New Jersey Department of Human Services
Division of Mental Health Services

Home to Recovery –
CEPP Plan

Plan to Facilitate the Timely Discharges of CEPP Patients in New Jersey's State Psychiatric Hospitals

Prepared By

New Jersey Department of Human Services
Division of Mental Health Services

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EXECUTIVE SUMMARY

New Jersey's commitment to the mandates of the U.S. Supreme Court decision of Olmstead v. L.C., 119 S.Ct., 2176 (1999) transcends any time limited plan. This is consistent with the NJ Division of Mental Health's (Division) concurrent planning documents, the Wellness and Recovery Transformation Action Plan and the Community Mental Health Block Grant. Collectively, these planning initiatives are guiding the Division's 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.

As New Jersey's state hospital population has decreased dramatically over the past several decades, the Division is faced with creating community-based services for consumers with complex needs. The focus of the Division's multiyear Home to Recovery – CEPP Plan spanning state fiscal years 2009-2014 is to reduce the length of stay on CEPP, reduce hospital admissions including inappropriate admissions, and hence decrease the state hospital census. To achieve these objectives, the following concurrent steps will be undertaken; (1) a series of policy reform, enhancements and refinements, and (2) the enhancement and creation of new community based infrastructure to support discharge opportunities. This CEPP Plan is a multiphase, multiyear initiative consisting of continuous stakeholder involvement and coordination to ensure meaningful planning and implementation objectives are targeted and achieved.

Section I – Introduction of the Plan highlights several significant initiatives which became the foundation of the present Home to Recovery – CEPP Plan. Redirection II which began in 2000; Rutgers Research Project in 2004; the Task Force on Mental Health Report in 2005; and the Wellness and Recovery Transformation Action Plan and the Community Mental Health Block Grant of 2007 all represent major steps that increased the scope and range of community based housing and services. As a result of these combined efforts and additional resources made available through the continued support of Governor Corzine, the pace of the census reduction and community integration activities has accelerated. Overall total community development since SFY 2006 through SFY 2008 is 1,100 community-based housing opportunities with service components for CEPP and non-CEPP discharges as well as consumers in the community at risk of hospitalization. Of those, 850 new housing units were created.

Section II – Legal Framework outlines the principles of the *Olmstead* decision, the statutory authority governing the creation of CEPP status in NJ, and the scope of the allegations asserted in the 2005 lawsuit filed by New Jersey Protection and Advocacy, Inc. against the Department of Human Services.

Section III – Baseline Data illustrates baseline data over the past ten years and provides decision support to the Division as it develops, implements, and refines its planning efforts designed to result in shorter length of stays, fewer admissions and a decreased census. Despite continued population growth in NJ, the Division has achieved its lowest census since 2001. Similarly, the state psychiatric hospital admissions have shown a

modest reduction. In SFY 2004, there were 3,177 admissions throughout the state system; in SFY 2007 there were 2,809 admissions, a 12% decrease. Conversely, as admissions showed a steady decrease, the utilization of non-emergency based services in the community increased over the last six years consistent with the initiatives implemented since SFY 2001. In SFY 2001, a total of 174,080 adults utilized non-emergency based services; in SFY 2007 it grew to 230,142, a 32% increase.

Section IV – Planning describes the Division's placement and diversionary targets as well as the corresponding implementation steps. The Division intends to reduce the average length of stay of the CEPP population by addressing or targeting resources for each year over the next six years to the following key areas: (1) identify and discharge up to 200 consumers who have been designated as CEPP for 6 months or longer from the state hospitals; (2) identify and divert from state hospital admission up to 100 persons who are in the community and at risk of hospitalization. Concurrently, the Division will strive to achieve the following placement targets designed to create a state hospital system that yields more timely discharges of consumers on CEPP until the goal of 100% of consumers are discharged within 6 months of their CEPP status is reached, as illustrated by the table below:

TABLE: Percent Targets on CEPP < 6 months Over 6 Years

Year End	Percent on CEPP < 6 months
6/30/09	62%
6/30/10	67%
6/30/11	70%
6/30/12	80%
6/30/13	90%
6/30/14	100%

Note: The Division may refine its targets annually based upon actual legislative appropriation.

Major implementation steps to achieve these placement targets will occur by executing the following actionable steps:

A. Policy Reform, Enhancements, and Refinements

1. Creation of Olmstead specific functions and committees to track, plan and evaluate existing policies and practices to ensure division wide coordination and community involvement with Plan mandates;

2. Utilization of Multi-dimensional Needs Assessment of the CEPP population to identify a plan for discharge within a reasonable timeframe;

3. Development of data infrastructure designed to monitor the plan's objectives and compliance as well as provide decision support throughout the plan's implementation.

B. Community Capacity Development

1. Development of Supportive Housing models and opportunities for the CEPP population;
2. Creation of support service models for the CEPP population;
3. Development of additional community infrastructure.

Section V – Implementation outlines the alignment of regional and hospital discharge practices and processes with community based providers to ensure the timely discharge and integration of consumers from the hospital into the community of their choice. These coordinative functions include the following structures: (1) a time limited Statewide Residential Workgroup to identify more uniform discharge processes representative of best and promising practices related to discharge; and (2) regional advisory committee designed to enlist feedback from various stakeholders, provide information to membership on new and expanded mental health initiatives, identify systemic needs and make recommendations for improved services.

In the A*ppendices*, a multiyear table is provided illustrating placement targets, census reduction goals and community integration objectives for each year over the next six years followed by the Division's Wellness & Recovery Transformation Action Plan.

In sum, as demonstrated by planning, appropriations and progress, the Division is committed to the requirements under the *Olmstead* decision, despite complex social, economic and political challenges facing the State, to ensure that people with mental illness live in the most integrated settings possible. The Division's Home to Recovery – CEPP Plan will guide systemic infrastructure expansion, the creation of new supportive housing models to ensure the timely discharge of consumers on CEPP status, and the development of preventative supports for those consumers in the community but at risk of hospitalization.

The Home to Recovery – CEPP Plan is envisioned as a multiyear, multiphase project to ensure meaningful planning and appropriate fiscal management without straining the operating budgets of the agency. Furthermore, this CEPP Plan consists of ongoing multi-agency and stakeholder involvement and coordination as well as benchmarking for monitoring progress and effectiveness. The Division will facilitate and participate in ongoing internal and external dialogue that allows for monitoring and evaluation findings as well as community insights to be brought back to the Division for continued joint planning and decision making.

The Division will retain and utilize a consultant to solicit further recommendations for plan implementation as well as post reports on the internet, tracking the achievement of this Plan's placement targets, census reduction goals and community integration objectives consistent with the six year Work Plan FY 2009-2014 provided in Appendix I.

SECTION I – INTRODUCTION

This *Home to Recovery – CEPP Plan* (CEPP Plan), describes the New Jersey Department of Human Services, Division of Mental Health Services' (Division) active efforts towards facilitating timely discharges of consumers with mental illness who are designated as Conditional Extension Pending Placement (CEPP) signaling readiness for discharge but waiting for a community based placement back into the community; and creating preventable supports to reduce the likelihood of hospitalization for consumers in the community who are at risk of hospitalization. This CEPP Plan outlines the Division's planning efforts and progress to date to increase state hospital discharges resulting in shorter lengths of stay and to reduce hospital admissions and sets forth a two pronged approach over the next six years that will progressively result in more timely discharges of consumers on CEPP status. This will be undertaken in two concurrent steps: (1) a series of policy reforms and procedural developments; and (2) the enhancement and creation of new community based infrastructure to support discharge opportunities for consumers.

As has been widely recognized and accepted, no single plan can achieve systematic success independently, therefore this CEPP Plan is an integral component of the various planning documents that are collectively guiding the Division's overall improvements to the state mental health system, including the Wellness and Recovery Transformation Action Plan, the New Jersey Community Mental Health Services Block Grant Plan, and the Governor's Task Force on Mental Health Final Report (Governor's Task Force). These interlocking planning efforts are both shaped by and consistent with the President's New Freedom Commission Report. Under Governor Jon Corzine, New Jersey has been engaged in comprehensive planning and development, and is committed to meeting the needs of consumers in the state psychiatric hospitals and community consistent with the mandates of the U.S. Supreme Court decision of Olmstead v. L.C., 119 S. Ct., 2176 (1999). These combined efforts are now resulting in shorter lengths of stays in the state hospital system, fewer admissions including inappropriate admissions into the state hospital system, and a decrease in the state hospital census.

In April 2005, NJP&A filed New Jersey Protection & Advocacy, Inc. v. James Davy, Commissioner of New Jersey Department of Human Services, (now NJP&A v. Velez). This lawsuit against the Department of Human Services is on behalf of individuals given a status of CEPP at the state psychiatric hospitals – meaning they have been adjudicated ready for discharge, but there is no appropriate and available community based placement. The focus of the lawsuit as well as the priority of this CEPP Plan is to develop opportunities for community reintegration and tenure as required under the mandates of the Americans with Disabilities Act as interpreted by the Olmstead decision.

To fulfill its obligations, the Division is proposing several actionable steps summarized in this CEPP Plan to expedite discharges of consumers from the state psychiatric hospitals and to create community based housing. This CEPP Plan provides a description of some of the programs that have been aggressively implemented in response to Division initiatives over the last several years. The most recent initiatives are based upon the

unique funding opportunities provided by the $200 million Special Needs Housing Trust Fund, making available capital funding for housing development by former Governor Codey as part of the 2005 Governor's Task Force, and on the models of the wellness and recovery that are an integral part of consumer centered services and planning.

The present CEPP Plan is envisioned as a multiyear initiative that incorporates current implementation efforts and spans state fiscal years 2009 through 2014. The CEPP Plan will focus on the creation of Olmstead specific activities dedicated to aligning new and existing policies and processes that support the timely placements of discharge ready consumers and fewer hospital admissions. Concurrently, the Division will be creating and funding infrastructure with service supports for consumers being discharged from the hospitals into the community.

COMMUNITY INTEGRATION/*OLMSTEAD* PLANNING PROCESS

The New Jersey Department of Human Services, Division of Mental Health Services has been engaged in several planning efforts within the past decade to strengthen community capacity available to state hospital discharges. Among these include:

- Redirection I and II Plans
- Achieving Community Integration for People with Disabilities: New Jersey's Comprehensive Working Plan for Meeting State Obligations Affirmed by the United States Supreme Court Decision in Olmstead v. L.C. (DHS 2003)
- the Division's Wellness and Recovery Transformation Statement
- the Division's Wellness and Recovery Transformation Action Plan
- the Community Mental Health Block Grant Plan

Resulting from the blueprint outlined in the Governor's Task Force's Final Report, the Division's Olmstead planning efforts are outlined in three separate but integrated planning documents: the Wellness and Recovery Transformation Action Plan, the Home to Recovery Plan – CEPP Plan, and the Community Mental Health Block Grant Plan 2008-2010. Over the past several years, the Division has been increasingly showing progress as a result of these planning activities. These multiyear planning activities are wide in scope, as illustrated by the following table. Funding allocation and awards for community service expansion have resulted from these efforts and are positively affecting patient census and the timeliness of discharges over time as illustrated in the Baseline Data section of this CEPP Plan.

Below is a description of planning activities and associated milestones related to Olmstead to date:

Date of Planning Milestone	Activity
November 2000	DHS Olmstead Stakeholder Task Force Created
2003	DHS *Achieving Community Integration for People with Disabilities* Completed
2004	The Division's Redirection II Planning and Implementation
2004	Rutger's Resident CEPP Profile Research Project Begins
November 2004	Governor Codey's Task Force on Mental Health Created
March 31, 2005	Governor's Task Force Final Report Released
July 2005	Special Needs Housing Trust Fund Created
January 2006	The Division's Olmstead Retreat
February 2006	The Division's Wellness & Recovery Statement Released
March 2, 2006	The Division's Executive Staff Retreat
June 2006 – January 2007	Wellness & Recovery Stakeholder Process
August 2006	Office of State Hospital Management Created
August 2007	National Association of State Mental Health Program Directors (NASMHPD) Consultant on Acute Care/Hospital Diversion
September 2007	Community Mental Health Block Grant 2008-2010 Application Submitted to SAMHSA
October 2007	Wellness & Recovery Transformation Action Plan Released
November 2007	Request For Proposal (RFP) Award for patients on CEPP 1+ years
January 2008	The Division's Home to Recovery - CEPP Plan Finalized
February 2008	Olmstead Planning Consultant Retained

REDIRECTION II

Redirection II was a plan for hospital consolidation and community expansion initiated in 2000, made possible by legislative funding of $32.725 million. In order to allocate these fiscal resources efficiently, the Division undertook the clinical assessment of over 1500 consumers in the state's four psychiatric hospitals to obtain baseline data and information

required to determine, target and create services in the community and consolidate inpatient services in existing facilities. The Redirection II Plan was completed in 2001 and its implementation spanned three state fiscal years 2003, 2004 and 2005, resulting in the following achievements:

- statewide expansion of Programs for Assertive Community Treatment (PACT);
- statewide expansion of Integrated Case Management Services (ICMS);
- crisis/respite, supportive housing and treatment options for individuals with co-occurring substance abuse disorders;
- 388 residential/housing opportunities for persons appropriate for community living created concurrent with service expansion;
- initiation of the construction for a new, **smaller** state-of-the-art facility to replace Greystone Park Psychiatric Hospital.

RUTGERS RESEARCH PROJECT- 2004

In 2004, the Division contracted with the Rutgers Center for State Health Policy to conduct a study of the CEPP population. The Rutgers Research Project was based on a stratified random sample of 222 current and discharged residents from the four state psychiatric hospitals, who were 18 to 64 years of age and had a diagnosis of schizophrenia or schizoaffective disorder. The data identified five subgroups that posed challenges to treatment teams in terms of discharge planning and placement. The identified subgroups that posed challenges are as follows: (1) consumers who are resistive to change; (2) consumers who had severe and persistent psychiatric symptoms coupled with continuing major behavior problems; (3) consumers who had major medical co-morbidities; (4) consumers who had a dual diagnosis of mental retardation; or (5) consumers who had a history of criminal sexual offenses.

The Division utilized the data from this research project to inform its decision-making process in creating new housing opportunities and developing request for proposals in subsequent fiscal years. Studies and data collection specific to this consumer population in the state hospital will be updated to provide additional information for planning and benchmarking purposes going forward.

GOVERNOR'S TASK FORCE AND HOUSING INITIATIVES IN FY 2006 -2008

The final report of former Governor Codey's Task Force on Mental Health, *New Jersey's Long and Winding Road to Treatment, Wellness and Recovery*, serves as a critical blueprint for the State's planning efforts under Olmstead. To view report, please visit: http://www.state.nj.us/humanservices/dmhs/Governor_final_report.pdf. The first two issues addressed in the recommendations section of the final report are the need to build a system centered on the principles of wellness and recovery and to address the housing needs of people with mental illness. The report states on page 15:

> *"Whereas, Redirection II was intended to be the foundation to address the Olmstead decision, additionally, the Task Force considers these specific Housing*

recommendations and those included in the Housing Domain of Study, to provide a more detailed and comprehensive blueprint for New Jersey's plan to continue to address the Olmstead decision and recommend as such to the Governor to expedite the process of discharging those persons in the State Hospital system currently deemed as Conditional Extension Pending Placement (CEPP) status."

Following the release of the Governor's Task Force Final Report, the Division has actively implemented the Governor's Task Force's recommendations and continued planning efforts that have collectively yielded the Wellness and Recovery Transformation Action Plan, the updated Community Mental Health Services Block Grant, and presently the Home to Recovery Plan – CEPP Plan. Once fully executed, this CEPP Plan ensures that consumers presently in the state hospitals are discharged into appropriate community services pursuant to Olmstead v. L.C. at the earliest appropriate time and that scarcity of appropriate housing options does not limit discharge opportunities.

As a result of the momentum from Redirection II and the mandate of the Governor's Task Force, there have been several important initiatives and developments which were supported by the Legislature's funding of $26 million for services in FY 2006. Under the leadership of Governor Corzine, these initiatives were significantly expanded by additional appropriations of $15.4 million for services in FY 2007 and $20 million for services in FY 2008. As the $200 million Special Needs Housing Trust Fund established by former Governor Codey is solely for capital based funding, the funding for services necessary for the development of community based housing and supports has been a function of legislative appropriations.

Overall total development from FY 2006 through FY 2008 is 1,100 new community - based housing opportunities with service components for CEPP, non-CEPP discharges, and at risk consumers currently in the community. Of those, 850 new housing units were created. The recent developments in these areas are as follows:

- FY 2006: the Division solicited bids for the expansion of supported housing for services for new housing development and created 495 new community based housing opportunities with flexible services.

- FY 2007: the Division solicited bids for supportive housing expansion with the emphasis on targeting the hospital census and created 212 community based housing opportunities with flexible services.

- FY 2007: there were additional program expansions which prioritized the CEPP population including but not limited to the new and expanded Residential Intensive Support Teams (RIST) programs in Middlesex, Ocean, Morris, Passaic and Mercer Counties creating an additional 90 community based housing opportunities.

- FY 2007 and FY 2008: a total of 12 beds were developed for dually diagnosed individuals with mental illness and developmental disabilities, who are not otherwise eligible for Division of Developmental Disabilities Services.

- FY 2007: programs creating residences on the grounds of state psychiatric facilities totaling 61 new beds.

- FY 2008: Housing opportunities targeted to individuals with status of CEPP from state hospitals, creating a total of 164 new housing opportunities.

WELLNESS AND RECOVERY

Following the Governor's Task Force Report and recommendations, the Division assumed ownership of the Governor's Task Force recommendations and issued a Wellness and Recovery Transformation Statement in February 2006. This statement, consistent with the Olmstead decision, emphasized the importance of community inclusion, and outlined the future direction of mental health services in New Jersey. Subsequently, the Division spearheaded a large stakeholder participation process, inclusive of consumers, family members, providers, etc., that spanned seven months to solicit additional feedback from the community on creating a system built on the principles of wellness and recovery. Recommendations made by participants during this process pertained specifically to community integration, least restrictive settings, and Olmstead-related activities. For additional details, please visit: http://www.state.nj.us/humanservices/dmhs/Stakeholder%20Summ_cover_03_07.doc for a summary of the feedback and recommendations received during this process.

The recommendations from the stakeholder participation process formed the basis for the Wellness and Recovery Transformation Action Plan released in October 2007. To view the plan, please visit: http://www.state.nj.us/humanservices/dmhs/Welln_Recov_action_plan_jan2008_Dec2010.pdf. The Wellness and Recovery Transformation Action Plan is a multi-year policy and work plan approach that seeks to transform the delivery of services in New Jersey by focusing on three independent yet interdependent areas: System Enhancements, Data Driven Decision Making, and Workforce Development. In order to support recovery and community inclusion, the Wellness and Recovery Transformation Action Plan establishes actionable steps that the Division will undertake to ensure that the continuum of community-based services is strengthened, funding for services is allocated toward the most efficient, effective services, and that both the hospital and community-based workforce are provided the training and education necessary to support these objectives.

A Wellness & Recovery Advisory Committee (WRAC) will be established and will participate in the implementation of the Wellness and Recovery Transformation Action Plan. The Olmstead Oversight and Advisory Committees described below will submit reports to the WRAC.

COMMUNITY MENTAL HEALTH BLOCK GRANT

The Community Mental Health Block Grant involves an extensive planning approach to address systemic activities within the state mental health system targeted towards adults with serious mental illness. The Division has routinely submitted the Block Grant Plan to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) for federal block grant funds. As an integral part of the Division's transformation efforts, the Division is more actively incorporating the block grant planning process into the overall planning and implementation strategy to avoid a fragmented planning approach.

The block grant planning process involves providing a comprehensive detailed description of the community based system of care organized around five legislated criteria in a multi year format. In addition, each state is required to annually report on National Outcome Measures for benchmarking purposes and is encouraged to select a series of state specific performance indicators to increase accountability and demonstrate whether the community based services lead to better outcomes for the people served. Every December, New Jersey is required to provide an Implementation Report that incorporates Uniform Reporting System data tables. The purpose of the Implementation Report is to provide the extent to which the State has implemented its plan with particular attention given to the goals, targets and performance indicators.

To aid in the planning and implementation of New Jersey's multi-year plan, the Mental Health Advisory Board and Planning Council (Planning Council), comprised of consumers, family members and professionals, functions as an advisory body to this annual process and meets monthly to assist with monitoring and the development of priority areas.

HOME TO RECOVERY PLAN

Since the 1999 U.S. Supreme Court decision, the New Jersey Department of Human Services has been engaging in various Olmstead planning activities. In 2003, DHS finalized *Achieving Community Integration for People with Disabilities*, a work plan for DHS divisions to reference and consult. At the same time, the Division was finishing the Redirection I Plan and was engaged in Redirection II, related to the downsizing and new construction of Greystone Park Psychiatric Hospital and community service expansion.

In November 2004, former Governor Codey created the Governor's Task Force on Mental Health which released its final report, *The Long and Winding Road to Treatment, Wellness and Recovery*, in March 2005. This report provided several strategies for systemic reform consistent with Olmstead. Along with this report was an infusion of $40M in new funding in the FY 2006 state budget dedicated not only to DMHS but also across multiple divisions/departments to support the strengthening of the mental health system.

One of the most significant recommendations from the Governor's Task Force was the creation of the *Home to Recovery* housing initiative and the Special Needs Housing Trust

Fund (SNHTF) which was funded with $200 million of capital funds to develop supportive housing opportunities for consumers with mental illness and other disabilities ready for discharge from state psychiatric hospitals, at risk of inpatient hospitalization or homelessness.

In January 2006, the Division held a staff retreat specific to Olmstead planning. This process reinforced the Governor's Task Force findings and recommendations, highlighted systemic strengths that support community integration, and noted areas for improvement. The Division has already incorporated several of the recommendations (e.g. program expansions, implementing best practice programs in hospitals, soliciting stakeholder input), and continues to reference retreat information in current planning activities.

SECTION II – LEGAL FRAMEWORK

NEW JERSEY DIVISON OF MENTAL HEALTH PLAN FOR IMPLEMENTAITON OF COMMUNITY SERVICES FOR INDIVIDUALS WITH DISABILITIES

The United States Supreme Court decision of Olmstead v. L.C., 527 U.S. 582 (1999) has given weight to accelerating policy and system changes at every level of government to expand opportunities for people with disabilities to live in the community. The Division of Mental Health Services (DMHS) affirms its commitment to the principles of the Olmstead decision and has targeted a specific population in state psychiatric hospitals for prioritization of community based resources. The initial focus of New Jersey's plan is the population in state psychiatric facilities who have been designated as ready for discharge, but do not have an appropriate placement. This population carries a legal designation of Conditional Extension Pending Placement (CEPP) and is the centerpiece for the state's current Olmstead planning and implementation efforts. Below is a brief discussion of the legal framework which informs the planning process.

CEPP POPULATION

In New Jersey the status of CEPP was created by a 1983 New Jersey Supreme Court decision, In re: S.L., 94 N.J. 128 (1983). The court recognized that there were individuals who no longer met the standard for involuntary commitment but for whom there was no present appropriate placement in the community. The court determined that the state's parens patriae authority was sufficient to continue to allow the individuals to remain in the state hospital and protect their well being pending efforts to place these individuals in proper supportive settings outside the hospital. In effect, the court recognized that these individuals required supportive settings in order to survive in the community. It is this population which is the focus of New Jersey's present intensive planning efforts.

GUIDING PRINCIPLES OF OLMSTEAD

The Olmstead decision is based upon Title II of the Americans with Disabilities Act (ADA) which was enacted "to establish a clear and comprehensive prohibition of discrimination on the basis of disability. There are two aspects of the decision which are particularly relevant: the court's interpretation of the "integration regulation" and the "reasonable modifications regulation". The integration regulation requires states to administer services and programs "in the most integrated setting appropriate to the needs of the qualified individuals with disabilities." The most integrated setting is described as a "setting that enables people with disabilities to interact with people who do not have disabilities within their community to the fullest extent possible."

The "reasonable modifications" regulation mandates "states will make reasonable modifications in policies, practices or procedures when the modifications are necessary to avoid discrimination on the basis of disability unless the [state] can demonstrate that making the modification would fundamentally alter the nature of the service, program or

activity." The Supreme Court provides the following, "if the State were to demonstrate that it had a comprehensive, effective working plan for placing qualified persons…in less restrictive settings and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep institutions fully populated, then the reasonable-modifications standard would be met." 527 U.S. 581 (1999).

The importance of this decision and subsequent federal appellate decisions elevates community integration as a significant state responsibility. And in doing requires each state to consider solutions that are based upon information and the resources currently available. The process envisions continuous planning efforts and readjustments. At the core of New Jersey's plan is reduction of the census in the state psychiatric hospitals and to provide supportive services for consumers already in the community, but who remain at high risk of hospitalization.

CURRENT LITIGATION REGARDING THE CEPP POPULATION

In April 2005, a lawsuit was filed by New Jersey Protection and Advocacy, Inc. (NJP&A) against the Department of Human Services on behalf of individuals with mental illness who are confined to a state psychiatric hospital within New Jersey whom the court adjudicated as no longer meeting the statutory requirement for commitment, but for whom there is no appropriate and available placement.

DHS is defending the suit and has been continually expanding community resources since the early 1990's. As the baseline data in this report illustrates, a recent trend is beginning to emerge in New Jersey state psychiatric hospital admissions showing a reduction in admissions, decreasing census, and shorter lengths of stay on CEPP. The baseline data is the first significant step in developing a meaningful and targeted approach to identified CEPP population so that the community based mental health system can be expanded to ensure resources for timely discharges for state psychiatric hospitals. The baseline data and the analyses and planning that are included inform the allocation of resources in the community in an efficient manner.

SECTION III – BASELINE DATA

In order to develop a comprehensive and effective CEPP plan, it is first necessary to review data that identifies trends and issues that help inform where new and existing resources should be dedicated in a manner that is the most efficient and cost effective. The purpose of this information is to direct the Division's planning efforts around identified service gaps and the relative need to develop specific service packages that result in fewer state hospital admissions and are designed to facilitate timely discharges to community-based services. The following 9 tables illustrate baseline data over the past 10 years and provide a data driven platform upon which informed and systematic programming and funding decisions can be made. The data presented has been used to inform, but has not been limited to the following selected measures.

State Psychiatric Hospital Census

All the state psychiatric hospitals utilize an Oracle Census Database to track the patient population. The Oracle Census Database was fully implemented in 2000 and captures admission, discharge, legal status, movement, insurance, demographic, and various related inpatient data elements. Please note the following list of abbreviations displayed throughout the data tables in this section: Ancora Psychiatric Hospital (APH); Greystone Park Psychiatric Hospital (GPPH); Hagedorn Psychiatric Hospital (HPH); Marlboro Psychiatric Hospital (MPH); and Trenton Psychiatric Hospital (TPH)[1].

Each of the four state psychiatric hospitals varies in size.[2] Since 1996, the percentage of patients on CEPP status has increased substantially. In SFY 2007, the greatest percentage of patients on CEPP status was at Trenton (58%), followed by Greystone (53%), Ancora (49%), and Hagedorn (47%). While the overall total census in the state hospitals has decreased, in SFY 2007 the total census was 2057, down 2% from 2105 in SFY 2004 (please refer to Table 1), the total population growth in the APH catchment area has increased by 14% over the last 10 years accounting for most of the census increases at APH. Particularly, Ocean and Gloucester counties have shown a dramatic adult population increase resulting in a total, ten-year percentage increase of 19.06% and 22.71% respectively (please refer to Table 2).

[1] Ann Klein Forensic Center was excluded from these tables since it does not routinely have consumers designated as CEPP on its census.

[2] Since hospitals vary in size, the percentage of CEPP patients at each hospital must be considered relative to the hospitals' total census.

TABLE 1: Total Census/CEPP Census

Hosp	SFY 1996 Total Census	SFY 1996 CEPP Census	%	SFY 2001 Total Census	SFY 2001 CEPP Census	%	SFY 2004 Total Census	SFY 2004 CEPP Census	%	SFY 2007 Total Census	SFY 2007 CEPP Census	%
APH	462	157	34%	707	234	33%	750	292	39%	742	367	49%
GPPH	627	301	48%	550	206	37%	557	300	54%	558	298	53%
HPH	164	92	56%	286	138	48%	292	137	47%	299	140	47%
MPH[3]	703	232	33%									
TPH	303	103	34%	463	165	36%	506	247	49%	458	265	58%
Total	2259	885	39%	2006	743	37%	2105	976	46%	2057	1070	52%

TABLE 2:New Jersey Population Estimates by County in APH Catchment Area

County	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Atlantic	177,961	179,425	180,746	189,100	190,903	193,933	197,446	201,307	203,579	206,637
Burlington	310,829	312,590	315,487	317,456	322,719	329,603	335,990	339,760	341,976	346,595
Camden	362,440	362,175	361,385	372,567	373,672	376,424	378,319	380,693	383,098	387,887
Cape May	74,707	74,844	74,920	79,460	79,408	79,433	79,689	78,858	78,121	78,088
Cumberland	101,885	101,557	101,424	109,158	109,714	110,720	111,790	112,910	114,787	117,491
Gloucester	176,509	178,230	180,141	188,062	191,204	195,890	200,720	205,264	209,121	216,599
Ocean	365,544	371,624	377,407	394,063	402,212	413,079	420,230	424,886	428,627	435,199
Salem	47,754	47,609	47,357	47,804	48,085	48,683	48,921	49,459	50,301	51,340

Total Percent Change in Adult Population in APH Catchment Area 1997 to 2006

County	1997-2002	2002-2006	1997-2006
Atlantic	8.98%	6.55%	16.11%
Burlington	6.04%	5.16%	11.51%
Camden	3.86%	3.05%	7.02%
Cape May	6.33%	-1.69%	4.53%
Cumberland	8.67%	6.12%	15.32%
Gloucester	10.98%	10.57%	22.71%
Ocean	13.00%	5.35%	19.06%
Salem	1.95%	5.46%	7.51%

State Psychiatric Hospital Admissions

From SFY 1996 to SFY 2004, New Jersey's state psychiatric hospital admissions have been increasing due in large part to continued population growth. However in SFY 2007, due to funding being allocated to the acute care system to divert inappropriate hospital admissions and enhanced community supports, the state psychiatric hospital admissions have shown a modest reduction. For example, in SFY 2004 there were 3177 admissions; in SFY 2007 there were 2809 admissions, a 12% decrease (please refer to Table 3).

[3] Redirection I and II plans resulted in the closure of MPH in 1998.

TABLE 3: Admissions

Hospitals	SFY 1996	SFY 2001	SFY 2004	SFY 2007
APH	983	1074	1233	1309
GPPH	516	271	347	337
HPH	277	494	490	467
MPH	1347			
TPH	369	1100	1107	696[4]
Total	3492	2939	3177	2809

Corollary to the decrease in admissions is the steady increase in the utilization of non-emergency based services in the community over the last 6 years. In SFY 2001, a total of 174,080 adults utilized non-emergency based services; in SFY 2007 it grew to 230,142, a 32% increase (please refer to Table 4).

TABLE 4: Utilization of Non-Emergency Services – Unduplicated Adult Clients (includes County Hospitals and Short Term Care Facilities)

SFY	SMI	NON-SMI	Total
2001	63748	110332	174080
2004	77132	134728	211860
2007	87090	143052	230142

CEPP Resident Length of Stay

The Individualized Client Assessment (ICA) was developed and has been used over the years to assist the Division in planning for the discharge of consumers from State psychiatric hospitals. In 1996, an assessment of all consumers in New Jersey's adult psychiatric hospitals using the ICA indicated that 39% of consumers were designated as CEPP[5] (please refer back to Table 1). The most common diagnosis was Schizophrenia. Among those on CEPP status, 45% were on this status for less than 6 months; 19% were on CEPP status for 6 months to 1 year; 30% were on it from 1 to 5 years; and 6% were on CEPP status for over 5 years (please refer to Table 5). Approximately 36% of the CEPP consumers were on this status for over 1 year. Thus the majority, 64% of the CEPP population appeared to be placed in the community or recommitted due to regression in their clinical condition within one year of being placed on CEPP status.

In CY 2004, the Division contracted with Rutgers Center for State Health Policy to conduct another research project to establish a resident, clinical CEPP profile. The research project was based upon a stratified random sample of 222 current and discharged residents from four state psychiatric hospitals, who were 18-64 years of age and had a diagnosis of Schizophrenia or Schizoaffective Disorder. The CEPP Resident Profiles created by Rutgers found that of the sample population; 56% were discharged

[4] The 35% reduction in TPH census is attributable to the successful cumulative results of Redirection II efforts, increases in community residential capacity, and targeted diversionary efforts within the acute care system to reduce overall state hospital admissions.

[5] A Profile of CEPP Clients, August 1996

within 6 months and 74% discharged within one year of their CEPP designation. Additional Oracle data runs on the SFY 2004 Census yielded a similar trend.

In SFY 2004, there were 3050 instances[6] of CEPP designations within a 12 month period of time. Among CEPP instances, 65% were discharged within 6 months and 81% were discharged within one year of their CEPP designation. In SFY 2007, there were 3248 instances (a 6% increase from SFY 2004) of CEPP designations and 59% were discharged within 6 months and 76% within one year (please refer to Table 5). Please note, since one person can have multiple CEPP designations within a 12 month period of time, the number of instances is a duplicated count. For example, a consumer could be designated as CEPP for 2 months and discharged, then return in one month and designated again as CEPP for 2 months and discharged, that would be counted as 2 instances with a length of stay of less than 6 months for the same consumer. Additionally, there is a cohort of consumers (i.e. consumers with a history of committing a sexual offense or other violent crime) whose length of stay on average is longer then the general consumer population, and that oftentimes skews the length of stay data.

The Division has identified consumers for whom no appropriate and available community based placement currently exists. For example, there are currently consumers who have chronic and/or complicated concurrent medical conditions and the community presently lacks the capacity to adequately treat and manage these conditions. There are also consumers who are required to register as a sex offender with law enforcement agencies and few communities are willing to accept. As a result the Division will be developing and funding appropriate placements and supports for community integration and sustained tenure for these special populations with aggravating discharge factors over the next several years.

TABLE 5: CEPP Length of Stay

	< 6 months	%	6 mos – 1 yr	%	1 – 5 years	%	> 5 years	%	Total
SFY 1996	**398**	**45%**	**168**	**19%**	**266**	**30%**	**53**	**6%**	**885**
APH									
GPPH									
HPH									
TPH									
SFY 2001	**1637**	**67%**	**353**	**14%**	**395**	**16%**	**64**	**3%**	**2449**
APH	**772**		**170**		**105**		**3**		
GPPH	**109**		**36**		**147**		**55**		
HPH	**294**		**67**		**70**		**4**		
TPH	**462**		**80**		**73**		**2**		
SFY 2004	**1987**	**65%**	**483**	**16%**	**496**	**16%**	**84**	**3%**	**3050**
APH	**946**		**205**		**164**		**7**		
GPPH	**194**		**91**		**143**		**70**		
HPH	**324**		**69**		**62**		**4**		
TPH	**523**		**118**		**127**		**3**		

[6] The Total field is representative of the # of CEPP instances and not # of persons on CEPP. The 1996 results are actual #s of persons placed on CEPP status within a 12 month period.

SFY 2007	1928	59%	554	17%	682	21%	84	3%	3248
APH	933		250		238		19		
GPPH	220		88		217		58		
HPH	286		86		60		3		
TPH	489		130		167		4		

Resource Data

In order to develop the service delivery capacity to meet the needs of the inpatient population in general and the consumer on CEPP status in particular, adequate funding and resources are critical. Inadequate capacity as well as limited capacity can max out limited resources and create an overload on other services often resulting in cost shifting. Table 6 illustrates the Division's multiyear resource allocations.

TABLE 6: Multiyear Resource Allocations

State Fiscal Year	New Funds
2001	$12,750,000
2002	$5,886,000
2003	$0
2004	$9,684,000
2005	$7,025,000

Note: The above amounts are net increases to community care including OMB cuts in certain years exclusive of amount rebudgeted to Medicaid and DCBHS. All amounts are exclusive of COLAs for that year.

Resource Availability FY 2006 – FY 2008

Following the Governor's Task Force Final report's multi-year recommendations, an influx of resources geared to mental health services to address Olmstead and community services can be realized. Please refer to Table 7 illustrating the level of new funding received over the last three fiscal years.

TABLE 7: New Funding Received for SFY 2006-2008

State Fiscal Year	New Funds
2006	$26,000,000
2007	$15,405,000
2008	$20,000,000

Note: A $200 million Special Needs Housing Trust Fund was created in FY 2006 to create housing opportunities for state hospital discharges as well as those at risk of institutionalization.

Total resources, including Medicaid, dedicated to the provision of the public mental health services in New Jersey for adult, mental health consumers are as follows:

TABLE 8: Total DMHS Resources for SFY 2005 – 2008

	SFY 2005	SFY 2006	SFY 2007	SFY 2008
Community Services	$268,829,000	$303,986,000	$297,228,000	$322,299,000
County Psychiatric Hospitals	$93,510,000	$104,575,000	$108,175,000	$122,039,000
State Psychiatric Hospitals	$257,399,000	$260,160,000	$277,576,000	$292,937,000
Central Administration	$11,769,000	$12,177,000	$13,587,000	$15,141,000
TOTAL	**$631,507,000**	**$680,898,000**	**$696,566,000**	**$752,416,000**

Note: The Arthur Brisbane Child Treatment Center closed 12/31/05 which impacts changing state hospital appropriations. Children's Mental Health programs were re-appropriated to the new Division of Child Behavioral Health effective 7/1/06 and state match for certain Medicaid services was rebudgeted to Medicaid which impacts changing appropriations. The increase in Central Administration between FY 2006 to 2008 reflects three new/increased components; 1) Fees to the Medicaid Administrative Claim consultant of 4.75% of FFP; 2) funding for new positions associated with the Gov's MH Task Force Initiatives (07 & 08) and the Olmstead Initiative (08); as well 3) assumed funding for salary raises which total approximately $486K in FY '08.

As illustrated below in Table 9, over the last four state fiscal years, the total DMHS dedicated resources has continued to increase along with new housing opportunities while the overall state hospital admissions and census have shown a moderate decrease. From SFY 2005 to 2007 the total DMHS resources have shown a 9% increase while there has been a modest decrease in state hospital admissions and census of 7% and 2% respectively over the same period of time.

TABLE 9

SFY	Total DMHS Resources	Housing Created	State Hospital Admissions	Total Census
2005	$631,507,000	388	3378	2293
2006	$680,898,000	495	3262	2304
2007	$696,566,000	375	3152	2253
2008	$752,416,000	438	2800*	2151**

*SFY 08 is a projection based upon 6 months of Admission data.
**SFY 08 is based on partial data thru 12/31/07 and not a full year

Overall, this baseline data provides the Division with key decision support critical to identifying and measuring planning and implementation efforts going forward. As the Division begins to incorporate data driven decision making into the creation and implementation of Olmstead specific activities, it will be better poised to develop, execute, and refine coordinative policies and processes designed to achieve census reduction goals and community integration targets.

The Division has taken into consideration the analysis of several data sets along with recommendations received from multi-level, multi-year stakeholder input and outlined several actionable steps designed to increase state hospital discharges resulting in shorter lengths of stay and reduce hospital admissions. This Home to Recovery – CEPP Plan sets forth a six year work plan (please refer to Appendix I) that identifies three priority consumer groups as part of the Division's census reduction and community integration efforts by targeting resources in selected areas. Further, the Division will facilitate and participate in ongoing internal and external feedback loops that allow for monitoring and evaluation findings, as well as community insights to be brought back to the Division for continued joint planning and decision making.

These efforts will be aligned with the principles of wellness & recovery and will produce outcomes to be considered as the Plan progresses and as the Division aims to assess the feasibility of reallocating funds from the state hospitals to the community.

SECTION IV – PLANNING PROCESS

The reduction of the CEPP population is a key priority in the Division's Olmstead planning and efforts. Thus the Division has determined a specific plan of action designed to begin reducing the length of stay on CEPP and hence, the size of this population. The Division aims to reduce the length of stay of the CEPP population by addressing or targeting resources for each year over the next 6 years to two key areas: (1) Identify and discharge up to 200 patients who have been designated as CEPP for 6 months or longer from the state hospitals; (2) Identify and divert from state hospital admissions up to 100 persons who are homeless or at risk of homelessness.

Further, the Division will strive to facilitate discharge in a timely fashion by achieving these objectives: Discharge up to 62% of patients within 6 months of their CEPP status (with percentage target to increase over next 6 years until the goal of 100% of patients within 6 months of their CEPP status are discharged is achieved). Targets are identified for each SFY over the next six years. Major implementation steps to be taken are as follows:

A. Policy Reform, Enhancements & Refinements

- Creation of Olmstead specific functions and committees to track, plan and evaluate existing policies and practices to ensure division wide coordination and community involvement;
- Utilization of Multi-dimensional Needs Assessment of the CEPP population to identify a plan for discharge within a reasonable timeframe;
- Development of Data Infrastructure designed to monitor the plan's objectives and compliance as well as provide decision support throughout the plan's implementation.

B. Community Capacity Development

- Development of Supportive Housing models and opportunities for the CEPP population;
- Creation of support service models for the CEPP population;
- Development of additional Community Infrastructure.

The Division will also retain a consultant to help guide further planning efforts and refine implementation strategies. Guidance from the consultant will be incorporated during the CEPP- Plan reviews.

A. POLICY REFORM, ENHANCEMENTS & REFINEMENTS

1. Creation of an Olmstead-specific functions and committees

The Division will create an Executive-level Olmstead Coordinator position to track, plan and evaluate existing policies and practices to ensure division-wide

coordination. The Olmstead Coordinator will chair the Olmstead Oversight Committee to monitor monthly progress of the Plan. Each Office within the Division will identify a point person to participate on the Olmstead Oversight Committee and work in coordination with the Olmstead Coordinator to achieve this Plan's objectives. The Olmstead Coordinator will also work closely with the Wellness & Recovery Advisory Committee.

Hospital-based Olmstead Committees will be created at each hospital to address hospital issues more effectively. Each committee will be comprised of hospital, community based providers and regional staff to locally plan, implement, track and evaluate existing policies and practices to ensure hospital-wide coordination. In addition to the Hospital-based Olmstead Committees, local Residential Planning Committees will be created to review eligible consumers and facilitate coordinated assessment, treatment, and timely discharges of CEPP consumers. Routine dialogue will occur between the Olmstead Oversight Committee, the Hospital-based Olmstead Committee, and the Regional Residential Committee.

The Division will organize an Olmstead Advisory Committee that will function as a subcommittee of the pre-existing Mental Health Planning Council to advise the Division in the planning and implementation process. This Olmstead Advisory Committee will submit semi-annual reports to the Wellness and Recovery Advisory Committee and the Assistant Commissioner for the Division. Committee membership will be jointly selected by the Division, inclusive of consumer, family, provider and stakeholder representation. The Olmstead Advisory Committee will be chaired by a member of the Division and co-chaired by one of the committee members.

2. Assessment of Current and Prospective CEPP population

In SFY 2009, the Division aims to discharge up to 62% of consumers within 6 months of their placement on CEPP. To accomplish this, hospital staff, regional staff and contracted community agency staff will be trained in new tools that use a multidimensional approach to assess current and prospective CEPP consumers for their discharge planning needs necessary to match each person with appropriate housing and community supports.

Assessing the individual needs and preferences of consumers on CEPP status is crucial for successful reintegration into the community. The multidimensional assessment involves the administration of a self-administered preference questionnaire, a level of care evaluation, and an individualized needs assessment. These assessments will drive the discharge planning process and allow treatment teams to provide clinical interventions and discharge arrangements earlier in the course of hospitalization. The treatment team as referenced throughout this section of the CEPP Plan is inclusive of active participation by both the community providers, including

pre-existing support services staff, and all family members with the consent of the patient in the treatment team process. The treatment teams will be incorporating these interventions in the treatment plan and discharge process.

After the required staff training on these new tools, the initiative will begin with the assessment of consumers on CEPP status. A start date will be designated and treatment teams will be given time frames to complete assessments. Consumers who have been on CEPP for 6 months or more (> 6 months) will be prioritized and will be the first to be assessed. The treatment teams will have four weeks from the designated start date to complete these assessments. For consumers who have been on CEPP for 6 months or less (< 6 months), the treatment teams will have four to eight weeks from the designated start date to complete these assessments. For consumers newly placed on CEPP status after the designated start date, treatment teams will be required to complete the assessments within one week of their designation. After eight weeks, all CEPP consumers within the state hospitals will have completed assessments.

After the initial multidimensional assessments are conducted on all civilly committed consumers who have been designated as CEPP, the Division will require treatment teams to begin conducting the multidimensional assessment on all newly admitted consumers (non-CEPP) to aid in the facilitation of proactive discharge planning. For newly admitted consumers, this process will take place at their 14 day Comprehensive Treatment Plan (CTP) review. Treatment teams will also be required to assess all civilly committed consumers[7] using these multi-dimensional assessments as the consumer's CTP comes due, and review and revise accordingly at every CTP review thereafter (no more than 90 days). Eventually, all civilly committed consumers within the state hospitals, CEPP and non-CEPP will have these multi-dimensional assessments completed. Once all hospital consumers are evaluated, consumers' assessed needs will be reviewed and amended as needed at every CTP Review thereafter.

The multi-dimensional assessments will be used to facilitate an individualized discharge plan and will assist the Division in funding and planning decisions related to housing development and support service provisions in subsequent years. The need for specialized services or particular housing models in geographic regions will be identified, planned for and ultimately implemented.

[7] Except consumers with forensic involvement whose discharge is being guided by the Court and whose discharge planning does not begin until the Court permits.

3. Components of Multi-dimensional Needs Assessment

a. Consumer Preferences for Housing & Other Aspects of Discharge

The *Consumer Preferences for Housing & Services* questionnaire is self-administered but assistance will be provided if needed. This questionnaire will examine three main areas: the preferred living arrangement; the perceived need for assistance; and services and supports in the community setting. Living arrangements will include housing type, location, and roommate preferences. Perceived assistance includes on and off site staff support and availability (minimal contact to 24 hour on site support). Types of services and supports will explore preferences for case management, assistance with daily living skills, social and other skill development, opportunities for socialization and recreation, work readiness and employment/education support, illness management, assistance to meet needs resulting from medical conditions, peer support, crisis intervention, etc.

b. LOCUS for Psychiatric and Addiction Services

The LOCUS for Psychiatric and Addiction Services (available at www.locusonline.com) is a level of care instrument with high reliability and validity that is being used in local and state mental health authorities throughout the country. The LOCUS was developed by the American Association of Community Psychiatrists as a clinical decision making tool to facilitate the consistent placement of clients in psychiatric or addiction services. Clinicians evaluate consumers using the LOCUS along six dimensions, after which the instrument automatically calculates a level of care recommendation.

This level of care recommendation can be used to guide individual treatment and discharge planning to help ensure the use of the most clinically appropriate and least restrictive service alternatives upon discharge. The LOCUS recommendations define six levels of care with varying resource intensity. These levels, from the least to the most intensive in terms of services, can be matched with the residential and treatment programs that are available in the New Jersey mental health system.

The plan for use of the LOCUS in the state psychiatric hospitals will be to have treatment teams conduct ratings on all consumers. Because LOCUS is a dynamic instrument, consumers' scores are expected to change during their hospitalization. Therefore, all hospital consumers will have LOCUS ratings reviewed and revised as needed every 90 days in accordance with their CTP reviews. Treatment teams will access the LOCUS and store the consumer evaluations on their hospital's server,

which allows the data to be aggregated and used to identify service gaps and to assist in program planning.

Treatment teams from the state psychiatric hospitals have already been trained on use of the LOCUS, and the instrument was recently piloted at Trenton Psychiatric Hospital, where the staff found that it was helpful and easy to use. However, because the level of care recommendations resulting from the LOCUS do not describe consumers' individual discharge planning needs, the Division will be using the LOCUS in conjunction with the Individual Needs for Discharge assessment to further inform the discharge planning process.

c. Individual Needs for Discharge Assessment

The *Individual Needs for Discharge* assessment will consider multiple areas in which the individual will need support or assistance upon return to community living. The domains on the *Individual Needs for Discharge* assessment include, but are not limited to, psychiatric/rehabilitation, recovery and family supports, substance abuse, medical, daily living/self-care, legal, financial, and housing. The last section of this assessment addresses other critical factors, such as, the consumer's motivation for discharge, major discharge barriers, and the potential need for community transition/pre-placement visits or for conditional release. In addition, the level of care recommended by the consumer's LOCUS score will be incorporated into the assessment. The treatment team will be required to provide a rationale for any differences or discrepancies in their clinical recommendations from that of the level of care recommended by the LOCUS and/or consumer preferences.

The *Individual Needs for Discharge* assessment will be completed after the LOCUS and Consumer Preference for Housing & Other Aspects of Discharge questionnaire are completed. The treatment team will then evaluate each consumer's needs based on the type of discharge preference that they indicated on their questionnaire. They will also specify barriers to discharge and the skills or supports that the consumer will require in order to achieve their discharge goals. When the consumer is stable and appears ready for discharge and/or is converted to CEPP status, the current *Individual Needs for Discharge* assessment will then be converted into a Discharge Plan.

4. Data Management, Monitoring & Evaluation

<u>At a Division Level</u>:

The success of this plan will depend on the development of processes that track the achievement of this Plan's milestones and targets as well as monitor

the progress being made towards each consumer's discharge plan. In this way, barriers can be quickly identified and corrective action plans developed. The Division will post reports on the Web illustrating achievement towards placement targets, census reduction goals, and community integration objectives consistent with the six year work plan provided in Appendix I.

As previously mentioned, an Olmstead Oversight Committee will be created at the Division to monitor monthly progress of this CEPP Plan, and will be chaired by the Division's Executive level Olmstead Coordinator position. The Regional Assistant Directors and Hospital Chief Executive Officers will be responsible for reporting on the progress being made. Hospital staff in coordination with regional staff will be responsible for reporting on the following discharge-related measures, including, but not limited to: residential and housing vacancies; referral process and subsequent admissions; time between designation of CEPP status to referral to discharge destination; and actual admission date to community based residential or housing program.

To assist in the reporting and data review process, various data collection tools will be developed to provide decision support for the review and monitoring of timely discharges and overall process compliance. To accomplish the collection and processing of multivariate data to serve the purposes of tracking consumer specific information, monitoring process flow and adherence, and evaluating the Division's overall compliance with the Plan, the Division's IT staff will be making significant changes to the hospital census database. IT will also install an Olmstead Dashboard that will provide a daily report on Olmstead-specific indicators for ease of tracking and evaluation by Management.

<u>At a State Hospital Level</u>:

The multi-dimensional assessments will be filed in the consumers chart and electronically stored and available on the hospitals' servers to allow access to this information by those who will assist the treatment team in formulating and carrying out consumers' discharge. Before a consumer is recommended for CEPP, or as soon as possible after CEPP has been ordered by the court, the social worker will be required to meet with Intensive Case Management Services (ICMS) staff and other community agency programs involved in the assessment and treatment planning process begun at the time of a consumer's admission, to schedule a discharge planning meeting with the consumer, as indicated, in order to finalize the discharge plan and set a date for discharge. Treatment team social workers will be required to meet or otherwise communicate regularly with any assigned ICMS case managers or placement workers; efforts at discharge planning and attempts at placement will be documented appropriately and routinely reviewed and discussed as part of the Division's ongoing performance improvement agenda.

The completion of the *Consumer Preference for Housing and Other Aspects of Discharge, LOCUS* and *Individual Needs for Discharge Assessment*, as well as any accompanying documentation in the consumers' records, will be monitored by the hospitals' Utilization Review Committees and the assessments and discharge plan recommendations will be reviewed by the hospitals' designated discharge committees. The Utilization Review Committees are new standing bodies charged with the tracking and monitoring of all consumers from the point of admission.

If for any reason, discharge within two months of CEPP designation is not possible, or if assistance is otherwise needed, the social worker shall contact the hospital's Intensive Case Review Committee in order to present the case to them for further review and facilitation. The Intensive Case Review Committee, inclusive of Central and Regional staff, will operate as a focused group. This Committee will track and monitor consumers after a CEPP designation to ensure that the consumer is offered a placement within six months of their CEPP designation. The number of cases referred to the Intensive Case Review Committee will be a standardized measure reported as part of the Olmstead Dashboard for routine tracking and evaluation by senior management.

Both the Utilization Review and Intensive Case Review Committees will routinely communicate and work closely with the Hospital-based Olmstead Committee and the Division's Olmstead Coordinator.

There will also be post discharge agency-specific information allowing follow-up calls to be made by hospital staff. This will help to assess community provider capacity to admit consumers in a timely manner and provide needed services; consumers' adjustment to the community; and suggest modifications to be considered to the referral process and/or the active treatment provided in hospital to ensure a smooth and successful transition.

<u>At the Regional Level</u>:

Currently the Division tracks residential vacancies on a regional basis. To strengthen monitoring, the Division will create a centralized database of all statewide residential vacancies that will be updated regularly and include data such as date a vacancy becomes available, date referral(s) was sent and length of time from referral to admission. The Division will also explore the possibility of linking its web-site to the New Jersey Affordable Housing Resource Center, a site that lists affordable housing locations statewide. A training in using the NJ Affordable Housing Resource Center (administered by the NJ Housing and Mortgage Finance Agency), will be arranged for the social work and social services teams at each hospital. Both of these resources will be used by state hospital staff, regional staff, community providers and consumers to help identify appropriate housing options.

A Short Term Care Facility (STCF) bed utilization software solution was piloted in the northern region in 2007. This solution provides real-time information to the state hospitals, county hospitals, psychiatric emergency screening systems and short term care facilities regarding beds that are available on the short term care facility units. In response to the successful implementation and usage of this system, utilization will be expanded statewide by 2008. The utilization of this bed management system will result in the following outcomes: quicker access to local, inpatient beds by reducing the amount of calls to inpatient units to identify available beds; diversion of individuals meeting commitment criteria from state psychiatric hospitalization into local inpatient (STCF) units and improved utilization of local, inpatient psychiatric beds.

B. COMMUNITY CAPACITY DEVELOPMENT

1. Development of Supportive Housing models and opportunities for the CEPP population

The Division has embraced a Supportive Housing approach that incorporates a "Housing First" philosophy in order to assist consumers with mental illness. In this approach, rental housing is provided upfront and is not contingent upon the completion of treatment, rehabilitation or other services, nor is it time-limited. Needed services, such as mental health or substance abuse treatment, rehabilitation, peer support, skill and resource development, are provided as wrap-around services and both supplement and promote the consumer's successful housing retention. Housing First models have demonstrated that providing housing assistance, case management and supportive services responsive to consumer needs is an effective way of sustaining a person's wellness. It recognizes the importance of stable housing for successful treatment and does not require the consumer to complete treatment programs in order to receive housing. The *Report of the Housing Transition Policy Group* submitted to Governor Jon S. Corzine in January 2006 strongly recommended the adoption of a Housing First Policy for those individuals with special needs, as appropriate.

The Division created an Office of Housing and Community Development in December 2006. One major goal of the Office is to develop more supportive housing for consumers with mental illness. A Supportive Housing approach provides rental housing upfront and completion of treatment, rehabilitation or other services is not a condition of continued occupancy. The strategy is twofold: (1) facilitating lease based housing; and (2) the development of new affordable housing to ensure a lasting legacy of affordable, permanent housing for very low income people with mental illness.

The Division provides funding for tenant based rental assistance paired with support services. These rental subsidies are administered similar to the New Jersey's Department of Community Affairs State Rental Assistance Program (SRAP). Individuals pay 40% of their income and housing is subsidized up to the fair market rent (FMR) as set by the US Department of Housing and Urban Development (HUD) for a given county. Individuals receive assistance to find an apartment and to negotiate the lease.

New Jersey is estimated to be one of the tightest rental markets in the nation. Additionally, it is one of the most expensive housing markets nationally. The state is facing a well established affordable housing crisis. According to a May 2006 report published by Cushman and Wakefield, a global real estate solution and research organization, NJ has an impressive occupancy rate of 96%. This means that there is a 4% vacancy rate creating a highly competitive climate for available rental housing. Additionally, the report lists average rent in NJ as $1,200 per month, exceeding most area fair market rents, and as such, pricing out most mental health consumers whose main source of income is SSI and relies on subsidized housing. This rate is expected to decrease even further with the current sub-prime mortgage crisis, subsequent foreclosures and increased need for rental housing. The low vacancy rate and the competition for the units that results, allows landlords the option of renting above fair market rents. For this reason, new affordable housing development is crucial to create capacity for this population.

Individual housing preferences are varied and change over time. While many do, not everyone wants to live alone in an individual apartment. Many prefer to live with a roommate or settings that provide private bedroom and bath, but have shared living and kitchen areas. Some prefer to live in neighborhoods with single family track housing, others in apartment building or complex settings. Most require housing conveniently located to shopping, recreation, community resources and services; and most notably, public transportation.

The Consumer Preferences for Housing & Other Aspects of Discharge questionnaire discussed in the previous section is one tool that will help to inform housing development going forward. As consumers articulate the types of housing desired and needed, models can be incorporated into issued Notices of Funding Availability to direct the design and development process of successful respondents.

All housing developed will strive to operate consistent with the supportive housing models to the extent possible. Consumers will have individual leases or similar occupancy agreements. At minimum, all housing will offer individual bedrooms and whenever feasible per the total development costs, a private bath as well. Support services will be available and delivered in a flexible manner according to the changing needs of the consumer. Housing will not be contingent upon participation in treatment or acceptance of

services. However, provider agencies will be required to make every effort possible to maintain a therapeutic and supportive relationship with the consumer to foster housing retention and successful community integration. The Division has begun to incorporate meaningful performance targets into contracts.

Efforts have been bolstered by the passage of former Governor Codey's Special Needs Housing Trust Fund Act (SNTF) which dedicated $200 million for the capital development of significant housing opportunities over ten years for individuals with special needs. Priority has been given to those with mental illness. The purpose of this special non-lapsing, revolving fund, which is administered by the New Jersey Housing and Mortgage Finance Agency (NJHMFA) is to develop special needs housing and residential opportunities as alternatives to prolonged hospitalization and homelessness. The Trust Fund is a key milestone in supporting the Division's Olmstead Home to Recovery – CEPP Plan since it will help enable consumers with mental illness to integrate into the communities of their choice by increasing the supply of affordable and quality housing.

2. Creation of support service models for the CEPP population

The other major goals of the Office of Housing and Community Development is to create models of services to meet various needs of people, inclusive of CEPP consumers identified in the 2004 Rutgers Research Project, challenged by serious co-occurring issues such as developmental disability, medical and substance abuse disorders. Historically, these consumers have been unable to access community based residential services. Capacity of community residential and housing providers will be developed to meet the service needs of these consumers essential for discharge to the community and necessary for successful community tenure.

Currently, there are several models that are successful in helping consumers return successfully to the community, as well as to prevent consumers from entering the state hospital system. These include the following:

- Supportive Housing (SH) – This model follows the traditional supportive housing model of access to affordable, lease based housing linked with flexible support services. Housing opportunities are developed accessing various sources of capital funding including the Special Needs Housing Trust Fund, HUD 811 and HUD McKinney programs or leasing in the private market. Housing settings vary according to availability and attempt to meet consumer preference. Housing is lease based (or similar occupancy agreement) and rent does not exceed 30% of consumer's income. In the case of the Division's rental subsidy, rent is set at 40% of income to ensure affordability and incentive to move onto state or federal subsidy. This allows for 'recycling' of Division subsidies to other

eligible consumers. Support services are provided and include assistance with moving and settling into a new home and neighborhood; rehabilitation services such as skills development in areas of daily living, socialization, financial literacy; assistance with medication and illness self-management; and peer support. Several providers have the capacity to provide temporary support on a 24 hour basis if needed. The Division is working with providers to increase their capacity, creativity and flexibility in being able to meet the varying needs of consumers as they change over time.

- Residential Intensive Support Teams (RIST) – This is an enriched supportive housing model, allowing for greater staff to consumer ratios and specifically serves consumers discharged from a state psychiatric hospital. Housing models are typically individual apartments and the model includes the Division's rental subsidy setting rent at 40% of consumer's income. Over time, as consumers establish housing stability and develop community based support networks, their services needs from the housing program decreases. This allows the team to add new consumers to the caseload.

- Programs for Assertive Community Treatment (PACT) – This model of community based service is an evidence based practice (EBP). It involves a multidisciplinary treatment team, including psychiatry, nursing, rehabilitation (including employment) and co-occurring services. Rental assistance may be provided, but not as a matter of course. Consumers reside in various living situations including those listed above under supportive housing, as well as boarding homes, Residential Health Care Facilities (RHCF), or rooming houses, with family as well as those who may also be homeless.

- Licensed Residential Programs – This model of housing opportunity consists of traditional group home and supervised apartment settings. They provide Medicaid reimbursable services dependant upon a contracted level of service, which is tied to a particular residential setting and not the consumer. Levels of service range from on-site 24 hour staffed and supervised settings, to on-site services provided for a minimum of 4 hours per day. In these programs consumers sign a residential agreement and do not have a lease. Consumers pay a residential fee often set by the provider.

  This housing is not intended to be permanent although there is no designated time limit. The goal is to stabilize consumers in the community and transition those, when ready, into supportive housing. As consumers living in these settings are targeted for transition to supportive housing, beds become available for those consumers on CEPP status who may require a more enriched level of service and supervision.

Additionally, the Division is researching the potential of converting some existing group homes into more permanent housing that provides on-site medical services for those consumers with co-existing mental illness and serious medical condition.

Specific service models are being researched and developed to meet the needs of many consumers on CEPP status, including in home medical support services. While many supportive housing and residential providers have nursing staff, these positions typically function in assessment and monitoring roles and do not directly deliver nursing care. Very few community services such as Visiting Nurse Associations come into a home on a long term basis to deliver services. For these and other reasons, consumers requiring daily assistance with such medical issues as insulin dependent diabetes, chronic pulmonary or other serious conditions have historically been denied placement.

Consumers presenting complex behaviors that may respond to skilled behavioral interventions also pose a challenge to existing providers. Many simply do not presently have the trained workforce necessary to successfully support these individuals. As part of the Division's Wellness and Recovery Transformation Action Plan, a system wide, comprehensive workforce development initiative is planned. This includes competency based training in identified core competencies including behavioral and cognitive-behavioral interventions. There are a few providers who have demonstrated experience with this population and the Division has been working with them to expand their services and housing capacity.

Additionally, a Department-wide Special Needs Housing Committee was developed to coordinate the activities of all its Divisions around the issue of special needs housing and to work in partnership with NJHMFA. The Division's leadership actively participates on the committee. The committee has coordinated training for staff and providers through the Corporation for Supportive Housing designed to increase knowledge of the supportive housing model and how to access the SNTF. The Special Needs Housing Committee also tracks the development of all special needs housing across all Divisions.

The Division is also emphasizing in new contracts the need to work with identified consumers who have been on CEPP status for long periods of time. A Notice of Funding Availability was issued in August 2007 targeting consumers on CEPP for period of time 1+ years and who may also experience co-existing medical conditions, developmental disability or challenging behaviors. A Request for Proposal was issued in part, in an effort to attract new providers with demonstrated experience in serving these populations in the community. It is expected to serve up to 200 discharged consumers.

3. Development of Additional Community Infrastructure

Consistent with the recommendations of the Governor's Task Force, the Division recognizes the need to supplement and expand access to community based services for consumers departing state hospitals. For the CEPP population returning to community residential settings, access to outpatient mental health services, including individual, group and medication management services, is a necessary component of support. While outpatient mental health services have been expanded by the Division, particularly in the area of Advanced Practice Nursing and Bi-lingual/Bi-Cultural clinicians, continued capacity development to expedite service availability is necessary. The Division is actively reviewing data with respect to access to determine those areas of the state where capacity development should be prioritized.

Similarly, the ongoing development and expansion of acute care alternatives to state hospital admissions is a priority service development area for both consumers previously on CEPP living in the community and for the community at large. While Designated Screening Centers provide service access statewide, their continued development and expanded ability to outreach and intervene at earlier points in the crisis cycle can serve to preserve community tenure. In that regard, the Division is presently negotiating two demonstration projects where additional mobile outreach, respite, non emergency room walk-in services and dedicated access to outpatient services will be provided in an effort to move the locus of crisis intervention into the community and away from utilization of emergency services.

While expanded outpatient access and earlier crisis intervention strategies can promote community tenure and support a consumer in their recovery, there remain circumstances where brief inpatient care is appropriate. The Division is currently working with the Department of Health and Senior Services (DHSS) to expand the availability of Short Term Care Beds in high need areas of the state. These beds, when closely tied to community support services, can offer a direct alternative to state hospital admissions and enhance the opportunity for consumers to rapidly return to their community residence. A Certificate of Need was issued in November 2007, and approximately thirty new STCF hospital beds opened in January 2008 through an emergency waiver through DHSS.

SECTION V – IMPLEMENTATION

REGIONAL PLANNING & IMPLEMENTATION STRATEGIES UTILIZED TO FACILITATE DISCHARGES

Each state psychiatric hospital along with their requisite regional office is continuing to develop discharge processes specific to the needs of the consumers in each hospital and the resources available in the community. Reviews of available data, planning, research and feedback, are informing discharge practices and program development on a regular basis.

Efforts in that regard will be accelerating as the Division works toward the implementation of specific data driven decision making objectives related to CEPP and discharge processes that are outlined in the 2008-2010 Wellness and Recovery Transformation Action Plan. As referral and placement system data capabilities are strengthened, and as county-specific mental health systems are mapped and matched to consumer needs, more focused decision making around housing and program development can occur**.**

A key to achieving designated timeframes will be aligning regional and hospital practices, allocation of resources consistent with Olmstead, and the development of appropriate community-based options for consumers to ensure timely discharges.

The regional offices have designated employees to work directly and in partnership with state hospital staff and community-based providers to facilitate the integration of consumers from the hospital to the community of their choice by engaging in the following actions:

1) Identify appropriate community-based services, in accordance with the clinical needs identified by the hospital treatment team, consumer, family and/or community provider, to facilitate successful community integration.

2) Address and mitigate barriers in accessing needed resources/services.

3) Provide education and training to hospital and community providers to promote discharges.

4) Facilitate communication and systems coordination through regularly scheduled meetings with hospital, regional and community service providers.

5) Track residential vacancies to optimize the utilization of residential services.

6) Monitor and evaluate the utilization and effectiveness of community-based services.

7) Conduct housing fairs and symposiums to market the housing needs of consumers and provide consumers with information about available resources in the community.

8) Provide direct services such as active participation in discharge planning, transportation and service linkage to, or on behalf of, consumers on an as needed basis.

There are common approaches related to discharge practices, processes and resources for each of the state hospitals and regional offices. Each of the four state hospitals is associated with a regional office and committed to the identification and execution of discharge related best and promising practices. One such approach is the collaboration and shared responsibility between the state hospital, regional offices, and community providers in facilitating discharges. The regional offices work directly with the continuum of public and private hospital and community-based service providers to promote a comprehensive mental health system of care that responds to the needs of consumers.

The Division is working towards developing more uniformity across the regions and hospitals in discharge practices and policies. In that regard, the Division will be convening a Statewide Residential Workgroup. This time limited workgroup will consist of representation from the Division's regional and central offices, state hospitals, residential providers, consumers, mental health administrators and family members. The workgroup will be charged with recommending more uniform discharge processes and identifying best practices related to discharge. Recommendations from the workgroup will be distilled and included in boilerplate affiliation agreements between the Division's contracted residential providers and the state hospitals. When applicable, the Division will incorporate recommended changes into contracts with residential providers.

The Division convenes meetings with residential providers to help facilitate placement for consumers in a state psychiatric or county psychiatric hospital. The formal structure of these meetings varies between the regions, based on the landscape of residential services in a particular county. However, the common structure includes participation from the state psychiatric hospital, county psychiatric hospital (where they exist) and representation from each of the Division contracted residential services. The meetings focus on reviewing the cases of consumers who are CEPP, identifying an appropriate residential service (and provider) based on the consumer's needs, manage bed availability and facilitate movement in residential services across the county. Typically this involves moving consumers into more independent settings to make more intensive residential options available to consumers requiring that level of service. These important coordinative meetings will continue to occur, and take on a more uniform structure (see page 19, Residential Planning Committees) and process as the recommendations of the Statewide Residential Workgroup referenced above, are blended into both affiliation agreements and the Division's contracts with residential providers.

The Division convenes two regional advisory committee meetings on a quarterly basis. Each of these advisory committees represents a state hospital catchment area. The Northern Region Advisory Group comprises of representatives from the six counties of the Greystone Park Psychiatric Hospital catchment area. The Southern Region Advisory Group is comprised of representatives from the eight counties of the Ancora Psychiatric Hospital catchment area.

The advisory groups are designed to enlist feedback from stakeholders representing different facets of the mental health continuum. Representation on each of these advisory groups consist of Mental Health Administrators, consumers of mental health services, family members of consumers, state hospital staff, Division staff and providers of mental health services. The advisory groups provide information to the membership on new or expanded mental health initiatives, identify systemic service needs and makes recommendations for new and innovative services and changes in existing services to meet current needs. The effect of these advisory groups will be strengthened by the availability of data and data systems being developed as part of the Division's Wellness and Recovery Action Plan**.** Advisory groups in the Senator G.W. Hagedorn Psychiatric Hospital and Trenton Psychiatric Hospital areas will be developed in 2008.

TIMEFRAMES

The Division recognizes the need to operate from a plan that includes manageable timeframes in order to remain focused on objectives and demonstrate accountability and transparency. This CEPP Plan involves a two pronged approach over the next six years that will progressively result in more timely discharges from CEPP status. One part of the plan implements a series of reforms and policy enhancements and one part expands community infrastructure to support discharge opportunities. Please refer to the six year Work Plan provided in Appendix I.

The Division is committed to reducing the average length of time a consumer is on CEPP status in the state hospitals, and will strive to achieve the following timetables. These timetables will incrementally reduce the length of time that a person is on CEPP status by ensuring discharge no more than six months after being designated CEPP.

Over the course of implementing this CEPP Plan, the Division will strive to achieve the following outcomes outlined below. Beginning in FY 2014, all consumers, within six months of being placed on CEPP status, will be offered an appropriate discharge placement.

TABLE 11: Percent Targets on CEPP < 6 months Over 6 Years

Year End	Percent on CEPP < 6 months
6/30/09	62%
6/30/10	67%
6/30/11	70%
6/30/12	80%
6/30/13	90%
6/30/14	100%

In support of this Plan, the Wellness and Recovery Transformation Action Plan has a detailed chart that outlines implementation steps that will be taken over the next several years, and is an integral part to building the principles and infrastructure key to this initiative. Please refer to the Wellness and Recovery Transformation Action Plan provided in Appendix II.

SUMMARY

The Division recognizes that planning and improving community reintegration consistent with the Division's adoption of the wellness and recovery model is an evolving process, requiring coordination among state agencies, consumers, the community, and other interested stakeholder groups. Successful legislative appropriations have enabled new and continued service expansion as well as community infrastructure support. Going forward, the Division will strive to reallocate funds from the state hospitals back into the community further strengthening the community's capacity to sustain and provide community options for at risk and discharged consumers. The Division further acknowledges that addressing timely access into the community from the state hospital system requires a systemic approach that must include the active and continual participation of both local community-based and hospital programs. An ongoing challenge to the success of this CEPP Plan will be to ensure that it continues to be properly funded and implemented in a planned and deliberate manner so as not to unduly strain the fiscal and operating resources of the Division.

There are various challenges that the State experiences when trying to facilitate the timely discharge of a consumer on CEPP into the community. Aside from funding, the lack of affordable housing statewide and the Not in My Back Yard (NIMBY) syndrome, especially for difficult to serve groups like those who also may be required to register under Megan's Law, are issues that confront the Division. The DHS Special Needs Housing Committee is working to develop a public relations plan to promote community relations, education and acceptance as the Department overall moves forward with its policy emphasis on housing and community based services.

The CEPP Plan will be reviewed annually in concert with the Wellness and Recovery Transformation Action Plan and the Community Mental Health Block Grant. This process will be transparent and inclusive of multiple stakeholders through various recurring and focused activities. The Division will retain and utilize a consultant to solicit further recommendations for plan implementation. The Division will post on its website the CEPP Plan's annual report and ongoing progress toward specified placement targets, census reduction goals, and community integration objectives consistent with the six year Work Plan provided in Appendix I.

The Division acknowledges that the success of this Home to Recovery – CEPP Plan will require the dedication and sustained commitment of many co-contributors. Transformation has policy, fiscal, regulatory, and practice implications. The transformation of a system is a complex process that requires full participation of community, regional, hospital, and public, private, and university partners. The success of this CEPP Plan will depend, in large measure, upon the degree to which our system can be flexible, responsive, accessible and unafraid of taking certain calculated risks. The Division welcomes this responsibility as inherent to its core mission to ensure that people with serious mental illness live successfully in the most integrated settings possible.

REFERENCES

Governor's Task Force on Mental Health Final Report:
http://www.state.nj.us/humanservices/dmhs/Governor_final_report.pdf

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Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, *Needs Upon Discharge/Discharge Plan Form,* DMH 942E 1190F 10/30/01.
http://www.dmhmrsas.virginia.gov/forms.asp

Wellness and Recovery Transformation Action Plan January 1, 2008 – December 31, 2010
http://www.state.nj.us/humanservices/dmhs/Welln_Recov_action_plan_jan2008_Dec2010.pdf

APPENDIX I

DIVISION OF MENTAL HEALTH SERVICES – CEPP PLAN
SIX YEAR WORK PLAN FY 2009 – FY 2014

SFY 2008	SFY 2009	SFY 2010	SFY 2011 thru 2014
TARGETS	• Discharge up to 62% of consumers within 6 months of CEPP status. • Discharge 200 CEPP • Divert 100 at risk of hospitalization	• Discharge up to 67% of consumers within 6 months of CEPP status. • Discharge 200 CEPP consumers • Divert 100 at risk of hospitalization	• Discharge up to 70%, 80%, 90%, 100% of consumers within 6 months of CEPP status. • Discharge 200 CEPP • Divert 100 at risk of hospitalization
Issue RFP "Home to Recovery SH initiative for consumers discharged from state psychiatric hospitals" Funds awards up to allotted $3.5M for up to 100 consumers. RFP funds both support services and project based rental assistance for new housing development.	RFP for services and rental assistance paired with new housing development for targeted CEPP population to promote increase in capacity and available contracted providers	RFP for services and assistance paired with new housing development for targeted CEPP population to promote increase in capacity and available contracted providers	RFP and/or RLI for services assistance paired with new housing development for targeted CEPP population.
Issue RLI for "Home to Recovery SH initiative for consumers discharged from GPPH" Funds awards up to allotted $2.5M for up to 75 consumers. RFP funds both support services and tenant or project based rental assistance for new housing development.	Issue RFP for new RIST teams in identified counties	Expansion of existing RIST teams statewide	
In partnership with DMAHS, submit state plan amendment, for Medicaid Rehab Option and/or DRA Community Support Services for eligible consumers.	Begin to implement new Medicaid RO Community Support Services and/or DRA Home and Community Based Services, subject to CMS' approval of state plan amendment.	Medicaid RO Community Support Services and/or DRA services fully implemented	Medicaid RO Community Support Services and/or DRA services continues to be implemented
Creation of Olmstead specific functions to advise, implement and enforce alignment of existing policies and practices to ensure Division wide and Hospital wide coordination	Continue to dedicate specific functions/practices to Olmstead related efforts	Continue to dedicate specific functions/practices to Olmstead related efforts	Continue to dedicate specific functions/practices to Olmstead related efforts
Olmstead Coordinator			
Olmstead Oversight Committee			
Hospital-based Olmstead Committee			
Regional Residential Committee			
Olmstead Advisory Committee			
Review, examine and refine/reform existing policies and practices	Continue to review, examine and refine existing policies	Continue to review, examine and refine existing policies	Continue to review, examine and refine existing policies
Administrative Bulletins			

SFY 2008	SFY 2009	SFY 2010	SFY 2011 thru 2014
Utilization Review Committee Established			
Intensive Case Review Committee Established			
Develop Current and Prospective CEPP Population Assessment Tools	Continue to Assess and Re-Assess Prospective CEPP Population	Continue to Assess and Re-Assess Prospective CEPP Population	Continue to Assess and Re-Assess Prospective CEPP Population
Consumer Preferences for Housing			
LOCUS			
Individual Needs for Discharge Assessment			
Develop Monitoring and Evaluation Protocols, Data Collection Instruments and Database Enhancements for phase-in and ongoing monitoring	Continue to develop and refine monitoring and evaluation protocols	Continue to develop and refine monitoring and evaluation protocols	Continue to develop and refine monitoring and evaluation protocols
Develop uniform application of Census database hospital-wide	Enforce uniform application of Census database hospital wide	Enforce uniform application of Census database hospital wide	Enforce uniform application of Census database hospital wide
Develop standard report to monitor CEPP patients including LOS, readmissions, community tenure, etc.	Refine standard reports	Refine standard reports	Refine standard reports
Develop Olmstead Dashboard for daily decision support	Implement Olmstead Dashboard for daily decision support	Implement Olmstead Dashboard for daily decision support	Implement Olmstead Dashboard for daily decision support
Create a centralized licensed, residential/ housing data system to inform Olmstead related discharge planning	Implement centralized licensed, residential/housing data system	Implement centralized licensed, residential/housing data system	Implement centralized licensed, residential/housing data system
Develop template for annual and quarterly progress reports to publish	Post reports on the Web	Post reports on the Web	Post reports on the Web
Research and evaluate capability of incorporating above system into existing mechanisms such as STCF bed tracking through 211 system	Link STCF bed tracking data through 211 with centralized residential housing database	Continue and improve data links	Continue and improve data links
Develop decision support report formats	Review and implement report formats	Routinely utilize report information	Routinely utilize report information
	Expansion of existing RIST teams statewide		
Research with DMAHS options to access FFP for medical services now being provided by SH providers	Pilot and/or begin In home medical services model	Expand In home medical services models as needed	Expand In home medical services models as needed
	RLI for services and project based rental assistance for homeless, at risk of homelessness and hospitalization; and to promote on-going housing stock development	RLI for services and project based rental assistance for homeless, at risk of homelessness and hospitalization; and to promote on-going housing stock development	RLI for services and project based rental assistance for homeless, at risk of homelessness and hospitalization.
	RLI for Service Coordinator/Property	If needed, issue RLI for Service Coordinator	If needed, RLI for Service Coordinator

SFY 2008	SFY 2009	SFY 2010	SFY 2011 thru 2014
	Manager only, attached to new housing development. Target is consumers in the community with existing services and in need of affordable housing. RLI intent is to promote on-going new housing development that can be accessed by discharged and consumers in the community for years to come as housing will be deed restricted for affordability and mental health consumers.	attached to new housing development	attached to new housing development.
		Program development to transition consumers living in on-grounds housing into SH in the community, creating opening for more challenging and/or reticent discharge eligible consumers.	Target use of community provider operated on-grounds residential programs for those CEPP consumers with more serious forensic backgrounds or challenging behaviors
	Implement Workforce Development Initiative Plan, including training on Core Competencies, including interventions for specialized populations, including those consumers who respond to/benefit from specialized behavioral plans and co-occurring substance abuse issues	On-going training on specialized populations, particularly those consumers who respond to/benefit from specialized behavioral plans and co-occurring substance abuse issues	
	On-going training on specialized populations, particularly those consumers who respond to/benefit from specialized behavioral plans and co-occurring substance abuse issues		

APPENDIX II