NEW JERSEY DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH
AND ADDICTION SERVICES

HOME TO RECOVERY 2
2017 to 2020
A VISION FOR THE NEXT THREE YEARS

Prepared By:

New Jersey Department of Human Services
Division of Mental Health and Addiction Services

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I. EXECUTIVE SUMMARY

New Jersey's commitment to the mandates of the Title II of the American with Disabilities Act and the United State Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999)[1] transcends any time limited plan. This commitment is demonstrated by the NJ Division of Mental Health and Addiction Service's (DMHAS) concurrent planning documents, the Community Mental Health Block Grant, DMHAS' Strategic Plan, the *Olmstead* Settlement Agreement, the 2017 NJ FamilyCare 1115 Comprehensive Demonstration Renewal Application and the US Department of Justice's June 22, 2011 guidance[2]. Collectively, these planning initiatives are guiding DMHAS' efforts to dramatically improve the availability of and access to high quality and efficiently provided mental health services at the adult state psychiatric hospitals and in the community.

The initial Home to Recovery Plan focused on two inextricably linked goals: (1) state psychiatric hospital census reduction and targeted reduction of length of stay for patients holding a Conditional Extending Pending Placement status (CEPP) and (2) creation of new community living opportunities opportunities for hospitalized psychiatric patients. Additionally, DMHAS and Disability Rights of New Jersey (DRNJ) reached a settlement on July 29, 2009 ending a four year lawsuit. The settlement agreement outlined policy enhancements, processes, time frames for timely discharge of consumers placed on CEPP status, and monitoring and reporting requirements.

Home to Recovery 2 represents the implementation plan for DMHAS' current systems level initiatives and reforms. There are several initiatives that build from the original Home to Recovery Plan. There is continued focus on improvement and transformation of the discharge process in the state psychiatric hospitals. A new element of Home to Recovery 2 builds on the infrastructure improvements to the state psychiatric hospitals and the community mental health system. One focus is on a fee for service delivery system which leverages new federal funding streams to create broader community access to services and more efficient delivery systems. Equally important is the utilization of the Housing Mortgage and Finance Agency (HMFA) and the Supportive Housing Connection to increase access for consumers to housing in the community as well as allow for greater administrative flexibility in managing these resources. Most importantly, Home to Recovery 2 has as its goal the continued movement towards community integration. It is the mission of DMHAS to assure that New Jersey residents with a serious mental illness can have a meaningful life in the community of their choosing in the most integrated setting possible.

Section I – Introduction of the plan introduces foundational initiatives that will be enhanced during the next phase of hospital and community service delivery. Home to Recovery 2 represents the next phase of the transformation that was begun under Home to Recovery 1. The Plan expands on the accomplishments of the original plan by enhancing and where possible expanding DMHAS' community integration initiatives that began during the *Olmstead* Settlement Agreement. New Jersey is committed to ensuring that consumers receiving services in its state psychiatric facilities remain only as long as necessary and are prepared as soon as possible for successful transition to the community. The State is also committed to diverting consumers from hospitalization to the extent possible. The infrastructure from the original Olmstead Plan has been enhanced with focus on monitoring and outcomes. These systems enhancements were achieved through the collaborative efforts of stakeholders such as the individuals who access mental health services and their families, as well as Central Office, state hospital and community provider staff. These enhancements included some of the following:

- Discharge process – Providers are now an active participant in the discharge planning process. Policies and system improvements have been made and providers are now assigned to serve an individual for discharge from a state hospital, as opposed to receiving a referral requesting consideration for admission to the service.
- Housing vacancy management system – DMHAS implemented a secure web-based application that accurately manages the status of available community based housing offered by contracted providers.

These and other enhancements will be further addressed in Section I.

In order to increase the scope and range of services in the community over the next three years, DMHAS is relying on the leveraging of federal funding and new service delivery models. The service models seek to support "whole person" needs and reduce over reliance on institutional care while increasing community capacity of services. Essential to this effort is the ability to coordinate services with other DHS agencies and other state departments to avoid service gaps for the consumer. These enhancements are made possible through the 2017 NJ FamilyCare 1115 Comprehensive Demonstration Renewal Application and its emphasis on movement towards managed care delivery models and leveraging Medicaid for supportive housing as well as the creation and the implementation of the Supportive Housing Connection through HMFA. Along with the strategic planning through the federal block grant in the areas of integration of primary and behavioral health through the Affordable Care Act (ACA) behavioral health homes, the next phase of planning is to further enhance the State's robust community based services system. Access to supports in the community is envisioned for both those individuals who are discharged from the hospital as well as those who remain at high risk of hospitalization in the community.

Section II - Legal Framework outlines the requirements of the New Jersey 2008 Olmstead Plan as well as the underlying principles of the Department of Justice (DOJ) guidance document from June 2011. The section further notes how the basic principles of the underlying Olmstead decision for least restrictive environment and integration are a thread throughout all of the policy making for DMHAS.

Section III – Data from over the past ten years is presented which demonstrates shorter lengths of stays, fewer admissions and a decreased census at the regional state psychiatric hospitals. Despite continued population growth in NJ, DMHAS has achieved its lowest total average census at the state psychiatric regional hospitals as of SFY 2016. In SFY 2006, the total average census was 2122. By SFY 2016, the average census had declined to 1406, a reduction of 33.7% over the 10 year period. From SFY 2010, there has been a reduction of 15.8% in the census with a decline from 1671 to 1406. Similarly, the regional state psychiatric hospital admissions have shown a significant reduction from SFY 2006 (2938 admissions) to SFY 2016 (1884 admissions). Over this 10 year period the reduction in admissions was 36%. At the time the Olmstead settlement was reached in SFY 2010, there were 2070 admissions that year in the regional state hospitals as compared to 1884 in SFY 2016. This is a decrease of 9.8% admissions throughout the regional state hospital system. At the end of SFY 2009 the percentage of individuals designated to CEPP status was at 43.6%. At the end of SFY 2016, this percentage stood at 21.8%

Section IV - Planning describes the goals DMHAS wishes to achieve during Home to Recovery 2. Wellness and recovery principles as well as introduction of peer support in the state psychiatric hospitals places an even greater emphasis in this new plan on treatment for the "whole person". The focus

remains on the closer partnership between the community provider agencies and the state psychiatric hospital system.

Major implementation steps to achieve these goals will occur by executing the following action steps:

- Fee for Service Planning and implementation
- Community Support Services implementation
- Separating housing and services management
- Sustaining the low percentage of individuals holding a CEPP status at the state psychiatric hospitals
- Ensuring that individuals who do hold a CEPP status do not remain in the state psychiatric hospital longer than clinically necessary.

One essential element of the planning process for this next phase of Olmstead planning is ongoing multi-agency and stakeholder involvement and coordination. As the original Olmstead Plan noted, no one planning document can fully undertake the implementation initiatives required for systems transformation. This document and planning process requires ongoing review and internal and external review as the initiatives are being implemented. Part of the process in Home to Recovery 2 specifically allows for continuation of the Olmstead Work Group, which will be enhanced to include peer and family membership in the work group. Members will be solicited from the Behavioral Health Planning Council and peer organizations. The Olmstead Work Group will continue to meet on a quarterly basis to review best practices and outcome data, as well as to ensure transparency in the delivery of services to DMHAS consumer populations.

Section V – Implementation outlines the implementation steps and monitoring for sustaining a low percentage of individuals holding a CEPP status as well as ensuring that those individuals who do hold a CEPP status do not remain in the state psychiatric hospital longer than clinically necessary. Implementation steps for several DMHAS initiatives to enhance consumer wellness and opportunities for self-directed and valued peer, whole health and housing services are also addressed. Wellness and recovery principles as well as introduction of peer support in the state psychiatric hospitals places an even greater emphasis self-directed care in this new plan. The focus remains on the closer partnership between the community provider agencies and the state psychiatric hospital system. While not exhaustive, Section V identifies global implementation goals and intermediate objectives for continuing to move New Jersey's system of care to one that is consumer driven and community based.

SECTION I – INTRODUCTION

The focus of DMHAS' initial multiyear Home to Recovery – CEPP Plan, which spanned State Fiscal Years 2009-2014, was to reduce the length of stay on CEPP, ensure timely discharge from state psychiatric hospitals and reduce hospital admissions through the development of less restrictive, community-based alternatives for treatment. The result has been a decrease in the state hospital CEPP census and the overall state hospital census. To sustain these gains consistently and meet the objectives outlined above, the Recovery II Plan will cover the next three years (SFY 2017-SFY 2020). During this period, DMHAS will focus on further reducing CEPP designations, reducing the amount of time consumers spend on CEPP status, diverting hospital admissions, and expanding the community infrastructure as funding permits.

Populations served by DMHAS consist primarily of adults. However DMHAS also works collaboratively with the Department of Children and Families, Division of Children's System of Care (DCSOC) in serving younger populations in programs such as screening and Affiliated Emergency Services (AES), providing the necessary services and linkages to ensure continuity of care across Divisions. Moreover, while the Home to Recovery Plan is specific to DMHAS within the Department of Human Services (DHS), DMHAS collaborates with its sister Divisions and other federal, state and local entities to address issues across Divisions and systems for purposes of expediting and optimizing community integration.

The Home to Recovery Plan 2 reflects DMHAS' continued commitment to providing individuals with disabilities the opportunity for a meaningful life in the community of their choosing where they can live, work, socialize, and receive necessary services within the most integrated settings possible. Development of this Plan is based on policy reform, enhancements, and refinements; community capacity development; data-driven decision making and outcome measurement; and community integration, recovery, and consumer choice. Throughout this Plan, DMHAS outlines its initiatives and collaborative efforts to expand opportunities for integration and alleviate the unnecessary segregation of consumers with disabilities. In order to ensure that DMHAS' initiatives and policies continue to be implemented, DMHAS has incorporated an Evaluation and Outcomes section of this Plan. The *Olmstead* Workgroup will continue to meet for purposes of reviewing outcomes as outlined in the plan. In addition, the *Olmstead* Advisory Committee of the Behavioral Health Planning Council will review the Home to Recovery Plan on an annual basis.

New Jersey, like many other states faces complex social, economic and political challenges, but maintains its dedication to its most vulnerable populations through the combination of building community partnerships, expanding capacity, and developing new initiatives and policy reform consistent with the Integration Mandate of the American's with Disabilities Act. Integral to this reform are several cornerstone initiatives that will be discussed in the ensuing plan. These are as follows:

- *Move to a Fee for Service payment structure*, which will enable DMHAS and providers to track and report discrete services received by each individual served, the agency providing the services and when the service was provided. As a result, it will improve individuals' access to the right level of care for the right duration at the right intensity. Moreover, through the ACA Medicaid expansion, more New Jersey residents have access to entitlement services through Medicaid. This produces greater federal financial participation in the delivery of these services, thereby improving the use of DMHAS resources for service access.
- *Community Support Services (CSS)*, a new rehabilitative service to New Jersey that provides consumers with the supports and services necessary to achieve their life's goals.
- *Separation of Housing and Services*, which will ensure individuals' right to non-segregated housing leased in their own name with all applicable landlord-tenant rights.

These and other reforms identified within DMHAS' Home to Recovery Plan 2 will guide systemic infrastructure expansion, the creation of new supportive housing services and supported employment programs to ensure the timely discharge of consumers on CEPP status, and the development of preventative supports for those consumers in the community who are at risk of hospitalization.

During the Olmstead settlement period and subsequent settlement extension timeframe DMHAS realized many achievements and systems enhancements through the collaborative efforts of

stakeholders such as the individuals who access mental health services and their families, as well as Central Office, state hospital and community provider staff. While not exhaustive, below is a description of planning activities and associated milestones related to Olmstead since the settlement agreement was reached:

Date of Planning Milestone	Activity
2008	Home to Recovery CEPP Plan is published, declaring DMHAS's commitment to community integration of its mental health consumers and to serving individuals with mental Illness in the least restrictive setting appropriate to their care.
2009	An office of centralized admissions was established at all of the regional hospitals, creating a central point of admissions and implementing a triage process for the acute-care system.
	Residential Intensive Support Teams (RIST) initiative was implemented statewide as a Supportive Housing option.
	Regional Olmstead Coordinators were appointed.
	Intensive Case Review Committees and Local Residential Olmstead Committees were implemented at the 3 regional state psychiatric hospitals.
2010 to 2016	1,274 supportive housing opportunities were developed for individuals receiving inpatient treatment at a NJ state psychiatric hospital; 534 housing opportunities were developed for individuals at risk of hospitalization or homelessness. Additionally, Social Service Block Grant (SSBG) funding was leveraged to provide 155 supportive housing opportunities to individuals with a co-occurring mental illness and substance use disorder who were impacted by Hurricane Sandy and were homeless or at risk of homelessness.
2010	Housing Preference Interview (HPI) and Individual Needs for Discharge Assessment (INDA) tools and processes were implemented at the regional state psychiatric hospitals.
2014	Office of Olmstead Compliance Planning & Evaluation was created, assuming responsibility for the implementation of the Home to Recovery Plan and the monitoring of related data.
	Quarterly state hospital and community provider Olmstead meetings were implemented to improve communication and enhance collaboration.
	Administrative Bulletin 4:27 was enacted, prescribing state hospital activities regarding patient identification procurement.
	Process implemented with NJ Vital Statistics for obtaining NJ birth certificates for individuals receiving treatment at a NJ state psychiatric hospital. A total of 986 birth certificates have been collected under this new protocol since its inception in December 2014.
	An Older Adult Committee (OAC) including Regional Olmstead Coordinator and representatives from the Division of Aging was formed. The Regional Olmstead Coordinator joined other DMHAS staff and Division of Aging staff on the Older Adult Committee (OAC).

2015	Individual Needs for Discharge Assessment (INDA) revised and repurposed as a tool for assigning housing and service providers to work with an individual receiving treatment at a state psychiatric hospital. INDA implemented in paper form.
	Treatment team scheduling revised at the 3 regional state psychiatric hospitals. Initial treatment plans are completed within 7 days, with 30 day reviews thereafter.
	Boarding Home and Residential Healthcare Facility consumer request protocol implemented. DMHAS central office staff meet with a consumer considering congregate care for discharge to discuss available housing options and ensure she/he is making an informed choice regarding the selected housing option.
	A revised version of the DMHAS Administrative Bulletin 5:11 (AB 5:11) was implemented, requiring early involvement of community providers in the hospital discharge planning process. AB 5:11 establishes a process for transitioning and discharging consumers to the community from the state hospital and into supportive housing or other residential services.
	Intensive Case Review Committee (ICRC) process was extended beyond CEPP designees to include all consumers on the census at each of the regional state hospitals.
	A tracking process began for pending Medicaid applications at all three regional state psychiatric hospitals, monitoring approval time frames for pending Medicaid applications. Began collaboration between the Olmstead office, Medicaid, and ISS to address delays and systemic barriers.
	Pre-Admission Screening and Resident Review (PASRR) and nursing facility/MLTSS discharge process was streamlined at each of the regional state hospitals.
	The Medicaid Community Care Waiver (enabling FFP for individuals diagnosed with a developmental disability) process was streamlined with a new instruction to staff to begin the application process upon approval of the patient's level of care.
	A Transitional Case Manager (TCM) from the Division of Developmental Disabilities (DDD) was assigned to each of the regional psychiatric hospitals to assist in transitioning individuals with developmental disabilities to community settings.
	New Jersey Housing and Mortgage Finance Agency (HMFA) was awarded a HUD 811 contract and, as the lead for 206 (811) subsidies, partnered with DMHAS to address its Olmstead-related obligations in moving consumers out of state institutions and into the community.
	A revised version of the AB 5:11 was implemented, requiring early involvement of community providers in the hospital discharge planning process.
2016	Housing vacancy management system is implemented. This secure web-based application accurately manages the status and availability of community based housing offered by DMHAS contracted providers.
2017	Increased staffing by 102 Full Time Equivalents (FTE's) in regional state hospitals in order to provide active treatment, including addressing discharge refusals.

HOUSING

As indicated in the table above, DMHAS has engaged in significant supportive housing development since the Olmstead settlement agreement. DMHAS strives to achieve optimal community integration for New Jersey's most vulnerable populations. To that end, DMHAS has reduced the average number of days individuals admitted to the regional state psychiatric hospitals remain on CEPP status and has significantly improved opportunities for discharge to the least restrictive setting possible. This change is reflected in the advancement of DMHAS' Supportive Housing model. Beginning in SFY2010, DMHAS committed to the creation of 1,065 additional supportive housing placements during the *Olmstead* Settlement Agreement period (SFY 2010-2014). Six hundred and ninety five (695) placements were to be created for the discharge of CEPP consumers from state hospitals, the remaining 370 were to be reserved for the diversion of at-risk populations from hospitalization. DMHAS has doubled the number of placement options during the period covered by the settlement agreement by creating 941 placements for the CEPP population and 495 placements for consumers in the community at risk of hospitalization or homelessness.

While no target existed beyond SFY 2014, DMHAS continued to cultivate its Supportive Housing stock, generating 185 placements for the discharge of CEPP consumers and 19 placements for the At-Risk population during SFY 2015. An additional 10 Supportive Housing placements were created during 2015 for the discharge of any consumer from state psychiatric hospitals, regardless of CEPP status. Moreover, the FY 2016 budget provided for the creation of 155 CEPP beds, 20 At-Risk beds, and 25 beds for the discharge of any consumer from state hospitals, and FY 2017 projects 140 CEPP beds, 55 At-Risk beds, and 25 beds for the discharge of the general psychiatric hospital population to be created during the fiscal year. DMHAS is tailoring services for individuals in Supportive Housing to meet the specialized needs of its target populations as follows:

1. *General Supportive Housing* with services in the consumer's housing location, which may or may not provide a housing unit, depending on the provider agency.

2. *Residential Intensive Support Team (RIST)* is a Supportive Housing services model in which services and supports are flexible, can be provided at a level and intensity based on the individuals need, including face-to-face contacts, which can be from one to five times a week and last from a minimum of 15 minutes to several hours, depending on need. Phone contacts are used as well, in the interim as a wellness check. Case managers, peer mentors, and life skill specialists connect consumers to needed services in their community and provide Wellness and Recovery services for each consumer. RIST housing is scattered site; services also include transportation to appointments, and assistance with needs such as money management, shopping, employment, education, medication monitoring.

3. *Enhanced Supportive Housing (ESH)* is an intensive Supportive Housing model to serve consumers with challenging behaviors resulting from issues such as long-term institutionalization, cognitive impairments, dual diagnoses, substance use issues, and legal involvement.

4. *Medically-Enhanced Supportive Housing (MESH)* is an enhanced Supportive Housing model for consumers with co-occurring medical conditions. These enhanced supportive housing services are available for consumers who are seriously mentally ill with co-occurring medical problems such as diabetes, obesity, hypertension, ambulation issues, cardiovascular disease, pulmonary conditions, metabolic syndrome, insulin dependent-diabetes, or substance use disorders. Staffing consists of case managers, life skills specialists, peer mentors, and certified psychiatric rehabilitation practitioners. MESH programs provide assistance with housing searches, skill building, money management, medication monitoring, Wellness and Recovery services, assistance with entitlements, landlord/property collaboration, and employment and educational assistance. Sites are scattered and clustered, and transportation is provided to appointments.

5. *Forensic Supportive Housing* is a Supportive Housing model to serve individuals in the state psychiatric hospitals who have a history of forensic commitment(s). This includes those with justice involvement, including Megan's Law Registrants and persons whose criminal histories include convictions or NGRI (not guilty by reason of insanity) designations for one or more of the following offenses: murder, aggravated assault, manslaughter, aggravated sexual assault, sexual assault, criminal sexual contact, robbery in the first degree, aggravated assault, aggravated arson, arson, kidnapping or a crime that is similar to one of the aforementioned crimes.

6. *DD/MI (dually diagnosed with a developmental disability and mental illness) Supportive Housing* is a Supportive Housing program developed to serve consumers with co-occurring developmental disabilities and mental illness.

7. "At-Risk" Diversionary Supportive Housing is designed to serve consumers who are at risk of hospitalization or homelessness. In their 2015 *Olmstead* Risk Assessment and Planning Checklist, the National Association of State Mental Health Program Directors (NASMHPD) notes that individuals who are at risk of hospitalization "have a history of cycling in and out of psychiatric hospitals, jails, emergency rooms, and/or homelessness due to their disability and/or lack of needed community services."

Many of the consumers served by DMHAS have histories of homelessness and/or unstable living conditions. These circumstances can often exacerbate untreated mental illness, substance use disorders, and other medical conditions. Homeless consumers cycling in and out of acute care services often cannot benefit from treatment because of their unstable housing circumstances. Homelessness contributes to repeated and extended hospitalizations.

Supportive housing can prove remarkably beneficial to consumers who frequently find themselves homeless or living in unsafe or unstable conditions. For these individuals, supportive housing promotes stability, wellness and recovery, supportive relationships, and continuity of many services geared toward community integration. Supportive housing services are designed to address the individual consumer in need of varying degrees of support while transitioning to stable housing. In meeting these needs, supportive housing services assist consumers in maintaining permanency in their living circumstances, thereby further promoting better mental health and overall well-being.

Through the creation of diversionary supportive housing placements, DMHAS has reduced its reliance on and use of acute care services, as consumers' needs are more effectively managed in a preventive and community integration-driven model. At-Risk services are designed as an alternative to hospitalization. This includes consumers at risk of admission to a state or county hospital or consumers at risk of homelessness.

SECTION II – LEGAL FRAMEWORK

In January 2008, DMHAS published its Home to Recovery CEPP Plan to facilitate the timely discharge of CEPP consumers from state psychiatric hospitals. Elements of the Plan included a Legal Framework, baseline data, and DMHAS' planning process.

In addition to the publication of the Home to Recovery CEPP Plan, a settlement agreement was reached in July 2009 between DMHAS and the Disability Rights of New Jersey (DRNJ) formerly known as NJP&A, which ended a four year lawsuit. Spanning SFY10 through SFY14, this agreement, which absorbed the initiatives outlined in New Jersey's Home to Recovery CEPP Plan, served as the primary directive for the state's efforts toward the effective community integration of its mental health services for consumers. Mandates from the *Olmstead* Settlement Agreement included:

- Discharge Targets: Annual number and percentage goals for discharging CEPP consumers from SFY10 through SFY14.
- Creation of Community Placements: Annual targets for the creation of new supportive housing placements (CEPP discharges vs. at risk of hospitalization or homelessness) from SFY10 through SFY14.
- Reports: Quarterly and annual reports examining progress toward meeting settlement targets, admissions, census, CEPP and total hospital discharges and lengths of stay, and *Olmstead*-related fiscal expenditures.

By the end of SFY 2014, the parties entered into an 18-month extension of the *Olmstead* Settlement Agreement. This extension included the development and implementation of a supplemental *Olmstead* Work Plan. In furthering its community integration efforts, DMHAS identified and examined systemic issues reportedly serving as barriers to timely discharges from state psychiatric hospitals. Analysis of these systemic issues was done on a quarterly basis via the *Olmstead* Work Plan, which began supplementing the data reports outlined in the *Olmstead* Settlement Agreement.

ADA INTEGRATION MANDATE

In its June 22, 2011 guidance regarding the ADA Integration Mandate[3], the Department of Justice defines "the most integrated setting" as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." Such settings provide individuals with disabilities the opportunity to, not only receive their necessary services outside of institutional settings, but also to live and work within the greater community and alongside individuals without disabilities. Positioned within mainstream society, truly integrated settings offer opportunities and activities within the community in accordance with the individual consumer's choice regarding scheduling and service provider; offer consumers choices within their own daily lives' activities; and, provide disabled persons the opportunity to interact with non-disabled persons to the fullest extent possible.

The Integration Mandate of the ADA identifies scattered-site housing with supportive services and competitive employment in a community setting as examples of truly integrated settings. Conversely, segregated settings have institutional qualities, such as congregation and/or interaction of primarily disabled populations; regimented daily activities; a lesser degree of privacy or autonomy; and/or limitations on visitors or the ability to engage within the community or manage one's own activities of daily living. While segregated settings are considered and utilized when warranted by consumer choice or necessary level of care, DMHAS remains committed to serving consumers in integrated settings to the utmost extent possible.

A cornerstone of DMHAS' encouragement of integrated settings over their segregated alternatives is the regional state hospitals' Intensive Case Review Committees (ICRC). Created as a result of the Home to Recovery CEPP Plan, these committees' initial focus was consumers on CEPP status identified as having certain barriers to discharge within the timeframes outlined in the *Olmstead* Settlement Agreement. In July 2015, an updated protocol for the ICRC was implemented. The ICRC integrates discharge planning by reviewing not only CEPP patients, but all consumers committed to State hospitals; every patient's discharge readiness is assessed. This administrative level review committee meets with the treatment team to provide recommendations and assign tasks as necessary that facilitate discharge to the most integrated setting in the most efficient manner and focuses discussion on strategies for resolutions of identified barriers that are impeding discharge to the most integrated setting. ICRCs will continue as described under Home to Recovery 2.

Another example of DMHAS' encouragement of integrated settings over their segregated alternatives is DMHAS' Boarding Home and RHCF Consumer Request Protocol. As stated above, DMHAS enacted this protocol for any consumer requesting placement into a congregate setting (i.e. Boarding Home or Residential Health Care Facility). Under this protocol, and in response to a consumer's request for discharge to either a boarding home or Residential Health Care Facility (RHCF), DMHAS central office staff meet with the consumer to discuss all of the appropriate and available housing options. The staff then provides recommendations from the interview to the treatment team regarding the consumer's choice. Senior staff reviews the documentation, and if the consumer's choice has changed to the DMHAS Supportive Housing option, senior management directs exploration of Supportive Housing. DMHAS implemented a tracking system for all boarding home, RHCF and other congregate site requests, and will continue to monitor these requests to assure consumer preference is at the center of all such discharges.

A final example of how the basic principles of the underlying Olmstead decision for least restrictive environment and integration are a thread throughout all of the policy making for DMHAS is the assignment process that was implemented during the Olmstead settlement extension. Community services providers are now included earlier in the discharge planning process at the state hospitals, with teams *assigning* (rather than referring) consumers to a provider, thereby ensuring that services are provided in a non-discriminatory manner based upon consumer choice and treatment team recommendations. Through this newly-standardized in-reach practice, providers are expected to develop a relationship with each consumer assigned to their service through various types of engagements, both within the hospital during the provider's meetings with the consumer and treatment team and out in the community. Such community engagements includes recreational day trips, visits to prospective apartments for rent, discharge preparations, and overnight visits, which are afforded at the request of the consumer and/or hospital treatment team. These in-reach activities will be funded within

the new fee for service payment structure (discussed in Section IV.A) using state resources for each individual who is successfully discharged. Provider assignment is a paradigm shift for the mental health system, one that uses provider in-reach to ease the transition from hospital to community; and holds providers accountable to either accepting assignments that have been sent to them or communicating to DMHAS that additional resources or supports are needed. The goal of this protocol is ensuring as timely a discharge is facilitated as soon as possible to the most integrated setting possible, so that the each consumer served by the Division has the best chance at a healthy and meaningful life within the community. The provider assignment process will remain a key protocol under Home to Recovery 2, with DMHAS collaborating closely with state hospital and provider staff to assure individuals are discharged to the most integrated setting of their choosing.

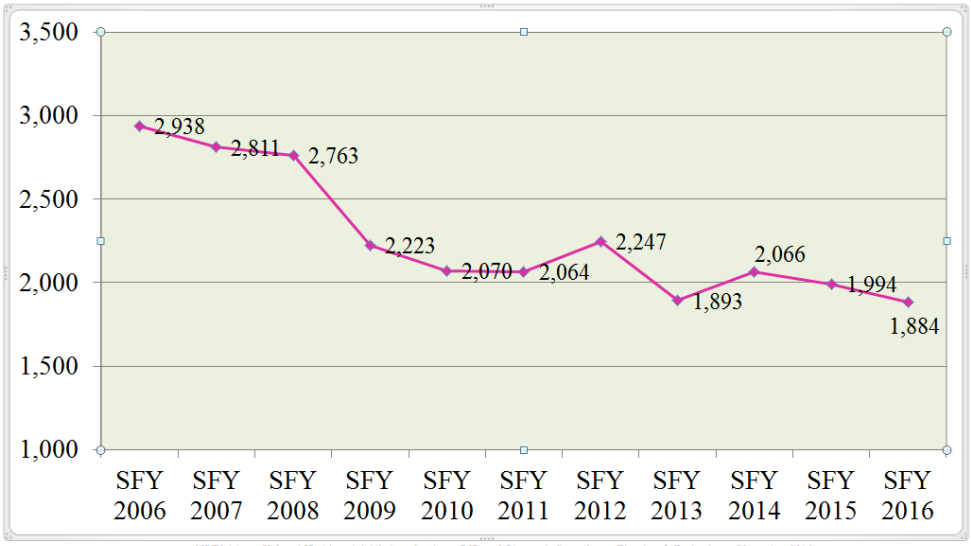
SECTION III – DATA

Over the past ten years, DMHAS has realized shorter lengths of stays, fewer admissions and a decreased census at the regional state psychiatric hospitals. Despite continued population growth in NJ, DMHAS has achieved its lowest total average census at the state psychiatric regional hospitals as of SFY 2016. During this time, DMHAS has invested more than $100 million to improve the community service infrastructure to make this census reduction possible. During the period covered by the settlement agreement, DMHAS has exceeded its targets for creating placements for the CEPP population as well as the At-Risk population. The following data underscores these accomplishments and serves as a benchmark for future infrastructure investments and enhancements.

State Hospital Census

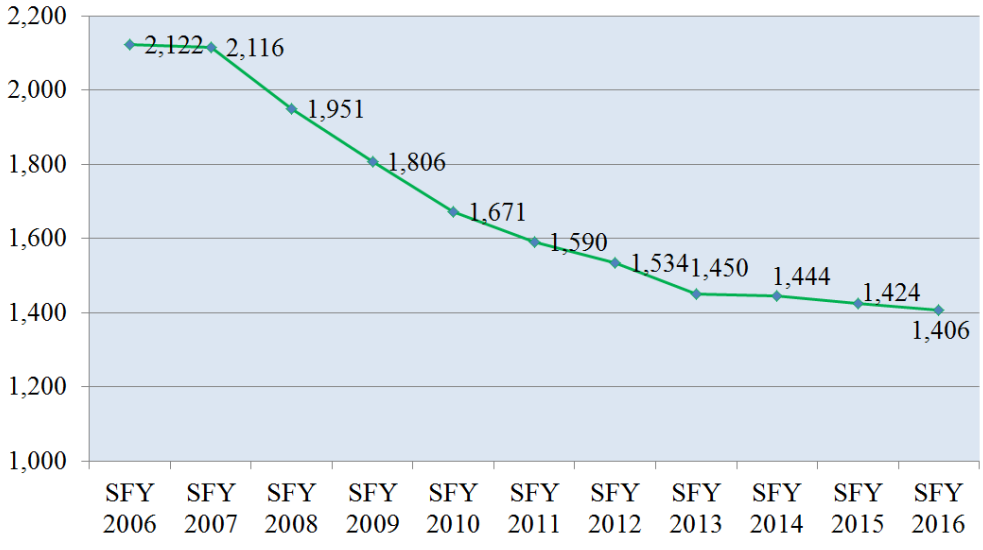
Admissions to regional state psychiatric hospitals declined by 36% (1054), from 2,938 in 2006 to 1,884 in 2016 (Figure 1). Average daily census within state hospitals declined by 33.7% (716), from 2,122 in 2006 to 1,406 in 2016 (Figure 2). The proportion of the year end state hospital census made up of CEPP consumers has decreased considerably from 50.0% in 2006 to 21.8% 2016 (Figure 3).

Figure 1: Admissions to NJ State Psychiatric Hospitals: SFY 2006-2016
(Excluding Ann Klein Forensic Center)



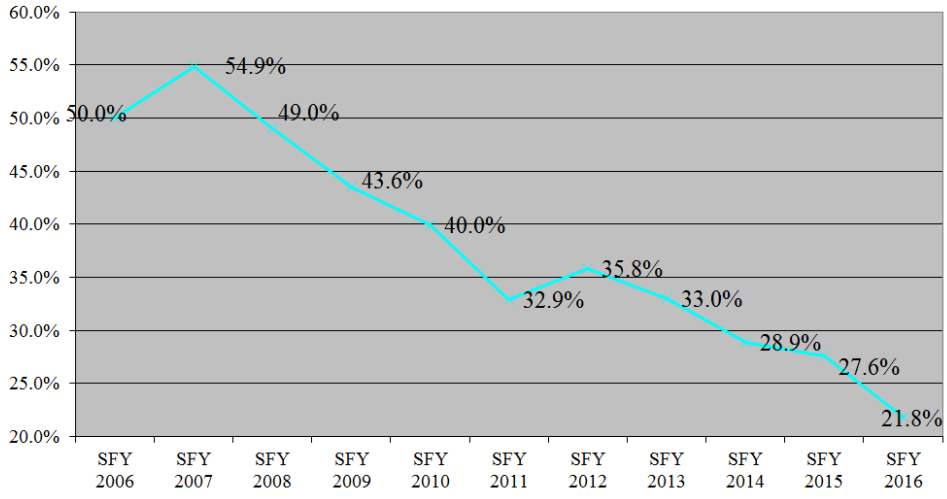
NJ Division of Mental Health and Addictions Services, Office of Olmstead, Compliance, Planning & Evaluation, November 2016

Figure 2: Total Average Census at NJ State Psychiatric Hospitals (excl. AKFC): SFY 2006 - 2016



NJ Division of Mental Health and Addictions Services, Office of Olmstead, Compliance, Planning & Evaluation, November 2016

Figure 3: Proportion of Year End NJ State Hospital Census on CEPP Status: SFY 2006 - 2016
(Excluding Ann Klein Forensic Center)

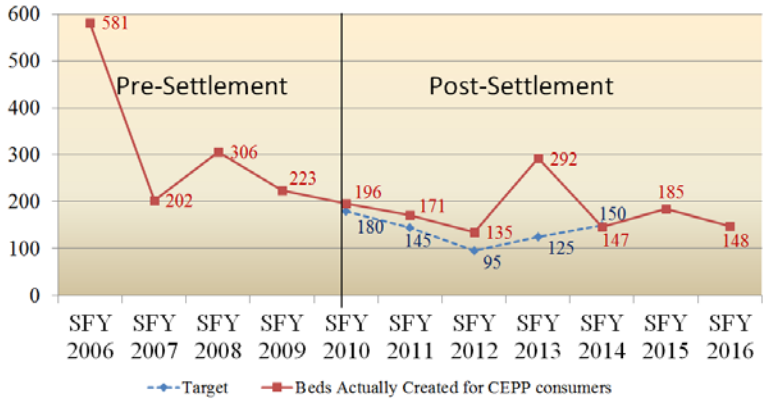


NJ Division of Mental Health and Addictions Services, Office of Olmstead, Compliance, Planning & Evaluation, November 2016

Supportive Housing Development

DMHAS has exceeded its targets during the period covered by the settlement agreement (SFY10 through SFY14) for creating placements for the CEPP population (695 target vs. 941 actual) as well as the At-Risk population (370 target vs. 495 actual) (Figures 4 & 5). The percentage of all regional state hospital consumers discharged to supportive housing increased from 8.49% in SFY10 (first year of *Olmstead*) to 21.77% in SFY16 (Figure 6). Consumers served in supportive housing increased significantly (4,165 or 195%) from 2,136 in 2006 to 6301 in 2016 (Figure 7). In 2006, the number of consumers served in the state hospitals exceeded the number of consumers served in supportive housing by 3,069, with 5,205 consumers served in state hospitals vs. 2,136 served in supportive housing. The number of consumers served in supportive housing now exceeds the number of consumers served in the state hospitals with 6,301 served in Supportive Housing in SFY 2016 and 3290 served in the regional state hospitals, a difference of 3,011. (Figure 8).

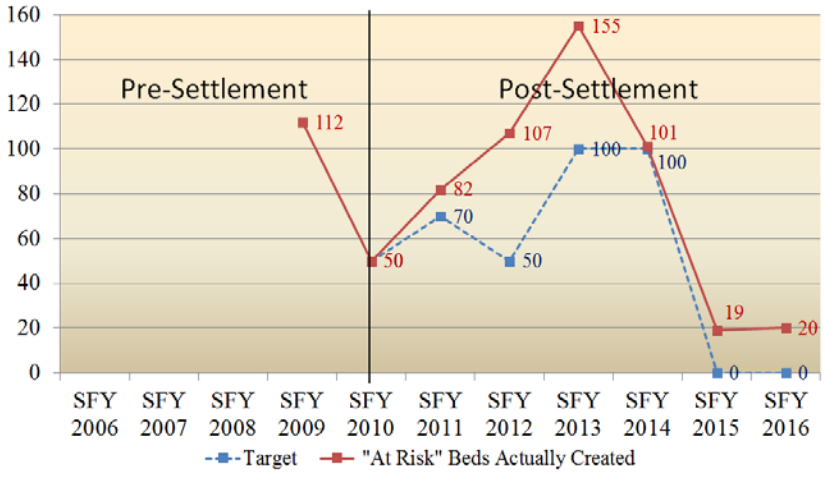
Figure 4: Supportive Housing (SH) Beds for *CEPP Clients in the State Hospital*:
Targets vs. Beds Actually Created, SFY 2006 – 2016[1]



[1] Prior to SFY 2009, the beds created were not reserved specifically for the target populations of CEPP consumers or those at risk of hospitalization.

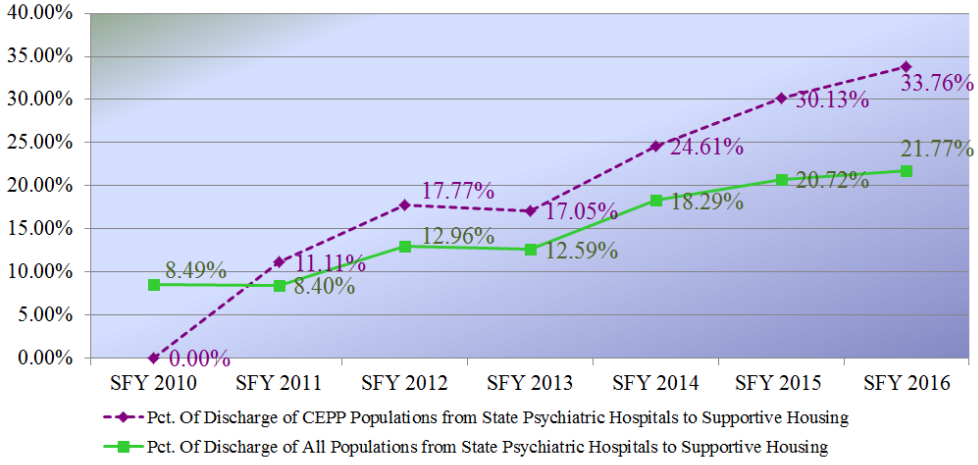
NJ Division of Mental Health and Addictions Services, Office of Olmstead, Compliance, Planning & Evaluation, November 2016

Figure 5: Supportive Housing (SH) Beds for *At-Risk Populations*:
Targets vs. Beds Actually Created, SFY 2006 – 2016[1]



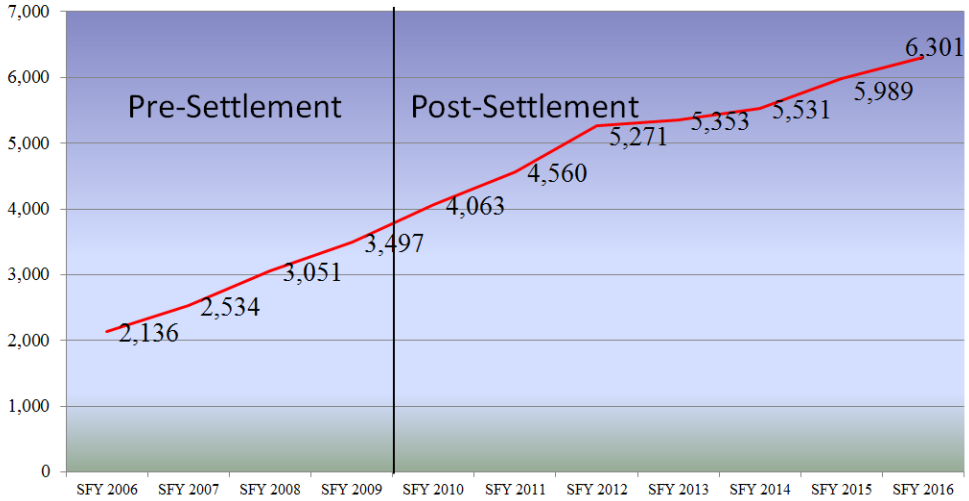
NJ Division of Mental Health and Addictions Services, Office of Olmstead, Compliance, Planning & Evaluation, November 2016

Figure 6: Percent of Discharges from NJ State Psychiatric Hospitals (excl. AKFC) to Supportive Housing (SH): CEPP Population and All Populations, SFY 2010 – 2016



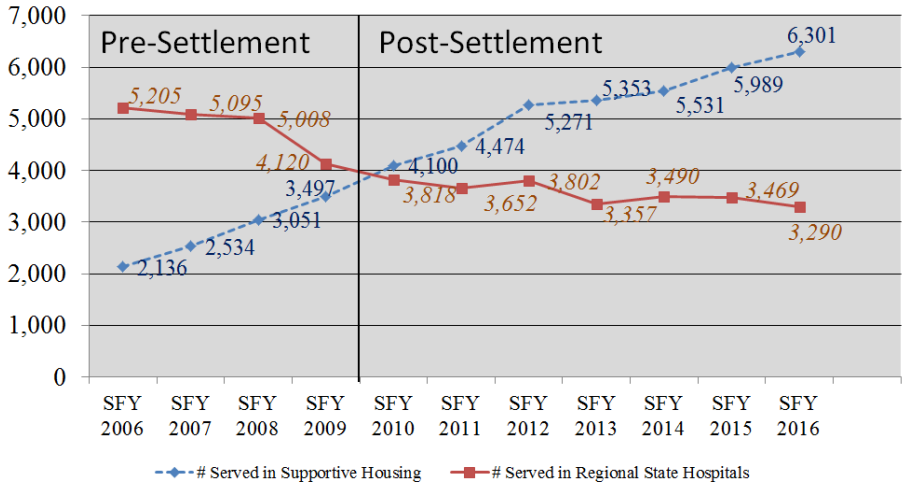
NJ Division of Mental Health and Addictions Services, Office of Olmstead, Compliance, Planning & Evaluation, November 2016.

Figure 7: Clients Served by the SMHA in Supportive Housing (duplicated) SFY 2006 – SFY 2016



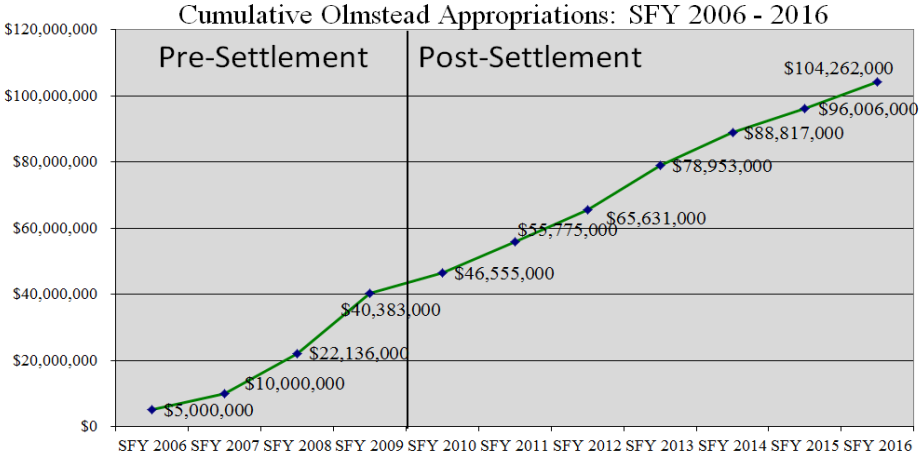
NJ Division of Mental Health and Addictions Services, Office of Olmstead, Compliance, Planning & Evaluation, November 2016

Figure 8: Clients Served by the SMHA in Supportive Housing (duplicated) and in the Regional State Hospitals SFY 2006 – SFY 2016



NJ Division of Mental Health and Addictions Services, Office of Olmstead, Compliance, Planning & Evaluation, November 2016.

Figure 9: NJ Division of Mental Health and Addictions Services:
Cumulative Olmstead Appropriations: SFY 2006 - 2016



NJ Division of Mental Health and Addictions Services, Office of Olmstead, Compliance, Planning & Evaluation, November 2016.

Resource Data

Adequate funding is essential to DMHAS' efforts to continue to develop the capacity to meet the discharge needs of individuals served at the regional state psychiatric hospitals and the service and support needs of individuals in the community who are at risk of hospitalization. In its commitment to meet these needs, New Jersey has made significant annualized funding available. Figure 9 illustrates DMHAS' resource allocations since the implementation of Home to Recovery 1.

DMHAS is planning significant service and support growth in SFY 18 that will annualize in SFY 19. DMHAS will plan for Olmstead related community capacity development throughout Home to Recovery 2, subject to the availability of appropriated funds.

Enhanced DD/MI Discharge Process

The DHS has made substantial improvements in the discharge and community services arrangements for individuals with developmental disabilities admitted to state psychiatric hospitals. This is a combined effort between DMHAS and the Division of Developmental disabilities (DDD). DDD has assigned 3 full time case managers for the state hospitals with primary responsibility to make DDD referrals and work with hospital staff to address any discharge barriers that may be present.

SECTION IV – PLANNING PROCESS

As a result of the increase in community capacity and the systems level changes described above, NJ has seen a realignment of its mental health system. These changes have resulted in a major shift in where services are provided, by whom, how and at what cost. The aim for these changes is to incentivize better access to and availability of best practice, most integrated community services and housing. With these changes, DMHAS is making possible a future with a continued decline in reliance on inpatient treatment in favor of community based consumer driven options that support personal wellness activities in the community of one's choosing.

Through the ACA Medicaid expansion and implementation of Medicaid presumptive eligibility in licensed clinic settings, more New Jersey residents have access to entitlement services through Medicaid. This produces greater federal financial participation in the delivery of these services, thereby improving the use of DMHAS resources for service access. DMHAS has begun and will continue to promulgate the initiatives described in this section. Stakeholder participation has been and will continue to be a key component of DMHAS' planning and implementation activities.

Guiding and coordinating this planning process is the centralized Olmstead Office which is an executive level office established in 2014 to coordinate policies and programming between and among the state hospitals, community providers and DMHAS central office. The centralization of this office has made possible more comprehensive policy development in furtherance of community integration. As such, this office is responsible for the planning, monitoring of the programming in Home to Recovery 2 and the outcomes of the initiatives in both hospital and community.

A. Move to Fee for Service (FFS)

During his 2016 State of the State and Budget Addresses, Governor Chris Christie announced that $127 million would be invested in enhanced behavioral health services rates for providers. It was the largest overall increase to this community in over a decade and is designed to strengthen the organizations that provide critical programs for some of New Jersey's most vulnerable residents. During SFY16 DMHAS released its new Medicaid and State rates for behavioral health services. In many instances rates were substantially increased from previous levels. In 2017, DMHAS began instituting a new approach to funding certain community based mental health services, known as the Mental Health Fee- for Service (MH FFS Program"). The MH FFS Program pays for provider agencies under contract with the DMHAS to deliver community based mental health services on a fee-for-services basis. The MH FFS Program is funded primarily from State appropriations. In order to conserve that limited resource, the MH FFS Program is the payer of last resort. As such, payment through the MH FFS Program is prohibited when other sources of payment are available, such as Medicaid, Medicare, charity care or private insurance.

Some of the anticipated outcomes are as follows:

- Increased service capacity
- Greater access for individuals seeking treatment to access services at the level of care needed at the time needed
- Standardization of reimbursement across providers
- Greater budgeting and expenditure flexibility for providers
- Ability to track expenditures by individual, by service and outcome

To support this initiative, DMHAS has developed the New Jersey Mental Health Application for Payment Processing (NJMHAPP), a web based application whereby contracted providers can submit payment request for state funding for services delivered through approved services and programs to eligible individuals. DMHAS contracted mental health service providers have a choice to transition to the fee for service payment system effective January 1, 2017 or July 1, 2017. Sixteen providers transitioned January 2017 and the balance of the mental health providers will transition July 2017.

B. Community Support Services

DMHAS in collaboration with the Division of Medical Assistance and Health Services (DMAHS), submitted a State Plan Amendment to CMS requesting permission to provide a new Medicaid billable rehabilitation service. Community Support Services (CSS) is a rehabilitation service that provides consumers with the supports and services necessary to achieve their life's goals. Regulations were promulgated in August of 2016. Contracted providers of CSS are required to obtain licensure through the DHS Office of Licensing, and Medicaid approval to initiate billing for CSS services. The Federal Financial Participation (FFP) garnered through this initiative will support the provision and sustainability of services. The total cost of CSS services will be supported by a combination of FFP to Medicaid enrolled beneficiaries, and state funds for individuals who do not have Medicaid. As a result, contracts will be significantly modified subsequent to the implementation of CSS. In order to ensure the commencement of Medicaid billing at the earliest possible time, existing and new Medicaid consumers will be prioritized. Molina, DMAHS' fiscal agent, will be responsible for the processing of CSS claims submitted by providers for payment, as well as the provision of training to providers (upon request) regarding billing processes.

Additionally, CSS establishes a new rehabilitative service for eligible consumers which allows them to exercise choice in provider and choice in housing. In the community if a consumer is refusing services, the CSS program has two elements that address consumer support and provide a more individualized service experience. The first element is CSS crisis intervention[4] and the second element is that those individuals receiving a housing subsidy allow for a wellness check once a month.[5] In both ways, this allows the individual to receive necessary services in the community and potentially avoid the risk of hospitalization.

C. Separation of Housing and Services

In 2015, DMHAS and the NJ Housing and Mortgage Finance Agency (HMFA) entered into a Memorandum of Agreement (MOA) to have a subsidiary of the HMFA, the Supportive Housing Connection (SHC), begin the process of paying the subsidies for individuals served by applicable DMHAS programs. Under this MOA, the SHC acts as fiscal agent and by agreement follows all DHS policy decisions. The SHC contracts with property managers and owners, completes all necessary apartment inspections makes subsidy payments to property managers and landlords. The SHC recruits landlords, provides training, assists with consumers completing paperwork and distributes welcome packets to afford a smooth transition for consumers. The SHC assists consumers in referrals for affordable housing units, administers DMHAS housing subsidies, and expands relationships for housing opportunities through developers and or other HMFA housing projects. In the event of disputes between consumers and landlords, the SHC brokers disputes and contracting issues. Phase 1 of this process began in August 2015, when 1,200 subsidies were transferred from contracts to the SHC for monthly rent payments. Phase 2 of this process began on January 1, 2016 when the SHC began making payments to landlords for an additional 1,200 consumers. In State Fiscal Year 2017, DMHAS issued supportive housing contracts that are for services only, with housing subsides no longer available through the contracts, rather the provider will access housing subsidies through the SHC. These service contracts will remain intact until July 1, 2017, when the DMHAS implements Fee for Service (FFS) payments for CSS providers.

D. HUD Award

New Jersey Housing & Mortgage Finance Agency (NJHMFA) in partnership with the Department of Human Services (DDD, DMHAS and DMAHS) applied for and was awarded a HUD 811 contract in 2015. NJHMFA as the lead for 206 (811) subsidies partnered with the DHS to address its *Olmstead* obligation in moving consumers out of the state institutions and into the community in an integrated fashion. This allows consumers choice in their selection of towns/cities, neighborhood, and apartment, as well as the freedom to choose the service provider with whom they would work. The Frank Melville Supportive Housing Investment Act of 2010 represents HUD reform of the Section 811 program.

E. Integrated Behavioral and Primary Health Services

The Behavioral Health Home (BHH) is a service designed to integrate physical and behavioral health care. BHH serve as a "bridge" that connects prevention, primary care, and specialty care, and is designed to avoid fragmented care that leads to unnecessary use of high-end services (i.e. emergency rooms and inpatient hospital stays.) BHHs in New Jersey have a five-member team led by a Nurse Care Manager. The team treats the whole person through person-centered treatment planning specific to his

or her individual needs. Each BHH focuses on the overall population health within their organization and utilizes care management over the traditional case management approach. The BHH initiative is being developed jointly by DMHAS, DMAHS and the NJ Department of Children and Families (DCF), with all partners having responsibilities for implementation of the service(s) upon approval by Centers for Medicare and Medicaid Services (CMS) of any and all submitted State Plan Amendments (SPAs). Four counties, Bergen, Mercer, Atlantic and Monmouth are offering behavioral health home services to individuals with a serious mental illness. SPAs have been approved in all of the aforementioned counties plus Cape May County. However, there isn't a certified provider in Cape May County. To build BHH capacity in approved counties, DHS and DCF have implemented Learning Collaboratives facilitated by the National Council on Behavioral Health. The state has developed a BHH certification and requires providers to become accredited as a BHH within two years of certification.

In addition, the DMHAS received a Certified Community Behavioral Health Center (CCBHC) planning grant from SAMHSA in FY 2016. DMHAS submitted a proposal to become one of the SAMHSA CCBHC demonstration states and received notice December 2016 of award. Similar to the BHH model, CCBHCs will integrate physical and behavioral health care. DMHAS has certified seven agencies as a CCBHC, all of whom are licensed to serve children and adults with a substance use disorder and a serious mental illness.

F. <u>Supported Employment</u>

NJ currently has 21 community mental health-based Supported Employment (SE) programs. One additional SE program is designed to assist aging-out youth to find their career path. SE is a unique employment service for individuals with severe mental illness who require ongoing support services to succeed in competitive employment. The ultimate goal of SE is to help enrolled consumers find and maintain meaningful jobs of their choosing in the community. The jobs are competitive (paying at least minimum wage) and are based on a person's preferences and abilities. Services include supports to access benefits counseling; identify vocational skills and interests; and develop and implement a job search plan to obtain competitive employment in an integrated community setting that is based on the individual's strengths, preferences, abilities, and needs. These services are tailored to the consumer's strengths.

On July 1, 2015, DMHAS implemented a pilot SE program targeted at the three regional state hospitals. This pilot assesses those individuals who are ready for discharge and examines their interest in employment outside of the state hospitals. All SE programs receive training and technical assistance from the Employment Institute at Rutgers-School of Health Related Professions (SHRP) and Mental Health Association in New Jersey (MHA-NJ). Community agencies along with consumers and their families receive training on benefits, career interest inventory, barriers to employment, and engagement. DMHAS will monitor the proportion of enrollees to the pilot in-reach program of all referrals from the state hospital to the in-reach program to ensure services are available for consumers interested in finding gainful employment or utilizing other services offered by the SE provider.

In addition to expanding its services to mental health consumers in institutions, DMHAS maintains a collaborative relationship with the Division of Vocational Rehabilitation (DVR), meeting on an as-needed basis to address and resolve case-specific issues and when necessary, more global systems issues. DVR has also requested inclusion in quarterly Supported Employment provider meetings. Upon request from

Supported Employment providers, Rutgers University's Employment Resource Institute offers training and technical assistance on the Individual Placement and Support Standards for Supported Employment.

DMHAS intends to increase the number of individuals obtaining competitive employment during Home to Recovery 2. A multilevel needs assessment will be conducted to determine geographic regions most in need of SE expansion. Resources available for SE expansion will be prioritized in subsequent expansion initiatives based on the outcome of the assessment. While the stated prioritization will occur, the overarching goal is to expand SE statewide as resources permit. As a means of examining the needs and prevalence of employment among the populations it serves, DMHAS will add employment indicators to its Quarterly Contract Monitoring Report (QCMR) for Community Support Services (CSS) that have been adapted from the Uniform Reporting System (URS) data tables. The four employment indicators are as follows: Employed, Unemployed, Not In Labor Force, and Not Available. Employed includes the following categories of employment: competitively employed, employed full or part time, and supported employment. Not In Labor Force includes the following: Retired, Sheltered Employment, Sheltered Workshops, and Other (e.g. student, homemaker, volunteer, and disabled). Collection of this information during SFY 2018 will allow for the establishment of a baseline for improvement in the percentage of consumers maintaining gainful employment within the CSS consumer population.

G. Peer Delivered Services

There are more than 30 peer operated wellness centers in New Jersey. Formerly referred to as self-help centers, the wellness centers are places where individuals with a mental illness can participate in activities that support their personal wellness goals. The shared successes and achievements can instill hope and serve as an inspiration for individuals who are struggling with similar challenges faced by their peers. DMHAS has a wellness center located in each of the regional hospitals which serves as a bridge to community programs. The regional state hospitals will be looking to maintain a minimum of 2 peer recovery support specialist in each hospital. Currently DMHAS is reviewing funding that supports wellness activities to develop new initiatives to enhance the competencies of the centers to deliver a variety of wellness services. One possible initiative is the development of a Wellness Institute that would have as its mission the provision of training and technical assistance around wellness activities to all of the centers.

In 2014, DMHAS awarded $2 million in annual funds to operate three Peer Operated Crisis Respite Programs that were each five bed programs. This Program is a residential home operated mainly by individuals in recovery. The program offers respite residential services for mental health consumers experiencing exacerbation of symptoms, severe emotional stress, or are in psychiatric crisis. Services re provided in a safe, home-like setting that is conducive to the recovery process. Services provided include peer coaching, medication prescription and education, peer coaching, and group supports. Staffing is on site 24 hours a day, seven days a week.

In SFY 2016, New Jersey DMHAS instituted its Forensic Peer Bridger program, offering education free of charge to consumers in recovery wishing to help those peers with criminal justice involvement in their transition into the community from an institutional setting. The program is geared toward those who have been institutionalized or at risk of institutionalization through a determination of "Not guilty by reason of insanity" (NGRI), a finding of incompetency to stand trial, or a Megan's Law registration requirement. The goal of the Peer Bridger is to establish a culture of mutual respect through mentoring,

role modeling, and linkages of service recipients to appropriate community resources and natural supports. Forensic Peer Bridgers empower justice-involved consumers to embrace the self-care and holistic practices defined by the Eight Dimensions of Wellness[6], and help consumers achieve community integration through the cultivation of valued social roles. Peer Bridgers seek to remove the institutional mindset from each consumer and help them develop effective mechanisms for success within the community. Made possible through a Transformation Transfer Initiative (TTI) through DMHAS, the Forensic Peer Bridger program consists of both classroom and internship components, which are offered by the Rutgers Department of Psychiatric Rehabilitation & Counseling Professions. DMHAS will continue to pursue similar grant opportunities to further promulgate peer delivered services in New Jersey.

SECTION V – IMPLEMENTATION

Critical to the implementation of Home to Recovery 2 are the steps for sustaining a low percentage of individuals holding a CEPP status, ensuring that those individuals who do hold a CEPP status do not remain in the state psychiatric hospital for an unjustified length of time, and diverting hospital admissions to the greatest extent possible. DMHAS has initiated many initiatives to improve hospital-community integration. Home to Recovery 2 is a multifaceted initiative to further the implementation, refine tools developed in previous years and make improvements where needed. DMHAS has and is establishing monitoring processes to measure outcomes. The assignment process is well underway. The housing vacancy management system will be fully implemented and new targets are set for multiple initiatives.

In concert with its community, hospital and other systems partners, DMHAS has realized significant improvements in the timeliness of discharges of individuals who no longer require inpatient treatment at state hospitals. Of equal importance, DMHAS has embarked on several initiatives to enhance consumer wellness and opportunities for self-directed and valued peer, whole health and housing services. Wellness and recovery principles as well as introduction of peer support in the state psychiatric hospitals places an even greater emphasis on self-directed care in this new plan. The focus remains on developing a closer partnership between the community provider agencies and the state psychiatric hospital system. While not exhaustive, the following section identifies global implementation goals and outcomes for continuing to move New Jersey's system of care to one that is more consumer driven and community based.

HOSPITAL DISCHARGE PLANNING

The reduction of the proportion of the regional hospital census on CEPP, the CEPP census, and the hospital length of stay are central features of the Olmstead settlement agreement. DMHAS has significantly reduced the number of CEPP designees at the state hospitals since the Olmstead lawsuit was settled in 2009. At the time the settlement was reached, the statewide number of CEPP designees stood at 735. As of December 1, 2016 that number has reduced to 317. DMHAS is proposing to obtain and maintain a net state psychiatric hospital CEPP Census at its regional state hospitals at or below 300. This threshold accounts for and removes from consideration individuals who are adjudicated CEPP but are refusing all discharge options. DMHAS will further work to maintain a net CEPP Census at or below 21.5% of total census at regional state hospital. DMHAS will continue to utilize and monitor the earlier described practices to reduce hospital lengths of stay and is proposing to obtain and maintain a median length of stay of 90 days for consumers in the regional state hospitals.

The hospitals' Intensive Case Review Committees, revised Individual Needs for Discharge Assessment (INDA), revised treatment planning schedule, assignment process and housing vacancy management system are all tools DMHAS will continue to use and monitor to meet the stated CEPP designation goals. Furthermore, DMHAS will continue to monitor quality and compliance with the utilization of the INDA and the revised treatment planning schedule on a quarterly basis through on site chart auditing by Central Office staff.

The INDA was originally developed as a means for hospital treatment teams to assess consumers' needs and barriers to discharge. At the hospital level, this assessment is not prescriptive but informative, providing information to hospital and regional staff, and allowing them to review and track major barriers that are preventing or significantly delaying consumer discharges. The INDA provides supporting documentation that mirrors the treatment team's efforts in finding community placements given each consumer's discharge barriers.

The INDA is a multi-dimensional discharge planning tool, examining potential areas of need/barriers to discharge such as:

- Legal Issues
- Finances
- Insurance
- Level of Care
- Challenging Behaviors
- Housing Preference and Discharge Interventions
- Diagnoses
- Medical Needs
- Medication Needs
- Functional Needs
- Substance Abuse Issues

Coinciding with the revised treatment planning process, in August 2015 the INDA was enhanced to include community providers, replacing the Agency Referral and Response Form (ARRF) as the communication tool for engaging providers in discharge planning. The updated INDA now also reflects provider involvement, with a section for the teams to note any prior provider history as well as the name(s) of the currently assigned provider agencies.

EXPAND SUPPORTIVE HOUSING CAPACITY

Equally important to the Olmstead settlement agreement was the creation of new supportive housing opportunities for the discharge of individuals from the state psychiatric hospitals and those who are at risk of hospitalization and homelessness. For each fiscal year since the settlement agreement was reached, DMHAS met or exceeded the supportive housing development targets. For FY17, DMHAS is creating an additional 220 funded supportive housing service slots with concomitant subsidies. DMHAS will create additional funded supportive housing service slots with concomitant subsidies from SFY 18 to SFY 20 pursuant to the assessed demographic and service level need, as annualized newly available funding permits.

MOVE TO FEE FOR SERVICE

Beginning January 1, 2017, the New Jersey Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS) is instituting a new approach to funding certain community based mental health services, known as the Mental Health Fee-for-Service Program ("MH FFS Program"). The MH FFS Program pays provider agencies under contract with the DMHAS to deliver community-based mental health services on a fee-for-service basis. The MH FFS Program is funded primarily from State appropriations. In order to conserve that limited resource, the MH FFS Program is the payer of last resort. As such, payment through the MH FFS Program is prohibited when other sources of payment are available, such as Medicaid, Medicare, charity care, or private insurance. Participation in the MH FFS Program is limited to provider agencies under contract with the DMHAS as of December 31, 2016. Those provider agencies have been offered the choice of transitioning from their current cost-related contracts with installment payments (also known as cost-reimbursement contracts) to a non-cost related contract with fee-for-service payment on either January 1, 2017 (Phase I) or July 1, 2017 (Phase II). All Medicaid State Plan approved and applicable state funded mental health services will be purchased on a fee for services basis by July 1, 2017.

STRENGTHEN AND IMPLEMENT COMMUNITY BASED INITIATIVES

Licensed Community Support Service (CSS) Providers began providing CSS services as of August 15, 2016. DMHAS with the support of the Rutgers University's School of Health Professions will conduct an outcomes evaluation of CSS in domains such as consumer retention, Wellness and Recovery Principles, Individualized Rehabilitation Plan, Housing Related Services, and Social Networks. An initial report on these outcomes will be produced by July 1, 2018. Evaluation of the domains will be ongoing with outcome reports produced at least yearly.

The Supportive Housing Connection (SHC) will continue to manage supportive housing subsidies, conducting crucial related services such as apartment inspections and rental payments to landlords. The SHC will respond to all submitted subsidy applications within one business day of receiving a complete package. The SHC will provide apartment inspections within five days of the provider's submitted request. The SHC will also make rental payments by the payment due date for all individuals with a subsidy managed by the SHC. The target compliance threshold for all of these requirements is 90%. These timeframes will enable the DMHAS and the SHC to maintain a low vacancy rate, with only new units or units becoming vacant as individuals move being available. This enables DMHAS and the SHC to meet their 85% occupancy goal. DMHAS initiated and will continue to convene a bi-monthly meeting of a stakeholder committee to address and resolve issues around subsidy management. The committee is attended by DMHAS representatives, SHC staff and supportive housing providers.

INCREASE INDIVIDUALS IN COMPETITIVE EMPLOYMENT

As indicated earlier, a multilevel needs assessment will be conducted to determine geographic regions most in need of Supported Employment (SE) expansion. Resources available for SE expansion will be prioritized in subsequent expansion initiatives based on the outcome of the assessment. While the stated prioritization will occur, the overarching goal is to expand SE statewide as resources permit. Consumers will continue to be referred to Supported Employment from State Hospitals. During FY17 40 individuals will be served at the state hospitals by a SE program. Additional service expansion to

individuals at the state hospitals during SFY 18 through SFY 20 will be contingent upon existing caseload capacity. Additionally, Programs for Assertive Community Treatment (PACT) will assist consumers enrolled in PACT to find and maintain employment. DMHAS will set a goal of 20% of consumers enrolled in PACT finding and maintaining employment. Additionally, the DMHAS will establish the baseline of individuals receiving CSS services who are competitively employed in FY18. In FY 19 the DMHAS has established a minimum target increase by 5% of individuals who are employed.

EXPAND ACCESS TO INTEGRATED BEHAVIORAL AND PRIMARY HEALTH SERVICES

It is expected that the use of a behavioral health home model will result in improved health outcomes for participating individuals with a serious mental illness. Additional expected benefits for participants are better quality of treatment, improved cost effectiveness, improved consumer experience with care and declines in the use of hospitals, emergency departments, and other costly inpatient care. Four counties, Bergen, Atlantic, Monmouth and Mercer, are offering behavioral health home services to individuals with a serious mental illness. A SPA has also been approved for Cape May county however a provider has not been certified to provide BHH services in that county as of yet. In addition, the DMHAS will make integrated primary health and behavioral healthcare available in seven Certified Community Behavioral Health Centers during the SAMHSA demonstration period of FYs 17 through 19.

SUMMARY

Through increased annualized state funding during every year since the Olmstead Settlement was reached, DMHAS has greatly enhanced housing, services and support capacity for individuals served at the state psychiatric hospitals and those who are at risk of hospitalization and homelessness. New Jersey's regional state hospital population has decreased dramatically over the past decade in correlation with DMHAS' continued investment in further developing the community infrastructure to expand existing services and develop new initiatives to meet the complex needs of individuals with a mental illness. Through effective oversight and monitoring of the successes of Home to Recovery 1 and the Olmstead Settlement Extension Plan, DMHAS is positioned to ensure continued progress of the initiatives begun under Home to Recovery 1 and the success of the Home to Recovery 2 Plan.

The successful implementation of new key systems level initiatives described in this plan is also critical to the success of Home to Recovery 2. These initiatives are milestones of some of the most critical system enhancements the mental health delivery system has seen in nearly a generation. The fee for service delivery system will create broader community access to services and more efficient delivery systems. The Housing Mortgage and Finance Agency and the Supportive Housing Connection will increase access for consumers to housing in the community as well as allow for greater administrative flexibility in managing these resources. The promulgation of the Community Support Service regulations and the implementation of CSS as a newly operational Medicaid billable service under New Jersey's State Plan will allow DMHAS to leverage significant Federal Financial Participation for a service that historically has been funded solely through state appropriations. The Federal Financial Participation (FFP) garnered through fee for service and CSS will support the provision and sustainability of CSS services and improve the use of DMHAS resources for other service access.

As stated in Home to Recovery 1, DMHAS recognizes that planning and improving community reintegration consistent with the wellness and recovery model requires coordination among state

agencies, consumers, the community, and other interested stakeholder groups. Stakeholder participation has been and will continue to be a key component of DMHAS' Home to Recovery planning and implementation activities. The Home to Recovery 2 Plan will be reviewed annually with the Behavioral Health Planning Council in concert with the Community Mental Health Block Grant. This crucial review will assure independent oversight of DMHAS' progress on the strategic goals of this plan, and well as deliver recommendations for any identified areas where performance improvement is required. Additional stakeholder forums will be convened to solicit subject matter expertise in the development and implementation of promising and evidence based practices around person-centered service delivery. DMHAS will post on its website the Home to Recovery Plan's annual report regarding progress toward the identified goals.

References

[1] *Olmstead* v. L.C. 527 U.S. 581 (1999)

[2] Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead* v. L.C. (June 22, 2011)

[3] Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead* v. L.C. (June 22, 2011)

[4] N.J.A.C. 10:37B-4.4(b)(24-25).

[5] N.J.A.C. 10:37B-3.3(b)(2).

[6] http://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness

DIVISION OF MENTAL HEALTH SERVICES – HOME TO RECOVERY 2 PLAN TARGETS AND OUTCOME MEASURES

	SFY 2018	SFY 2019
Complete Medicaid applications within 30 days of admission to a regional state psychiatric hospital.	80%	85%
Filled Peer Support Specialist positions in the state hospitals as a proportion of targeted positions.	100%	100%
Expand Behavioral Health Homes in additional counties to serve consumers with Serious Mental Illness	1	2
Increase employment of consumers served by Community Support Services (CSS) providers	Establish a baseline from employment indicators to be added to CSS QCMR	5% increase in employment among CSS population served.
Increase utilization of Supported Employment In-Reach slots available to state psychiatric hospitals	56%	60%
Housing Stability – Consumers who remain in supportive housing during the course of the fiscal year as a proportion of consumers served in Supportive Housing. [Until baseline data from CSS is reported, the SMHA will use QCMR data from Supportive Housing].	85%	85%
Target expansion of Supportive Housing Bed Development CEPP/Non CEPP State Hospital Clients and At Risk Beds	200	TBD based upon DMHAS funding for SFY 2019 budget
Awarded Supportive Housing Beds for CEPP/Non CEPP State Hospital Clients	To be reported when awards are made	To be reported when awards are made
Percent of CEPP Discharges from Regional NJ State Psychiatric Hospitals to Supportive Housing	38%	40%
Percent of All Discharges from Regional NJ State Psychiatric Hospitals to Supportive Housing	24%	25%
Percentage of Clients Served by the SMHA in Supportive Housing versus Clients Served by the SMHA in the Non-Forensic State Hospitals.	67% Supportive Housing	68% Supportive Housing
Improved Utilization of Housing Service Slots: DMHAS will monitor occupancy rates via the new web-based vacancy tracking system. [In SFY 17 the occupancy rate (without an assignment) is 80.9%, this value was generated by hard copy reports].	83%	85%

	SFY 2018	SFY 2019
State Hospital Average Census	1,350	1,300
State Hospital CEPP Census:	285	270
State Hospital Admissions	1,825	1,750
Proportion of Year End State Hospital Census on CEPP Status	21.5%	21.3%
Median State Hospital Length of Stay	90 days	90 days
Maintain and reduce CEPP lengths of stay (these are cumulative percentages)	• 3 Months: 65% • 4 Months: 80% • 6 Months: 85% • 9 Months: 90% • 1 Year: 95% • 2 Years: 98%	• 3 Months: 65% • 4 Months: 80% • 6 Months: 85% • 9 Months: 90% • 1 Year: 95% • 2 Years: 98%