ACTION PLAN: RESPONSE TO EXECUTIVE ASSESSMENT OF NJ STATE PSYCHIATRIC HOSPITALS

August 22, 2018

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INTRODUCTION:

In late December 2017, the New Jersey Health Care Facilities Financing Authority (NJHCFFA or the Authority) engaged New Solutions, Inc. (NSI) to conduct a comprehensive analysis and make recommendations for the State's four adult Psychiatric Hospitals. Impetus for the engagement was in large part due to Governor Christie's Reorganization Plan 001- 2017, which took effect on August 28, 2017.

The intent of the analysis was to provide an assessment of the organizational and operational issues affecting each psychiatric hospital, and to provide recommendations to meet the challenges with the overall goals of achieving the most important objective: improving the quality of patient care delivered to service recipients. The scope of the engagement included: review of the current inventory of services, human resources and staffing assessments, clinical issues, operations issues, governance and administration functions, finance, and physical plant issues.

The Department of Health (DOH) is currently charged with the responsibility and oversight of the administration of the State Psychiatric Hospitals. As such, the Department and the administration have not waited for the results of the assessment before beginning improvement efforts, which began in January of 2018, at the outset of the Murphy administration. The Department of Health hired a Deputy Commissioner with extensive experience and expertise in hospital operations and behavioral health services, addressed Joint Commission recommendations related to seclusion and restraint, continued efforts to manage the census levels at all facilities, pursued implementation of a Human Resources Information System (HRIS) system in order to achieve better staffing and human resources management, and planned for the development of an electronic health record, which will facilitate evidence-based, efficient care provision.

The findings of New Solutions, when taken in the aggregate, present a picture of a hospital system that has been under-resourced, understaffed, and otherwise afflicted with a culture that has not prioritized the system's role in achieving patient-centered clinical care delivery. Broadly, these shortcomings are not due to a lack of investment or skillset from front-line clinicians; nor are they due to leadership shortcomings in the division. Rather, they are rooted in systems of care that are in significant need of quality improvement, which have resulted from underinvestment in key areas of clinical quality (most notably, appropriate staffing levels), or have not benefited from the expertise or management attention needed to keep pace with high-performing inpatient psychiatric services.

Therefore, DOH has launched a turnaround effort to achieve rapid quality improvement in the clinical care delivered across all of the state psychiatric hospitals. This will require the full attention of executive teams at each hospital, as well as significant, direct management from the Deputy Commissioner for Integrated Health, who brings a strong background of operations management and quality improvement in other behavioral health facilities across New Jersey, for an estimated 18 months of dedicated improvement efforts. In addition, the Commissioner of Health offers direct experience in health care quality, patient safety, and improvement of troubled government hospitals at the Department of Veterans Affairs, and will continue to bring this experience to bear in improving care that these hospitals provide.

The single, most important goal for the psychiatric hospitals is to bring their systems of care to a level that will allow an adequately staffed clinical workforce to achieve care delivery that service recipients deserve. As such, DOH will focus its efforts on mitigating the findings and recommendations that either directly speak to lapses in clinical care, or most directly relate to staffing, management, governance, and infrastructure changes that will be needed to improve care delivery.

SUMMARY OF FINDINGS

OVERVIEW

New Solutions identifies numerous opportunities to improve performance or efficiency of the four psychiatric hospitals including but not limited to the following areas:

- Human Resources and Staffing
- Clinical Issues
- Operations Issues
- Governance and Administrative Functions
- Finance
- Physical Plant Issues

PRIORITY AREAS

The Department determined that findings in the following categories need to be prioritized for mitigation, given the more direct relationship between said findings and clinical outcomes:

1. **Clinical Issues**
2. **Governance and Administrative Functions (specifically, structures and functions around *clinical and medical* governance)**
3. **Physical Plant Issues**

Justification around these specific areas of focus are outlined below.

CLINICAL ISSUES

It is imperative that patients receive clinical care that reflects the latest evidence and clinical best practices in behavioral healthcare. Consistent adherence to the most up-to-date practice standards, while maximizing interface time between clinicians and service recipients, speaks to the most important priority of enhancing clinical outcomes and ensuring safe transitions of care to community settings. Efforts to ensure clinical best practices are followed, and that patients receive the appropriate attention and care from all clinicians, will be prioritized.

GOVERNANCE AND ADMINISTRATIVE FUNCTIONS

As is the case across health care institutions, medical staff are self-governed by a body of responsible, well-trained clinicians. Effective clinical governance provides important assurance that practice follows standards of care across the hospital, irrespective of the practitioner. Clinical peer review, ongoing professional practice evaluation, and decisions around notifications of state licensing boards or the national practitioner databank in cases of notable deviations from practice standards all require effective clinical governance structures and objective decision-making processes. In addition, management structures that ensure accountability are particularly imperative in hospitals: for example, failure to follow clinical directives (i.e., physician orders) can compromise the health of patients. Therefore, the Department will focus intently on this category of findings upfront.

PHYSICAL PLANT ISSUES

The infrastructure surrounding patients comprise the environment of care. Much literature highlights the direct importance of physical plant issues in ensuring the safety of patients, particularly in inpatient mental health settings. Indeed, mental health environment of care literature directly associates environments that minimize ligature (points of physical contact off of which a patient can endanger themselves) risks and reduced suicide rates. Therefore, findings related to physical plant and infrastructure issues, especially those that implicate ligature risks and other patient safety hazards, will be prioritized for mitigation.

New Solutions evaluated the environment of care at each of the four psychiatric facilities and prioritized recommendations on impact to patient risk grouped into Short Term and Long-Term goals. Because ligature and other environmental risks can be mitigated with shorter term, targeted projects, the Department will focus on the short-term actions that will eliminate such risks for service recipients expeditiously. The feasibility of addressing the longer-term projects will be evaluated concurrently with targeted decisions at a later date, as they do not pose immediate risks to patients and are not immediately feasible from a budget standpoint.

A thoughtful and careful analysis on our part is required to determine how best to approach addressing the findings and recommendations that are outlined by New Solutions. This analysis must include the administrative and medical leadership at the psychiatric facilities along with the Office of State Hospital Management. Improving the performance and efficiency of the hospitals will require a focused and concerted effort by a team of people over 12 - 18 months in order to bring all four psychiatric hospitals to a strong level of performance.

ASSESSMENT LIMITATIONS

New Solutions supported much of its recommendations with anecdotal reports, inconsistent data sources and paper medical record review. Information was not mined from other states on the topic of violent episodes, inpatient suicide rates, or other metrics that reflect hospital quality for direct comparison and benchmarking. Nevertheless, from a global/macro level, one can support and concur with most recommendations within the context of building a high-performing, integrated delivery system. In addition, New Solutions does not rate findings by severity or direct attention to priority areas for improvement (the Joint Commission, as an example, now has a heat-map system to direct the attention of facility management to findings to those that are most severe and most prevalent, ultimately highlighting those that pose the most risk to patients). Finally, New Solutions did not consider reasonable resource constraints in some of its recommendations to address key areas (e.g. infrastructure), again requiring the Department to do the work of prioritizing those that most directly relate to patient safety and care delivery quality.

The Department does recognize that anecdotal observations of the care environment can be valuable contextual information on hospital quality, and that surveying agencies often make accreditation decisions and quality ratings on such findings.

APPROACH TO IMPROVEMENT EFFORTS

The New Jersey Department of Health concurs with the proposed vision for the state psychiatric hospitals:

The New Jersey State Department of Health will operate a high quality, patient-focused system of inpatient psychiatric hospitals dedicated to the mission of wellness and recovery, and will be recognized as a leader among publicly operated psychiatric hospitals.

Remedying the issues identified by New Solutions requires more than just funding. It requires a re-emphasis of crucial principles in how state hospital management teams view their mission of wellness and recovery. This approach will continue to require the full attention of management teams across the state hospitals with instituting evidence-based clinical protocols, supporting high-functioning and objective clinical governance structures, and removing patient safety hazards from existing infrastructure. It will also require an intense focus on employee engagement to ensure that changes are adopted rapidly and thoroughly.

The Department's first step is to establish strategic goals:

- To manage and operate the four Psychiatric Hospitals as a Hospital System that is clinically and operationally integrated with standardization of policies, procedures, protocols and best practices;
- To consistently provide high quality Mental Health and Substance Use treatment services that are integrated, patient focused, evidence based and in support of our patients and family's needs;
- To encourage and support innovation in care delivery and patient care management;
- To develop a pragmatic, multi-faceted system-wide approach to reduce violence;
- To function as a strong, collaborative partner in the continuum of inpatient and outpatient Behavioral Health Services and community support services that are essential to the reintegration of our patients into the community;
- To offer a rewarding and professional working environment to recruit and retain healthcare providers, staff and management; and
- To improve efficiency and productivity through technology and a data driven approach to patient care.

PSYCHIATRIC HOSPITAL TURNAROUND ACCOMPLISHMENTS UNDER THE MURPHY ADMINISTRATION

SYSTEM WIDE ACCOMPLISHMENTS

- Across the hospital system, there has been an 11% reduction in violent patient assaults—or 138 fewer incidents—in the first quarter of this year vs. the first quarter of last year;
- The census at the four hospitals has declined 3.8% from 1500 in January 2018 to 1453 last month; and
- Restraint usage at all four hospitals is below the national average.

ANCORA PSYCHIATRIC HOSPITAL

APH Significant Accomplishments in 2018 include:

ADVANCEMENT OF APH'S CLINICAL ANALYTIC CAPABILITIES AND COMPETENCY IN CLINICAL DATA MANAGEMENT TO DRIVE EFFECTIVE, TIMELY, AND EFFICIENT DEPLOYMENT OF HOSPITAL EXPERTS AND RESOURCES

APH is developing a data analysis plan that guides program development and evaluation processes. A newly hired data analyst has begun producing point in time outcome measures, calculations to derive scores, and other metrics that are being used to evaluate the attainment of program and project aims. APH has created models that enable treatment teams to gather pretreatment information on target behaviors (baseline measures / dependent variable) in order to be able measure not only a change but the degree of change throughout the process of treatment. Early identification of patients who are struggling will allow APH leadership to more quickly and effectively deploy specialized clinical support.

Currently, APH is able to create metrics that track patient progress while on their current treating unit; length of time spent on that unit; date/time/shift a target behavior (maladaptive behavior) has been exhibited; type and number of target behaviors exhibited, and whether the patient is currently trending better or worse compared to their baseline, as defined by treatment team. APH is now able to evaluate if the implementation of an evidenced based program (i.e. Dialectical Behavior Therapy) is being implemented effectively.

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)

The ASAM Program was designed to produce a clearer clinical picture of the needs in relation to treatment of substance use disorders according to ASAM criteria so that clients can receive the appropriate services according to his/her needs. The ASAM program helped clients achieve specific objectives as they work towards their treatment goals while at the same time providing a Client Centered approach. The new

process helps clients to identify where they are in recovery along with learning new skills to help prevent relapse.

CHAIN ANALYSIS OF BEHAVIOR

Starting in May 2018, all patients who have been restrained are assessed for Antecedent/Behavior/Consequence (Chain Analysis) by their unit psychologist. The information gleaned from these analyses is used to inform the treatment team about the behavior that lead up to the restraint incident. Treatment Plans (TPs) are often updated based on this information. Current treatments are improved and new one(s) applied to help the patient develop more adaptive skills/responses to the triggering stimulus (event).

CORE GROUPS

Core Groups is a nursing care delivery model that focuses on the improvement of patient engagement on the unit. Initial implementation was in July 2018 in Holly Hall. Data is being collected and will be analyzed in order to assess the effectiveness of the program.

NURSING CARE ENGAGEMENT DELIVERY CARE MODEL (ZONAL)

Nursing initiated a nursing care and engagement care delivery model that monitors and provides therapeutic interventions for patients associated with high risk behavioral patterns by engaging in activities to reduce aggression toward self/others and maintain safety. The initial implementation was in April 2018 to address the high acuity patients. Success with this program includes improvement in patient engagement that has resulted in significant reduction on the use of 1:1 precautions to almost no precautions.

The most recent data from the period July 1, 2018 to July 23, 2018 in Cedar Hall reveals that there were a total of 80 incidents of falls, assaults, and restraints as compared to 185 for the same time period in June. Because of the success of this Nursing Care Engagement Delivery Model, the plan is to expand the principals on the geriatric units targeted for September 2018.

NURSING SIMULATION LAB

On July 10, 2018 the Nursing Simulation Laboratory opened. The lab includes both psychiatric and medical modules and is designed to give employees hands-on clinical experience to practice skills needed to manage complex high-acuity patients, providing drills for emergency preparedness, build and encourage interdisciplinary collaboration.

On July 11, 2018, Ancora Psychiatric Hospital started Nurse Education Day (NED) with our Human Service Assistants/Technician throughout the hospital. Every Wednesday morning, 10 to 15 staff will receive training on different topics, such as: ABCs of Behavior, Symptoms of a Deteriorating Patient, Trauma Informed Care (TIC), Illness Management and Recovery (IMR), etc. In the afternoon session, staff will experience a live psychiatric simulation which will require hands-on interventions to deescalate a patient without the use of restraints or medication.

The first data gathered for nursing education training in the Simulation Lab reveals the pre-test score was 16% and the post-test score was 91%, resulting in an 84% improvement after the training session. The data suggests that with the appropriate training, the nursing skill set will improve to achieve clinical excellence.

PROGRAM DEVELOPMENT IN APPLYING THE EMOTION REGULATION SKILLS SYSTEM FOR COGNITIVELY CHALLENGED CLIENTS

APH began implementation of the Emotion Regulation Skills System for Cognitively Challenged Patients. Testing the application of this approach with APH patients has begun. Next steps are for a full implementation on APH dually diagnosed and most acute female IDMI unit (Intellectual Disability (*Intellectual Developmental Disorder*) / Mentally Ill). Bimonthly case consultations and service

implementation guidance will be provided over the next 12 months. The goal in creating the Skills System is to use a DBT-based framework that helps people experience a dialectical synthesis (the ability to be in pain AND be effective at the same time) versus polarization during emotional, cognitive, behavioral, relationship, and self-processes in complex life contexts.

RECOVERY LIBRARY

Recovery Library is a Pat Deegan & Associates, LLC production. It is made for people in recovery by people in recovery. The program was created for individuals pursuing their own wellness and recovery and the people who support them in their journey. Recovery Library provides the practical tools that help practitioners and peer supporters integrate health, behavioral health, and recovery-oriented practice in their daily work. Six groups have been developed and 29 staff members have been certified in Recovery Library.

ROLE PLAY GROUP PROJECT

Role Play trainings for the Rehabilitation staff were created to help staff practice and refine skills used with patients in social skills groups. Real-life examples are used to simulate behaviors on the unit with appropriate interactions on the part of staff being emphasized. Benefits of the training are expected to be noted in the next Treatment Mall Evaluation which is being scheduled to take place within the next year.

SAFEWARDS

In May 2018, Rutgers staff began training Managers/Supervisors/ADON's Building Administrators/ Discipline Heads in using Trauma Informed Care principles and six core strategies. The Safewards model reinforces the need for individuals to feel safe, hopeful, connected and valued, a recognition of the connection between trauma and mental illness, and the need for staff to work in a caring, mindful and empowering way to promote individual autonomy. The Six Core Strategies include leadership involvement, data Collection/Utilization, staff Development, integrated use of S/R Prevention Tools, consumer involvement, and de-briefing. Implementation meetings are planned in August with a targeted implementation date of October 1st, 2018.

SUICIDE RISK ASSESSMENT (SURA)

The SuRA is to identify, analyze and either mitigate or eliminate environmental risks for inpatient suicide and suicide attempts, to heighten the clinical staff's awareness of environmental hazards, and focus specific attention on psychiatric unit safety, above and beyond the routine inspections made for facility safety. In reporting the hospital's progress with anti-ligature completion, the hospital increased by 17%, from January 1st at 57% to July 1st at 74%.

TRAUMA ADDICTIONS MENTAL HEALTH AND RECOVERY TREATMENT (TAMAR)

The 2017 Psychiatric Inpatient version of Trauma Addictions Mental Health and Recovery Treatment (TAMAR) was adapted specifically for the psychiatric inpatient population and modified with Rutgers, Department of Psychiatric Rehabilitation and Counseling Professions. The Addiction Services Department has successfully completed four cycles of the TAMAR groups in each treatment mall with approximately 60 patients completing the program to date.

TRAUMA INFORMED CARE APPROACH

As part of implementation of the SAMSHA Trauma Informed Care approach, in 2018, the hospital expanded the trauma informed training to the Charge Nurses and Rehabilitation Staff. The primary purpose is to promote awareness of universal precautions for trauma by being sensitive to trauma needs for all, by demonstrating safety first, empowering others, thinking before talking, assisting in identifying coping skills, increasing trauma awareness, validating others, and empathizing with others.

TREATMENT PLAN IMPROVEMENT INITIATIVES

Hospital leadership recognized the need to focus on enhancing the skills of our treatment teams in order to improve the quality of care. The areas of improvement included improved communication and the use of a tool to better communicate about patient behavior; decrease the rate of incidents; provide patients with skills to better manage their own behavior; and ease of documentation for staff.

WORKFORCE DEVELOPMENT

The hospital leadership recognized that in order to achieve clinical excellence, using QI tools is essential to improving patient care, safety and clinical outcomes. In the spring of 2018, the Quality Assurance & Nursing PI staff began working on obtaining their yellow belt in Lean Six Sigma. The goal is to increase their skills levels in creating dashboards with leading and lagging indicators to measure the effectiveness of evidence-based-practice programs and identifying high risk behaviors/patient care issues in need of improvement.

ANN KLEIN FORENSIC CENTER

Ann Klein Forensic Center (AKFC) was cited by The Joint Commission (TJC) during a visit in December of 2017 for multiple findings in quality of care and patient safety. At the outset of the Murphy administration, the Department of Health immediately began a comprehensive improvement effort in the care delivery system across clinical delivery, governance, and patients' environment of care. In July of 2018, AKFC was granted full accreditation status from the Joint Commission, and all of the original findings were considered resolved. These accomplishments are outlined below, and serve as a model for the improvement approach across the remaining 3 psychiatric hospitals. The Joint Commission survey staff also encouraged the Department of Health to contribute this experience as a case study in medical literature for rapid and effective turnaround of the environment of care to improve safety in psychiatric hospitals.

ELIMINATING ADMINISTRATIVE SECLUSION FOR PATIENTS

Locking patients in their rooms for operational and administrative reasons. Minimally, these lock-ins occurred three times during the day, 11 am – 12:30 pm (first shift), 4:00 pm – 5:30 pm (second shift) and 9:00 pm – 6:30 am (third shift). In addition to the previously referenced timeframes units would administratively lock patients in their rooms during other times of the day, particularly when they were short-staffed. TJC asserted that anytime a patient is locked in their rooms and cannot freely leave, it is considered seclusion.

TJC standard requires seclusion to be driven by a patient's medical need, with ongoing assessments to determine need for continued seclusion. In addition, each seclusion episode must include documentation that articulates the criteria for seclusion to be terminated. Due to the population at AKFC (60% are have a detainer and are correctional inmates placed for psychiatric stabilization, are placed for determination of competency to stand trial, are receiving treatment to restore competency or have served their full prison sentence but require psychiatric inpatient treatment). In order to meet TJC standards and eliminate use of administrative lock-ins AKFC needed to hire 90 staff (70 Medical Service Officers (MSO) for coverage of units, 12 MSO staff to establish a team to provide training and coaching to staff on de-escalation techniques and therapeutic interventions when there is a need to physically intervene in a crisis intervention, 1 FTE MSO Supervisor and 7 FTE Charge Nurses) to meet the need.

In less than six months since the administration began, all units have eliminated administrative lock-ins on all shifts, as of June 25, 2018. In order to achieve this, and to improve care delivery in other areas, the hospital has done the following:

- New Jersey Division of Mental Health and Addiction Services (DMHAS) staff and the Ann Klein Forensic Center Chief Executive Officer (CEO) met with all applicable unions to introduce the plan to eliminate the practice of Administrative Lock-in on March 27, 2018. The Chief Executive Officer and his Executive Staff conducted open dialogue town hall meetings with staff on all shifts on March 28, 2018. The Medical

Director has reviewed and revised the Seclusion policy to be in alignment with Joint Commission standards and the DMHAS Administrative Bulletin. The policy was presented at the Institutional Executive Committee Meeting and signed by the Chief Executive Officer on March 7, 2018. Union members and leadership have been key partners ever since.

- Communication to Patients – Community meetings with patients to discuss changes in security and solicit their input occurred between March 29, 2018 and April 2, 2018.
- Communication with Families – The Department of Social Services completed coordination of informing families and significant others of the changes and solicit their feedback on April 6, 2018.
- The Training Director and clinical leadership developed and coordinated the implementation of new employee orientation around the new seclusion policy and the elimination of administrative on April 9, 2018.
- Department Heads provided training to current staff on March 28 & 29, 2018.
- The CEO chairs a weekly Steering Committee with all level of staff, and the team has completed a full FMEA (Failure Mode Effects Analysis) on opening the doors. Twenty-two staff actively participated to develop the hospital's implementation plan. Several initiatives have been piloted as a result of this, including changes with team rounds and medication administration on highly acute units.
- All 82 FTE Medical Security Officers (MSO) of the 82 new FT positions are now filled, 59.5 FTE MSOs out of the 82 FTEs are working on the units.

IMPROVING THE ENVIRONMENT OF CARE BY ELIMINATING LIGATURE (SUICIDE BY HANGING) RISK

- Ligature Resistant Beds: Installation of 197 ligature resistant beds was completed by 5/15/18, two patient rooms have medical hospital beds installed, and the bed in the last room was transitioned to a ligature-resistant bed (completed 6/25/18).
- Ligature Resistant Stools: By 2/7/18 all ligature risk stools were cut/removed from 150 patient rooms. The installation of 150 ligature resistant stools commenced on 4/25/18 and was completed on 5/4/18.
- Shave Sink Exposed Plumbing and Faucets: By 2/28/18 all exposed sink plumbing had protective covers installed, and faucets were replaced with ligature resistant models.
- Staff Telephone in Patient Care Areas: By 2/9/18 all wall mounted staff phones located on the patient living units were replaced with ligature resistant wall mounted phones. In addition, wall mounted staff phones located in the Rehabilitation Treatment Mall were replaced with the ligature resistant model as well.
- Courtyard Interior Door Handles: By 2/26/18 the Courtyard interior door handles were replaced with ligature resistant door handles.
- Ceiling Mounted Electrical Raceways in Courtyard Foyers: By 1/9/18 the ceiling mounted electrical raceways were resealed in all patient living units, removing ligature risk.
- Unsecured Cords in Rehabilitation Treatment Mall: As of 5/15/18 all loose or hanging cords in the classrooms were secured and covered with protective conduit.

OTHER TANGIBLE IMPROVEMENTS IN PATIENT SAFETY AND SUPERVISION

- Medical Security Supervisors are completing the 1:1 Observation and Seclusion Monitoring Log, and monitor at least 15 patients on 1:1 Observation and Seclusion Monitoring per week on all three shifts (started on 1/26/18). This is also a PI indicator and is monitored by Senior Leadership.
- Administrative rounds started 1/28/18 by Executive Staff to ensure Treatment Team members and Nurses are visible on the unit and clinically monitoring patients and providing clinical direction to Medical Security staff.
- Executive staff began using an Administrative Round Checklist starting 2/5/18. May 2018 compliance rate is at 100% with level of observation.
- Immediate retraining and counseling is provided to staff that are noncompliant. Ongoing non-compliance of policy will be addressed through corrective/disciplinary action.

- The HR and Training Department worked with Medical Security Leadership to add these requirements to the Orientation Checklists and incorporated into the New Employee Orientation and Annual Life Safety training in January 2018.
- Reiteration of Policy was reviewed and explained in Town Hall Meetings held on 1/30/18 on all three shifts and during individual unit meetings.
- Other improvements include making sure that appropriate labels with expiration dates are in place for all medications and having a pharmacist review 100 percent of patient charts monthly to ensure that allergies and adverse drug reactions are clearly separated and listed.

PROGRESS IN REDUCING PATIENT RESTRAINTS

- Total Seclusion and Restraint (S&R) Hours have steadily declined since January 2018. April 2018 numbers are 40% lower than December 2017, and each month shows a 10-15% decrease. This is attributed to increase monitoring and clinical oversight.
- New seclusion and report monitoring forms were implemented in the last week in March 2018 and all Nursing and Medical staff received training. The new procedure requires that the Register Nurse increase monitoring and assessment of patients in seclusion and restraint from once per hour to every 30 minutes and the assignment of a 1:1 Medical Security Officer. The new forms document the clinical condition in real-time, and includes clear release criteria. Supervisors of Nursing and Medical Security Supervisors conduct rounds twice per shift to review the compliance with the process and procedure. A shift report is sent to Department Head and the CEO about the compliance rate.
- Beginning 5/14/18, QI staff were reassigned and trained to conduct S&R documentation and process monitoring. The two staff assigned looked at post S&R and real-time documentation. Reports are being aggregated and followed up on; however, immediate retraining and support were offered. The QI staff are meeting with the Director of QI and CEO to review the findings each week.

New procedure changes were implemented that increase staff checks of patients who are high-risk, which include MSOs documenting on the Ward Count and Patient Status sheets that patients are safe through direct observation. The Administrator of Medical Security and Director of Medical Security collaborated with the Director of Nursing and revised hospital policies to include the new Q15 Minute Check Procedure. The HR and Training Department worked with Medical Security Leadership to add these requirements to the Orientation Checklists and incorporate into the New Employee Orientation and Annual Life Safety Training. These new procedures were also explained during Town Hall Meetings with all staff on 1/30/18.

ENSURING THAT ADMINISTRATIVE ROUNDS OCCUR FREQUENTLY AND RELIABLY IN ORDER TO ENHANCE VIGILANT DETECTION OF, AND RESPONSE TO, LAPSES IN CARE

- Executive Staff began increasing off shift rounds in May 2018. Administrators On-Call need to make one off-shift tour per week. Rounds logs demonstrate a 100% compliance for May.
- The CEO, Administrator of Medical Security and Director make rounds during each unit on the day the administrative lock-in is eliminated opening and have reviewed staff compliance with S&R procedures, 1:1 Observations and presence of the nurse on the units.

ENSURING CLINICAL NURSING PRESENCE AND ATTENTION TO PATIENT NEEDS

- Nurses are now required to be in the Unit Center, Medication Room or on the Floor with patients and out of the team room. This requirement has been reinforced during Administrative Rounds and Staff Meetings.

ENSURING TIMELY ACCESS TO INPATIENT CARE FOR THOSE WHO NEED IT MOST

AKFC had had a significant waiting list of inmates waiting to be admitted for competency and sanity evaluations. This list was as long as 40-60 patients, at times. Actions taken include:

- Data was analyzed for the number of evaluations per psychologist and steps taken to shorten the time to complete the evaluations. AKFC's census had always been at 200 with a waiting list.

- This year, the census has dropped to 198 and the waiting list has been eliminated.

REDUCING PATIENT-TO-PATIENT ASSAULT RATES

In January and February of 2018, several patient-to-patient episodes of assault occurred that rattled both patients and staff. As a result of comprehensive improvements in staffing, security, and the environment of care, Ann Klein Forensic Center now has the lowest assault rate out of all the psychiatric hospitals, despite the higher-acuity patient population that the facility serves.

GREYSTONE PARK PSYCHIATRIC HOSPITAL

Greystone Park Psychiatric Hospital (GPPH) has faced many issues in the past several years, including with significant leadership vacancies. Specifically, the Medical Director position was filled November 2017, Director of Quality position was filled in September 2017 and Deputy Chief Executive Officer position over clinical services was filled September 2017. A new Chief Executive Officer was named in August 2018. The new leadership team has enabled an increase in supervision, monitoring, accountability, support and coaching for the clinical disciplines in the hospital. The focus of recent turnaround efforts have included efforts to reduce census, improve care quality, and strengthen clinical and administrative governance.

REDUCTIONS IN CENSUS

Specifically, the capacity of Greystone is 552, the August 22, 2017 census was 548. Progress on census includes:

- As of January 2018, census was 510 and August 13, 2018 census was 486. This represents a substantial decrease in census since the beginning of the Murphy administration and a 12% decrease since the census reached a peak last summer. As we continue to review the data we continue to observe a steady decline in our census.
- Additionally, the Medical Director assumed responsibility of the Violence Prevention Committee. Under his leadership and in collaboration with the Director of Quality each unit has incorporated violence prevention (reduction of assaults) as a performance improvement initiative. We continue to monitor our assault rate and provide ongoing feedback to this committee to generate feedback and recommendations. At this time, we have not seen an increase in assaults and will continue to monitor.

IMPROVEMENTS IN CLINICAL GOVERNANCE AND CARE QUALITY

- There is now a Program Oversight Committee (POC) meeting held bi-weekly to ensure the quality and quantity of programming meeting the needs of our patients and standards of practice set by the hospital.
- In the past several months, a programming catalog (J-Wing Catalog) that allows a true conversation/engagement amongst the clinical team and the patient regarding their treatment and scheduled programming. This allows the patient to have a true participation in the selection of groups in which they are required to attend. Group participation is also tracked through this committee.
- The Medical Director implemented 1:1 daily meetings with GPPH psychiatrists effective January 2018. All psychiatrists who have placed patients on a 1:1 status are required to attend this meeting to provide a status update. DCEO, Nursing leadership and unit administration also attends. Psychiatrists are responsible for presenting their patients who are currently on 1:1 status, while also addressing which patient(s) are doing well enough to be removed from 1:1. If they are ineligible for removal from this status, the psychiatrist is required to provide clinical rationale for continued 1:1 status. Recommendations are provided by the Medical Director and DCEO to decrease the number of hours ordered on 1:1, while concurrently ensuring safe periods for our patients i.e. while patients are asleep. This has contributed to the decrease of 1:1s. With this practice in place, GPPH has seen a 32% reduction in the number of 1:1 orders from January to June 2018, which as liberated critical resources to meet the needs of higher acuity patients.
- Regarding staffing, GPPH now has a full complement of nurses and support staff.

- A group of 18 employees successfully completed the Certificate in Public Leadership Program through Fairleigh Dickinson University (FDU). This program provided ten core courses such as: Administrative Leadership in Complex Organizations, Collaborative Leadership, Strategic Thinking and Implementation, Managing Organizational Change, Organizational Decision Making and Problem Solving, Creativity, Change and 21st Century Leaders, Productivity and Human Performance, Group Dynamics and Motivation, Building Teams and Partnership, and Communication, Conflict Resolutions, Ethics and Public Values. This has been an influential program in empowering our employees with leadership objectives.

TRENTON PSYCHIATRIC HOSPITAL

As of October of 2017, Trenton Psychiatric Hospital is a Joint Commission Accredited Hospital and achieved deemed status with the Medicare Conditions of Participation for Hospitals in January of 2018.
Trenton Psychiatric Hospital has made significant headway in the following areas:

PROGRESS IN REDUCING RESTRAINTS

Implementation of the Six Core Strategies to reduce Seclusion and Restraint. The hospital's restraint rate is well below state and national averages. TPH does not use seclusion.

IMPLEMENTATION OF TRAUMA-INFORMED THERAPIES

Utilization of evidence-based Trauma Informed affect modulation therapies to treat patients; including Acceptance and Commitment Therapy (ACT), Trauma Addictions Trauma, Addictions, Mental Health, and Recovery, (TAMAR), and the Creative Arts therapies. Trauma therapies such as Seeking safety, Trauma group and Dialectical Behavior Therapy (DBT) are utilized. The DBT clinicians at TPH received clinical consultation and fidelity feedback on a bi-monthly basis. Our evidenced based treatments consist of Cognitive Remediation, Substance abuse treatment and other SAMHSA supported programming. TPH has increased Trauma Informed Programming as an intervention to decrease violence as recommended by SAMHSA recommendations.

CMS (IPFQR) AND NASMHPD (HBIPS)

Participation in both the CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program and the National Association of State Mental Health Program Directors (NASMHPD) Hospital-Based Inpatient Psychiatric Services (HBIPS) quality measurement programs with the goal of improvement in the quality of care provided to patients. Across all measures Trenton Psychiatric Hospital consistently meets or exceeds programmatic requirements and benchmarks.

BEST PRACTICE COLLABORATION WITH RUTGERS UBHC

Partnering with the Rutgers University Behavioral Health Care Dept. of Psychiatric Rehabilitation to collect data and to implement treatment that supports the Best Practice principles. TPH collaborates with Rutgers consultants on numerous projects such as Trauma Informed Care, Three Steps to Safety, and Therapeutic Options.

CENSUS REDUCTION

Embracing several census reduction efforts with the end result of meeting all of our Olmstead discharge goals well beyond the identified targets.

WELLNESS AND RECOVERY MODEL

Providing a wide array of Wellness and Recovery programming to support the clinical program offerings. We offer patients programming in three treatment blocks with added evening and weekend treatment opportunities. Wellness programming is based on principles that have been outlined by SAMHSA to guide Wellness and Recovery. SAMHSA's 8 Dimensions of Wellness are used as focus areas for patient programming and activities.

SUBSTANCE ABUSE INITIATIVES

Piloting Substance Abuse Services programs to be aligned with the system of care in the community; TPH now has access to the community's NJSAMS (NJ Substance Abuse Monitoring System) with the ability to complete an ASI (Addictions Severity Index) and a LOCI (Level of Care Index) on all newly admitted individuals with a DSM V Substance Use diagnosis. The goal is to improve the continuum of care for substance use services from the community to TPH and upon discharge from TPH to the community provider. Providing more seamless care should decrease length of stay for these individuals.

ENVIRONMENTAL SAFETY AND SECURITY

Trenton Psychiatric Hospital Maintenance and Safety staff completed an environmental Suicide Risk Assessment in June of 2018; purchase of equipment and prioritization of renovation work will be done in collaboration with Office of State Hospital Management.

STRENGTHENING SYSTEM-WIDE OVERSIGHT WITH THE OFFICE OF STATE HOSPITAL MANAGEMENT

An additional position was added to the Office of State Hospital Management (OSHM) within the last year. The new position has enabled the OSHM to establish reporting consistencies in fiscal operations across the hospital that will result in a fair distribution of resources in the areas of the hospital spending plans and staffing. In addition, a format for budgets that provides transparency and an easy system of balancing the payments has been introduced.

IMMEDIATE NEXT STEPS FOR COMPREHENSIVE TURNAROUND OF PSYCHIATRIC HOSPITAL PERFORMANCE

Steve Larsen and Baines Consulting for Joint Commission Survey Readiness Consultation:

- **COMPLETED** April 25-27,2018

Build consensus among the NJSPHs leadership concerning the vision for the future of the hospitals:

- **COMPLETED***,* May – June 2018

Identify membership and convene cross-sectional internal workgroups at each psychiatric hospital to begin organizational and care redesign efforts:

- **COMPLETED**, May 2018

Continue internal workgroups across all finding priority areas:

- *In progress,* May 2018-May 2019

Develop communication plans for sharing information with DMHAS staff, Boards of Trustees, consumers, family members, provider agencies, etc.:

- *In progress*

Recruitment and processing of critical personnel:

- *In progress,* May 2018–December 2018

Convene an inter/intradepartmental Delta team to include Finance, Human Resources, Legal, IT, Facilities, Office of State Hospital Management, Quality, Licensing, Civil Service Commission, Treasury to review and approve recommendations for improvement/innovations/state process changes etc. and to remove barriers to successful implementation:

September 2018, will meet as needed

Proceed with early-stage implementation of selected recommendations:

- June – September 2018

Determine the level of financial opportunity and commitment that is possible to support recommended changes (revenue enhancements, redirected cost savings, increases in operating costs and capital funding:

- July 2018 – January 2019