Division of Mental Health & Addiction Services

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Review of the Wellness and Recovery Transformation Action Plan from 2008-2010

Summer 2012

NEW JERSEY DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
REVIEW OF ACTION PLAN FOR ACHIEVING A RECOVERY-ORIENTED SYSTEM

EXECUTIVE SUMMARY

In November 2005 the Governor's Mental Health Task Force was developed through Executive Order. The Task Force was asked to recommend specific changes to the Mental Health System that would improve the lives of mental health consumers and their families. The Task Force met for four months and held three public hearings, allowing many consumers and other stakeholders to contribute to the Task Force's final report. That report was published in March of 2005 and provided a blue print for systems change.

The Task Force Report proposed a new vision and set of values for the Mental Health system, including a vision of a Recovery Oriented system of care driven by consumers and their families. The report went on to outline a list of specific recommendations needed to achieve this vision, and identified Wellness and Recovery as Issue #1.

Following the recommendations of the Governor's Mental Health Task Force, New Jersey's Division of Mental Health Services (DMHS) utilized the "Stakeholder Participation Plan" as a vehicle to organize, plan and implement meaningful, effective, and long lasting systems change. The division issued the Wellness and Recovery Transformation Statement on February 10, 2006. Following the development of that statement, the planning process began. After countless hours of work and input from several hundred stakeholders in nine (9) sub-committees and focus groups throughout New Jersey, DMHS held an event on March 2, 2007 to discuss the summary recommendations gathered from participants of the stakeholder process. The summary of the findings of that stakeholder process resulted in the long and detailed New Jersey Division of Mental Health Services Wellness and Recovery Transformation Action Plan for Achieving a Recovery – Oriented System. The plan outlined steps and actions necessary to move the existing mental health system to one in which wellness and recovery was the goal for all who entered the system of care in New Jersey. The actions and steps to be taken were outlined by year and covered years 2008, 2009, and 2010. The plan and many of the supporting documents can be found at http://www.state.nj.us/humanservices/dmhs/recovery/.

Once the plan was in place, the Department of Human Services, DMHS, providers, families, consumers and other stakeholders went into action. Since its development, the division and stakeholders have been using the plan as the ongoing guidance for service delivery, advocacy, policy, funding and regulation. As you will see in the enclosed Review of the Wellness and Recovery Transformation Action Plan, an incredible amount has been accomplished and the system has moved considerably.

However, the systems change did not stop in 2010, as 2011 and 2012 were very busy years for the division. The DMHS merged with the Division of Addiction Services to form the Division of Mental Health and Addiction Services (DMHAS). Prior to and during the merger, the division had two acting Assistant Commissioners before Assistant Commissioner Lynn Kovich was appointed in August 2011. In addition, the DMHAS has participated in the development of the systems changing New Jersey Medicaid Comprehensive Waiver application and the division also closed a state psychiatric hospital in June of 2012. Through all of this change, the principles of wellness and recovery were

never lost. Indeed, the Division continued to accomplish significant and important steps toward continuing the systems changes that were started many years earlier in 2005.

In 2011 the division began a formal review of the progress made on the plan's objectives with the goal of publishing the enclosed review. Although the work of system changes continues, the enclosed review relates directly to the steps recommended for each year of the plan.

The matrix document herein provides a detailed review on those three key areas and the steps that were taken in response to the Wellness and Recovery Transformation Action Plan for Achieving a Recovery Oriented System across the identified years. The Matrix includes three columns, with the first describing the recommendations made in the original action plan. The recommendations are organized by year and each is numbered. The second column details the accomplishments toward those objectives. The accomplishments are also numbered and correspond directly to the objective, with each numbered recommendation having a numbered accomplishment. Finally, the last column details any future goal that corresponds directly to a recommendation.

The DMHAS hopes that you find the report informative and helpful. I know that I find it gratifying to see how much can be accomplished when the behavioral health community works together for the good of the system and those whom we serve.

Lynn A. Kovich
Assistant Commissioner
Division of Mental Health and Addiction Services
Department of Human Services
August, 2012

SYSTEMS ENHANCEMENTS THAT PROMOTE WELLNESS AND RECOVERY

OBJECTIVE/ACTION STEPS	PROGRESS IN CY 2008-2010	FUTURE PLANS
Increase Consumer and Family Role in the System		
New Consumer/Family Roles **2008**: 1. Peer Specialists in State Hospitals and Screening Centers 2. Consumer Advisory Committee 3. Family Advisory Committee **2009:** 4. Expand roles for consumers and families in designated screening centers and conduct evaluation. 5. Design and implement additional roles for peer specialists based on stakeholder input and Consumer Advisory Committee **2010:** 6. Integrate peer specialists' roles throughout workforce and ensure equivalence to related staff roles; 7. Evaluate effectiveness of consumer specialists and families in screening.	1. In 2008 DMHS implemented 4 peer positions at State Hospitals. Positions are funded through CSP NJ. 1. Twelve of the state's 23 designated screening programs report having peer-provider staff. A total of 42 peer-provider staff are employed across these 12 screening programs with eight of these employed in a full time capacity. Nine of the state's 23 designated screening programs report having family member provider staff. A total of 19 part-time family member staff are employed in these programs. Overall, fourteen of the state's 23 designated screening programs report having either or both types of staffing positions. The 3 state hospitals have on-site self-help centers that are run by consumers 1. There is ongoing technical support to peers and families in designated screening centers through the Mental Health Association (MHA). Technical support is provided to families in the screening centers through the Acute Care Family Support programs. Acute Care Family Support is offered in twelve counties. There are eleven funded programs. 2. In 2009, there were more peers on the Planning Council; an increase in peers involved in RFP reviews, licensing and Patient Services Compliance Unit (PCSU), and peers on key DMHS committees and Task Forces. CSP and UMDNJ-SHRP entered in to a collaboration to develop a curriculum to prepare peers to become wellness coaches. The training curriculum consisted of 90 hours. Financial support for six undergraduate semester credits or three graduate credits were provided through a NASMHPD-administered Transformation Transfer Initiative (TTI) Grant to the New Jersey state mental health authority. Thus far, 33 peers in recovery have completed the academic training in peer wellness coaching. 2. The regional Consumer Advisory Committee (CAC) meetings have been occurring since 2008 and continue to occur. These meetings	3. The development of a Family Advisory Committee 4 & 7. The evaluation of the effectiveness of consumer and family involvement in screening will be studied by the DMHAS.

	have been strengthened by the active participation and involvement of Regional Coordinators. The Statewide Consumer Advisory Committee (SCAC) is still under development. Representatives from the three Regional Advisory Committees have been selected and a meeting is in the process of being scheduled for early Fall 2012. This entity will serve in an advisory capacity to the leadership of the Division. 3. See Future Plans 4. Consumer and Family roles have been expanded, evaluation to be completed 5. All new RFPs have delineated peer roles as a requirement when applicable. For many years, the Mental Health Association of New Jersey (MHANJ) has operated Peer Outreach Support Teams (POST), which are located in Atlantic, Hudson, Ocean and Union Counties. These teams are comprised of mental health consumers who have received peer specialist training through MHANJ's Consumer Connections training program. POST workers provide one to one peer support to almost 300 consumers across NJ each year. This includes assistance with systems advocacy, linking consumers to community services, and providing individualized support from a peer perspective. In addition, POST workers facilitate groups on a variety of wellness and recovery based topics, attend county-wide mental health planning meetings (ie, are members of their county's Professional Advisory Committee and Systems Review committee, etc) and provide educational workshops on such topics as Psychiatric Advance Directives. MHANJ has interwoven its POST teams into the 3 Self-Help Centers that they oversee in NJ, giving each an outreach component that is capable of going into hospitals, jails and individuals' homes in order to provide peer services. 5. In 2009 and ongoing, there were more than 20 peers involved in RFP reviews, PSCU, Task Forces and licensing. 5. Since 2008, the DMHS contracts for the provision of Acute Care Family Support programs in twelve counties. The majority of staff in these programs are family members who have a mentally ill loved one. They provide education i.e. the Screening Law, advocacy, support and referral to family support programs such as NAMI NJ. Short term follow up is also often conducted. Monitoring to ensure effectiveness occurs through off site face to face visits and Quarterly Contract Monitoring	

	Reports (QCMRs) 6. Peer specialists roles have been integrated in workforce and new Community Support Services (CSS) Medicaid waiver will further expand their role and the reimbursement of their work 7. See future plans	
Training **2008**: 1. Implement training on supporting a consumer workforce 2. initiate at Statewide conference in Spring 2008 3. Identify training needs for participants on Advisory committees 4. Training provided to participants on advisory Committees **2009:** 5. Ongoing training on supporting a consumer workforce 6. Ongoing training for Advisory Committee participants	1. 32 Peer Wellness Coaches were trained through the Transformation Transfer Initiative (TTI) Grant. 1. Approximately 30 Self Help Center Managers were trained in Spring of 2008. NJ partnered with Collaborative Support Programs of NJ (CSP NJ) and developed a best practice model. The training topics included: time management for self-help center managers, training for self-help center facilitators, peer support and peer employment, conflict resolution and managing gossip. 2. The division contracted for the Peer Wellness Conference held in 2008 and supported the annual Coalition of Mental Health Consumer Organizations (COMHCO) conference 3. In 2010, MHA and CSPNJ completed a statewide survey of 45 providers and 124 peer providers. This initiated a newsletter for peer providers as well as 30 wellness forums for support around wellness. 4. COMHCO has done training to prepare peers for serving on Provider Advisory Committees and other community Boards through their annual conference which is supported by DMHS. 5. See Future Plans 6. In February 2009, the National Association of Mental Health Planning and Advisory Councils (NAMHPAC) completed training with current and interested families and consumers for participating in the Mental Health Planning Council.	1. DMHAS is developing "Wellness Counts", a modularized program to address healthy lifestyles for mental health consumers. It addresses the issues of nutrition, exercise, substance abuse and smoking. It is currently being reviewed by a Subcommittee of the Hospital Wellness Committee. Once finalized, it will be available to consumers, family members and professionals as a vital tool towards reducing early mortality and medical co-morbidity. 5. Trainings for participation on Mental Health Planning Council and participation in other advisory committees will be ongoing and include addictions consumers 5. Ongoing training for consumer workforce will be included in the DMHAS workforce development activities as resources allow

Emphasize and Integrate Tools to Promote Consumer Empowerment		
Psychiatric Advanced Directives **2008:** 1. Statewide training on DMHS website 2. CDs for Statewide Training 3. Staff training to Facilitate PADs at all state hospitals 4. PAD Regulations (adopted 2007) **2009:** 5. DMHS contracted service providers document that consumers receive education & given opportunity to complete PADs 6. Consumers who have not completed PADs receive Facilitated PAD intervention **2010:** 7. Trainings on PAD continue as needed	1. Sample PADs in English and Spanish as well as directions are available on the Division Website. 1 and 2. The Division and UMDNJ-UBHC 2007 training powerpoint titled, "Advance Directives for Behavioral Health Care," is available on the UMDNJ-UBHC website. The UMDNJ-UBHC website also contains 3 training modules: Introduction and Legal Considerations; Ethical Considerations and A Mental Health Advocate's Perspective; and Clinical Considerations. The Division's 2011 training powerpoint titled, "Hospital Training on PADs – What You Must Know to Comply with the Law," is available on the Division website. 3. A Facilitated PAD is a way of providing more assistance to consumers. It is a manualized service intervention that provides orientation, consultation, and structured personal assistance program for consumers that was developed by Duke University. 3. DRNJ has conducted advance directive trainings for consumers, family and professionals as follows: in 2007, 19 trainings with 587 attendees; in 2008, 20 trainings with 666 attendees*; in 2009, 6 trainings with 207 attendees; in 2010, 6 trainings with 124 attendees; and in 2011, 6 trainings with 97 attendees. In 2008, trainings were conducted for professional staff at each of the state psychiatric hospitals by the Division and DRNJ jointly. (*The number of DRNJ trainings and attendees for 2008 included the joint Division and DRNJ trainings conducted at the state psychiatric hospitals in 2008.) In 2011, DMHAS conducted trainings for professional staff at each of the state psychiatric hospitals. 3. There is no statutory or regulatory requirement for community providers to report on advance directives for mental health care to the Division. Between 2009 and 2010, a few community providers submitted data to the DHS and Division. Pursuant to N.J.S.A. 30:4-177.59, N.J.A.C. 10:32-1.4 and A.B. 3:37, Section IX, the five state psychiatric hospitals are required to collect and submit data through the Division to the DHS annually regarding advance directives for mental health care.	5. Monitor that service providers have documentation that consumers receive educational materials and are given the opportunity to complete the PAD 6 and 7. Develop program and monitor F-PAD intervention

	4. N.J.A.C. 10:32-1.1 et seq., Advance Directives for Mental Health Care, became effective on June 18, 2007. These regulations address annual reporting by and policies of the state psychiatric hospitals regarding advance directives for mental health care, and the creation and access to a Division registry of mental health care directives submitted voluntarily by individuals. **Other:** • A.B. 3:37, Advance Directives for Mental Health Care, was issued on November 17, 2010. This Bulletin reflects existing statutory law and Division regulations regarding the validity and invocation of advance directives, as well as guidelines for access to the Division Directory of Advance Directives by Division and state psychiatric hospital staff, licensed independent practitioners and mental health screeners. • The Division is coordinating with the Department of Health and Senior Services on a joint report to the Governor and Legislature regarding implementation of the NJ Advance Directives for Mental Health Care Act. At this time, the DHSS is in the process of reviewing regulatory development related to advance directives for mental health care. • As of March 30, 2012, the Division had 857 PAD's (including 2 revocations) in the Division Directory of Advance Directives. The Division Directory is a depository of advance directives submitted to the Division and converted into “read only” documents in a computer file accessible to Centralized Admissions and designated Division staff. Centralized Admissions is responsible for providing information contained in the Directory to authorized individuals pursuant to the procedures set out in A.B. 3:37. The Directory is comprised of advance directives submitted primarily from the community; participation in the Directory by consumers is voluntary. • On May 11, 2011, the Division issued a brochure, “Understanding Mental Health Advance Directives – Information for Consumers and Families,” providing information to consumers and families about mental health care advance directives, including the benefits	

	of an advance directive, execution and form requirements, examples of treatment preferences and registration of an advance directive with the Division. The brochure is available in English and Spanish, is accessible on the Division website and at the state psychiatric hospitals, and is distributed to hospital staff at mental health advance directive trainings conducted by Division staff. • The Division is enhancing the Oracle database, the centralized database of all consumers admitted to the state psychiatric hospitals, in order to allow state psychiatric hospital staff to directly input advance directive information into the database. As of April 2012, the project is in the final stages of development. The advance directive module is currently in the testing phase at Centralized Admissions; testing will be conducted at the state psychiatric hospitals at a future date. • Community providers are expected to provide ongoing training to staff and consumers.	
Individual Integrated Recovery Plan (IRP) **2008** 1. Establish workgroup for standardized IRP and documentation **2009** 2. Pilot IRPs incorporating WRAP 3. IRP becomes part of Core Competency 4. Incorporate IRPs into licensing standards and regulations as these come up for review 5. Evaluate feasibility of an electronic IRP to be shared among providers **2010** 6. All DMHS contracted providers use IRP as primary service/TX	1. Internal workgroup established 2. The concept of the IRP was incorporated into patient-centered treatment planning efforts that were initiated in several of the state hospitals. However, IRPs have not been piloted in any agencies in the community 3. Over the last three years, there have been trainings in the State Hospitals for IRP and WRAP to strengthen consumer driven treatment planning. 4. IRP and WRAP are incorporated into the Partial Care and Screening Regulations. 5. Feasibility of an electronic IRP was reviewed. Currently, due to lack of funding, the division did not pursue the development of an electronic IRP. However, as we move to EHR, IRP will be included in the planning. DMHS has been working with the department regarding	6. As the DMHS moves forward, the IRP will be incorporated in

plan 7. Electronic IRP (if feasible)	privacy, feasibility and other concerns with EHRs which will lay the ground work for an electronic IRP. 7. See above	conjunction with other future changes such as the merger with addiction services and the move to an Administrative Services Organization (ASO). The ASO will be required to conduct outcomes driven planning. Outcome can be evaluated in part via consumer attainment of IRP goals.
Illness Management and Recovery (IMR) **2008** 1. Incorporate IMR into objective on evidence-based practices	1. IMR has been incorporated into trainings and regulations for DMHS funded and licensed services.	
Primary Care & Mental Health		
Primary Care/Mental Health Task Force **2008** 1. Convene Task Force **2009** 2. Task Force issues final report with recommendations &. Timelines 3. Implement recommendations **2010** 4. Continue implementation	1. The Primary and Behavioral Care Task Force has been convened. 2. The Task Force is developing their final recommendations. Recommendations have been delayed in light of the ACA and ACO and implications for services in the State. As indicated earlier, DMHAS is developing "Wellness Counts" a modularized program to address healthy lifestyles for mental health consumers. It addresses the issues of nutrition, exercise, substance abuse and smoking. It is currently being reviewed by a Subcommittee of the Hospital Wellness Committee. Once finalized, it will be available to consumers, family members and professionals as a vital tool towards reducing early mortality and medical co-morbidity.	3 & 4. When full recommendations received the DMHAS will implement them in conjunction will other initiatives to promote the integration of Primary and Behavioral Health Care

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Collaborative Models for Co-occurring Medical Conditions **2008** 1. Develop models with community healthcare providers, including FQHC & VNA **2009** 2. Continue to develop collaborative models **2010** 3. Continue to develop collaborative models	1. The Task Force visited various FQHCs and Primary Care organizations to learn about their models 1. Changes on the Federal and State level in regards to the Affordable Care Act and Accountable Care Organizations and Medicaid's possible Global Waiver will have an impact on the collaborations developed and models used. 2. DMHAS is collaborating with NJAMHAA, UBHC, NAMI and the hospitals to improve health outcomes for consumers, i.e. Learning about healthy Living- Smoking Cessation, CHOICES, Tool kit to deal with metabolic syndrome, Hearts and Minds Program, Peer Wellness Coaching. 3. DMHS is meeting with DHSS, the NJ Primary Care Organization and FQHCs to go discuss funding, HIEs, regulations and licensing changes needed to be able to integrate behavioral and physical health care.	1. There are multiple integration models currently being explored and developed including, behavioral health homes and the coordination between and Administrative Services Organization (ASO) and the Medicaid Managed Care Organizations. 2. & 3. The ACA, the Global Waiver application and other developments have created increased opportunities for this integration which the DMHAS will continue to pursue.

Multiple Systems Integration		
DHS Integration **2008** 1. Work with sister divisions to develop consumer-focused approach to serve consumers w/ cross-cutting needs 2. Identify areas for partnership (e.g., jointly funded housing) 3. Develop data collection system to track consumers in multiple systems to research best practices **2009** 4. Define processes, roles and responsibilities for access points of access to services on data collection systems. 5. Establish agreements for shared service provision 6. Strengthen System Review Committees (SRC) and other structures to ensure seamless transition among systems for shared consumers **2010** 7. Implement processes, roles, etc as defined.	1. The Developmental Disabilities /Mental Illness and Co-Occurring Task Forces have met and completed recommendations that were presented to the Commissioner. DMHS and Division of Developmental Disabilities (DDD) have jointly funded programs for dual diagnosis consumers. 2. The Acute Care Task Force (ACTF) also began meeting in 2009 and provided recommendations to the Commissioner in 2010 to improve the acute care system. The ACTF included recommendations for making SRCs more useful and ensuring the system is more seamless for consumers 3. DMHS has improved the data collection for SRC's so that it is more useful and relevant. 4. DMHS has not developed a client specific data base that would be able to track consumers in multiple systems. Funding for IT infrastructure was not available due to budget issues 5. DMHS has been working with Medicaid to manage resources more efficiently and consumer based in the integration of DAS and DMHS. 5. In July 2010, DMHS and DAS began merging to be the DMHAS and joint projects that serve those with co-occurring mental illness and substance abuse are being developed. 6. SRC information has been modified to be more effective and DMHS is working with NJHA to provide training to 4 county SRC's.	1. DMHAS will continue to work with sister divisions to develop consumer-focused approaches to serve consumers with cross cutting needs, as evidenced in the behavioral health component of the Comprehensive Waiver, development of health homes, and plans for a preferred provider network and specialized service array for individuals with intellectual/developmental disabilities and mental illness 3. 4. & 7. DMHS has not developed a client specific data base that would be able to track consumers in multiple systems such as those enrolled in mental health and addictions services funded by DMHAS and services funded by the Division of Developmental Disabilities. Funding for IT infrastructure was not available due to budget issues

Integration with Other State Agencies **2008** 1. Work with Special Needs Housing & other interdepartmental committees 2. Issue RLI and award for up to 3 new Jail Diversion or 2 combined Jail Diversion/Re-entry programs **2009** 3. Establish agreements with Criminal Justice system, Labor, DCF and DHSS for shared consumers 4. Expand Jail Diversion pilots to counties with limited criminal justice mental health services **2010** 5. Continue expansion of jail diversion pilots	1. DMHS, DDD and Department of Health and Senior Services (DHSS) cooperatively working with Housing and Urban Development (HUD) vouchers from DCA. 1. Working with HFMA and the Special Needs Housing Trust Fund (SNHTF) on specific housing projects that provided 3 million in capital dollars and DMHS sits on their Board. Working with DFD in repatriation of consumers. 2. Request for Letters of Intent (RLI) for Jail diversion/re-entry was issued in early SF 2008 and awarded to Camden, Ocean, Mercer for diversion @ $250,000 each & Cumberland @ $135,000 for re-entry. 3. Cross Systems Mapping with the Criminal Justice System was completed. 3. Working with the DHSS regarding CN processes, acute care and access, uniform medical clearance protocols, regulations regarding integrated and co-located mental health, addiction services, and primary care, and PASSR. 3. Working with the Division of Child Behavioral Health Services (DCBHS) with Aging Out mental health consumers. 3. Working on developing an MOU with the Department of Labor, DVR. 3. Working with Department of Military and Veterans Affairs (DMAVA) on collaboration for veterans to get appropriate mental health services and trainings have been provided to clinicians regarding veteran's benefits as well as clinical needs. 3. Working with DHSS and other New Jersey State Departments on Electronic Health Records (EHR). 4 and 5. In December of 2010, DMHS received American Recovery and Reinvestment Act (ARRA) funding through the Office of the Attorney General Division of Criminal Justice which expanded the number of re-entry programs by 4; Burlington, Monmouth, Middlesex and Morris @ $150,000 each. This brings the total counties with a JIS program to 16 out of the 21 counties with Somerset funding its own.	Continue integrations with other State Divisions and Departments as needed to improve services.

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Mental Health/Substance Abuse Co-Occurring Competent System **2008** 1. Establish Task Force to make recommendations for competent system by 2010 and report **2009** 2. Implement Task Force recommendations **2010** 3. Continue implementation to ensure competence by 2010	1. A Co-Occurring Disorders Task Force was convened jointly by The Division of Addiction Services and DMHS. The Co-Occurring Task Force recommendations were given to the Commissioner in the fall of 2010. 2. In July 2010 the Governor's Budget merged the DAS and the DMHS into the Division of Mental Health and Addiction Services (DMHAS). The joint division has been using the Task Force report as one of the guiding documents in the merger planning. 3. DMHAS has been collecting stakeholder input during the implementation of the merger through provider surveys, consumer forums, county forums and a Stakeholder Advisory Committee. This feedback, along with the Task Force report will guide implementation of a co-occurring capable system going forward. To date there have been implementation steps in the area of regulation, funding and information technology. DMHAS recently facilitated a learning Community that included 8 agencies that provide addictions, mental health or co-occurring services. This Learning Community received technical assistance from Dartmouth University. DMHAS plans to engage additional agencies in new Learning Communities in the future.	3. There were 3 regional strategic planning meetings with mental health and addiction stakeholders held in late 2011 and early 2012 and a strategic plan for co-occurring disorders is now being put together to help promote integrated treatment for consumers with co-occurring disorders in the future.

State Hospitals: Olmstead & Active Treatment		
Olmstead-related **2008** 1. Implement strategic plan to promote active treatment 2. Ongoing development of supportive housing (through 2013) 3. Implement census reduction strategies for CEPP 4. Implement Regional Residential Committees for assessment, transition & discharge of CEPP 5. Implement Utilization Review to prevent unnecessary hospitalization 6. Reduce LOS on CEPP status 7. Ensure attainment of Year 1 benchmark 8. Establish Intensive Case Review Committee (ICRC) for long-term CEPP **2009** 9. Ongoing development of supportive housing (through 2013) 10. Request new service $ through state budget process 11. Ongoing meetings of established Regional Residential Committees 12. Implement Utilization Review process consistently across state hospitals 13. Implement Medicaid reimbursable community support services together with housing 14. Ongoing implementation of CEPP Review Committee 15. Ensure attainment of Year 2 benchmark	1. DMHS developed the Home to Recovery CEPP Plan based on the terms of the Olmstead Settlement. The Olmstead Settlement Agreement is available at http://www.state.nj.us/humanservices/dmhs/olmstead/olmstead_settlement_agreement.pdf. The Home to Recovery CEPP Plan is found at http://www.state.nj.us/humanservices/dmhs/olmstead/CEPP_Plan_1_23_08_FINAL.pdf. 2, 10 and 17. DMHS has developed and funded a number of Supportive Housing programs with flexible supports in order to meet the needs of the consumers that we serve and provide them with the most integrated setting possible in the community. In 2008, 306 units were developed; in 2009, 335 units were developed; and in 2010, 246 units were developed. 3. Reduction strategies outlined in the Home to Recovery CEPP Plan and Olmstead Settlement. See 1. above. 4. Implemented Local Residential Meetings and ICRC at each State hospital. There have been cross departmental meetings at each hospital to become familiar with housing alternatives. 4, 11, and 18. Implemented the Regional Advisory Quarterly Meetings that include consumers, families, providers, regional staff and hospital staff. And they continue to meet 5, 12 and 19. Centralized Admissions is reviewing all admissions for appropriateness to the State hospital. Admissions processes are also reviewed by the community providers (i.e. Short Term Care Facilities (STCF), etc.) for appropriateness of referral as needed such as cases that present as systems challenges. The information is shared with the local stakeholders at the county specific Systems Review Committees (SRC) meetings and has proven successful to manage utilization. 5. There is a draft triage bulletin regarding the triage process for accepting	

16. Continue Intensive Case Review Committee activities

2010

17. Ongoing development of supportive housing (through 2013)
18. Ongoing meetings of established Regional Residential Committees
19. Ongoing implementation of Utilization Review process consistently across all state psychiatric hospitals
20. Ongoing implementation of CEPP Review Committee
21. Ensure attainment of Year 3 benchmark

patients from STCF first instead of from Screening.

6. There was an AB published in 2010 that established time frames and expectations for providers who have contracted for services to State hospital consumers.

7. The division has reduced the average LOS for those consumers on CEPP in 2008, 2009 and 2010

7, 15, 21. Per the settlement agreement is: 62% of all consumers designated CEPP after July 1, 2008 will be discharged within 6 months of CEPP designation. In base years SFY 2008, the outcome was 79.2%, SFY 2009 it was 77.2%. In SFY 2010, the outcome was 77.5%, thus exceeding the target in the settlement agreement.

8, 16. ICRC committees began in each State hospital in 2010 and continue to meet on a regular basis

8. The number of supportive housing units developed in 2009 is 335

10. Each year the division has requested and been appropriated money for residential and other services to decrease inpatient census and access to community resources so that the division can comply with the Olmstead Settlement.

APPROPRIATION RECAP	**TOTAL**	**CHANGE**
FY 2007	$ 10,000,000	
FY 2008	$ 22,136,000	$ 12,136,000
FY 2009	$ 40,383,000	$ 18,247,000
FY 2010	$ 46,555,000	$ 6,172,000

10 and 13. A Medicaid State Plan Amendment for community support services to be covered under the Medicaid Rehab Option has been submitted and approved. This will bring in additional revenue from Medicaid to cover community based support services.

11. See above

17 thru 21 – All activities continuing as developed.

	12. See above 13. The Division has funded supports with housing units and targeted some supportive housing to specific support needs. Residential Intensive Support Teams (75 units), -MESH (Medically Enhanced Supportive Housing) (76 units), and Supportive Housing - ESH (Enhanced Supportive Housing for Challenging Behaviors) (72 units). In addition, the Division funded 112 units of Supportive Housing units for those at risk of hospitalization. Our Supportive Housing programs follow a Housing First Model. 14 and 20. CEPP review Committee continues 15. Year 2 benchmarks were attained 16. ICRC continues 17. The Division was charged with creating 180 placements for consumers who are designated as CEPP and 50 placements for consumers who are at risk for institutionalization or homelessness. As of June 30, 2010, the Division awarded 201 placements for consumers who are designated as CEPP and 50 placements for consumers who were at risk. The annual percentages that are reported above are based on the SFY 2011 second quarter Olmstead report (data extracted January 3, 2011). 18. See above 19. See above 20. See above 21. See above	
Active Treatment & Wellness in State Hospitals **2008** 1. Implement hospital workgroups to promote wellness 2. Analyze staffing patterns with goal of increasing active treatment	1. Each hospital has Wellness Committees that began in 2010 that discuss on going wellness needs and improvement projects. 1. State hospital's staff have been trained on WRAP and WRAP for co-occurring disorders. As stated earlier, DMHAS is developing "Wellness	

3. Conduct assessment to identify & address safety concerns 4. Use 3-Year Federal Grant to implement plan to reduce or eliminate seclusion & restraints in state hospitals 5. Develop assessment & treatment to provide trauma informed care in state hospitals 6. Complete training for medical staff on prescribing for nicotine replacement therapies 7. Implementation of Management Support Team at Ancora **2009** 8. Implement pilot programs identified by the workgroup for building wellness culture and healthy habits and evaluate outcomes to recommend expansion or changes. 9. Continue implementation of 3-Year Grant 10. Continue assessment & treatment to provide trauma informed care in state hospitals **2010** 11. All hospitals have programs or activities to promote healthy lifestyles and wellness culture 12. Continue implementation of 3-Year Grant 13. Continue assessment & treatment to provide trauma informed care in state hospitals	Counts" a modularized program to address healthy lifestyles for mental health consumers. It addresses the issues of nutrition, exercise, substance abuse and smoking. It is currently being reviewed by a Subcommittee of the Hospital Wellness Committee. Once finalized, it will be available to consumers, family members and professionals as a vital tool towards reducing early mortality and medical co-morbidity. 2. Staffing patterns were analyzed and staffing ratios have improved and meets Department of Justice (DOJ) standards as State hospital census has declined. In 2008, each hospital began planning for treatment malls that included focus groups of consumers to determine their needs to promote wellness. Staffing allowed for Treatment Malls in all State hospitals to provide active programming and expectations that everyone capable participates. 3. As a result of Administrative Order (AO) 1:91 safety issues improved at Ancora as well as the other State hospitals with a decrease in the number of walkaways from the hospitals grounds and an increase in the monitoring of patient injuries and assaults. 4, 9 and 12. The Seclusion and Restraint Grant was implemented through December 2010. 5. There have been Trainings on Trauma Informed Care (TIC) to all State Hospital Employees and each hospital has a TIC Committee. 6. Smoking Cessation training was completed. UBHC (University Behavioral Healthcare) is tracking data regarding nicotine replacement therapies use. 7. The AO 1:91 was implemented at Ancora and there were consultants used to develop an improvement plan. Some consultation and ongoing support continue. 8. Wellness activities continue in each State hospital with smoking cessation classes, self-medication education, use of the Treatment Malls and the implementation of Self Help Centers at three of the State hospitals 9. See above 10. Efforts continuing, see # 5	3. There is an ongoing effort to conduct assessments to identify and address safety concerns at the State hospitals. 7. The AO 1:91 was implemented at Ancora and there were consultants used to develop an improvement plan. Some consultation and ongoing support continue. The DOJ dropped its investigation of Ancora. The A.O. 1:91 was an important factor in the success of the Ancora efforts, as was increased staffing, training and program development, as well as a significant census reduction from increased community discharge options. 8. Outcome evaluation of the programs that build wellness culture and healthy habits is not available at this time. Outcome measures will need to be developed and implemented with review from the Wellness Committees

11. There is also an effort to reduce Polypharmacy of Psychotropic meds through an AB that tracks and monitors data and use of meds.
11. Improved Patient education materials on medication-on website.
11. State hospital staff has been trained in the MANDT system of care.
11. There are Linguistic Competency Teams in each hospital to meet consumer's needs.
11. There is an Administrative Bulletin 3:36: Metabolic Tracking Form to be used at each State hospital to monitor Metabolic Syndrome.

12. See above

13. See above

Hospital Training

2008

1. Continue contract to provide consumer-delivered Recovery activities
2. Complete training of direct care staff in implementation of Learning about Healthy Living manual to address smoking in state hospitals

2009

3. State hospitals establish training units or teams and provide ongoing Wellness & Recovery related training
4. Assure that consumers and families are integrated into hospital training activities

2010

5. Continue to provide Wellness & Recovery related training
6. Assure that consumers and families are integrated into hospital training activities

1. Completed numerous consumer-delivered wellness and recovery activities from FY08 through FY10. Following are the activities that were accomplished:

Wellness/Recovery Activities	FY '08 # Activities	FY '08 Undup.	FY '08 Duplicated	FY '09 # Activities	FY '09 Undup.	FY '09 Duplicated	FY '10 # Activities	FY '10 Undup.	FY '10 Duplicated
Smoking Cessation Groups	34	76	195	54	169	373	76	215	673
Alcoholics Anonymous	289	N/A*	976	318	N/A*	1230	467	N/A*	1703
Double Trouble/DRA/MICA	445	N/A*	3892	573	N/A*	5150	531	N/A*	4823
Nicotine Anonymous	10	N/A*	84	57	N/A*	517	47	N/A*	396
Narcotics Anonymous	27	N/A*	158	59	N/A*	498	59	N/A*	333
Substance Abuse/MICA Link	5	31	38	41	113	497	17	57	74
Total	810	107	5343	5343	282	282	1197	272	8002

	***By definition, unduplicated count is unavailable for anonymous groups** 2. Completed training but due to funding, was not able to continue fully. Following are the trainings that were accomplished: Healthier Living: Tobacco Awareness the Next Step • Trenton Psychiatric Hospital (14 trained on 5/8/2008) • Hagedorn Psychiatric Hospital (17 trained on 5/30/2008) Identification and Assessment • Trenton Psychiatric Hospital (17 trained on 3/6/2008) • Hagedorn Psychiatric Hospital (8 trained on 6/12/2008) Learning About Healthy Living • Trenton Psychiatric Hospital (14 trained on 5/8/2008) • Hagedorn Psychiatric Hospital (13 trained on 6/27/2008) 2. A curriculum was also developed and implemented for training State Hospital staff. 3. & 5. The University of Medicine and Dentistry of New Jersey, School of Health Related Professions, has staff at four of the hospitals who are conducting training and supervision for staff in IMR, Person Centered Treatment, DBT, and other recovery service supports. 4. & 6. Consumers are included in the orientation training of State hospital staff. 4. & 6. The Healthy Living Manual was developed and training was provided to consumers and families. It is available online in English and Spanish.	

Evidence-Based Practices		
General strategies **2008** 1. Identify outcome & fidelity measures for each evidence based practice implemented **2009** 2. All new funding opportunities will require incorporation of relevant EBP, Promising or Best practices 3. Initiate statewide training in evidence-based practices. 4. Conduct assessment of fidelity to model practices and assure consistent and effective **2010** 5. Assessment of model fidelity; assure consistent, effective implementation	1. Since 2008, the Division has continued to employ multiple strategies for promoting fidelity to evidence-based Assertive Community Treatment (ACT) and for increasing access to this EBP. First, The ACT regulations were re-adopted in 2008. Most aspects of a high fidelity ACT program are integrated into this regulatory scheme. 1. Integrated Dual Diagnosis Treatment (IDDT) and fidelity monitoring is completed by the division through a contract with the UBHC Technical Assistance Center (TAC) 1. Illness Management and Recovery (IMR) is implemented by the division at the state hospitals through a contract with UMDNJ School of Health Related Professions. UMDNJ SHRP trains and monitors for fidelity. 2. Since 2009, Requests for Proposals (RFP's) in residential are for supportive housing models that meet the specialized needs of the individuals served. The contractee must identify how the Supportive Housing EBP will be utilized in the proposed program. 2. RFP's ask agencies what EBPs or best and promising practices will be utilized in working with consumers in all new applications. 3. There was training provided in Motivational Interviewing, CBT, IDDT, and DBT Statewide. 4. & 5 See Future Plans	1. Identify outcome and fidelity measures for EBP's for DBT , peer services and other EBPs being implemented

Supportive Housing (SH) **2008** 1. Issue RFP & award funds for development of up to 100 supportive housing units & services. 2. Proposal to DMAHS for Medicaid-reimbursable services model under the Rehab Option. 3. Issue funding Announcements and award additional supportive housing opportunities contingent upon resource availability. **2009** 4. Medicaid reimbursement for Supportive Housing community services fully implemented if CMS approved 5. Issue announcements & award additional SH contingent upon new funds through budget process. **2010** 6. Issue announcements & award additional SH contingent upon new funds through budget process.	1. & 3. A total of 306 housing opportunities were awarded in FY08. 2. In March 2011, DMHS in conjunction with Medicaid, submitted a State Amendment Plan that will include reimbursement for SH services under the Rehab Option. 3. DMHAS continues to issue housing RFPs and announcements of awards each fiscal year. 4. See future plans 5. A total of 335 housing opportunities were awarded in FY09. 6. A total of 246 housing opportunities were awarded in FY10. 1., 5. & 6. The Division has hit each year's target regarding award and development of new community residential capacity.	4. Community Services were not approved by CMS until 2011, so not able to fully implement during this time period. However, DMHAS will continue to implement community support services (CSS) and is currently developing the CSS regulations.

Supportive Employment (SE)/ Education (SEd) **2008** 1. Issue RLI/award up to 3 SE expansions for persons in PC; also up to 2 SEd components to existing SE programs **2009** 2. Expand SE to become Career Development & incl. Supp Ed services (if new funds) 3. Work & educational readiness incorporate into Partial Care **2010** 4. Expand SE & Supportive Education services, contingent upon new funds through state budget process	1. RLI for Supported Education (SED) went out in early 2008 with the final awards in late 2008. Implementation began in 2009. 2. See Future Activities 3. Work and Education readiness has been incorporated into the PC regulations. 4. Eleven counties are currently covered by the four SED providers; Passaic, Morris, Bergen, Essex, Union, Hudson, Middlesex, Gloucester, Camden, Burlington, Monmouth, Ocean, and Atlantic. 463 consumers were enrolled in SEd services in 2010. 1003 consumers were provided with information and consultation that were not enrolled.	2. SE and SEd to become Career Development in FY 2011.
Peer-delivered & Consumer-Operated Services **2008** 1. Fund enhanced consumer-operated self-help centers in Hudson & Sussex 2. Fund 3 new self-help centers (Passaic, So. Ocean & Camden) 3. Strengthen role of peer support 4. Evaluate pilot Self-help center outreach to CEPP at TPH for program engagement 5. Leadership Training Academy provide training & support to center managers & facilitators 6. Evaluate Leadership Training Academy 7. Evaluate existing pilots for replication 8. Work with Medicaid re: feasibility of statewide Medicaid reimbursable peer-support in community agencies	1. Enhanced consumer-operated centers were developed and implemented in Sussex, Hudson and Cape May Counties. Components of "enhanced model" include: wellness screenings; personal wellness; health and recovery techniques; alternative healing; health literacy-leadership training; conflict resolution skills; stress management; wellness coaching; anger management; and peer employment support. 2. In 2008, providing funding to add an additional SHC in Ocean, Passaic and Camden Counties. 3. Peer support models (such as WRAP, IPS, PADs) and self-help centers are actively engaged in community outreach activities to partial care programs, outpatient programs,	6. Evaluate Leadership Training Academy 7. Evaluate existing programs for replications

2009 9. Expand self-help center outreach to CEPP status persons to 2 additional state hospitals 10. Include information about/access to self-help dual recovery groups: Self-Help Clearinghouse manual & 800 #, transportation & self-help group talks 11. Continue support training for self help center mgrs & facilitators 12. Issue RFP/RLI to expand Consumer-operated svc model to include Warm Line & crisis diversion 13. Establish partnerships with Partial Care programs to promote center engagement 14. Begin replication of promising practices 15. Implement pilot peer support projects & evaluate **2010** 16. Self-help center outreach available to all CEPP in state hospitals 17. Self-help centers fully integrated into service continuum 18. Continue replication of successful programs & monitor outcomes 19. Based on Year 2 outcomes, refine & implement service model	PACT, ICMS, boarding home outreach, RHCF's shelters, and food pantries. Peers are increasingly recognized as "true partners" in the provision of quality mental health services across the continuum of care. 4. A program evaluation demonstrated that over two-thirds of study participants who completed the assessment reported that the group was either “very helpful” or “helpful” in becoming aware of strengths and skills, improving a sense of hope, defining recovery goals, learning coping skills and preparing for possible relapse. 5. Training has been provided to Self Help Center Managers through the Leadership Training Academy. The Leadership Training Academy continues to provide training and support. 6. See Future Activities 7. Currently collecting program outcomes for existing pilots. 8. As part of the Community Support Services (CSS) State Plan Amendment, there is a proposal to have peer services be a part of the Rehab Option. 9. Self help center opened on the grounds of APH in 2008 and at GPPH and TPH in Spring, 2011. 10. & 12. In 2009, a Warm Line was created through MHA that uses Intentional Peer Support to work with consumers who call in. Currently collecting program outcomes. 11. Support Training has continued for Self Help Managers to the extent that current budget allows. A Statewide Leadership Training Academy operates out of "Wildwood Retreat" in Wildwood, NJ. 13. Many of the 33 self-help centers reach out to all of the community programs, including partial care and partial hospitalization programs as part of their general outreach and recruitment. The self-help centers have been proactively connecting to partial care programs.	9. Increase to info about access to self help dual recovery, transportation and self-help group talks 15. On July 25, 2012 DMHAS issued an RFP to pilot the integration of peer positions within Integrated Case Management Service (ICMS) teams.

	Presentations are made by the center managers and facilitators to both staff and the membership of the partial care programs. The relationship between most centers and partial programs is somewhat informal, however some are more formalized. 14. & 18. Promising Recovery and Wellness and Peer Services have been replicated, such as the Peer Specialists in each of the State hospitals and Self Help Centers on the Grounds of all State Hospitals as of May 2011. 16. & 17. Self Help Centers are fully integrated into the State hospital system and available to all CEPP consumers as of May 2011. 18. & 19. Based on the success of the new pilots, DMHAS will replicate successful programs as funding permits to further implement these service models.	
Assertive Community Treatment (PACT) **2008** 1. Implement PACT Outcomes Initiative to standardize & incorporate outcomes into svc commitments **2009** 2. Standardized outcomes fully implemented into svc commitments & contracts 3. Research & pilot specialized PACT services, e.g., forensic	1. Outcomes standardized 2. Consumer outcomes related to hospital reduction, employment and education have been incorporated into PACT program contract scoring. 3. Explored ACT for criminal justice specific PACT but research indicates that the impact of Assertive Community Treatment on specific criminal justice outcomes is limited. Based on funding limitations that started in 2009 specialty PACT expansion has been prioritized for state hospital CEPP consumers.	

Co-Occurring Services **2008** 1. Fund IDDT training to targeted agencies 2. Evaluate effectiveness of IDDT training 3. Implement IDDT in state hospitals 4. Continue to distribute and provide training and use of DMHS co-occurring manual 5. Create Task Force to promote co-occurring competent system **2009** 6. Begin to implement TF recommendations 7. Continue state hosp implementation of IDDT **2010** 8. Begin to implement TF recommendations 9. Continue state hosp implementation of IDDT	1. & 4. IDDT training is provided by UBHC-TAC upon interested agencies request. DMHS funds the training and consultation provided by UBHC-TAC. Individualized trainings are provided to each agency 2. IDDT effectiveness is evaluated through an annual Fidelity Scale conducted by UBHC-TAC. UBHC-TAC are currently in progress to train the current IDDT providers how to self-administer their annual Fidelity Scale. 3. Components of the IDDT model have been implemented in the state hospitals 4. A best practices manual for co-occurring disorders was developed and all contract agencies trained in it's use 2008 and 2009 5. A COD Task Force was convened jointly by DAS and DMHS. The Co-Occurring Task Force recommendations were given to the Commissioner in the fall of 2010 and continue to be used as guiding principles in the merger of the division. 6. & 8. Implementation of TF recommendations being accomplished through the planning and implementation of the merger of DAS and DMHS into DMHAS. 7. & 9. IDDT provides for standardized admission screening, and integration of substance use interventions into the treatment plan using the stages of change approach. Included is coordination with substance abuse counselors/programs and discharge planning with community substance abuse providers, as well as mechanisms for staff training and supervision and for collecting outcomes and measuring fidelity +to the model. N.J. state hospitals have had training on IDDT beginning in 2009, and have implemented components of the IDDT model.	7. & 9. Continue evaluation of fidelity to IDDT in state psychiatric hospitals and work toward increased fidelity.

Illness Management & Recovery (IMR) **2008** 1 Expand IMR to all state hosp & select agencies 2. Design plan to evaluate effectiveness of IMR training, model fidelity & outcomes 3. Begin evaluation in selected agencies and state hosp. **2009** 4. Continue to offer IMR training to DMHS contracted providers 5. Increase the # of IMR teams per agency 6. Evaluate fidelity & outcomes of existing IMR & assess sustainability **2010** 7. IMR training offer to all DMHS contracted providers 8. IMR available to interested consumers; for those with goals, shared among all providers	1. IMR expanded to all state hosp & select agencies. DMHS prioritized agencies providing Partial Care. 2. UMDNJ-SHRP also continues to evaluate the training provided. University staff conducted ongoing training and provided direct supervision to hospital staff assigned to run IMR groups. They have evaluated program fidelity in order to prevent "drift" from the evidence based IMR model and promote better outcomes. They also had also looked at penetration rates (number of hospital patients in IMR groups) and collected staff ratings and at hospitals consumers' self ratings of progress to measure outcomes. 3. UMDNJ-SHRP has conducted evaluation of training, and has evaluated the fidelity to the IMR model and outcomes related to consumer participation in IMR groups for all of the state hospital programs. 4. By 2009 46 agencies had been trained in IMR 5. Seventeen additional teams were added 7. By 2010 a total of 74 agencies were trained in IMR. UMDNJ TAC and the training provider hold quarterly IMR Facilitator meetings in the North and the South to aid in IMR implementation. 8. In 2010 a total of 1307 consumers have received IMR	4. and 7. Continue trainings for IMR as funding permits 6. Evaluate fidelity and outcomes of existing IMR and assess sustainability
Family Psycho education **2008** 1. Inventory existing family-based services to identify use of psycho education practices 2. Evaluate existing services capability to establish multiple family psycho-education groups; monitor fidelity & outcomes	1. Family psycho-education is an integral component of each of the twenty-one DMHS funded Intensive Family Support Services programs. 2. The need in each program/county is determined annually during the contract negotiation process and it is significantly	

2009 3. Provide incentives & training so existing services can modify practices to offer multiple family psycho-education 4. Fund avail, DMHS use to present multiple family psycho-education model to key stakeholders 5. Explore feasibility of Medicaid reimbursement for multiple family psycho-education 6. Establish practice group focused on multiple family psycho-education groups **2010** 7. Continue to evaluate ongoing family psycho-education needs & services	based upon program performance via the Quarterly Contract Monitoring Reports (QCMRs). Fidelity outcomes are not used at this time for family psycho-education services. 3. In FY'09, the DMHS contracted with three Intensive Family Support Services programs to provide Psycho educational Multifamily Group Treatment (PMFG) on a pilot basis. Prior to the commencement of services, each of the three programs were trained and supervised by a DMHS funded consultant who was familiar with the model. Program performance is monitored via phone consultation with DMHS and Quarterly Contract Monitoring Reports (QCMRs). 4. Resources were not made available to for start up funds to present the multiple family psycho-education group model to key and relevant stakeholders in FY 2009 due to budget constraints. 5. Explored the feasibility of adding multifamily psycho education to Medicaid. It was decided that family psycho-education would not be an identified service in the State Plan Amendment that was submitted to CMS in FY 2011. 6. Resources were not made available to establish practice groups focused on multi-family psycho-educational groups. Performance is monitored via phone consultation with DMHS and Quarterly Contract Monitoring Reports (QCMRs). 7. Intensive Family Support Services staff meet quarterly to discuss pertinent program issues including psycho education. DMHS staff attend these meetings. 7. Program performance is monitored via phone consultation with DMHS and Quarterly Contract Monitoring Reports (QCMRs).	7. Continue to evaluate ongoing family psycho-education needs & services

NEW JERSEY DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
REVIEW OF ACTION PLAN FOR ACHIEVING A RECOVERY-ORIENTED SYSTEM

Acute Care Models **2008** 1. Align the acute care system with Wellness and Recovery principles by working with Designated Screening Centers (DSC) to ensure a welcoming approach for consumers in time of crises, and by researching alternative and peer-delivered crisis intervention models such as the Living Room model for crisis diversion; Crisis respite and Warm Lines 2. Fund demonstration projects for alternative Early Intervention to crisis management. **2009** 3. Evaluate Early Intervention demo projects for effectiveness & replication	1. DMHS contracted UMDNJ to complete this research. Literature review completed by UMDNJ in FY 2010. 2. DMHAS is currently developing an RFP regarding peer operated crisis services. It is expected that the RFP will be issued in the fall of 2012. 2. Three additional Early Intervention Support Service programs were awarded in Camden, Ocean and Middlesex Counties during FY 2011. 3. Evaluation of early Intervention Support Services constrained by human and data infra-structure limits	3. Evaluation of the Peer crisis services resulting from the FY13 RFP will be completed when program has begun.
Medication Algorithms **2008** 1. Reconvene & expand Medication Related Services Work Group to expand Pharmacological Practice Guidelines for Treatment of Schizophrenia to include other behavioral disorders 2. Develop plan to implement guidelines in psychiatric hosp and community services 3. Begin discussions with Medicaid to monitor prescribing practices and promote compliance with guidelines; incl. medication histories**.** **2009** 4. Increase staffing resources in the Office of the Medical Director to allow monitoring of prescription practices and implementation of a feedback system.	1. The Medication-Related Services workgroup was never reconvened. It was apparent that the workgroup would not be able to ensure the future implementation of any practice guidelines that it had developed. DMHS did not have any authority to require community providers to adhere to the guidelines, unless there was commitment from DMAHS (Medicaid) and others to the initiative. 1. Since the plan was written additional information and focus has been necessary for the prevention and treatment of metabolic disorders secondary to the use of antipsychotic medications. This issue had become a focus of consumer groups and other work groups within the division and federally because of the large numbers of consumers who were being adversely affected by this. Medical Directors Office has focused on addressing this issue as more imminent. Guidelines for measuring and tracking metabolic indicators was implemented in the state psychiatric hospitals	3. 4. & 5. Resources to implement Algorithms in the community are not available. The plan had been to augment a pre-existing Medicaid (DMHAS) prescribing project called Behavior Pharmacy Management (BPM), which was a program supported by a pharmaceutical company that had monitored prescribing and provided feedback

2010 5. Fully implement the monitoring & feedback mechanisms to ensure full compliance with guidelines	in 2010, and the plan is to work with experts, such as Essex County Hospital Center, which has a metabolic disorders research center, to disseminate these to community practitioners. DMHAS is also funding a Complete Wellness project with UBHC that developing and piloting a tool to help consumers understand metabolic syndrome so that they can be partners in their own care. 2. Algorithms have been partially implemented in the State psychiatric hospitals; algorithms have not been implemented in the community. Beginning in 2010, the DMHAS Medical Director implemented an Administrative Bulletin that monitors prescribing of polypharmacy and other high risk or high cost regimens, and this also provides feedback to psychiatrists in State psychiatric hospitals. This has been successful in reducing rates of antipsychotic and interclass psychotropic polypharmacy, as well as use of PRNs for behavioral reasons. 3. & 5. See Future Plans 4. Resources did not allow for more fully staffing the Office of the Medical Director.	to physicians who were outliers. However, the BPM prescribing project was discontinued by Medicaid in 2008 and no additional staff were hired for the office.

DATA DRIVEN DECISION MAKING

OBJECTIVE/ACTION STEPS	PROGRESS IN CY 2008-2010	FUTURE PLANS
Performance-Based Contracting		
Olmstead-related **2008** 1. Create a residential/ housing data system incl. consumer needs and geog, tracking vacancies, timeframe from vacancy to referral & admission 2. Incorporate housing database into existing systems such as STCF bed tracking thru 2011 3. Create data collection & analysis system to facilitate decision making and action on information obtained through the newly crated Utilization Review Policy and procedures in the State hospitals. **2009** 4. Implement data collection & tracking to ensure that Olmstead/ CEPP requirements & targets are met 5. Implement Utilization Review data collection and analysis system implemented in state hospitals **2010** 6. Ongoing use of data collection & tracking to ensure that Olmstead/ CEPP requirements & targets are met 7. Ongoing use of Utilization Review data collection and analysis system implemented in state hosp	1. DMHS has developed and maintained an Excel-based residential tracking system, but continue to anticipate development of a more comprehensive and user-friendly Web-based system, as the Division becomes able to address its ongoing and significant IT-related issues and needs. 2. Existing data from more manually-maintained systems are incorporated into ongoing Hospital venues, including the Local Residential Olmstead Committees (LROC), including existing residential vacancies by housing type. 3. See Future Plans 4. Data collection and tracking of information related to Olmstead Settlement requirements are completed quarterly and reviewed by the Plaintiff and the Olmstead Advisory Council. 5. See Future Plans 6. Data collection and tracking of information related to Olmstead Settlement requirements are completed quarterly and reviewed by the Plaintiff and the Olmstead Advisory Council. 7. See Future Plans	3., 5. & 7. A Utilization Review Policy was not created and therefore data collection and analysis system was not implemented regarding State hospital utilization. The transition to system management through an ASO will create opportunities to improve data collection and analysis.

Recovery-oriented **2008** 1. Identify recovery oriented system benchmarks: convene stakeholder groups for input, range of outcomes 2. Create or identify outcome and service/EBP fidelity measures associated with benchmarks **2009** 3. Ongoing evaluation of Recovery-oriented benchmarks and Wellness & Recovery Plan implementation 4. Incorporate Wellness & Recovery outcomes into all QCMR, Annex A & contract commitments **2010** 5. Ongoing evaluation of Recovery-oriented benchmarks and Wellness & Recovery Plan implementation	1. Development, use, and evaluation of W&R benchmarks were developed as part of the Division's development of outcome measures for Supportive Housing and its evaluation of existing management data systems in place for SRCs, STCFs, and DSCs, as well as PACT and other best practice models. 2. Efforts to develop a full system of benchmarks have been hindered by ongoing deficits in staffing and IT capabilities. 3. Ongoing evaluation of the Wellness Oriented Benchmarks in the WRTAP was completed, including this final report. 4. In 2008, the Self-Help Centers Annex A and QCMR were revised to incorporate the following measures: • Number of participants in peer support activities • Number of wellness/recovery activities provided • Number of participants in wellness/recovery activities • Number of training/education activities provided • Number of participants in training/education activities • Number of advocacy activities 4. In 2008, the Mental Health Justice Involved Services Annex A and QCMR were revised to incorporate the following measures: • Number of APN/Psychiatrist psychiatric evaluations completed • Number of face to face nursing units with consumers for medication administration and management • Measure of successful linkages to health providers specified as medical/dental for both Annex A and QCMR. 4. In 2011 for PACT, the number of enrollees in “Other employment” added as a measure to be tracked in Annex A and QCMR; previous version tracked only “independent competitive employment”.	3. As stated in previous objectives, the move toward an ASO will create opportunities to develop IT capabilities to enhance our data collection and analysis.

	4. In 2009, the Intensive Outpatient Treatment and Support Services (IOTSS) Annex A and QCMR were developed to track contract commitments for this new service include the following measures: • Total number of Wellness and Recovery Action Plans (WRAPs) to be developed • Total number of Consumers to receive Illness Management and Recovery (SAMHSA EBP) • Total Number of Physical Health Care Referrals • Total Number of Consumers to be educated about Psychiatric Advanced Directives • Total Psychiatric Advanced Directives to be completed 5. Evaluation of the plan indicates a very successful Recovery and Wellness implementation. With most incomplete objectives due to the lack of resources to develop IT infrastructure and hire the staff that had been attended. A renewed plan that incorporates addiction objectives is under development.	

Performance-Based Contracting **2008** 1. Refine units of service commitments 2. Research funding mechanisms including Medicaid, bundled/unbundled, rate structures 3. Require demonstration of outcomes in all issued RFP/RLIs 4. Create and implement feedback loop to ensure effective implementation of contract reform. **2009** 5. Continue with contract reform activities 6. Design & implement data collection & analyses infrastructure 7. Integrate outcome/measures into licensing standards and Regulations 8. Create baseline database based on identified outcomes **2010** 9. System wide performance based contracting implemented 10. Implement systems incentive program tied to outcomes and redirect funding as appropriate 11. Issue & publish Performance Report Cards	1. See Future Plans 2. Community Support Services State Plan amendment submitted in March 2011. Committed to developing SPA for Screening/Emergency, IOTSS and GA recipients of PACT and Residential during CY 11 and CY 12. 3. Outcomes are required in all new RFPs and RLIs. 4. DMHS has been updating NJMHAA during meetings and NJAMHAA members are on workgroup addressing further contract reform. 5. In 2009 DMHS began moving system toward fee-for-service contracting for services as applicable with overlay of managed care principles to an as yet unspecified degree. 6. DMHS is programming a web based Annex Z/QCMR application. DMHS is in preliminary stages of working with addiction services to review and make a final determination concerning utilizing the CIMS contract system for MH contracts.. This electronic system will improve the division's ability to collect and analyze contract data. 7. See Future Plans 8. Baseline database on identified outcomes is accomplished for PACT but not other services as yet. 9. See "6." Above 10. Adverse State budget restrictions has prevented requested efforts to pool funds for incentives 11. See "6." Above	1, 8, 9, and 10 The transition to contracting through a managed system FFS system will enable the division to collect client level data, better refine units of service, track contractee performance and measure and incent outcomes. 3. The ASO initiative includes the division working with an actuarial firm to assess and reset specific rates. 7. Regulations are being reviewed and revised as part of the merger with addiction services. Outcomes will be included in those revisions

Systems Wide Needs Assessment		
Conduct Systems Wide Needs Assessment **2008** 1. DMHS will work with county Mental Health Administrators to design process for system mapping to be conducted in Year 2 **2009** 2. Conduct both statewide and county-specific system mapping to obtain clear picture of strengths, weaknesses, opportunities and problems. **2010** 3. Issuance of RFPs/RLIs will consider findings of county and statewide system mapping and other needs assessments undertaken by DMHS.	1. In 2009 and 2010, Systems Mapping has occurred in eight counties involving the criminal justice services, mental health and addictions services. 2 & 3. In January 2010, there was legislation passed that required DHS and DCF to identify available mental health services and perform needs assessments. This law requires a mechanism to be established to make available to the public an inventory of all county-based public and private behavioral health services that will be done annually.	1. As part of the Joint Block Grant Application to SAMHSA, the joined Division of DMHAS will be putting into place a plan for a system wide needs assessment to be completed. 2. DMHAS' Research, Planning and Evaluation Office and Office of Prevention, Early Intervention and Community Services are collaborating to include the Regional Program Analysts and Addictions Program Monitoring Officers in the Addictions county planning process. Opportunities to include planning around county mental health services will be assessed during this process as well. 3. The contracted ASO will supply the data necessary to build a network of services based on need and current capacity.

WORKFORCE DEVELOPMENT

OBJECTIVE/ACTION STEPS	PROGRESS IN CY 2008-2010	FUTURE PLANS
Develop a Workforce Development Plan **2008** 1. Convene a Workforce Development Committee to coordinate and advise on a statewide workforce development initiative 2. Develop a Workforce Development Plan 3. Create timeline to incorporate core competencies into all contracted services, licensing and regulations**.** **2009** 4. Begin to implement the Workforce Development Plan. 5. Core competencies and training become incorporated into agency contracts, licensing standards and regulations. 6. Develop a certificate program to demonstrate acquisition of core competencies. 7. Begin to establish and create the application process for Centers of Exemplary Practice for evidenced-based, promising or best practices sites. 8. Recruitment and Retention Strategies that support a competent workforce by convening focus groups to explore recommendations and identify best practices and strategies for staff recruitment and retention and incorporate training and supervision-related standards into licensing and regulations. **2010** 9. On-going implementation of the Workforce Development Plan.	1. Work group convened and all training contracts reviewed. Recommendations for priority training, which agency was best for carry through of specific initiatives, reallocation of some resources made in 2009. 2. Statewide workforce development plan was developed and submitted that included core competencies for staff and the following: • Competency based supervision model developed. Use of adaptation to WRAP developed for promotion of well teams and well offices developed and submitted. • Consumer based outcomes for quality measures developed through consumer focus groups and submitted 2010. • QCMR and new template for contracting with training agencies using consumer based outcomes developed and proposed 2009- UBHC TAC using draft of this model this FY 2011. • NJ selected to pilot NASMHPD modules for Workforce Development. All state hospitals have incorporated some aspects of the modules in their all staff orientation and ongoing training. Modules contain pre/post testing, evaluation in 19 core areas. • A best practices manual for co-occurring disorders was developed and all contract agencies trained in it's use 2008 and 2009 • Model developed for strengths based supervision and staff goal setting. • Implementation of workforce development products is pending at this time. • Strengths based supervision model developed.	As the Divisions continue to merge, a workgroup will be convened to examine the existing workforce development plans on both sides and make recommendations: • For inclusion of core competencies in contracting of all agencies • Examine the needs of agencies in the merged system for core competencies. • Identify training programs and curriculum for providing staff throughout both addictions and mental health with basic skill building as well as training through to advanced skill levels. • Examine supervision models that use competencies in promotion, retention and employee growth plans • Make recommendations for inclusion of workforce development issues in licensing standards for addictions and mental health agencies • Use focus groups to identify best practice models. • Use SAMHSA and

10. Establish Centers of Exemplary Practice for additional evidence-based, promising or best practices.	3. See Future plans 4. & 9. The Workforce Development plan was implemented. 5. Core competences and training were proposed to be incorporated into agency contracts, licensing standards and regulations but not completed for all programs. 6. See Future plans 7. & 10. Centers for exemplary practice concept developed, also to include training and development for peers, self help centers and consumers. These were not implemented due to lack of resources. 8. Core competences and training were developed for inclusion into agency contracts, licensing standards and regulations – see future plans. 9. See Above 10. See Above	NASMHPD models for recruitment and retention, basic skills, core competencies and workforce development. • Upon merger of training and workforce development staff in both divisions, use focus groups to identify and make recommendations for systems issues relating to workforce. • Survey and inventory areas within the merged division for overlap, duplication and gaps in workforce development, training and technical assistance.