Level II PASRR Psychiatric Evaluation that is sent to Deb. In addition, if this individual is Medicaid eligible or will be Medicaid eligible with 180 days of admission, then they require a Pre Admission Screening.
    vii. At DMHS, it is determined if the mental health issues of the individual can be met in the nursing home facility or not. If they need a higher level of care, there may be need for specialized care in another facility. Deb will work with the nursing home to address the behavioral health issues and will make recommendations as to what mental health treatment may be helpful to support the individual's needs.
    viii. This process takes 1-3 days to complete at DMHS once all documentation is received.
    ix. Deb included the website for a list of all the long term care facilities in NJ in her handout.
f. Questions/Comments/Answers:
    i. MV: What is the volume of people served? A: In CY 2010, there were 830 PASRR reviews. In October 2010, there was a change in how we review PASRRs which increased the volume but this is a good change. To date in CY 2011, Deb has completed 550 PASRR reviews.
    ii. HK: Sometimes there is an inmate who has dementia and a psychiatric disorder with psychosis who does not qualify for a nursing home placement. DOC has no access to screening. Is there some consideration

for DOC to discuss the case since options are limited? A: Frequently we get the scenario of someone with dementia and psychiatric disorder. We need to determine which is more prominent and which may be stable. Deb recommend Herb reach out to her in that situation to discuss.

iii. PL: There are 4 specialty care nursing facilities with 144 beds. Is there an ability to increase these beds? A: The DHSS doesn't have a mechanism to evaluate people in these beds to move them on. DMHS is not as involved with them but DHSS has relaxed the rules to allow an individual from STCF's to go to one of these beds. There should be more funding for these beds but none is known or available at this time.

iv. JR: STCFs have been made more dangerous as people with detainers can be admitted making older adults more vulnerable with a mixed population. Most screening centers try to admit to private geriatric facilities. May need to designate a completely integrated Geriatric STCF Unit. A: The Older Adult Workgroup will be looking at accessing the private beds and the specialized care beds. We are aware of the potential patient mix.

v. Angel Romano-Lucky (ARL): There are other people who have health related needs and mental illness who do not need a nursing home but need further assistance to remain in the community. A: One resource you may want to explore is Global Options or PACE programs run out of DHSS to help people in the community. However, one needs to be on Medicaid to be eligible for these services.

vi. Mary Ditri: There is a Webinar today: Dr. Eilers reported that there is a Webinar later today regarding the new Medical Clearance Protocol for psychiatric admissions from ER's, STCF,s and inpatient settings. It was a collaborative process with psychiatrists, mental health clinicians, ER physicians, and primary care doctors. Mary will email the information to attend.

VI. Readoption of the Regulations related to Governing the Community Mental Health Citizen's Advisory Board – Dee Schlosser

a. Copies of the Regulations and Authoritative Statute were passed out as well as a draft of suggested changes. The language in the statute could be improved and there is antiquated language.
b. These Regulations should reflect the merger of the Planning Council and the Community Mental Health Citizen's Advisory Board.
c. Next month, Dee will return to the Planning Council and will be taking suggestions and comments at that time.
d. The Regulations are due by December 2011 so information is needed to go the DHS by September 2011.
e. In the copy marked draft of the Statute, page 2-c should read "Institutional" instead of "Instructional".
f. The Regulations are good for 7 years but could be amended if needed.
g. After the Regulations are proposed, there is a Public Comment period.

h. MV Question: Will there be one set of rules for the joint Divisions to merge the Planning Councils? A: Do not know but will take that back and get back to the Planning Council.

VII. Review of Subcommittee information/Future Agenda

a. The Wellness and Recovery Transformation Action Plan (WRTAP) Review Subcommittee meet this am and went over information regarding the Data Driven Decision Making and Workforce Development. The WRTAP Subcommittee will wait for DHS to complete their own internal assessment to be made available and will then review and offer feedback to the Planning Council and recommendations going forward. This Subcommittee will go hiatus until the document is public.

b. Proposed agenda items for May and months to follow:
   i. DD/MI Task Force Update – Donna Icovino and Paula Hayes
   ii. Information about Consumer Operated Services.
   iii. The Council should have updates regarding the various Task Forces as a standing agenda item.
   iv. Director Turbetti from DCBHS Office of Adolescents Services to talk about aging out services.
   v. Susanne Borys and Molly Greene should present about the Federal data collection tools used for addiction services.
   vi. Speaker about veteran's services.
   vii. The issue of the County hospitals not being included in the Olmstead Settlement
   viii. Dee Schlosser regarding Regulations

Next Meetings:

MHPC General Meeting: 05/11/11, **10:00am-12:00** noon, Room 336

Membership/Nomination Subcommittee:
5/11/11, **9:00am**, Rm. 378

Community Mental Health Block Grant Subcommittee: 5/11/2011, **12 noon**, Room 378