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Acting Assistant Commissioner

September 27, 2010

Dear Colleague:

On behalf of the Acute Care Task Force (ACTF), the New Jersey Division of Mental Health Services (NJDMHS) is pleased to release the task force's final report. The Acute Care Task force was convened in January of 2008 by the NJDMHS and was charged with developing recommendations for system improvements specific to the New Jersey mental health acute care system. The release of the report was delayed largely due to several challenges confronting the Division, including budget planning around the State's fiscal crisis and implementation of the *Olmstead* settlement agreement.

The enclosed report represents the efforts of the broad range of stakeholders that participated in the ACTF over the course of approximately seventeen months. Representatives of state agencies, community hospitals, non-profit mental health provider organizations, professional trade associations, family advocates, consumers and experienced practitioners from the varied acute care service programs in the mental health system contributed to the recommendations in this report.

The release of this report follows on-going system improvement initiatives, with some of the recommendations articulated by ACTF members during the earlier stages of the task force's efforts having already been achieved. For example, the creation of a Centralized Admissions Unit to manage admissions to the state's four regional public psychiatric hospitals occurred during the fall of 2009. Also in the fall of 2009, efforts to amend the state's screening regulations to reflect ACTF members' input were advanced via publication of a regulatory proposal notification.

The report also necessarily includes considerations related to events that have occurred subsequent to the ACTF's deliberations. These considerations include recent passage of legislation at both the federal and state levels, as well as the release of salient professional literature related to emergency department utilization and capacity that continues to inform the field.

The scope of the recommendations in this report is extensive. The ACTF recognizes that some recommendations will not be readily achieved. Budgetary constraints among the varied acute care system partners will impact the system's capacity for implementing some recommendations. Nonetheless, the ACTF membership is hopeful that efforts to implement these recommendations will be embraced. The ACTF envisions a mental health acute care system that compassionately and effectively meets the needs of consumers and their families and does so in a way that reflects a commitment to the principles of wellness and recovery.

Sincerely,

Valerie L. Larosiliere
Acting Assistant Commissioner

VLL:pjt
Enclosure

NEW JERSEY DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH SERVICES
REPORT OF THE
ACUTE CARE TASK FORCE

September, 2010

Background

In January, 2008, the New Jersey Division of Mental Health Services (DMHS) convened the Acute Care Task Force (ACTF). This task force report builds upon the DMHS Wellness and Recovery Transformation Action Plan[1] and *Olmstead* planning efforts[2]. The task force was charged with conducting an examination of the existing mental health acute care system, developing a series of recommendations for system improvements and guiding DMHS Wellness and Recovery Transformation efforts related to acute care.

The composition of the ACTF included representatives of state agencies, community hospitals, non-profit mental health provider organizations, professional trade associations, family advocates, consumers and experienced practitioners from the varied acute care service programs in the mental health system. Stakeholders from these diverse backgrounds participated in ACTF meetings that were conducted over the course of seventeen months. This broad range of participation resulted in the recommendations that are presented in this report.

According to the Governor's Task Force on Mental Health[3], based upon generally accepted incidence data, close to 1.7 million New Jersey residents will experience some form of a mental illness in the course of a year. In any given year, about 5% to 7% of adults, equating to over 500,000 people in New Jersey, have a serious mental illness, according to several nationally representative studies. A similar percentage of children - about 5% to 9% - have a serious emotional disturbance. Currently, the Division of Mental Health Services, through its network of community providers, funds services for approximately 175,000 unduplicated individuals annually. The Division of Child Behavioral Health Services in the Department of Children and Families provides funding that serves approximately 42, 000 children annually. The demand for mental health services may exceed what currently funded resources can deliver. However, one aim of this report is to maximize the use of all currently available resources.

Acute care services currently funded by DMHS include intensive community services such as crisis residences, intensive outpatient and support services, acute partial care, early intervention programs, warmlines, and jail diversion programs. For those consumers who can not be stabilized in these community mental health care settings, designated screening services, affiliated emergency programs and acute care inpatient units in general hospitals provide assessments, crisis intervention, civil commitment, and short term hospitalization. Furthermore, the boundaries of the acute care system extend well beyond emergent settings into other well established community based programs such as residential services, residential intensive support teams, and assertive community treatment. These non emergent programs, by virtue of serving individuals with chronic and severe mental illness, are integral to the acute care system.

The acute care system in New Jersey has provided the state's residents access to immediate care in times of crisis. The creation of the state's designated screening centers in all New Jersey counties in the late 1980s was a watershed development in the history

[1] http://www.state.nj.us/humanservices/dmhs/recovery/Welln_Recov_action_plan_jan2008_Dec2010.pdf
[2] http://www.state.nj.us/humanservices/dmhs/olmstead/CEPP_Plan_1_23_08_FINAL.pdf
[3] http://www.state.nj.us/humanservices/dmhs/recovery/Governor_final_report.pdf

of this system. Most screening centers are located in or contiguous to emergency departments of general community hospitals. The DMHS funds 23 Designated Screening Centers and 10 Affiliated Emergency service programs across the 21 Counties at an annual total cost of approximately $52.1 million. While it was recommended by the Governor's Mental Health Task Force to add $34.5 million to the screening system over a three year period, this investment was never fully made due to budgetary constraints. However, from FY2006 through FY2009, $14.8 million was added to the state's designated screening centers to create new and expanded Screening and Screening Outreach services. Additionally, DMHS funds state psychiatric hospital care in the annual amount of $285 million, short term care facility treatment at $23.3 million and County Psychiatric Hospital care at $120 million.

The public mental health system is one part of the larger and highly intricate healthcare system. The difficulties encountered by local mental health system users and providers are not unique to New Jersey and many of these concerns are not particular to the mental health sector. A recent and comprehensive synthesis of studies that examined national emergency department (ED) utilization across healthcare specialties, conducted by the Robert Wood Johnson Foundation (RWJF) (2009)[4] contained several findings contextually relevant to the ACTF. First and foremost, ED overcrowding results from a complex interplay of factors across the entire healthcare system. Challenges related to moving ED patients to intensive care and critical care were underscored. Second, although ED visits by patients with psychiatric diagnosis are increasing faster than ED visits overall, patients with psychiatric needs still comprise a small share of total ED volume – five to eight percent. Additionally, the RWJF report notes that a relationship between psychiatric ED visits and ED overcrowding has not been quantified in any study. Third, despite anecdotal appeal, this research synthesis suggested that use of the ED by uninsured patients and by patients with non urgent needs was not a driver of ED overcrowding. Fourth, research suggests that improved utilization of existing hospital capacity may be more viable than developing new capacity. A recent two state analysis of emergency room use by persons with mental illness, conducted by the National Institute of Mental Health[5], revealed ED volume for this group to be between 3.3% and 5.2%.

These national report findings suggest that psychiatric acute care system trends mirror broader healthcare system phenomena, and that the recent passage of the Patient Protection Affordable Care Act (PPACA) should provide improved coverage and access for consumers in the next few years. The findings also highlight the reality that governmental entities alone can not effect the desired systemic improvements. All system partners have a role and a responsibility if these improvements are to be realized.

In creating the ACTF, the DMHS endeavored to facilitate a planning process through which constituents could work toward the development of innovative solutions to the complex, multifaceted access, quality and capacity issues occurring in the acute care system.

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[4] Robert Wood Johnson Foundation (2009). The Synthesis Project: New Insights from Research Results, Report No. 17, Emergency Department Utilization and Capacity.

[5] http://www.nri-inc.org/conferences/Presentations/2009/30RivardPlenary.pdf

Data

While there is some perception among system partners that the volume of psychiatric patients using the designated screening centers is significantly increasing, the available data indicates otherwise. Between state fiscal year 2007 and state fiscal year 2009, the volume of users of New Jersey's 23 designated screening centers has not dramatically increased (See Appendix A). Although the state's population has increased slightly since 2007, utilization rates (per 1000 residents) increased modestly between 2007 and 2008, and then decreased between 2008 and 2009. This observation holds true when looking at two independent datasets maintained by the New Jersey DMHS — the Quarterly Contract Monitoring Report (QCMR) and the Systems Review Committee (SRC) datasets. It is noteworthy that both the QCMR and SRC are comprised of data that is self-reported by the designated screening centers.

Nevertheless, as referenced below, waiting times in designated screening programs, particularly in instances involving a disposition to involuntary hospitalization, have been problematic in the acute care system in New Jersey. ACTF deliberations on this critical issue contributed to a number of the recommendations in this report.

Current Reforms

The Division has diligently implemented system reforms over the past several years, working from key planning documents developed with the mental health community. These include former Governor Codey's Task Force on Mental Health's report, the Division's *Wellness & Recovery Transformation Action Plan*, and the Olmstead *Home to Recovery* plan. While the ACTF process zeroes in on acute care issues even further, significant systems enhancements directly related to the acute care system were concurrently initiated by the DMHS to address issues emerging in ACTF deliberations. Through the end of state fiscal year 2010, those enhancements included:

- The creation of new Intensive Outpatient Treatment and Support Services programs in seventeen counties. These new programs are designed to create dedicated access for consumers referred from Designated Screening Centers, affiliated emergency services, and other acute settings and became operational during the late spring of 2008. The investment in these programs is $5.6 million annually.

- Issuance of a Certificate of Need (CN) call from the Department of Health and Senior Services to add 83 new Short Term Care Facility (STCF) beds statewide at a cost of $4.8 million annually for DMHS. The CNs, now approved, expand the capacity of community hospital based involuntary psychiatric inpatient services by 24%. DMHS sustained Mental Health Subsidy Funding to existing STCF beds and increased the availability of funding to support the additional STCF beds.

- Development of a state-wide consumer operated Peer Recovery Warm Line Service which utilizes intentional peer support to offer callers an alternative to services at an emergency room based Screening Center.

- Invested $3.0 million to pilot non-hospital based early intervention programs in Morris and Atlantic Counties designed to provide access to community based diversion services to consumers beginning to experience crisis, diverting them from emergency room based Screening Centers. DMHS had planned to expand these early intervention programs in additional Counties during FY ’11.

- To ease access to inpatient services in Ocean, Atlantic and other Southern Counties, DMHS is purchasing access to 24 beds at Hampton Hospital and Carrier Clinic.

- DMHS has created a Centralized State Hospital Admissions services designed to both facilitate appropriate admissions and to maximize opportunities to divert consumers to community care.

- DMHS worked collaboratively with DHSS to preserve Short Term Care Facility access in Union County when Muhlenberg hospital closed by facilitating transfer of affected beds to Trinitas Hospital and Princeton House and in Passaic County when St. Mary's Hospital’s financial constraints necessitated a transfer of these services to Clara Mass Hospital.

- DMHS is working with county hospitals in order to maximize the use of available inpatient bed capacity.

Additionally, the Division has expanded several non-acute care related services (e.g. supportive housing, expanded outpatient services) in order to reduce the need for acute level of care services. These infrastructure enhancements directly address many of the systemic strains articulated by ACTF participants and augment other recent DMHS initiatives. In light of these developments, implementation of the ACTF’s recommendations will be built upon a strengthened foundation.

In August of 2009, subsequent to ACTF deliberations, Governor Corzine signed P.L. 2009, ch. 112, commonly known as the Involuntary Outpatient Commitment (IOC) to Treatment Law. The law was to take effect statewide on August 11, 2010 with respect to many of its provisions. For example, it specifically reiterates the state’s obligation to provide treatment in the least restrictive appropriate setting, even if the consumer will not consent to treatment, and it makes a number of changes in the definitions of “dangerousness” and “reasonably foreseeable future” that will affect all consumers of mental health services being evaluated for the need for involuntary treatment. The clear intent of the law, however, is to provide a new option: supervision in the community for a class of consumers that the legislature agreed was not well-served without this law. This population comprises those who are not willing to receive treatment voluntarily and will become, in the foreseeable future, dangerous enough because of a mental illness to require supervision, but who are not so imminently dangerous that they need to be physically confined in an inpatient program.

Mental health providers in seven counties were to be designated by the Commissioner of Human Services to provide court-supervised treatment as of August 11, 2010, with seven

more counties implemented in each of the following two years. Designated Screening Centers are obligated to play an additional role under IOC as well. DMHS has estimated the cost of the program to be approximately $10 million annually, once fully phased in. However, because no appropriation, as of yet, has been made to support the law, DHS has had to delay its implementation. Once implemented evaluation of the program will occur annually during the 3-year phase-in and then at the four- and six-year anniversaries.

Acute Care Task Force Values

The ACTF was guided by several fundamental principles. First, the larger mental health system must continue to develop access to effective prevention services so that there is a reduced need for acute care services. Second, the acute care system must evidence a "No Wrong Door" orientation that creates and sustains rapid access to needed services. Current system limitations related to location, program 'silos,' after-hours access, and cross-system barriers must be overcome. Third, these services should be offered by providers who can deliver evidence-based, best and promising practices. This echoes a main theme of the DMHS Wellness and Recovery Transformation Action Plan, which identified workforce development as critical to a transformed mental health system. Fourth, services must promote and facilitate recovery. The acute care system, as a critical sub-component of the larger mental health system, must emphasize, embody and communicate recovery values (e.g. hope, empowerment, choice) especially during acute episodes. Fifth, consumers and family members must inform and drive system improvement efforts. This maxim is true of the mental health system at large, but is especially poignant in acute care settings. Sixth, task force members were in consensus that individuals presenting to emergency rooms, who are determined to be in need of in-patient psychiatric services, should be able to access this level of care within twenty four hours of a receiving a psychiatric evaluation.

Summary of Deliberations

Among the system challenges examined by the ACTF were long waiting times in emergency rooms for mental health services; inconsistencies around the operational definition of "medical clearance;" length of stay at short term community psychiatric units; use of emergency department based designated screening centers by consumers with non-emergent needs; use of emergency department based designated screening centers by individuals who have no mental illness, but nonetheless use psychiatric emergency services, consumers having insufficient after-hours access to outpatient providers; and difficulties related to meeting the needs of consumers with complex needs related to forensic considerations, co-morbid medical conditions, co-occurring developmental disabilities and co-occurring substance use disorders.

Other challenges include: access to intensive outpatient services in every county; additional availability of early intervention programs; adequate number of crisis/respite beds; peer supports as alternatives to traditional facility based centers; outreach and after hours capacity of existing ambulatory mental health programs; and the design of

integrated primary and behavioral health care services with adequate funding mechanisms.

Cross-systems coordination challenges involving local police, county corrections, nursing homes and schools generated informative dialogue that resulted in a series of recommendations that will necessitate partnerships (e.g. Memoranda of Understanding) among system partners.

The viability of alternative models of acute care received considerable attention. Positioning screening services outside of hospitals, evaluating and expanding existing early intervention pilot programs in New Jersey and further exploration of models involving integration of law-enforcement and mental health staff were concepts that shaped multiple ACTF recommendations.

Consonant with the stakeholder input processes of the DMHS Wellness and Recovery Transformation Action Plan, considerations related to data-driven decision making were prominent during ACTF deliberations. Data management challenges specific to acute care related to high variability of hardware and software found within the provider community; the impact of staff turnover on data management functions; and the lack of an agreed upon automated method for data collection and analysis. Furthermore, recommendations that speak to revisions to the state's twenty one Systems Review Committee's (SRC) practices involve information or data considerations to a significant degree.

Consumer participants contributed valuable input on a range of concerns germane to the ACTF. The need for greater commitment to core human service concepts such as full respect for service recipients' dignity and greater adherence to patient rights policies by hospitals was underscored. Consumers' perspectives on the negative effects of long waiting times in emergency rooms, of not having access to patient advocates, and of being offered limited treatment options (e.g. pharmacology only) were also considered. The desire for greater utilization of Wellness Recovery Action Plans (WRAP) and Psychiatric Advance Directives (PADs) by hospitals in acute care settings was reinforced.

The perspective and concerns of family members of consumers were considered in ACTF deliberations. These included dissatisfaction with waiting times in emergency rooms and the need for greater access to outpatient services as an alternative to emergency room based care, the preference for treating children in need of crisis intervention outside of emergency rooms and the desire for greater collaboration with their loved ones and providers in the treatment and recovery planning activities. Family member participation has pronounced importance in acute care settings and the complex interplay of federal and state confidentiality laws requires on-going commitment of all acute care service providers with regard to staff education in this critical area.

To manage the large and complex task at hand, the ACTF was organized into three sub-committees: Policy, Service Delivery, and Data. Each sub-committee focused on one domain of the task force's larger goal. Sub-committees efforts converged on numerous key concerns. Therefore, recommendations are presented in this report according to a thematic categorization. Recommendations range from highly specific to necessarily general. Due to the broad and wide reaching nature of some recommendations,

categorical overlap is acknowledged. The Division will incorporate recommendations to the extent possible.

Recommendations:

Policy/Regulatory Recommendations

- Adoption of revised Screening Service Regulations that are permissive in terms of the location of screening; ensure that the service is mobile, flexible, and accessible anywhere in the community; ensure access and linkage to community support programs 24/7; articulate the criteria and condition for the use of tele-psychiatry; and involve family members consistent with the Health Information Privacy/Portability Act.

- Review the admission to state hospital protocols that developed as a result of Administrative Order 1:90. (AO 1:90 refers to placement of patients with forensic backgrounds in state psychiatric hospitals).

- DMHS develop a Centralized Admissions process for admission to adult state psychiatric inpatient facilities and companion Administrative Bulletin detailing its operations. The role of Centralized Admissions service should facilitate appropriate State Hospital admissions while working to ensure timely access to the least restrictive, most clinically appropriate treatment setting.

- The development of a standardized Medical Clearance policy to facilitate improved state, county and local psychiatric hospital/unit admission processes.

- The development of a policy encouraging the development of Electronic Health records that meet the national certification requirements.

- Development of regulations for Intensive Outpatient, Involuntary Outpatient Commitment, ICMS and any newly developed acute care services that come on line.

Early Intervention and Alternative Screening Models Recommendations

- Existing early intervention models in New Jersey should be comprehensively examined to determine effectiveness of these programs with regard to diverting emergency room admissions, crisis stabilization, and linkage to services. Expansion of Early Intervention Service (EIS) models can follow as indicated, so as to maximize opportunities for consumers and families to access care early in the crisis cycle and averting the need for emergency room based interventions.

- Develop and implement peer run alternative crisis centers, utilizing research on existing national models.

Systems Monitoring/Data Driven Decision Making Recommendations

- Identification and application of measures to evaluate and determine performance improvement strategies for patient throughput (flow) in hospital emergency rooms.

- Revise policies, procedures, and practice guidelines that empower county based System Review Committees (SRC)s to become a more precise tool for acute care system monitoring and utilization management: Elements must: 1) Establish mechanism for continuous reporting and feedback between System Review Committees and providers; 2) Rely on the principles of performance improvement; 3) Identify high users of acute care services; 4) Assess the use of co-occurring resources in designated screening centers; 5) Collect more detailed data on mobile outreaches; 6) Collect information on the numbers of consumers served through tele-psychiatry; 7) Track wait times to service disposition for persons served in Designated Screening Centers; and 8) Include SRC Membership considerations.

- The establishment of a single, centralized, web-based, client specific data collection set that would facilitate the creation of local and statewide data dashboards, and provide comparable cross-county data to support data-driven planning. This database would collect outcomes, service utilization, fiscal and contract compliance data at the consumer, program element, provider, county and state level. In order to improve the general understanding and use of this newly-modified tool and glossary, DMHS would provide several training opportunities and documentation.

- Complete a Perception of Care Survey for Designated Screening Services that would allow consumers and families to provide feedback regarding their experiences of services received.

- Develop performance based outcome measures to be collected and monitored by SRC committees. Outcome measures include the following:

    1. Decreased wait time for service in DSC.
    2. Decreased wait time for disposition or transfer to an appropriate level of care (e.g. Individuals in need of in-patient psychiatric services, should be able to access this level of care within twenty four hours of a receiving a psychiatric evaluation).
    3. Reduction in recidivism.
    4. Increase in number of DSC community mobile outreach visits resulting in ER/DSC diversion, when clinically appropriate, rather than the consumer being transported to DSC for care.

- Revise existing definitions found on the Quarterly Contract Monitoring Reports, DMHS contract commitments (Annex A) and SRC data collection forms to remove ambiguity and inconsistency in reporting. These revised definitions must be widely disseminated and training options must be made available.

- Evaluate the impact of the newly funded Intensive Outpatient Treatment Support Services (IOTSS). This will include a review of data collection protocols.

- Identify, study, and recognize programs of excellence in the acute care system in order to promote best practices across the system of care.

Improve Access to After-Hours Care in Non ED Settings Recommendations

- Develop incentives to increase community agency provision of crisis intervention services for currently enrolled agency consumers through the application of Wellness Recovery Action Plans and other consumer specific crisis planning tools.

- Require organizations to have 24 hour access to agency staff in order to provide support to individuals experiencing a crisis, in order to decrease the need for more intensive, hospital-based interventions for support. Develop policies, contract monitoring mechanisms and incentives that will increase enrolled consumer access to agency crisis support services during non-business hours so as to provide interventions and supports to deflect enrolled consumers from seeking services in emergency departments.

Funding Recommendations

- Develop funding mechanisms with regard to on-call, after-hours coverage for agency based consumer crisis support services; Tele-psychiatry services; Allowance of modifier codes with higher reimbursement rates for approved services that feature a unique crisis stabilization component. Pursue Medicaid reimbursement for screening-related services that will enable state funds to be re-allocated for preventative services.

- Through Medicaid State Plan Amendments, pursue Federal Medicaid financial participation for non-facility based service interventions designed to offer pre-crisis support and interventions for families and consumers in the community. In like manner pursue support for the inclusion of Peer Wellness Coaches as Medicaid-reimbursable service.

Cross-Systems Coordination Recommendations

- Refine the collaborative relationship between the Division of Child Behavioral Health Services and DMHS funded emergency mental health response services at

the County level through Policies/Protocols and Memorandums of Understanding (MOUs).

- Develop a civil commitment mechanism, specific to the needs of children.

- Evaluate the impact of co-occurring specialist staff currently in Designated Screening Centers and expand co-occurring staffing to additional Screening Centers.

- Develop a systemic mechanism whereby children can receive non-emergent services in their community such as at the school, at home or at an outpatient mental health provider, rather than inappropriate referral to the emergency room screening center. Develop a monitoring system to quantify the prevalence of schools referring children to ERs and DSC for purposes of risk assessment/school clearance. The Department of Education should be consulted on this.

Extended Acute Care Inpatient Service Development Recommendations

- Develop a program and financial model with the Department of Health and Senior Services (DHSS) and the Division of Medical Assistance and Health Services (DMAHS) for community hospital based Inpatient Services, capable of providing an extended length of stay beyond that currently provided by STCF's for consumers who otherwise would require ongoing services at a State or County Hospital.

Physical Healthcare Recommendations

- Recommend that feedback on the Atlantic County collaboration of Early Intervention Support Services (EISS) and Federally Qualified Health Centers (FQHC) is gathered and analyzed to inform future activities and potential replication in other geographic areas.

- DMHS, DCBHS, and DMAHS should convene community-based providers, hospitals, FQHCs and primary care to ensure care coordination (e.g. "Medical Homes") for people with mental illness to help reduce ED recidivism.

Expanded Consumer/Family Involvement in the Acute Care System Recommendations

- Creation of new and expanded roles for consumers in early intervention, outreach and support services programs so as to augment the availability of peer provided support to persons living in the community at risk. Pursue federal financial participation for peer operated outreach services to support such an expansion.

- Implement a Psychiatric Advance Directive (PAD) and Wellness Recovery Action Plans registry that is web-based and accessible, with consumer consent, to the provider community.

- Expand peer and family staff in all mental health acute care settings.

- Ongoing training should be provided to families, agencies and consumers as to the correct application of confidentiality laws within the health care process.

Systems Mapping Recommendations

- Conduct a statewide and county based comprehensive mental health system mapping that:

    1. Delineates the optimal mental health system of care, inclusive of adequate detail of both non-acute and acute care services in both hospital and non-hospital based settings.
    2. Develops a template for the continuum of care.
    3. Identifies and addresses gaps, access and capacity issues in the county mental health service delivery system.

Considerations – Next Steps

The vast series of recommendations produced by the ACTF must be integrated into the larger framework of system transformation activities already underway in New Jersey's mental health system. These activities have been articulated in the DMHS' Wellness and Recovery Transformation Action Plan (October, 2007) and the Home to Recovery – CEPP Plan (January, 2008). The concurrent efforts of three other task forces will also inform the context in which the ACTF recommendations will be considered. These include the following:

- Primary Care Task Force, led by the Division of Mental Health Services
- Co-Occurring Disorders Task Force, led jointly by the Division of Mental Health Services and the Division of Addiction Services
- Dual Diagnosis Task Force, led jointly by the Division of Mental Health Services and the Division of Developmental Disabilities

Collectively, the recommendations of the ACTF envision an acute care system that better meets the needs of consumers and families in several fundamental ways. First, the full range of preventative community mental health services will be more available to system users. As preventative and least restrictive service options within the larger mental health system are further developed and enhanced, a more proportional use of acute care settings will ensue.

Second, acute care system users will experience improved access to recovery oriented mental health services. This improved access will take the form of more rapid access in many instances, and to a greater degree, come from service providers with whom consumers already have a relationship. Existing program boundaries related to hours of availability will be redefined with after-hour service and non-hospital based options being more prevalent.

Third, a greater emphasis on evaluation of the effectiveness of acute care programs and systems will be evident. Evaluation of programs and systems will occur at both local and statewide levels. These evaluative activities will identify system strengths, needs and gaps, while providing decision makers with more robust data for system enhancement initiatives.

Fourth, the idea that consumers can guide and drive their own recovery services will further penetrate the acute care system as evidenced by more widespread recognition and use of Psychiatric Advance Directives and Wellness Recovery Action Plans within acute care contexts.

Fifth, consumers will more readily receive services that are integrated and holistic as more cross-system capacities are developed within both the acute care and the larger public mental health system. Artificial bifurcations related to healthcare, developmental disabilities, substance use and forensic considerations will fade as more system partners develop competencies across current “specialties.”

The scope of these recommendations is great, and many will not be easily or quickly achieved. Given the existing budget constraints, the ACTF is hopeful that efforts to implement these recommendations will be embraced and will move forward.

APPENDIX A

Utilization of New Jersey Designated Screening Centers: 2007 – 2009.

In recent years, the use of New Jersey's designated screening centers has not dramatically increased. This observation holds true when looking at two independent datasets maintained by the New Jersey Division of Mental Health Services (DMHS)—the Quarterly Contract Monitoring Report (QCMR) and the Systems Review Committee (SRC) datasets. It is noteworthy that both the QCMR and SRC are populated by data that is self-reported by the screening centers themselves.

The QCMR database collects quarterly, cumulative, program-specific data from each of the service providers contracted by DMHS. Approximately 175 separate agencies provide QCMR data on roughly 630 separate program elements on a quarterly basis.

Systems Review Committee (SRC) meetings are county-level meetings convened since the 1980s for the purpose of sharing local (county-specific) information to stakeholders and the general public. The DSC providers in each county self-report their SRC data to DMHS central office for data scrubbing and aggregation into both regional and statewide data. SRC data is helpful for comparing system flow among agencies, identifying service gaps, and identifying efficiencies.

Table 1: Counts of Admissions to DSC, NJ Population and Utilization Rates

Counts					
Year	Total Admissions Served in DSC (Adults and those under age 18)		US Census Population Estimates of New Jersey as of July 1	Utilization Rate per 1000 state residents	
	SRC Data	QCMR dataset		SRC Data	QCMR dataset
2007	83,225	90,003	8,636,043	9.6	10.4
2008	87,036	91,781	8,663,398	10.0	10.6
2009	85,236	88,127	8,707,739	9.8	10.1

In Table 1 the results of the SRC and QCMR datasets are compared to each other, as well as to population estimates provided by the US Census Bureau[6]. Considering the large number of values recorded by both the SRC and QCMR protocols, the magnitude of difference among the two is slight (ranging between 4% - 8%), particularly when considered that each data set is self-reported by providers.

[6] See: http://www.census.gov/popest/states/tables/NST-EST2009-01.xls

The percent change between 2007 to 2008, and from 2008 to 2009 are indicated below in Table 2.

Table 2: Percent Changes in Admissions to DSC, NJ Population and Utilization Rates: 2007 to 2009

Table 2

Percent Change					
Year	Total Admissions Served in DSC (Adults and those under age 18)		US Census Population Estimates of New Jersey as of July 1	Utilization Rate per 1000 state residents	
	SRC Data	QCMR dataset		SRC Data	QCMR dataset
2007 - 2008 Change	4.58%	1.98%	0.32%	4.25%	1.65%
2008 - 2009 Change	-2.07%	-3.98%	0.51%	-2.57%	-4.47%
2007 - 2009 **Total Change**	2.42%	-2.08%	0.83%	1.57%	-2.89%

Although state population has increased slightly, utilization rates (per 1000 residents) increased modestly between 2007 & 2008, and then decreased between 2008 and 2009.

APPENDIX B

ACUTE CARE TASK FORCE PARTICIPANTS

PARTICIPANT	AFFILIATION
Alkhalailah, Michele	Care Plus Behavioral Healthcare
Anderson, Chris	Morristown Memorial Hospital
Axelrod, Sylvia	National Alliance on Mental Illness, New Jersey
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Caliwan, Julie	NJ Division of Developmental Disabilities
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Dauerman, Rebecca	St. Clare's Hospital
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Gantner, Ellen	Hunterdon Medical Center
Gevirtz, Larry	Archway Programs
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Goodman, Elaine	National Alliance on Mental Illness - LEEP
Gutstein, Joseph	Bergen County Mental Health Board
Hayes, Paula	NJ Division of Mental Health Services
Kaldany, Herbert	NJ Department of Corrections
Kruszczynski, Mark	NJ Division of Mental Health Services
Larosiliere, Valerie	NJ Division of Mental Health Services
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Miller, Joseph	Meridian Health System
Miller, Michele	University Behavioral Health Care
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Moore, David	South Jersey Behavioral Healthcare
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Noto, June	New Jersey Association of Mental Health Agencies
Nussbaum, Chuck	NJ Division of Mental Health Services
Oakes, Anthony	Care Plus Behavioral Healthcare
Ownes, Loyal	Steininger Behavioral Health
Pedley, Marguerite	Princeton House
Poag, Jonathan	NJ Division of Mental Health Services
Powlikowski, Mary	Carrier Clinic
Quinn, Thomas	St. Mary's Hospital
Rainier, Susanne	NJ Division of Mental Health Services

Reilly, Joanne	Ramapo Ridge, Christian Health Care Center
Remington, Judy	New Jersey Association of Mental Health Agencies
Reynolds, Mary Lynn	Mental Health Association of Southwest NJ
Richardson, Shalet	Collaborative Support Programs of New Jersey
Robinson, Nadia	NJ Division of Children's Behavioral Health Services
Romer, James	Kimball Medical Center
Rosamilla, Tom	Morristown Memorial Hospital
Ruooco, Lorraine	Buttonwood Hospital
Sarle, Richard	Carrier Clinic
Schade-Button, Lisa	St. Clare's Hospital
Tilley, Steve	Healthcare Commons Inc.
Ume, Joseph	Newark Beth Israel Hospital
Velez-Rigney, Lenore	NJ Division of Mental Health Services
Verney, John	NJ Division of Mental Health Services
Wohl, Richard	Princeton Behavioral Health

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