Olmstead Planning and Systems Changes: Realignment of the New Jersey Mental Health System 2006 - 2016

DONNA MIGLIORINO, MPH, RN, NE-BC, DEPUTY ASSISTANT DIRECTOR, OFFICE OF OLMSTEAD, COMPLIANCE, PLANNING, AND EVALUATION, NEW JERSEY DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

DOMENICA NICOSIA, MS, RESEARCH SCIENTIST, OFFICE OF OLMSTEAD, COMPLIANCE, PLANNING AND EVALUATION, NEW JERSEY DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

Olmstead in New Jersey

- In April 2005, New Jersey Protection and Advocacy, Inc (NJP&A) filed a lawsuit against the Dept. of Human Services on behalf of individuals with mental illness who are confined to a state psychiatric hospital within NJ whom the court adjudicated as no longer meeting commitment standards, but for whom there is no appropriate and available placement.
- In New Jersey, these consumers are given a status of "Conditional Extension Pending Placement (CEPP)."

Olmstead in New Jersey

- The lawsuit, originating in Georgia and known as Olmstead vs. L.C. claimed that under Title II of ADA:
  - The state was in violation of Title II in failing to place these consumers in community-based programs once their treating professionals have determined that such placements are appropriate.

Olmstead in New Jersey

- During the course of the Olmstead lawsuit, DMHAS published its Home to Recovery CEPP Plan (2008)
  - Policy Reform, Enhancements, and Refinements
  - Community Capacity Development
- A settlement agreement was reached in July 2009 between DMHAS and Disability Rights of New Jersey (DRNJ) formerly known as NJP&A
  - Timely discharge of CEPP consumers
  - Creation of community placements for CEPP discharges and consumers at risk of hospitalization/homelessness

Olmstead in New Jersey

- Olmstead Settlement Agreement
  - Originally spanned SFY 2010 through 2014
  - Extended through March 2016
  - Closed in March 2017 under a finding of substantial compliance
    - Significant shift in service delivery from reliance on state psychiatric institutions to a focus on community integration
    - Exceeded targets for placement creation
    - Significant decreases in the utilization of CEPP status
    - Publication of New Jersey's Home to Recovery II Plan (2017)
    - Successful community integration initiatives beyond the scope of Settlement Agreement requirements.

Office of Olmstead, Compliance, Planning and Evaluation

- Established 2014
- Centralized administration of Olmstead-involved offices
- Comprehensive policy development geared toward community integration
- Collaboration among:
  - Central Office Administration
  - Regional Olmstead Staff (On-site at state hospitals)
  - State Psychiatric Hospitals
  - Community Providers

Individual Needs for Discharge Assessment (INDA)

- 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

Individual Needs for Discharge Assessment (INDA)

- Originally developed as a means for hospital treatment teams to assess consumers' needs and barriers to discharge

- 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.

Intensive Case Review Committee (ICRC)

- Created as a result of the Home to Recovery CEPP Plan
- Initial focus on Conditional Extension Pending Placement (CEPP) consumers difficult to discharge within the timeframes outlined in the Olmstead Settlement Agreement.
- Updated protocol (July 2015)
  - Review of all state hospital consumers for discharge readiness
  - Meetings with administration and hospital treatment teams
  - Facilitation of discharge and community integration
  - Focus on resolution strategies for discharge barriers
  - Recommendations and assignment of tasks

Hospital Project Teams

- Follow-up on systems issues raised by ICRC and discussion of resolution strategies
- Chaired by the CEO or Deputy CEO and Medical Director
- Core committee membership: Medical Director, Social Services Director, Placement Entity, Regional Olmstead Coordinator (ROC), and Olmstead Executive Staff
- Required Support by DMHAS Hospital Legal Specialists
- Weekly meetings occur immediately after ICRC in order for potential systems issues raised at ICRC to be discussed at Project Team.
  - Systemic issues arising from ICRC
  - Recent ICRC/newly-made CEPP consumers
  - One to two case presentations by the ROC as needed
- ROC will update committee on Administrative Bulletins, potential best practices, and implementation of new processes and data systems

Transitional Case Manager (TCM)s

- Representative from the Division of Developmental Disabilities (DDD)
- Stationed at each regional state psychiatric hospital
- Assist in transitioning hospital patients with developmental disabilities to community settings
  - DDD Referrals
  - Supports related to developmental disabilities

Mental Health in New Jersey: Then and Now

- Data-Driven Analysis of Systemic Changes under Olmstead
  - Institutionalization vs. Community Integration (2006 through 2016)
  - Pre and Post-Olmstead Summary (2010 vs. 2016)

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

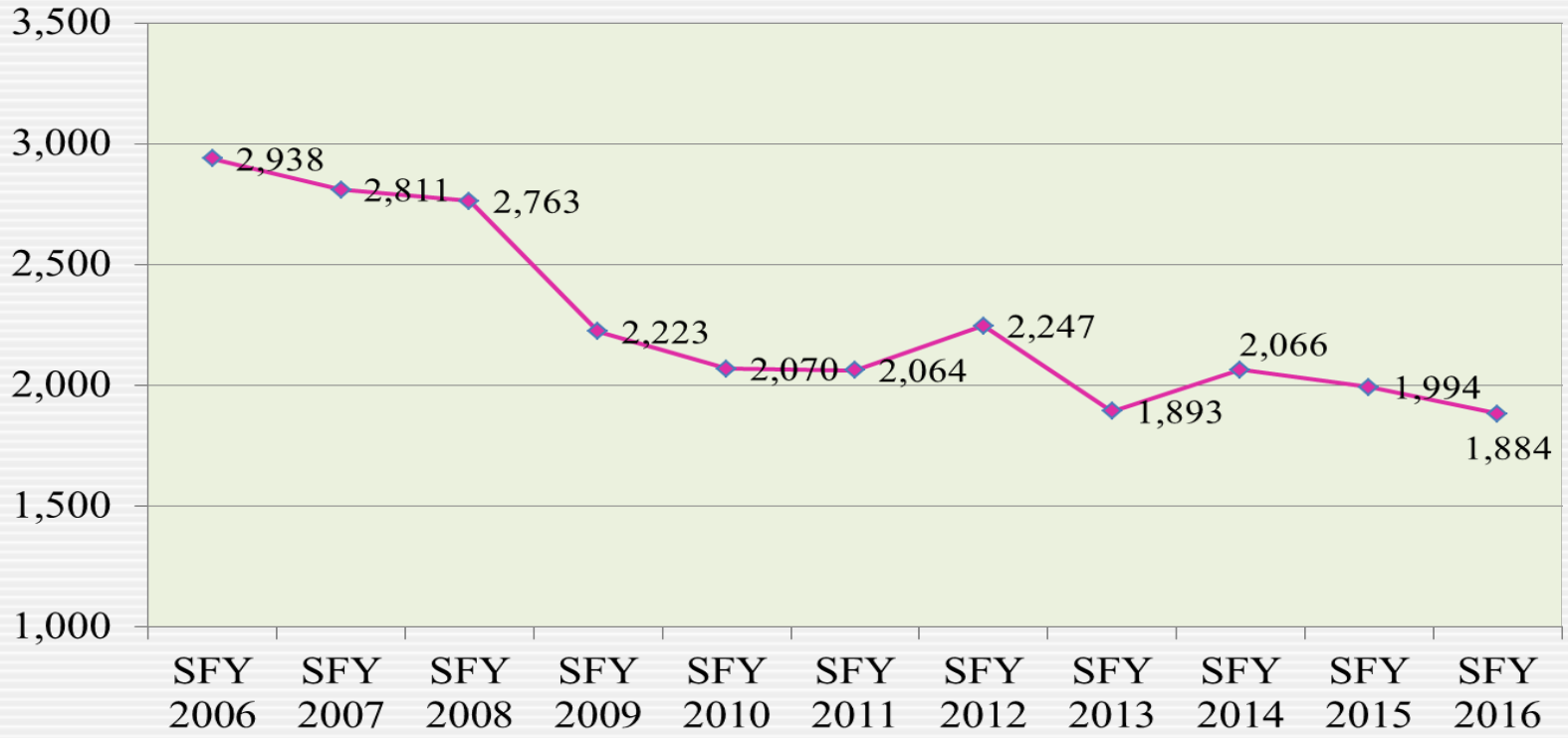


Figure 2: Total Discharges from NJ Regional State Psychiatric Hospitals (excl. AKFC): SFY 2006 - 2016

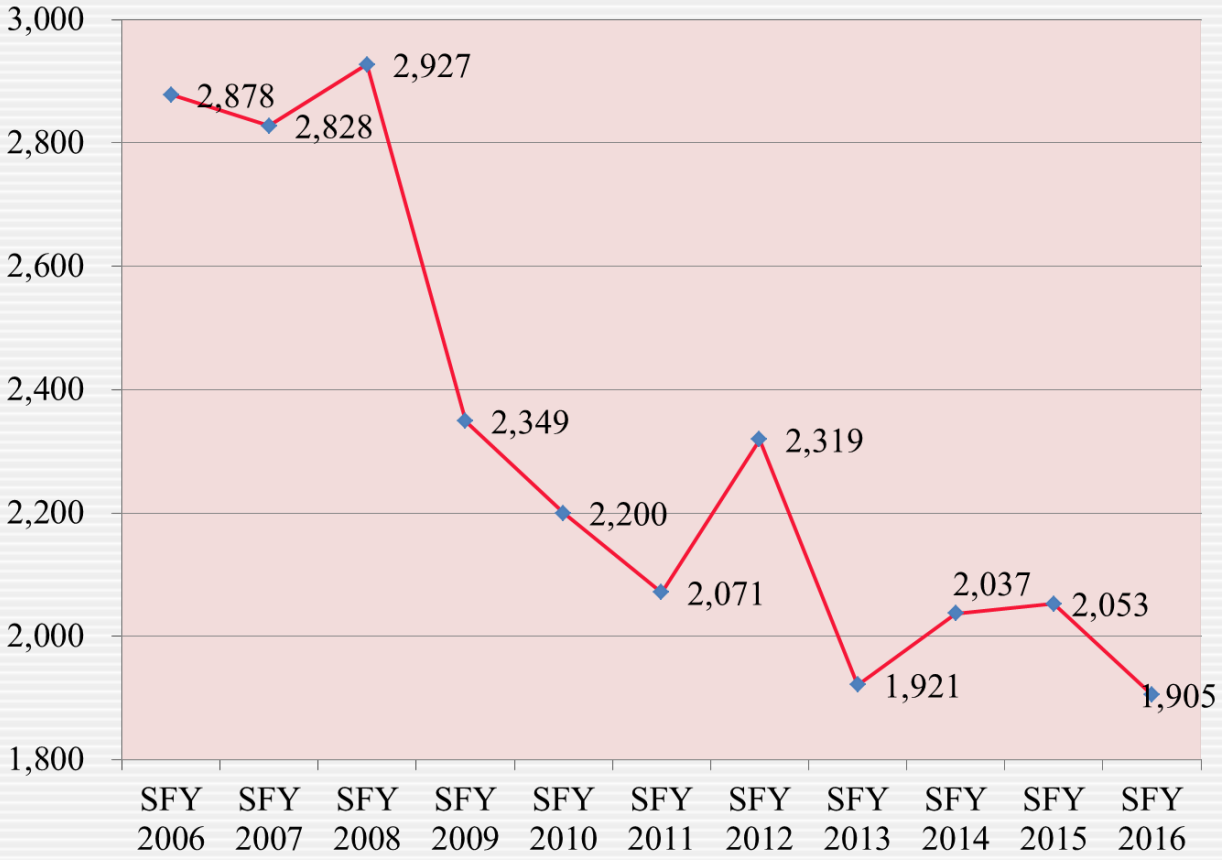


Figure 3: Total Average Census at NJ Regional State Psychiatric Hospitals (excl. AKFC): SFY 2006 - 2016

Figure 4: Proportion of Year End NJ Regional State Psychiatric Hospital Census on CEPP Status: SFY 2006 - 2016
(Excluding Ann Klein Forensic Center)

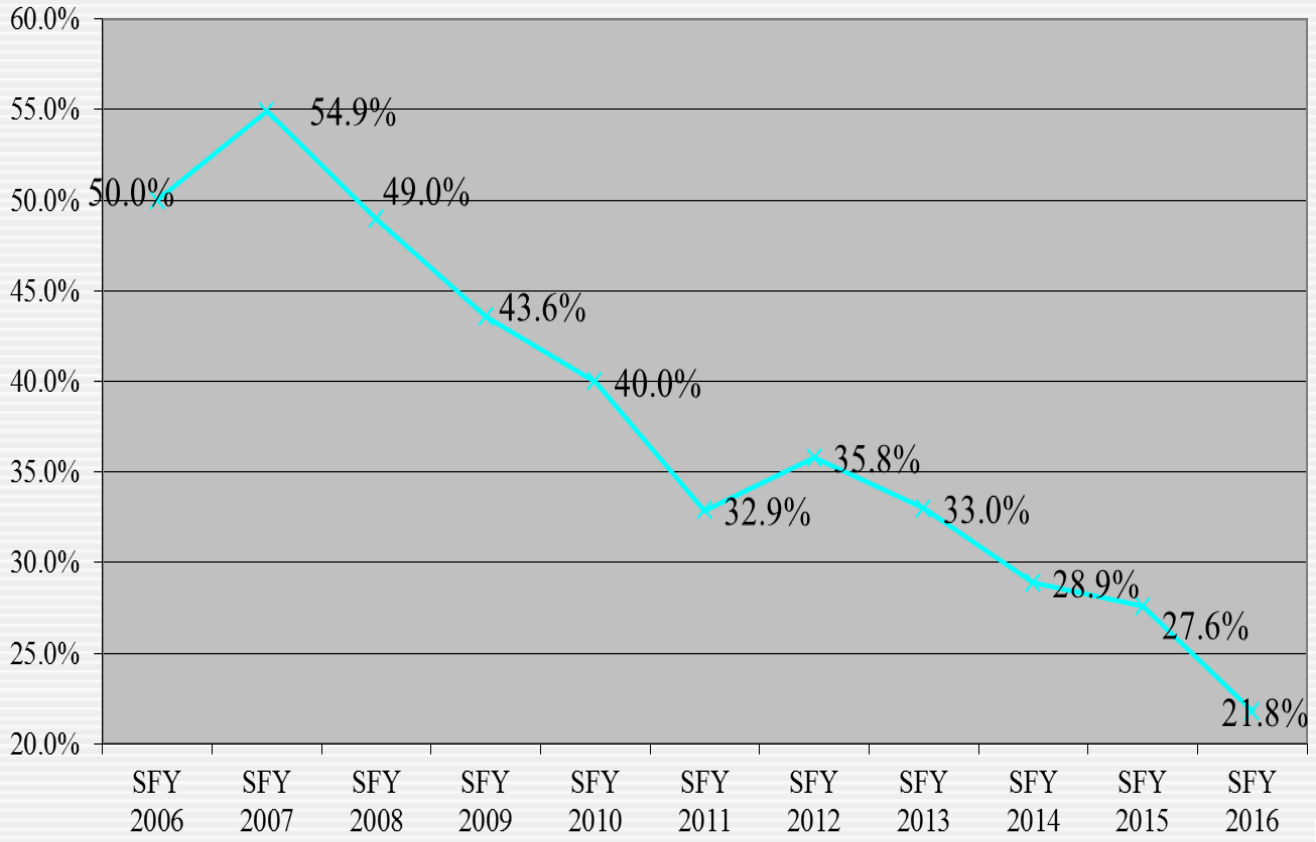
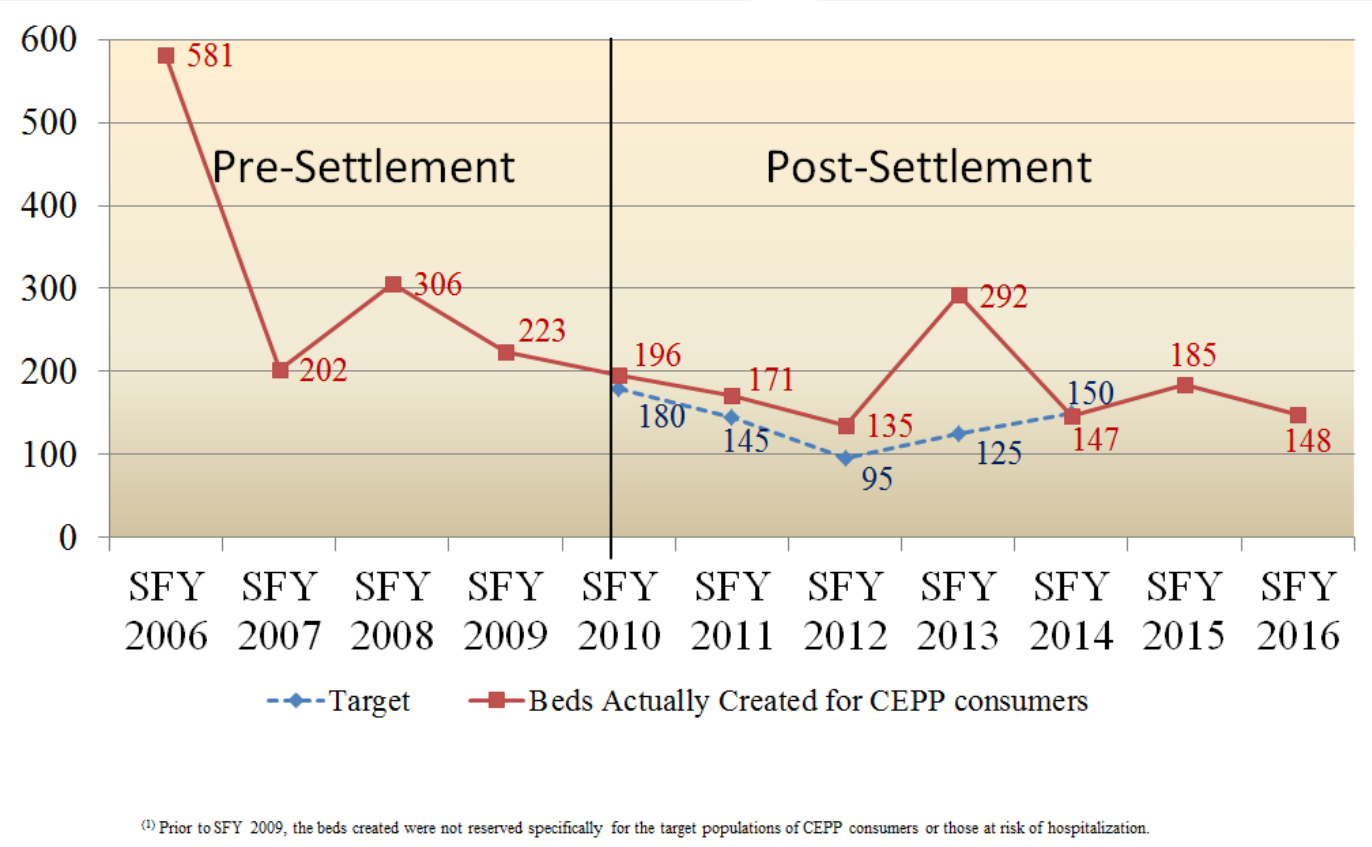


Figure 5: Supportive Housing (SH) Beds for CEPP Clients in the Regional State Psychiatric Hospitals: Targets vs. Beds Actually Created, SFY 2006 – 2016[1]



[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.

Figure 6: Supportive Housing (SH) Beds for At-Risk Populations: Targets vs. Beds Actually Created, SFY 2006 – 2016

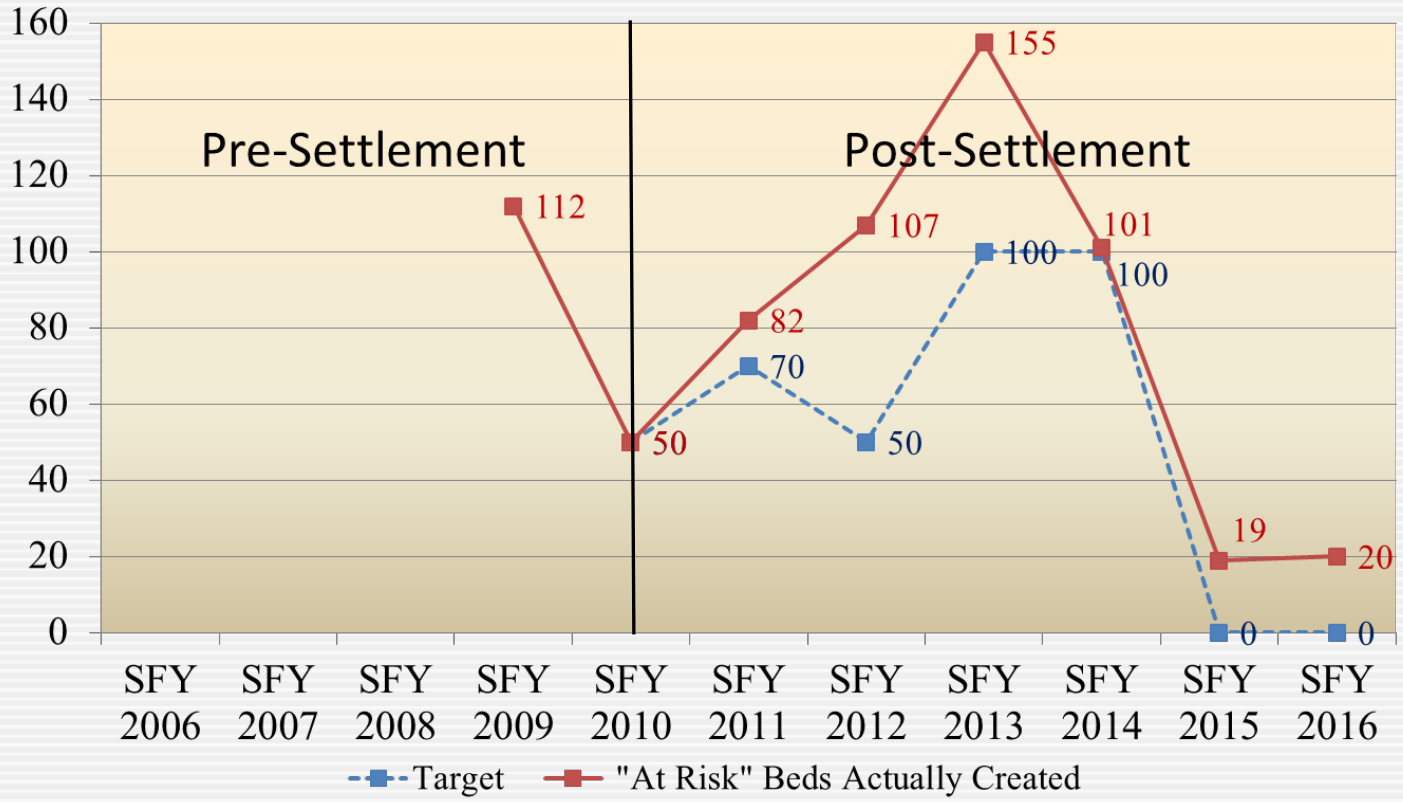


Figure 7: Clients Served by the SMHA in Supportive Housing (duplicated) SFY 2006 – SFY 2016

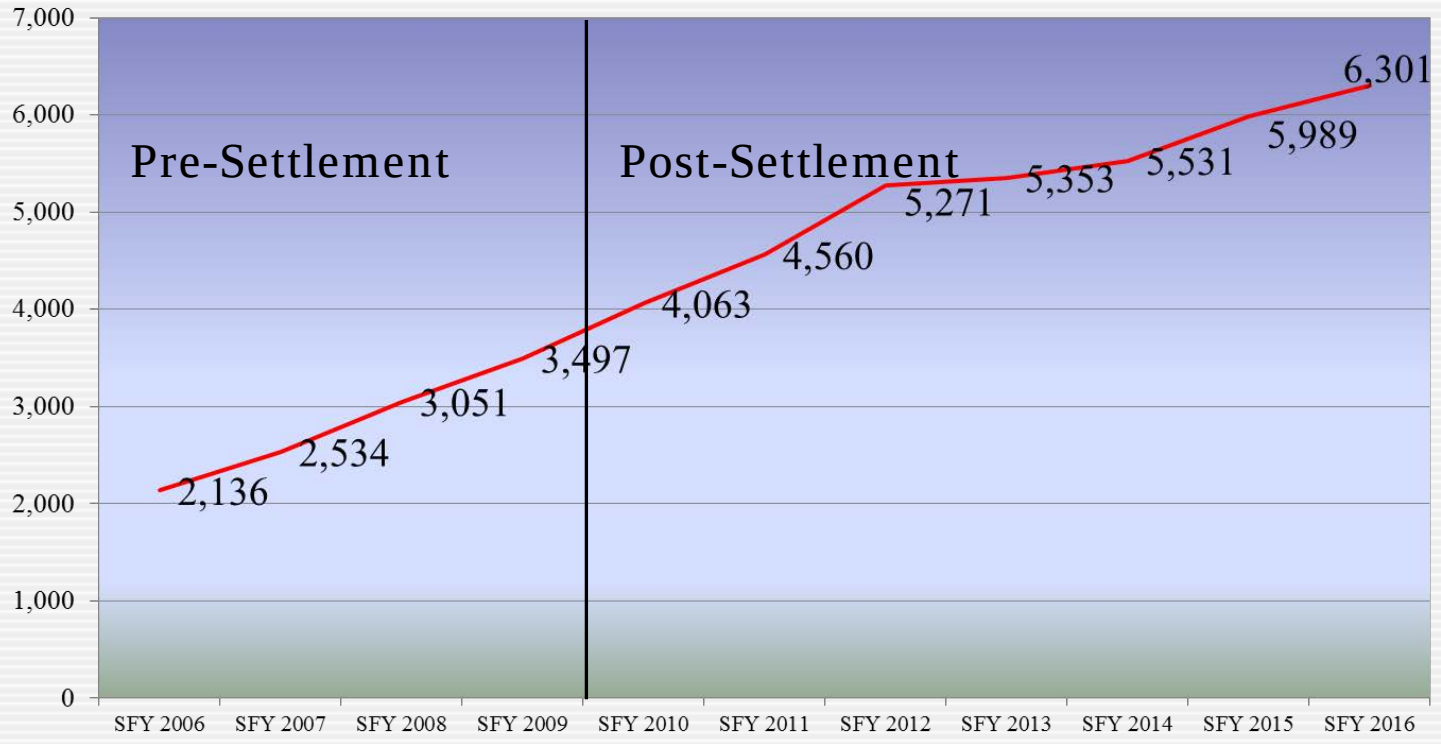


Figure 8: Percent of Discharges from NJ Regional State Psychiatric Hospitals (excl. AKFC) to Supportive Housing (SH): CEPP Population and All Populations, SFY 2010 – 2016

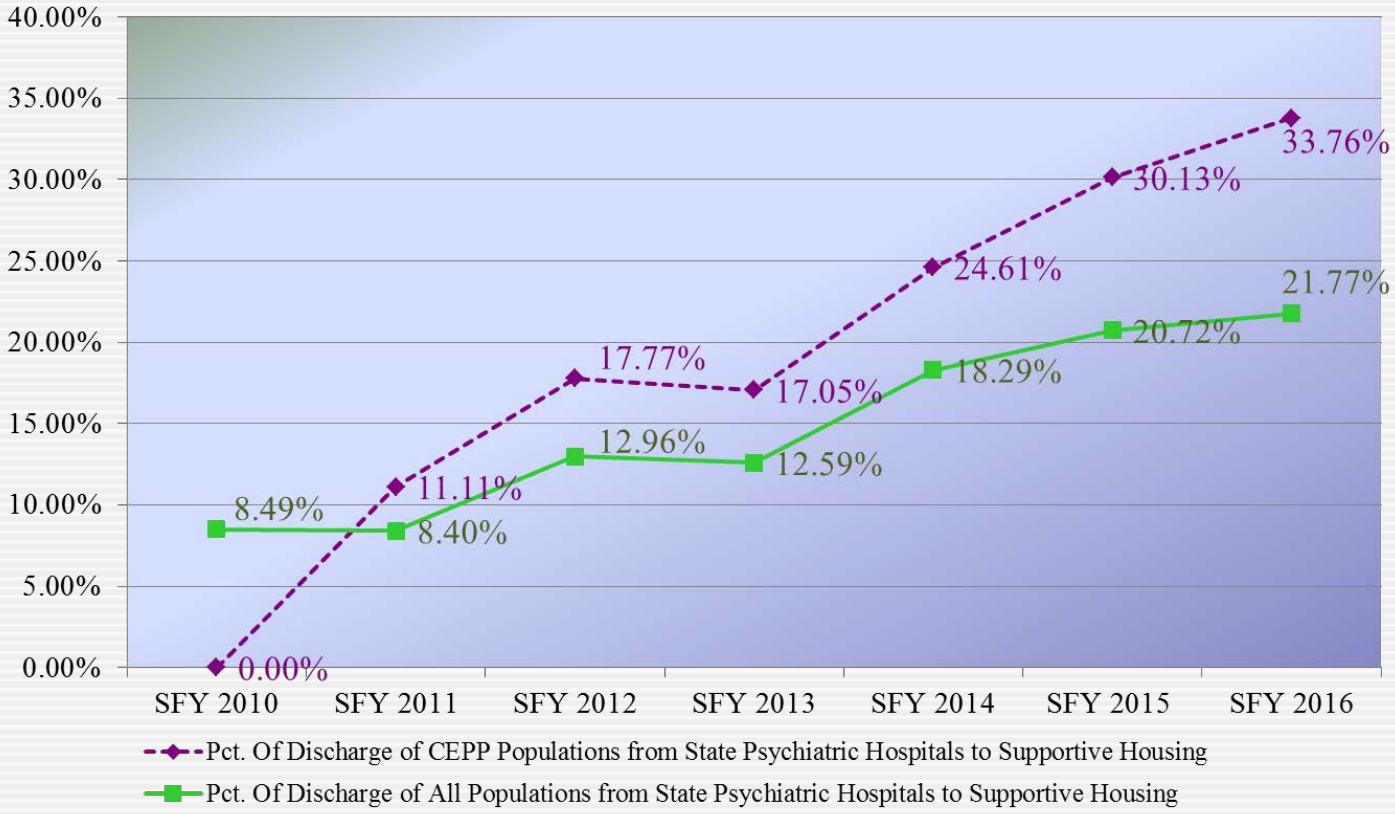


Figure 9: Clients Served by the SMHA in Supportive Housing (duplicated) and in the Regional State Hospitals SFY 2006 – SFY 2016

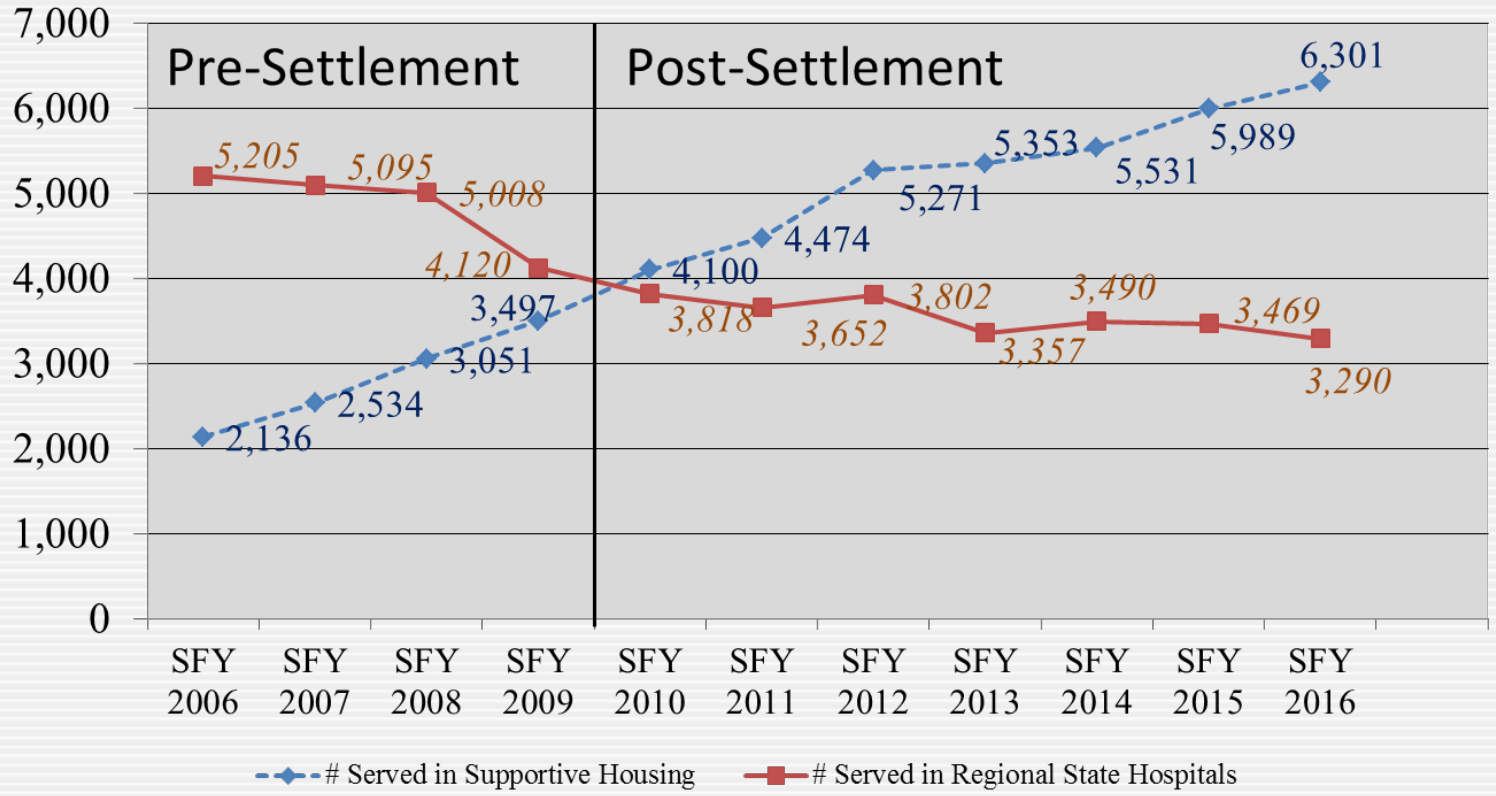


Figure 10: NJ Division of Mental Health and Addictions Services Cumulative Olmstead Appropriations: SFY 2006 - 2016

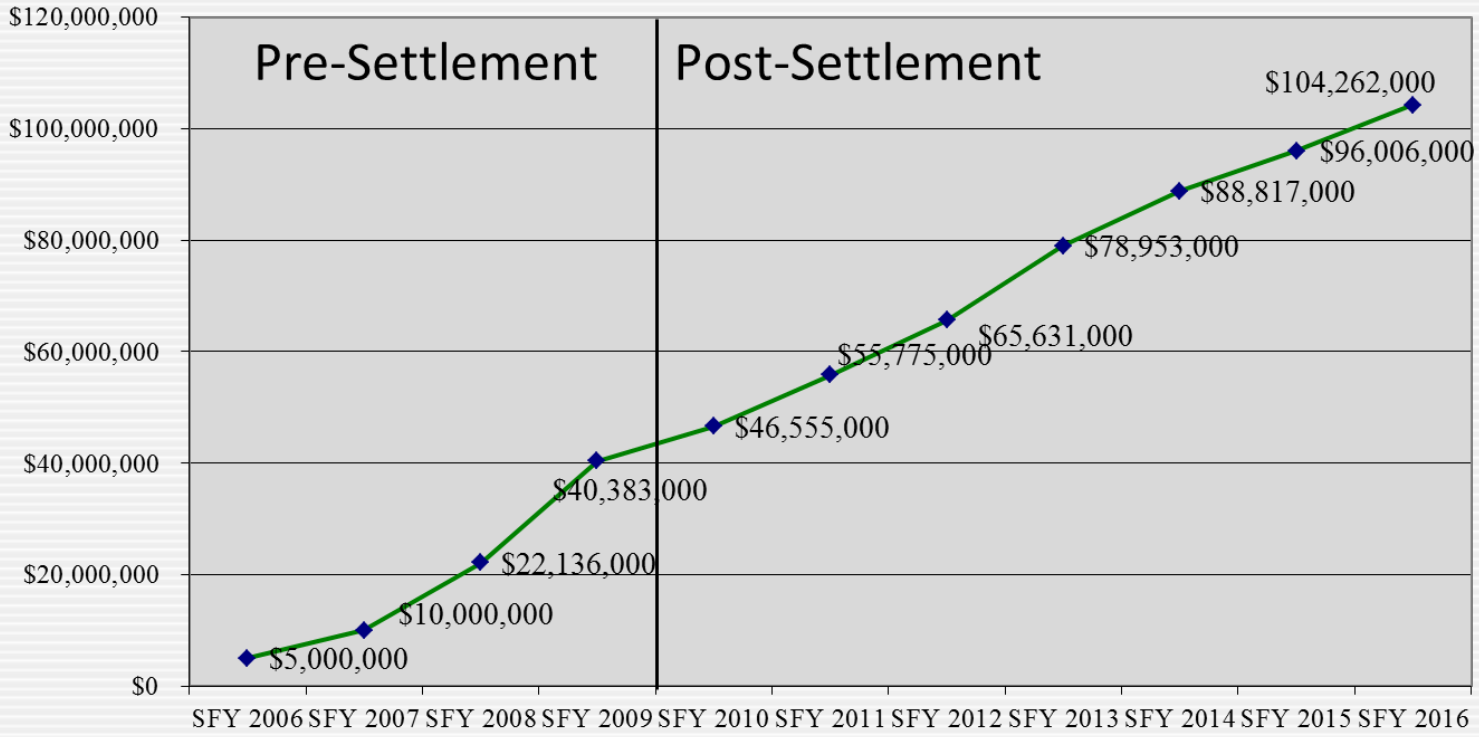


Figure 11: Pre and Post-Olmstead Summary Total Hospital and CEPP Census

Total Hospital vs. CEPP Census (Olmstead Report Data)				
	Total Hospital Census	CEPP Census	% CEPP	Pre-7/1/08 CEPP Census
Olmstead Settlement Data (extracted 7/10/2009)[1]	1,734	735	42%	297
SFY 2016 Report Data (extracted 7/12/2016)	1,364	297	22%	3

[1] The Olmstead Settlement Data, which was extracted on 7/10/2009, did not originally include a total hospital census count. This figure was calculated on 1/30/2017 for comparison to SFY 2016 hospital census via Oracle canned reports.

Figure 12: Pre and Post-Olmstead Summary CEPP Discharges

Top Three Placements of CEPP Discharges SFY 2011 vs. SFY 2016					
2011			2016		
Top Three Discharge Placements	Count	% of Total Discharges	Top Three Discharge Placements	Count	% of Total Discharges
Private Residence	464	37.9%	Supportive Housing	288	33.8%
Group Home	262	21.4%	Private Residence	210	24.6%
RHCF	165	13.5%	Group Home	143	16.8%

Figure 13: Pre and Post-Olmstead Summary Hospital Discharges

Top Three Placements of All Discharges SFY 2010 vs. SFY 2016

2010			2016		
Top Three Discharge Placements	**Count**	**% of Total Discharges**	**Top Three Discharge Placements**	**Count**	**% of Total Discharges**
Private Residence	947	44.2%	Private Residence	687	36.0%
Group Home	261	12.2%	Supportive Housing	415	21.8%
RHCF	186	8.7%	Group Home	230	12.1%

Boarding Home/RHCF Request Protocol

- In 2015, DMHAS implemented a new policy to ensure that congregate care settings such as boarding homes and residential health care facilities (RHCFs) are minimally utilized in favor of more integrated settings, such as Supportive Housing within the community.
- When a consumer requests discharge to a boarding home or RHCF:
  - DMHAS Olmstead 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 senior management directs exploration of the resulting option of the consumer's choice.
- DMHAS implemented a tracking system for all boarding home and RHCF requests, and will continue to monitor these requests to assure consumer preference is at the center of all such discharges.

Figure 14: Pre and Post-Olmstead Summary Boarding Home and RHCF Utilization

Discharges to Boarding Homes and RHCFs SFY 2010 vs. SFY 2016				
Type of Discharge Placement	SFY 2010	% of Total Discharges	SFY 2016	% of Total Discharges
Boarding Home	49	2.3%	17	0.9%
RHCF	186	8.7%	110	5.8%
Total	*235*	*11.0%*	*127*	*6.7%*

Figure 15: Pre and Post-Olmstead Summary Hospitalization vs. Supportive Housing

DMHAS Populations Served (2009 - 2016): State Hospitals vs. Supportive Housing

Population Served in:	SFY 2009		SFY 2016	
	Count	% of Total	Count	% of Total
State Hospitals	4,120	54.1%	3,290	34.3%
Supportive Housing	3,497	45.9%	6,301	65.7%
Total[(1)]	**7,617**	**100.0%**	**9,591**	**100.0%**

[(1)] Reflects only the total number of consumers served in state hospitals and supportive housing combined. Excludes all other settings (e.g. group homes, supervised apartments, etc.) in which consumers received DMHAS services during the fiscal year.

Figure 16: Pre and Post-Olmstead Summary Utilization of Community Services

Total Adults Served in Community Services SFY 2009 vs. SFY 2016		
Total Served in Community Services	SFY 2009	SFY 2016
	280,633	337,519

Patient Identification Documents

- In October 2014, DMHAS issued Administrative Bulletin 4:27 in response to delays in hospital discharges resulting from missing patient identification documents. Under AB 4:27, the process for alleviating IDs as a barrier to discharge is as follows:

- Upon admission to the hospital, all individuals will be asked about their available forms of identification;
- When it is determined that an individual does not possess the forms of identification that are required for discharge planning, the hospital will take the necessary steps to ensure that the documents are obtained in a timely manner;
- Upon obtaining patient consent the hospital will contact family members and/or significant others to confirm the existence of the original documents and retain copies of the documents; and
- The hospital will monitor compliance with this policy.

Figure 17: Pre and Post Olmstead Summary Birth Certificates for Discharge Readiness

Birth Certificates Collected during SFY 2009 vs. SFY 2016		
	SFY 2009	SFY 2016
Number of Birth Certificates Collected		493

Home to Recovery II Plan

- DMHAS's Home to Recovery II Plan (accessible here) was published in June 2017.
- In addition to the above, the Plan discusses such Division changes as:
  - DMHAS's transition to a fee-for-service model of collaboration with community providers
  - Adoption of Community Support Services (CSS) as an enhancement of Supportive Housing
  - Separation of Housing and Services
  - BEDS Community Vacancy Tracking System
  - Adoption of new assignment process for hospital discharges
  - Integration of Behavioral Health and Primary Care (Behavioral Health Homes)
  - Enhancements to the Supported Employment program

Home to Recovery II Outcomes

- Complete Medicaid applications within 30 days of determination of necessary level of care.
- Filled Peer Support Specialist positions in the state hospitals as a proportion of targeted positions.
- Expand Behavioral Health Homes in additional counties to serve consumers with Serious Mental Illness.
- Increase employment of consumers served by Community Support Services (CSS) providers
- Increase utilization of Supported Employment In-Reach slots available to state psychiatric hospitals.
- Housing Stability – Consumers who remain in supportive housing during the course of the fiscal year as a proportion of consumers served in Supportive Housing.

Home to Recovery II Outcomes

- Targeted expansion of Supportive Housing Bed Development (State Hospital Clients and At Risk Beds)
- Percent of CEPP Discharges from Regional NJ State Psychiatric Hospitals to Supportive Housing
- Percent of All Discharges from Regional NJ State Psychiatric Hospitals to Supportive Housing
- Percentage of Clients Served by the SMHA in Supportive Housing versus Clients Served by the SMHA in the Non-Forensic State Hospitals.
- Improved Utilization of Housing Service Slots: DMHAS will monitor occupancy rates via the new web-based vacancy tracking system.

Home to Recovery II Outcomes

- State Hospital Average Census
- State Hospital CEPP Census
- State Hospital Admissions
- Proportion of Year End State Hospital Census on CEPP Status
- Median State Hospital Length of Stay
- Maintain and reduce CEPP lengths of stay

Questions?

DONNA.MIGLIORINO@DHS.STATE.NJ.US

DOMENICA.NICOSIA@DHS.STATE.NJ.US