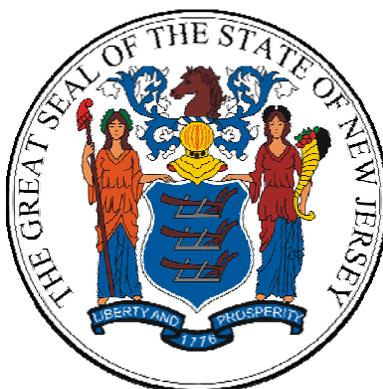


New Jersey
State Mental Health Facilities Evaluation Task Force

A Review of the Department of Human Services
Plan for the Closure of the Senator Garrett W. Hagedorn
Psychiatric Hospital

Final Report

Submitted to Governor Chris Christie
and
the New Jersey Legislature



February 1, 2011

Report of the Mental Health Facilities Task Force

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Executive Summary

The State Mental Health Facilities Evaluation Task Force was created by the New Jersey Legislature and signed into law (P.L. 2010, c. 081 (A2866 1R)) by Governor Chris Christie to evaluate the Department of Human Services “Plan for the Closure of Garrett W. Hagedorn Psychiatric Hospital.” Membership of the Task Force was established by the Legislature. There was disagreement by some members regarding the charge of the Task Force, nonetheless, the Task Force endeavored to comply with the law as written.

The Task Force was unable to reach consensus regarding whether Hagedorn should close. At the last meeting, a vote was taken with ten members in favor of keeping the hospital open and seven supporting the closure; there were four abstentions¹. Several members felt there was insufficient time to make an informed decision.

Despite lack of consensus on closure, four key themes were prevalent throughout the deliberations that should guide decision-makers. First, all persons receiving mental health services are entitled to be treated with dignity and in the least restrictive setting appropriate to their needs. Second, the public mental health system should provide a continuum of quality community and hospital-based services to meet the needs of consumers at various points in their recovery. Third, should any facility be closed or savings realized through census reduction, funds should be reinvested into community-based services consistent with New Jersey’s Community Mental Health and Developmental Disabilities Services Investment Act. Fourth, budget reductions should not be extracted from community-based services in lieu of state hospitals if a decision is made not to close a state hospital.

Over the past six fiscal years, resources have been made available to the Division of Mental Health Services in the Department of Human Services to implement its *Olmstead* plan and settlement agreement resulting in the development of community placements and a significant decrease in the state psychiatric hospital census. The decrease in state hospital utilization, the need to preserve community-based services while maintaining safety net inpatient care, and the residual impact of the recession prompted the Department of Human Services to re-examine the most efficient allocation of its resources to meet the diverse needs of New Jersey residents with mental illness.

This report summarizes the deliberations of the Task Force members and information received at three public hearings in considering the Department’s plan to close Hagedorn. Multiple perspectives are reflected throughout the report suggesting the complexities in such a decision, including the need to balance resources, provide a statewide continuum of services, and ensure quality. The report considers an alternate four-page proposal submitted by five members to close Trenton Psychiatric Hospital, consumer perspectives and recommendations to further explore privatization.

¹ Some members opposed ex-officio members voting. Under Roberts Rules of Order, “Without exception, ex-officio members of boards and committees have exactly the same rights and privileges as do all other members, including, of course, the right to vote.” <http://www.robertsrules.com/faq.html#2>

Introduction

Over the past six fiscal years, resources have been made available to the Division of Mental Health Services (Division/DMHS) in the Department of Human Services to implement its *Olmstead* plan² and settlement agreement³ resulting in the development of community placements and a significant decrease in the state psychiatric hospital census (See discussion of *Olmstead* on page 7). Previously, many patients who no longer met civil commitment criteria waited long periods of time for community placement.

The decrease in state hospital utilization, the need to preserve community-based services while maintaining safety net inpatient care, and the residual impact of the recession prompted the Department of Human Services (the Department/DHS) to re-examine the most efficient allocation of its resources to meet the diverse needs of New Jersey residents with mental illness. Consistent with national trends, the Department released a plan⁴ in November 2010 to close the Senator Garrett W. Hagedorn Psychiatric Hospital in Glen Gardner, New Jersey. Among the factors considered by the Department in its recommendation included rebalancing the state hospitals due to significant census decline as a result of *Olmstead*, savings that could be reallocated as a result of a full facility closure, capital cost avoidance, campus interoperativity, maintaining geographic accessibility for consumers and families, and forensics.

Subsequently, a State Mental Health Facilities Evaluation Task Force was created by the legislature and signed into law by Governor Chris Christie to evaluate the closure plan. The legislation (Attachment 1) required the Task Force to “at a minimum, review and assess the viability of the department’s “Plan for the Closure of the Senator Garrett W. Hagedorn Psychiatric Hospital” and its impact on New Jersey’s State psychiatric facility system.” Further, the Task Force was directed to advise DHS on the following six issues:

- (1) The plan’s consistency with the United States Supreme Court *Olmstead* decision and the Department’s July 2009 *Olmstead* Settlement Agreement;
- (2) Whether sufficient capacity and appropriate staff expertise will be made available in the remaining State psychiatric facilities to accommodate the current and future needs of patients requiring that level of care, including, but not limited to, an evaluation of geriatric care;
- (3) Whether geographic accessibility for State psychiatric facility care is maintained throughout the State, while considering the option of specialization of care at a single location;
- (4) Whether the State psychiatric facility system can accommodate patients with a forensic background, while considering the option of specialization of care at a single location;
- (5) Whether the Plan adequately examines the allocation of State resources between the State psychiatric facility system and community system of care, while

² See http://www.state.nj.us/humanservices/dmhs/olmstead/CEPP_Plan_1_23_08_FINAL.pdf

³ See http://www.state.nj.us/humanservices/dmhs/olmstead/olmstead_settlement_agreement.pdf

⁴ See <http://www.state.nj.us/humanservices/dmhs/home/HPH%20-%20Plan%20for%20Closure.pdf>

considering how to yield the most savings from the State psychiatric facility system;

- (6) The impact on other State and private agencies that share State-owned campuses, as well as the impact on area hospitals and the community mental health system.

In addition to its meetings and deliberations, members attended three public hearings, one scheduled in each of the State's regions. One of the Task Force meetings was held at Hagedorn Psychiatric Hospital, where a tour was provided to interested Task Force members, and a tour of Greystone Psychiatric Hospital was provided to interested Task Force members in conjunction with the public hearing held there.

This report summarizes the public hearings and the deliberations of the Task Force members regarding each of the six issues as they pertain to the Department's plan to close Hagedorn. Contained within the report are details of budget and property considerations that were topics of concern to Task Force members. In addition, the report reflects the introduction of an alternate proposal, submitted by five Task Force members, to close Trenton Psychiatric Hospital instead of Hagedorn (Attachment 4), as well as a paper presented by four Task Force members on consumer perspectives and system considerations (Attachment 5). Both documents are attached as submitted.

Although the Task Force was not able to reach consensus regarding the State's Closure Plan, four key themes were prevalent throughout the deliberations. First, all persons receiving mental health services are entitled to be treated with dignity and in the least restrictive setting appropriate to their needs. Second, the public mental health system should provide a continuum of quality, community and hospital-based services to meet the needs of consumers at various points in their recovery. Third, should any facility be closed or savings realized through census reduction, funds should be reinvested into community-based services consistent with New Jersey's Community Mental Health and Developmental Disabilities Services Investment Act (See Attachment 6). Fourth, budget reductions should not be extracted from community-based services in lieu of state hospitals if a decision is made not to close a state hospital.

Process

Membership of the Task Force was established by legislation and consisted of 21 members. The selection of Task Force members was detailed in the enabling legislation to include four ex-officio members from the Department of Human Services, two members each from the Senate and the General Assembly, representing both political parties, and 13 public members who are residents of New Jersey. Eleven of the members were chosen by the Governor. Their membership was required to include a county mental health administrator, a county human services director, a member of the board of trustees of a state psychiatric facility, and one member of the general public with an interest or expertise in the work of the task force. In addition, persons were appointed based upon the recommendations of the following:

- New Jersey Association of Mental Health and Addiction Agencies
- National Alliance on Mental Illness New Jersey
- Mental Health Association in New Jersey
- Institute for Health, Health Care Policy, and Aging Research at Rutgers, The State University of New Jersey
- New Jersey Psychiatric Rehabilitation Association
- New Jersey Hospital Association
- Coalition of Mental Health Consumer Organizations of New Jersey

Two additional members with interest or expertise in the work of the task force who have or have had a family member who is or has been a mental health consumer at a state psychiatric facility were also selected. One each was appointed by the President of the Senate and the Speaker of the General Assembly. The full list of Task Force members is appended to this report.

The Task Force met on the following dates:

November 18, 2010	Department of Human Services	1:00 – 4:00pm
December 3, 2010	Department of Human Services	1:00 – 4:00pm
December 17, 2010	Hagedorn Psychiatric Hospital	1:00 – 4:00pm
January 7, 2011	Department of Human Services	1:00 – 4:00pm
January 14, 2011	Department of Human Services	1:00 – 4:00pm
January 21, 2011	Department of Human Services	1:00 – 3:00pm
January 28, 2011	Department of Human Services	1:00 – 4:00pm

Note: January 21, 2011 meeting was a conference call due to inclement weather. All other meetings were held in person, and when Task Members were unable to be physically present at any meeting they had the opportunity to participate via conference call.

Meetings were structured around discussion of the legislated topics. Meeting summaries were provided to the Task Force at each subsequent meeting with an opportunity to correct or modify them as needed. The meeting summaries are included as Attachment 7. Speakers were brought in by DHS as needed to provide additional information requested by Task Force members. They included Dr. Robert Eilers, DMHS Medical Director, Steve Adams, DMHS Chief Financial Officer, and Katherine Fling, Director, DHS Office of Property Management and Construction.

At the meetings, the Task Force attempted to answer each of the questions outlined in the legislation. There was disagreement on the process initially in that some Task Force members wanted to vote on whether the hospital should remain open, while others asserted that the Task Force's charge was to answer the questions outlined in the legislation in order to inform decision-makers going forward. At the last meeting, a vote was taken with ten members in favor of keeping the hospital open and seven supporting the closure; there were four abstentions. Several Task Force members expressed concern that the duration of the Task Force process was insufficient to address these very complex issues.

Although the Task Force was unable to reach consensus regarding either the Department's Plan or the alternate proposal to close Trenton, the Task Force considered the questions, to the extent possible, in the context of the legislation as applicable to the Department's plan to close Hagedorn and the alternate suggestion to close Trenton Psychiatric Hospital. This report reflects the diverse views of the Task Force members.

Public Hearings

As required by statute, notification was given and three public hearings were held, one each in the northern, central and southern parts of the State in order to provide ample opportunity for individuals who wanted to provide testimony. Speakers were asked to submit their statements in writing. The names of people who testified and their affiliations can be found in Attachment 3.

In total, 63 people provided testimony at the three hearings with most opposing closure. These included a heavy presence from Hagedorn Psychiatric Hospital staff, union representatives, family members with relatives at the hospital, a representative of NAMI-NJ, local business representatives, and a representative of Freedom House, a not-for-profit agency based on the grounds of Hagedorn. Individuals also spoke in support of closure, including mental health consumers and representatives of consumer advocacy organizations, a family member with a relative residing in the community, a representative from Disability Rights New Jersey, and representatives from several mental health community provider organizations. At least eight individuals, some supporting closure, some opposing it, spoke at more than one hearing. Written testimony was also submitted by individuals or on behalf of organizations through emails or letters sent to the Task Force. Most of the letters opposed the closure of Hagedorn.

The Northern Region hearing was held on December 1, 2010 at Greystone Park Psychiatric Hospital, and the following Task Force members attended: Jennifer Velez, Chair, Carolyn Beauchamp, Robert Bollaro, Assemblyman DiMaio, Assemblyman Diegnan, Ken Gill, Gilbert Honigfeld, Barry Johnson, Karen Kubert, Valerie Larosiliere, Judy Lucas, Rosalyn Metzger, Joseph Miller, Ed Smith representing Senator Doherty, Wayne Vivian, and Debra Wentz.

One of the twenty-one individuals testifying supported closing Hagedorn. Twenty individuals were opposed to closing the hospital. Of those twenty opposing the closing, ten were employees of the hospital. Others providing testimony included a mental health provider, advocates (2), family members (4), Hagedorn Board members (2), union representatives, some of whom also were hospital employees (3) and one Hagedorn employee who read a letter from a patient at the hospital.

Recurrent themes of the testimony included the following:

- Individuals opposing the plan to close Hagedorn indicated that the hospital has specialized equipment such as wall oxygen and suction machines, that Hagedorn has a good physical set-up to meet the needs of older adults, such as elevators,

ramps, wide doors, etc. and that Hagedorn is a well run facility that provides unique care.

- The individual providing support for the plan to close Hagedorn indicated strong support for community placements.

The Central Region hearing was held at the Division of Developmental Disabilities Central Office in Hamilton Township on December 8, 2010 with the following Task Force members in attendance: Jennifer Velez, Chair, Margaret Swarbrick, Vice-Chair, Dawn Apgar, Sylvia Axelrod, Carolyn Beauchamp, Robert Bollaro, Kenneth Gill, Gilbert Honigfeld, Candice Howard representing Assemblyman Diegnan, Valerie Larosiliere, Judith Lucas, Rosalyn Metzger, Joseph Miller and Ed Smith representing Senator Doherty.

Six of the twenty-two individuals testifying supported closing Hagedorn. Sixteen individuals were opposed to closing the hospital. Of those sixteen opposing the closing, ten were employees of the hospital, some of whom had also testified at the Northern Region hearing. Others providing testimony included: mental health advocates (3), union representatives (2), consumers (2), family members (2) and concerned citizens (2).

Recurrent themes of the testimony included the following:

- Individuals supporting the plan to close Hagedorn indicated strong support for community living for consumers in general, specific support for the development of services to support older adult consumers in the community and support for rebalancing resources from the hospital to the community.
- Individuals opposing the plan to close Hagedorn saw the small size of Hagedorn Hospital as an advantage, were pleased with the good care provided to family members and pointed to Hagedorn's unique programs.

The Southern Region hearing was held at Rutgers-Camden on December 15, 2010 with the following Task Force members in attendance: Jennifer Velez, Chair, Dawn Apgar, Ken Gill, Barry Johnson, Karen Kubert, Valerie Larosiliere, Gail Masson-Romano, Ed Smith representing Senator Doherty, and Debra Wentz.

Twenty individuals provided testimony. Six of the twenty were in support of the plan to close Hagedorn Hospital. Fourteen were opposed to closure. Of the fourteen opposed to closure, nine were staff at Hagedorn, some of whom testified at previous hearings. Others presenting testimony included providers (3), consumers (3), mental health advocate (1), union representatives (2), professor (1) and concerned citizen (1) with two of these people also testifying at the previous hearing.

Recurrent themes of the testimony included the following:

- Individuals supporting the plan to close Hagedorn indicated strong support for community living for consumers in general, specific support for the development of services to support older adult consumers in the community and support for rebalancing resources from the hospital to the community.
- Individuals opposing the plan to close Hagedorn indicated concern regarding the outcomes for individuals discharged into the community, considered the small size of Hagedorn Psychiatric Hospital as an advantage and pointed to its unique programs and trained staff.

Legislative Questions

1. Plan's Consistency with *Olmstead* and with the 2009 *Olmstead* Settlement Agreement

Background:

The 1999 U.S. Supreme Court's *Olmstead* decision (*Olmstead v. L.C.* 527 U.S. 581) required public entities, under Title II of the Americans with Disabilities Act (ADA), to provide services in the "most integrated setting appropriate to the needs of qualified individuals with disabilities." The "most integrated setting" is one in the community where people with disabilities can participate fully in all aspects of community life. 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."

In 2009, DHS settled *Olmstead* litigation brought by Disability Rights, NJ that alleged that people who no longer met civil commitment criteria were unnecessarily confined to state psychiatric hospitals on Conditional Extension Pending Placement (CEPP) status. New Jersey's *Olmstead* Settlement Agreement consists of annual discharge targets for individuals placed on CEPP status after July 1, 2008, and the requirement that the 297 consumers placed on CEPP status prior to July 1, 2008 be discharged by June 30, 2014. In addition, the agreement commits DHS to utilize a combination of Residential Intensive Support Teams (RIST), Supportive Housing (SH), Programs of Assertive Community Treatment (PACT) and Specialized Housing to create 695 placements for individuals on CEPP status and 370 placements for individuals "at risk" of hospitalization who reside in the community.

The plan envisions reductions in the number of geriatric and non-geriatric beds in the State hospitals based upon the creation of community residential and treatment options as proposed in the State's *Olmstead* Settlement Agreement and "Home to Recovery" CEPP Plan.

Discussion:

Task Force members generally agreed that the Department's plan for the closure of Hagedorn Psychiatric Hospital (HPH) is consistent with the 1999 US Supreme Court's *Olmstead* decision and the 2009 *Olmstead* Settlement Agreement. There was recognition by some that a decreasing patient census is resulting in a smaller state hospital system requiring DHS to examine hospital re-configuration and the most efficient allocation of resources. However, four general qualifiers emerged in the discussions.

- One view was that consistency with *Olmstead* exists to the extent that new less restrictive alternatives to institutional care are developed for people with current and future CEPP status, as well as others who may be better served outside of an institutional environment. Building on this approach would favor community treatment options that reduced the need for state hospital level care and stabilized individuals without requiring inpatient commitment. Some Task Force members, as well as testimony received in public hearings, alluded to research favoring non-institutionalized settings for older adults. Task Force members voiced concern that some of these community programs and placements are not currently in place for the gero-psychiatric population and cost data were not discussed.
- Another perspective suggested that while closing Hagedorn is consistent with *Olmstead*, its closure may result in additional unused beds in the state hospital system at some point in the future. According to this view, closing a larger facility, such as Trenton, would be more consistent with the reductions achieved through *Olmstead*. The issue is whether having closed Hagedorn, the State would find itself needing to contemplate further reductions in just a few years, or whether Hagedorn's closure would allow each of the remaining hospitals to operate at a lower, more optimal capacity.
- Third, while the DHS Plan's emphasis on community integration may be deemed by many Task Force members to be consistent with *Olmstead*, some Task Force members contend that *Olmstead*, in and of itself, does not mandate the closing of a facility. Rather, they suggest that it is an administrative decision on managing resources and other cost-cutting options may exist that could avoid Hagedorn's closure.
- Fourth, continuing implementation of the *Olmstead* Settlement Agreement will generate less need for state hospital capacity and greater need for community services. Several Task Force members recommended creation of a standing planning body composed of mental health experts to help guide this process, including decisions regarding proposed closures or bed reduction strategies.

Recommendations:

Any plan for the closure of Hagedorn that relies on nursing homes and board and care facilities would not have the endorsement of the Task Force, would be contrary to the *Olmstead* decision and perceived as trans-institutionalization. Regardless of whether Hagedorn closes, the Task Force recommends appropriate program alternatives that include, but are not limited to: the Geriatric Mobile Outreach Team described in the Department of Human Service's closure plan. Additional recommended options that support community integration include PACT, SH, and RIST (which combines elements of PACT and SH), as well as PACE, the Program of All-Inclusive Care for the Elderly. All of these models currently provide services to persons in their homes. The staffing pattern, expertise and training for these programs would have to be adapted to meet the needs of older adults, including those with complex medical needs. Given the minimal numbers involved, this is feasible. It was noted by a Task Force member that limited research and evidence-based programs exist for older adults in New Jersey and nationally.

Other alternatives suggested are residential arrangements such as supportive housing with a strong focus on medical and geropsychiatric needs. It is important that appropriate placement opportunities be developed prior to the closure of Hagedorn. The Department of Human Services should work with the Department of Health and Senior Services to optimize existing community services for individuals with Alzheimer's and other dementias who have behavioral disturbances.

- 2. Whether sufficient capacity and appropriate staff expertise will be made available in the remaining State psychiatric facilities to accommodate the current and future needs of patients requiring that level of care, including, but not limited to, an evaluation of geriatric care.**

Background:

As a result of *Olmstead*, the Department has experienced a significant reduction in the statewide patient census. Since 2006, there are approximately 600 fewer patients in state hospitals who are now living in more integrated community-based settings. This has resulted in significant available capacity throughout the system. Based on current trends and planned *Olmstead* placements, DHS projects a state hospital system of approximately 1,350 patients (1,550 including Ann Klein Forensic Center) by June 2012.

On the demand side, population projections indicate continuing growth in the number of older adults (those 65 and older) as the baby boomer generation ages. In 2009, U.S. Census Bureau estimates for New Jersey indicated that older adults made up 13.5% of the State's population; there were 1,173,024 older adults out of an estimated state population of 8,707,739. Population projections suggest that older adults could make up 15% of the population by 2015. Better information about their impact on the state's population will become available later this year as more Census 2010 information is released and projections are updated. Currently, there are about 13

older adult admissions per month into the state hospitals. Statewide, DHS anticipates one additional older adult admission per month by SFY 2012 and two additional admissions per month by 2014.

Of concern is the dearth of literature regarding best practices and outcomes for older adults with mental illness. New Jersey is not unlike other states needing to develop a continuum of care for this population, including aftercare for those discharged from institutional settings, particularly important in light of *Olmstead*.

Hagedorn and Division staff have assessed patients at Hagedorn according to their characteristics (e.g. psychiatric and medical diagnosis, behaviors, barriers to discharge). Information regarding older adults currently served suggests that most have diagnoses of serious mental illness and about 25% have dementia with emotional disturbances. Most patients in the entire system have significant co-morbid medical diagnoses that are managed currently by the hospitals, often in coordination with local acute care hospitals depending on the level of need.

Discussion:

There was consensus that sufficient capacity and adequate expertise exists in the three other psychiatric hospitals to serve the non-gero-psychiatric consumers served currently at Hagedorn. There is not universal agreement that with *Olmstead*, sufficient capacity exists at Ancora and Trenton to serve the older adult population.

However, some task force members disputed the Department's growth projections, and believed that the system, without Hagedorn, could not accommodate growth in the older adult population. Further, most Task Force members did not feel that the plan was specific enough in its description of the community-based services and state hospital inpatient services that will be provided to the gero-psychiatric population. These members wanted assurances that appropriate services would be available and operational for this population if Hagedorn were to close. Task Force members would not endorse any proposal that does not strengthen the continuum of care in the community, particularly for older adults.

A variety of concerns were expressed by Task Force members regarding quality of care for the older adult and medically vulnerable populations. Several Task Force members believed that Hagedorn provides a higher level of care that cannot be replicated elsewhere in the system. They suggested that transfers from other hospitals to Hagedorn are evidence of this higher quality.

DHS staff was asked to provide information on quality and system capabilities. Given the high incidence of co-morbid medical conditions that exist in the mental health population, such as diabetes and metabolic syndrome, DHS staff indicated that all of the hospitals now serve individuals with serious medical co-morbidities. DHS also presented data on various quality indicators to suggest that each of the facilities is comparable in quality of care and has unique strengths and weaknesses.

Examples of indicators monitored across the state hospitals that were discussed included the following:

- 30-day recidivism (Greystone lowest followed by TPH.)
- Polypharmacy⁵ (Greystone had the highest use of combination antipsychotics followed by Hagedorn; Trenton had the lowest use of multiple psychotropic medications followed by Hagedorn.)
- Assaults (Hagedorn had highest rate of patient to staff assaults resulting in minor or moderate injury; TPH had highest rate of patient to patient assaults resulting in major injury.)
- Falls (Trenton had lowest fall rates due to seizure or unsteady gait; Hagedorn had highest rate of falls with injury in all categories but two.)
- Restraint use (Decreased most at Greystone followed by Hagedorn and Ancora; TPH had no change.)
- Accreditation (All facilities currently meet standards of care established by CMS and are accredited by the Joint Commission; at this time, neither Ancora nor Hagedorn have final reports from CMS for their most recent surveys.)

Several Task Force members remained unconvinced that older adults with mental illness would receive the same quality of care at another facility. Their concerns were many and varied, including issues regarding locating older adults in hospitals that share the same grounds as facilities with forensic patients even if patients were in separate buildings or separate units. Some Task Force members expressed unease about the impact that transfers could have on a vulnerable population still in need of inpatient care. Others worried that staff training would be needed to ensure appropriate care and stated that the type of training and its costs were not adequately addressed in the Hagedorn Closure Plan.

Among Task Force members and those who testified in opposition to a Hagedorn closure, there was the view that the hospital's culture is more family-like and supportive of quality care. While Hagedorn staff might be offered transfers to geropsychiatric units at other facilities, some might choose to go elsewhere or retire, a factor regardless of the facility that is chosen for closure. Despite DHS's intent to offer the same or better complement of services for older and medically complex adults elsewhere in the system, the opinion of some Task Force members was that replication of the "parts" that make Hagedorn successful might not reproduce beneficial outcomes elsewhere.

Regarding staffing, a closure of Hagedorn would have less of an impact on employees who are New Jersey residents whereas a closure of Trenton would have a greater

⁵ Polypharmacy refers to the prescribing of multiple psychiatric medications and complex medication regimes. Polypharmacy increases the potential drug interactions and adverse side effects. Adverse side effects, particularly in an older adult who is prescribed multiple psychiatric medications can increase the individual's risk for falls, increased confusion and metabolic effects (i.e. weight gain, cardiovascular disease, increased lipids and glucose).

impact on employees who are New Jersey residents. As discussed in the Department's Hagedorn Closure Plan, currently, 37% (268) of Hagedorn employees are Pennsylvania residents and 63% (462) are New Jersey residents (April 2010 data). With legislation that recently passed the legislature requiring state employees to be New Jersey residents, Hagedorn will begin to experience recruitment issues if the bill is signed into law. With the alternate proposal to close Trenton Psychiatric Hospital, the Department examined Trenton's staffing data. At Trenton, 88% (1028) are New Jersey residents and only 12% (139) are Pennsylvania residents. A closure of TPH will disproportionately impact New Jersey residents.

The alternate proposal, as written, to close Trenton Psychiatric Hospital in one year would not provide sufficient bed capacity to meet current system needs. However, keeping roughly six of the patient care buildings operational but under the oversight of Ann Klein Forensic Center could provide enough bed capacity system wide, but would require a major reconfiguration at each of the hospitals and could not be accomplished in one year. The proposal did not detail staffing and space needs pertaining to forensics. Should this proposal move forward, additional planning and a longer time-frame for closure would need to be considered.

Overall, there is a general view that a specialized facility is best suited to offer appropriate and optimal care for older adults who meet civil commitment criteria, yet some Task Force members wondered whether there is the statewide demand to justify a distinct specialty hospital for older adults. For this reason, several Task Force members proposed inclusion of medically-compromised younger adults as an additional hospital specialty, though it was generally accepted that each of the hospitals will need to serve these individuals given the prevalence of medical problems in the population. It is debatable whether, under *Olmstead*, an inpatient state psychiatric facility is the least restrictive and most appropriate setting in which to serve the vast majority of individuals with Alzheimer's or other dementias. An alternative suggested is to convert Hagedorn to a private, non-profit specialty hospital representing a private-state partnership under state authority and oversight. Such an approach allows the state to explore new models of care that have the potential for both cost savings and quality care.

Recommendations:

- Hospital quality of care poses significant concerns. Efforts must be made to improve care quality at each hospital and to ensure that all facilities, including gero-psychiatric units, provide safe, clinically appropriate care that embodies best practices, including the requisite medical expertise, technology, and nursing and other professional support.
- Provisions should be made for staff training to ensure quality care for older adults on all specialty gero-psychiatric units.
- To the extent possible, complete staffing units should move with patient groups to other hospitals.

- An advisory panel of consumers, families and mental health professionals should be convened to monitor patient/family concerns during the transition. Special attention should be given to protocols for transferring current patients who may be frail or medically-vulnerable to ensure their well-being and safety.
 - Should Hagedorn close, consideration should be given to using the facility to provide community care to older adults with mental illnesses.
 - Consideration should also be given to convert Hagedorn to a private, non-profit specialty hospital representing a private-state partnership under state authority and oversight.
- 3. Whether geographic accessibility for State psychiatric facility care is maintained throughout the State, while considering the option of specialization of care at a single location.**

Background:

The Department of Human Services has traditionally structured its service system to optimize geographic accessibility in order to facilitate family contact while consumers are in state psychiatric hospitals. The belief values the importance of family support in a person's recovery and that families are more likely to visit relatives who are situated closer to home. In addition, providers have a better opportunity to facilitate linkages back into the community of residence at a critical juncture in a patient's return to the community when there is geographic proximity to a hospital. Having to travel long distances increases the cost and decreases the efficiency of these services. In previous county reconfigurations over the years, family members, consumers, providers, and elected officials all stressed the importance of ensuring geographic access to minimize travel burdens.

The Hagedorn Closure Plan calls for serving older adults with mental illness and other adults with medically complex conditions at Trenton and Ancora, with younger adults served according to their county of residence.

Discussion:

Most Task Force members agreed that geographic accessibility is important, but some asserted that location should not be the sole reason for deciding which hospital to close. Some members felt that quality of care was more important than geographic accessibility and indicated that families are typically willing to travel longer distances to ensure that their loved ones receive better care. However, others noted the relatively remote location of Hagedorn and favored serving this population within specialty units not only at Ancora and Trenton, but also Greystone. These considerations are not, however, mutually exclusive inasmuch as those patients wishing to be placed close to home, regardless of which facility is closed, could be accommodated.

Questions were raised as to whether Greystone would also serve the older adult population with mental illness or younger adults with complex medical conditions as

this would be most consistent with maintaining geographic accessibility and this hospital might be most adaptable to the modifications needed for optimal geriatric care.

Some Task Force members favored a hospital system that increases its emphasis on specialty care, serving all forensic consumers at an expanded Ann Klein Forensic Center complex (that would include buildings at Trenton) and all gero-psychiatric consumers and consumers with mental illness and complex medical conditions at Hagedorn (See Attachment 4). However, it was noted that with the prevalence of medical co-morbidity in the mental health population, Hagedorn alone could not meet the system-wide needs in this area. This alternate proposal formally closes Trenton Psychiatric Hospital, and leaves Greystone and Ancora hospitals in the northern and southern parts of the state respectively to serve a general psychiatric population. Some Task Force members suggested that access to all facilities might be structured along something other than either specialty or geographic lines, e.g., consumer or family preference.

Given the concentration of population in the northern counties (compared to the southern) and the presence of specialized units at both Greystone (deaf and hard-of-hearing;) and Ancora (secure, forensic unit and unit for people with a developmental disability and mental illness), such a reorganization would require more extensive planning and cannot be done in the same one-year time-frame proposed for closing Hagedorn. Even though some states have successfully closed state hospitals within one year⁶, some Task Force members felt that a one-year time frame for Hagedorn's closure was also unrealistic.

The point was made by Division staff that closing Hagedorn requires much less reconfiguration of the state hospital system compared to the alternate proposal to close Trenton. In a Trenton closure scenario, the entire state hospital system would need to be re-configured and would impact every county in the state. For instance, the following system changes would need to occur:

- Older adults who now go to Ancora, TPH and GPPH would be re-directed to Hagedorn.
- General civil commitments at Hagedorn and Trenton would be re-directed to Greystone or Ancora.
- Forensic patients who now go to Ancora and GPPH would be re-directed to a newly configured Ann Klein Forensic Center.

In a Hagedorn closure scenario, the following system changes would need to occur:

- Older adults would be re-directed mostly to existing capacity and newly created older adult units at Trenton and Ancora.

⁶ Last year, Pennsylvania announced closure of Allentown State Hospital in late January 2010 with the actual closing occurring in early December 2010. Georgia recently announced it will close Northwest Regional Hospital by June 30, 2011 in less than one year.

- Adults under the age of 65 from Hunterdon County would be re-directed to Greystone.

Recommendations:

- In a Hagedorn closure scenario, DMHS should consider serving older adults with mental illness and younger adults with complex medical conditions at Greystone as well as Ancora and Trenton, on discrete, specialized units.
- DMHS should consider the possibility of a public/private partnership in which the Hagedorn campus continues to be utilized as a specialty gero-psychiatric facility, but not as a state psychiatric hospital.
- In either a Hagedorn or Trenton closure scenario, consideration should be given to extending the closure process beyond one year.

4. Whether the State psychiatric facility system can accommodate patients with a forensic background, while considering the option of specialization of care at a single location.

Background:

The forensic population as a whole is diverse, including consumers judged not guilty by reason of insanity (KROL/NGRI), incompetent to stand trial (IST), on detainer from jails for mental health assessment, current Megan's Law offenders, and offenders who have maxed out their sentences but are still considered a danger to the community. This is a population that presents differing levels of dangerousness as well as varied treatment, staffing, programming and security needs.

New Jersey currently maintains one forensic hospital in the center of the state, Ann Klein Forensic Center (AKFC) with a census of 200 consumers. This hospital serves patients with the most serious charges who present the greatest level of danger and need for security. Ancora, Trenton and Greystone also serve legally involved patients. Greystone is designated to serve only the KROL/NGRI population needing the least security, while Ancora has the most secure units outside of AKFC. Hagedorn is not designated to serve any forensic consumers.

Discussion:

Task force members acknowledged the trend in New Jersey and nationally that state psychiatric hospitals are serving more patients with mental illness who have legal involvement, and fewer people with mental illness who can be served in less restrictive settings. Task Force members were in agreement that older adults should not be commingled with younger adults, especially individuals with forensic involvement.

There was some discussion about the unmet mental health needs of individuals in the local jails or prisons, but there was no available data to suggest how many incarcerated individuals required state hospital level care. Currently, if a jail inmate

is in need of acute psychiatric treatment, they are referred and treated in the state psychiatric hospitals until stabilized for return to jail. There was discussion of the fact that Ann Klein Forensic Center (AKFC) has a waiting list and jails cannot always transfer their inmates on a timely basis.

Some Task Force members asserted that older adults with mental illness should not be placed on a campus that includes forensic consumers, even if they receive services in discrete units. A suggestion was made that the entire campus at Trenton Psychiatric Hospital come under the auspices of Ann Klein Forensic Center and be designated exclusively for forensic patients because this facility is uniquely situated to serve a forensic population (See Attachment 4). Proponents of the Trenton closure scenario feel that there would be minimal community resistance since the campus already houses a forensic population and the Department of Correction's Central Reception and Assignment Facility (CRAF). A variation of this proposal would maintain a forensic presence at Ancora while closing Trenton and retaining Hagedorn for both general civil commitments as well as a gero-psychiatric population. Others stated that it is important to maintain Trenton Psychiatric Hospital for general civil commitments in order to serve the population residing in the State's Central Region.

Given the expertise that also exists at Ancora and Trenton, most Task Force members felt that the existing security and specialized units at these regional hospitals should be preserved. Task Force members were in agreement that the increasing importance of forensic issues and the heterogeneity of the forensic population favored specialized units within one or more hospitals in addition to AKFC.

Recommendations:

- Consider continuing specialized forensic units at Trenton and/or Ancora in addition to Ann Klein Forensic Center.
- In a Hagedorn closure scenario, DHS must prevent co-mingling of older adults on units with younger forensic adults.
- Refine estimated on-going costs/savings projections to the system to convert the Trenton campus entirely to forensics and retain Hagedorn as specialty care for older adults.

5. Whether the plan adequately examines the allocation of State resources between the State psychiatric facility system and community system of care, while considering how to yield the most savings from the State psychiatric facility system.

Background:

The Hagedorn Closure Plan describes the disproportionate resources spent on the small percentage of persons with serious mental illness served in state psychiatric hospitals, with 37% of DMHS funding allocated to the 1% served in state institutions. On average, it costs over \$200,000 per year to treat a patient in a state hospital whereas it costs less than \$100,000 in the community's most expensive settings. In

fact, most community-based services cost less than \$50,000, including the cost of medications and housing.

The Plan describes how *Olmstead* funding will be used to meet the needs of individuals on CEPP status, including programs specifically designed to meet the needs of older adults with serious mental illness.

Discussion:

Task Force members strongly agreed that any savings due to a hospital closure be reinvested in community alternatives. The Department's closure plan suggests that a closure of Hagedorn would result in \$9.4 million in savings in Fiscal Year 2012 and \$44 million annually beginning in Fiscal Year 2013.⁷ Further, Task Force members would strongly oppose any closure if resources were not redirected into community services. Reference was made to NJAC 10:10, New Jersey's Community Mental Health and Developmental Disabilities Services Investment Act, which statutorily requires that operational and capital savings from institutional closures be reinvested in the community. Task Force members asserted that the system does not have sufficient funding to meet the needs of the broader system and that additional funding is needed. In addition, it was noted by some Task Force members that redirecting funds to the community could leverage additional federal dollars through the Medicaid plan. Still, there was strong concern that even with a Task Force recommendation and DHS support that funds could not be guaranteed without the State's legally mandated commitment.

There was also substantial concern that fewer state hospital beds might exacerbate existing crowding in emergency rooms, and it was even suggested that additional state hospital beds be added to the system. However, it is generally accepted that a stronger community-based system decreases the reliance on state hospital care, and most agreed that funded placements coming from the state hospitals as a result of *Olmstead* are succeeding. Comparatively, New Jersey has more inpatient beds per capita than most states, and spends more per capita on state hospital care than most states. However, some Task Force members felt that some consumers as a function of the severity and acuity of their mental illness and co-morbid conditions will always be more costly to serve. Other Task Force members indicated that even if costs in the community were no less than hospital care that there was still an obligation under *Olmstead* to provide treatment in the most integrated setting that is clinically feasible.

Task Force members discussed community needs and cited examples of the best use of redirected funds, including Residential Intensive Support Teams (RIST) and Programs of Assertive Community Treatment (PACT), and geriatric mobile outreach. Nonetheless, Task Force members felt that more should be done to alleviate emergency room issues and resources should be allocated for that purpose.

⁷ While a savings estimate for a Trenton closure has not been finalized, savings are estimated to be comparable.

Some task force members suggested keeping all five hospitals open and closing additional units as the census decreases to realize savings. The Department indicated that it has closed units in each of the hospitals which have resulted in some savings, but that reorganization of the state hospitals that includes a closure would yield more savings and more efficient allocation of resources. The Division's fiscal office developed savings estimates for both the Hagedorn proposal and the alternate Trenton closure scenario, which yield generally the same amount; some Task Force members challenged the veracity of the Trenton estimate. Note that the Hagedorn estimate was prepared over a period of months; the Trenton estimate was developed in response to the alternate proposal and within less than two weeks. However, it would be prudent to continue to refine these estimates, for example, incorporating staff training costs associated with both proposals.

Note: See additional Budget section on Page 21.

Recommendations:

- Redirect all, if not most, savings from the hospital closure to community services in keeping with the Community Mental Health and Developmental Disabilities Services Investment Act for *Olmstead* and other community infrastructure.
- Implement strategies, including those articulated in the recommendations of Governor Codey's Task Force on Mental Health and the Division's Acute Care Task Force, to alleviate the pressure on the acute care system, including development of intermediate beds to address the length of stay gap between Short Term Care Facilities (STCF) and state and county psychiatric hospitals.
- Address emergency department waits for service with savings from a closure by expanding diversionary services such as supportive housing and Early Intervention Support Services and Intensive Outpatient Programs.
- Ensure that usable structures at the closed facility be dedicated to providing community services for the population that the closed facility served and not be allowed to fall into disrepair.

6. The impact on other State and private agencies that share State-owned campuses, as well as the impact on area hospitals and the community mental health system.

Background:

The Division of Mental Health Services implementation of its *Olmstead* plan and settlement agreement has produced an array of community placements and a significant reduction in the state psychiatric hospital census. Previously, many patients who no longer met civil commitment criteria waited long periods of time for community placement. The Department's plan to close Hagedorn seeks to reallocate state hospital beds in the system without decreasing needed state hospital bed capacity.

The Plan calls for a variety of diversionary options that will be funded through *Olmstead* to support the reintegration of state hospital patients and the diversion of consumers at risk of inpatient hospitalization. Using *Olmstead* funding, and in accordance with the settlement agreement, the Department will create 370 diversionary placements through SFY 2014. These are community placements, including RIST, supportive housing, PACT, and other similar services that are designed to serve individuals in the community who are at risk of hospitalization.

The Plan also calls for enhancing crisis support services through Intensive Outpatient Treatment and Support Services (IOTSS) available 24/7 to deal with short-term symptom exacerbation, Early Intervention and Support Services (EISS), which provide short-term crisis support and mobile outreach, and expanding off-hours availability for the Peer Recovery warm-line to allow consumers more community options when crises occur outside of normal program hours. In addition, the Division of Mental Health Services will issue an RFP for Geriatric Mobile Outreach to provide support to families, nursing homes and other community providers to address behavioral and other issues that emerge around the care of older adults with mental illness.

A centralized admissions process was recently implemented to review referrals to the state psychiatric hospital system to ensure appropriateness of admission and facilitate less restrictive options where appropriate. Some county hospitals maintain intermediate care beds for out-of-county admissions to address the gap between the relatively brief length of stay (LOS) typical for Short Term Care Facility (STCF) beds within general hospitals and the much longer stays that occur in state psychiatric hospitals.

Both Trenton and Ancora campuses are shared and interconnected with other state and private agencies in a complex way. One private agency shares the Hagedorn campus. That is Freedom House, which is a licensed, residential substance abuse treatment provider under contract to the Division of Addiction Services and other state agencies to provide halfway house services to adult males with substance abuse disorders. The Hagedorn site has been in operation 25 years and consists of 37 residential substance abuse treatment beds that serve 24-30 men annually.

Discussion:

Some Task Force members raised the concern that the existence of fewer state hospital beds would exacerbate existing crowding in emergency rooms, and it was suggested that additional state hospital beds be added to the system. There was general agreement that the state's public mental health system is under funded, struggles to meet demand and that no resources should be lost. In addition, there are individuals in need who are not currently being served by the mental health system, including those who may be incarcerated or homeless.

For consumers who are served through available funding, the community-based system possesses the necessary skills and knowledge to successfully enable most

people with mental illness to live in the community. There was agreement that as long as funding is available and appropriate services can be developed, providers can and do serve much of the population in need of mental health services. However, there were misgivings, regarding the ability of providers to support individuals being discharged, as well as others in need of mental health services, without new resources. Mention was made of the Involuntary Outpatient Commitment (IOC) law that could address some of this unmet need, but has not been implemented due to budget constraints. A suggestion was made that some of the savings in a closure could be re-directed to support implementation of IOC.

There is no evidence to suggest that there will be a shortage of state psychiatric hospital beds for older adults with mental illness, although they will be allocated among GPPH, TPH and APH. Similarly, there is no indication that emergency department volume would increase, as long as *Olmstead* placements continue to be funded. Further, it is generally accepted that a stronger community-based system will reduce the reliance on state hospital care, and that funded placements coming from the state hospitals as a result of *Olmstead* are succeeding.

Still, many Task Force members felt that additional community resources are needed, particularly more intermediate beds in the community as a step-up from STCF beds and better capacity to serve older adults in community settings. In addition, the Division should continue to implement the recommendations of Governor Codey's Task Force on Mental Health and the Division's Acute Care Task Force, which both provide strong recommendations for the community system of care.

There was consensus that the Department should find a way to preserve Freedom House and the services it provides, either on campus or elsewhere in the community, and also ensure that if Hagedorn closes, the facilities be made available for other services to older adults or community non-profit programs. Some Task Force members favored expansion of Freedom House services to the co-occurring (i.e. mental illness and a substance abuse disorder) population should Hagedorn close. Proponents of closing Trenton felt that the main hospital could be closed with minimal impact to other agencies on the campus.

Recommendations:

- Preserve Freedom House and the services it provides.
- If Hagedorn were to close, the campus including North Hall, should be made available for other providers to serve older adults or community non-profit programs after Hagedorn's closure.
- Previous task force reports, specifically Governor Codey's Task Force on Mental Health and the Division's Acute Care Task Force are strong guiding documents that DHS should continue to implement.
- DHS should expand intermediate care beds in order to divert people from state hospitals as well as examine current STCF capacity, particularly with regard to the medically-compromised gero-psychiatric population.

- In a Trenton closure scenario, the Travers transitional cottages that serve 96 individuals should also be preserved and utilized in some fashion for community housing. Alternatively, a public/private partnership could be established to re-develop this housing in another location.
- The Division's plan for Geriatric Mobile Outreach should be implemented. In addition, savings realized from downsizing or closure should be invested in the expansion of mobile outreach and other community diversion programs that will reduce overuse of emergency departments and divert individuals from inpatient units. Funding should also be used for IOC implementation.
- To the extent consistent with *Olmstead*, DHS should explore the feasibility of use of buildings on the grounds of closed state psychiatric hospitals and other facilities for service to persons with mental illness and/or persons with co-occurring disorders to be operated by non-profits or in a special public/private partnership.

Budget and Property Considerations

As requested by the Task Force, DMHS staff presented on January 7, 2011 to explain how the savings estimates were calculated for the closure of Hagedorn. This included implementation savings in Fiscal Year 2012 and annualized savings beginning in Fiscal Year 2013, costs associated with transfers of staff, physical plant considerations and overtime savings.

In response to the alternate proposal to close Trenton Psychiatric Hospital instead of Hagedorn, DMHS developed savings estimates to the best of its ability given the short notice and presented them for discussion at the January 14 and January 21 meetings. Considering this reconfiguration affects each of the hospitals more so than the Hagedorn plan, the additional buildings that would need to remain operational under AKFC oversight, loss of revenue and other factors, savings to the system would closely approximate the Hagedorn scenario, even though TPH is a larger hospital. Further refinement of both sets of estimates was recommended by Task Force members.

By retaining operations at all five hospitals, the State would need to continue to invest significant capital funds into all the facilities in perpetuity. In the Hagedorn closure scenario, capital investments would only be needed at four hospitals, going forward.

Placing TPH under AKFC oversight would reduce revenue to the state. AKFC is not certified by CMS for Medicaid funds and thus expenses are ineligible for Disproportionate Share Hospital (DSH) funding. Under TPH, the hospital can generate expenses that are reimbursable under the DSH program, but those same beds under AKFC would not be eligible for federal funds.

Closure of a facility may reduce the financial impact to county government. Currently, all 21 counties contribute to the cost of providing care for county residents in state hospitals. The State pays for 85% and the county in which the patient resides

pays 15% of the cost of providing care. When a patient is treated in community-based services or inpatient care at a local acute care hospital, the county is not required to contribute. A smaller state hospital infrastructure and more consumers served in non-state hospital settings will contain the per capita costs and may diminish the financial impact on counties as compared with operating a larger system. Because the State reserves the right to change the county/state formula for maintenance of care, the cost to the counties may vary from one budget year to the next.

As part of the budget discussions, questions emerged around whether Hagedorn or Trenton had greater potential resale value. Task Force members expressed their desire to not repeat the Marlboro experience. One member suggested that the re-use of former residences on the grounds of Marlboro be pursued again for potential affordable housing for mental health consumers.

In its plan to close Hagedorn, DHS considered the potential re-use of the campus. Several of the buildings are in good condition and could be re-used for similar, or other purposes. While the campus is located in the Highlands preservation area, much of the campus already is paved over and could present alternate re-development options for the area, including adding the property as a ratable. However, there are several local zoning issues that need to be discussed, and a clear understanding of the Highlands Planning Area is needed before any determination can be made regarding the most appropriate use of the Hagedorn campus.

Regarding the alternate TPH closure scenario, a few Task Force members suggested that the Trenton campus may be more valuable and offer greater re-development options. However, several issues (i.e. much of the campus will remain in use by DHS and other state agencies, several of the buildings have historical relevance, proximity to the forensic hospital and prison) significantly reduce the amount of available acreage that could be used.

Task Force members felt that absent a full appraisal on both campuses, they could not comment on the future use of the campuses. Should Hagedorn close, Task Force members support re-using the campus for older adults or non-profits in some capacity. In a TPH closure scenario, there was concern about what would happen to the Travers transitional cottages, which are hospital-based residences for 96 people located in a potential redevelopment area on the campus. Several Task Force members indicated that a reconfiguration that did not preserve the Travers transitional cottages on campus or elsewhere in the community would be detrimental to the system.

CHAPTER 81

AN ACT establishing the State Mental Health Facilities Evaluation Task Force.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. As used in this act:

“Commissioner” means the Commissioner of Human Services.

“Department” means the Department of Human Services.

“State psychiatric facility” means a State psychiatric hospital listed in R.S.30:1-7.

2. a. There is established the State Mental Health Facilities Evaluation Task Force.

b. The purpose of the task force shall be to review and assess the viability of the department’s “Plan for the Closure of the Senator Garrett W. Hagedorn Psychiatric Hospital” and its impact on New Jersey’s State psychiatric facility system.

c. In order to effectuate the purposes of subsection b. of this section, the task force shall, at a minimum, advise the department on the following issues:

(1) the plan’s consistency with the United States Supreme Court Olmstead decision and the department’s July 2009 Olmstead settlement agreement;

(2) whether sufficient capacity and appropriate staff expertise will be made available in the remaining State psychiatric facilities to accommodate the current and future needs of patients requiring that level of care, including, but not limited to, an evaluation of geriatric care;

(3) whether geographic accessibility for State psychiatric facility care is maintained throughout the State, while considering the option of specialization of care at a single location;

(4) whether the State psychiatric facility system can accommodate patients with a forensic background, while considering the option of specialization of care at a single location;

(5) whether the plan adequately examines the allocation of State resources between the State psychiatric facility system and community system of care, while considering how to yield the most savings from the State psychiatric facility system; and

(6) the impact on other State and private agencies that share State-owned campuses, as well as the impact on area hospitals and the community mental health system.

d. The task force shall include 21 members, as follows:

(1) the Commissioner of Human Services and the Directors of the Divisions of Mental Health Services, Medical Assistance and Health Services, and Developmental Disabilities in the department, or their designees, as ex officio members;

(2) two members each from the Senate and the General Assembly, to be appointed by the President of the Senate and the Speaker of the General Assembly, respectively, who in each case shall be members of different political parties; and

(3) 13 public members who are residents of this State, as follows:

(a) 11 public members to be appointed by the Governor, including: one person who is a county mental health administrator; one person who is a county human services director; one person appointed upon the recommendation of the New Jersey Association of Mental Health and Addiction Agencies; one person appointed upon the recommendation of NAMI New Jersey; one person appointed upon the recommendation of the Mental Health Association in New Jersey; one person upon the recommendation of the Institute for Health, Health Care Policy and Aging Research at Rutgers, The State University of New Jersey; one person upon the recommendation of the New Jersey Psychiatric Rehabilitation Association; one person

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upon the recommendation of the New Jersey Hospital Association; one person upon the recommendation of the Coalition of Mental Health Consumer Organizations of New Jersey; one person who is a member of the board of trustees of a State psychiatric facility; and one member of the general public with an interest or expertise in the work of the task force; and

(b) two additional members of the general public with an interest or expertise in the work of the task force, who in each case have, or have had, a family member who is, or has been, a patient in a State psychiatric facility, one of whom shall be appointed by the President of the Senate and one of whom shall be appointed by the Speaker of the General Assembly.

e. The legislative members of the task force shall serve during their terms of office. Vacancies in the membership of the task force shall be filled in the same manner provided for the original appointments.

f. The commissioner or the commissioner's designee shall serve as chairperson of the task force. The task force shall organize as soon as practicable following the appointment of its members and shall select a vice-chairperson from among the members. The chairperson shall appoint a secretary who need not be a member of the task force.

g. The public members shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties and within the limits of funds available to the task force.

h. The task force shall be entitled to call to its assistance and avail itself of the services of the employees of any State, county or municipal department, board, bureau, commission or agency as it may require and as may be available to it for its purposes.

i. The task force may meet and hold hearings at the places that it designates during the sessions or recesses of the Legislature, but shall hold a minimum of three public hearings, one each in the southern, central, and northern regions of the State.

j. The department shall provide staff support to the task force.

k. The task force shall report its findings and recommendations to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), along with any legislative bills that it desires to recommend for adoption by the Legislature, no later than February 1, 2011. The report shall contain an analysis of the issues set forth in subsection c. of this section.

3. This act shall take effect immediately and shall expire upon the issuance of the task force report.

Approved October 7, 2010.

ATTACHMENT 2

State Mental Health Facilities Evaluation Task Force

1. Jennifer Velez, Commissioner
Chairperson Department of Human Services
2. Peggy Swarbrick, PhD.
Co-Chairperson General Public Member
3. Senator Doherty Senate Representative
4. Senator Codey Senate Representative
5. Assemblyman Diegnan Assembly Representative
6. Assemblyman DiMaio Assembly Representative
7. Rosalyn Metzger General Public Member, Legislative Appointment
8. Gilbert Honigfeld, PhD. General Public Member, Legislative Appointment
9. Valerie Larosiliere DHS, Division of Mental Health Services
10. Dawn Apgar DHS, Division of Developmental Disabilities
11. Bob Bollero DHS, Division of Medical Assistance
12. Karen Kubert County Human Service Directors
13. Judy Lucas, PhD. Rutgers Institute for Health, Health
Care Policy and Aging Research
14. Barry Johnson County Mental Health Administrators
15. Debra Wentz, PhD. NJ Association of Mental Health and Addiction Agencies
16. Carolyn Beauchamp Mental Health Association of New Jersey
17. Sylvia Axelrod NAMI NJ
18. Ken Gill, PhD. NJ Psychiatric Rehabilitation Association
19. Wayne Vivian, President Coalition of Mental Health Consumer Organizations
20. Joe Miller, PhD. NJ Hospital Association
21. Gayle Masson-Romano Hagedorn Board President

ATTACHMENT 3

Public Hearing Testimony

December 1, 2010

Greystone Park Psychiatric Hospital
Morris County
6 PM to 8 PM

Individuals presenting testimony:

Bob Davison	MHA Essex
Phil Lubitz	NAMI-NJ
Kimberly Higgs	NJPRA
Mary Zdanowicz	Family member
Walter Dudzinski	HPH Board member
Patti McNeel	Hagedorn staff reading a letter from a Hagedorn patient
Nancy Koch	Concerned citizen (Hagedorn staff)
Lisel Hutchins	Hagedorn staff
Bill Fallon	Family member
Joseph Kosek	Hagedorn staff
Dr. Victoria Petivan	Hagedorn staff
Jennie Youtz	Hagedorn staff
Chris Young	CWA Local 1040
Dr. Jude Germaine	Hagedorn staff
Kathy Avery	Hagedorn staff
Susan Levenbach	HPH Board Member
Laura Blaine	AFSCME, Local 2212, Hagedorn staff
Richard Stevens	Hagedorn staff
Jeff Nelson	Family member
Brett Miller	Hagedorn staff, AFSCME
Linda Fahmie	Family member

December 8, 2010

Division of Developmental Disabilities

Mercer County

10 AM to 12 PM

Individuals presenting testimony:

Nora Barrett	NJPRA
Kim Heft	representing businesses in Glen Gardner(Hagedorn Staff)
Dr. Ronald Schroeder	Clinical Psychologist at Hagedorn
Rich Beers	Concerned citizen (Hagedorn staff)
Donald Klein	CWA local 1040
George Brice	Consumer
Laura Tarlowe	Family member
Ann Murphy	Citizen/consumer
Dr. Ed Caruso	Acting Chief of Psychiatry, Hagedorn
Jerry St. Onge	Concerned citizen
Carmella Sylvestri	Concerned citizen
Walter Ludeke	Family member
Esther Post	Hagedorn staff
Joseph Young	Disability Rights, NJ
Thomas Pyle	Family member
Patti McNeel	Hagedorn staff
Jennie Youtz	Hagedorn staff
Nancy Koch	Concerned citizen (Hagedorn staff)
Mary Zdanowicz	Family member
Sheryl Cooper	Concerned citizen (Hagedorn staff)
Linda Zimmerman	NAMI Hunterdon County
Diane Cameron	Hagedorn Staff, AFSCME

December 15, 2010
Rutgers University, Camden
Camden County
2 PM to 4 PM

Individuals presenting testimony:

Audrey Seguine	Hagedorn Staff
Maria Kirchner	Hagedorn Staff
William Green	Professor of Psychiatric Rehabilitation
Moshood Animasaun	Concerned citizen (Hagedorn Staff)
George Brice	
Carolyn Wade	CWA Local 1040
Tom Bruno	Concerned citizen
Paul Kovalsky	Hagedorn Staff
Eileen Joseph	Care Link Community Support Services
Nancy Koch	Concerned citizen
Cynthia Voorhees	Somerset Office on Aging
Hilary Hanchuk	Hagedorn Staff
Barbara Johnston	Mental Health Association in New Jersey
Fred Reihl	Freedom House
Angel Gambone	COMHCO
Tim Klein	Consumer
Dr. Victoria Petivan	Hagedorn Staff
Carmela Sylvestri	Concerned citizen
Suzanne Bunting	Hagedorn Staff (sent testimony read by Nancy Koch)
Kathy Kane	Hagedorn Staff (sent testimony read by Patti McNeel)

ATTACHMENT 4

Proposal to Close Trenton Psychiatric Hospital

Endorsed by:

Karen Kubert
Gil Honigfeld
Rosalyn Metzger
Senator Doherty
Assemblyman DiMaio

**Proposal to the Task Force on Mental Health Facilities Evaluation:
A More Cost-Effective Alternative to the Draft Plan to Close Hagedorn Hospital**

January 4, 2011

The following proposal is submitted to the Task Force for consideration. It meets the mandate of reducing costs while preserving Hagedorn Hospital, an invaluable and cost-efficient asset to one of the most vulnerable populations in New Jersey.

The NJ Department of Human Services and the Division of Mental Health and Substance Abuse Services have made enormous progress in improving the state mental health system as evidenced by the Wellness and Recovery Transformation Action Plan, the Governor's Task Force on Mental Health Final Report, the Home to Recovery – CEPP Plan, the Division of Mental Health Acute Care Task Force Report, and the NJ Community Mental Health Services Block Grant Plan. NJ has been continually 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 in Olmstead v. LC, 119 S. Ct, 2176 (1999).

But, now New Jersey is facing serious budgetary constraints. State agencies have been asked to review their plans with an eye toward trimming costs while still meeting their overall programmatic missions. Nowhere is that a more difficult balancing act than in Human Services where the citizens served are among the most vulnerable and therapeutically deserving.

In the field of mental health services delivery, the cost-cutting mission is complicated by philosophical and legal cross-currents concerning the proper role of hospital care. In the current context of changing hopes and expectations among consumers of mental health services, it is imperative that essential services are provided in the least-restrictive environments. The difficulties of the current situation are embodied in the requirements of the Olmstead settlement that suitable placements be found for the scores of NJ citizens who are still receiving care in hospitals because adequate community-based accommodations are not yet in place. Funds for additional Olmstead-related placements might be found in part by reducing the number of more costly hospital beds and using those monies more effectively and efficiently in support of additional, less expensive and less restrictive community housing units.

The Department of Human Services draft plan to close Hagedorn Hospital -- actively under review by this Task Force through the end of January 2011 -- aims to do that. This plan would shutter Hagedorn hospital within one year, eliminating all 300 of its hospital beds, subsequently redirecting saved funds to expand community housing and support functions, while providing some relief to overburdened NJ taxpayers.

However, the current proposal to close Hagedorn Hospital will not save the taxpayer as much money as this proposed alternative, and the overall mental health needs of the state's citizens would be better served by a different overall configuration of facilities. The shape of a more far-reaching and potentially more cost-effective proposal is outlined next.

The current proposal to close Hagedorn has targeted the wrong hospital. A more practical course from both the financial and clinical perspectives would be to eliminate the substantially larger number of general-purpose psychiatric beds at Trenton Psychiatric Hospital, and dedicate some of those beds for any shortfall in forensic needs to enhance the capacity of Ann Klein's administration to fulfill a minimum-security forensic operation at the former TPH site. Hagedorn Hospital would be maintained as a statewide specialty-care hospital for medically vulnerable and gero-psychiatric patients. Why?

The primary reason is financial. Careful review of the costs-of-care data in the following summary table shows clearly that of the four psychiatric hospitals and Ann Klein Forensic Center, both the gross and net per diem costs of care are lowest at two of these: Hagedorn Hospital and Ann Klein Center. By directing a patient to Hagedorn rather than the more costly Trenton Psychiatric Hospital, the state would save \$5,730 per month in net costs (an estimated total annual savings to the state of \$68,760 per patient).

Facility	Gross Per Capita Cost/Day (FY 2009 est)	Annual Insurance Revenues Returned to NJ State Treasury (FY 2009 est)	Average Daily Census (FY 2009)	Per Patient Daily Offset to State Treasury from Insurance Revenues*	Net Per Capita Cost/Day (FY 2009 est)
Hagedorn	\$384.47	\$19,300,000	285	\$185.53	\$198.94
Ann Klein	\$355.83	\$3,500,000	199	\$48.19	\$307.64
Greystone	\$422.22	\$7,900,000	465	\$46.55	\$375.67
Trenton	\$438.27	\$7,700,000	451	\$46.78	\$390.27
Ancora	\$451.50	\$13,000,000	605	\$58.87	\$392.63

Why is there such discrepancy in costs of care among the hospitals? The two facilities with the lowest per capita net costs (Hagedorn and Ann Klein) are both 'specialty care' sites, one for forensic patients, the second for medically vulnerable or gero-psychiatric patients. Apparently, specialty care facilities have found ways to provide services of a quality that is at least as high as anywhere else in the state and at lower costs. While it is anticipated that Medicare/Medicaid dollars will follow the patient (yielding a high offset from Hagedorn to the state from insurance) their staff have also been more aggressive in going after these dollars. Thus, from a clinical triage perspective alone, the two lowest-cost facilities (Hagedorn and Ann Klein) should always run at full capacity, potentially expanding if necessary to meet the challenges of changing demographic pressures.

Another demonstration of Hagedorn's aggressive management style is a 0.5 staff/patient ratio which is unsurpassed at other hospitals. Hagedorn is the only hospital from FY 2007-2009 that maintained a 0.5 staff/patient ratio and was the only hospital expected to continue to do so in FY 2010. The other hospitals in the state have staff/patient ratios of 0.4. In essence, at Hagedorn two staff can handle one patient while at other hospitals it take 2 ½ staff to do the same job. That translates into a direct 20% savings in labor costs.

* Formulas: Offset = 'Revenue' divided by 'Census' divided by 365 (and 'Gross Cost' minus 'Offset' = 'Net Cost').

Wherever more costly facilities can be identified for down-sizing or elimination, they should be targeted. Some of the Trenton Psychiatric Hospital buildings are over 150 years old and would require significant expenditure for continued use, and per diem care costs there are among the highest in the state. The budget request of the DHS for FY 2011 includes a capital expenditure request for Trenton Psychiatric Hospital of over \$22 million. This one item represents 42% of the total amount requested by the Department for all five existing hospitals. Why spend the bulk of the Department's capital projects budget to maintain decaying and unsafe buildings, when a fraction of that can be used to maintain and upgrade Hagedorn? The structures at Hagedorn are newer and in better condition; one building, North Hall was built less than 15 years ago.

This proposal recommends that New Jersey's mental health hospital system of the future be reduced by one hospital – Trenton Psychiatric Hospital -- currently handling about 450 patients. This alternative plan would call for referring all current CEPP patients at Trenton Psychiatric Hospital (estimated currently at about 46) to community-based housing wherever possible, then re-distributing all others a) to Hagedorn if their medical needs require specialty care, b) to Ann Klein if there are forensics issues, c) to Greystone if a resident of northern NJ counties, or d) to Ancora if a resident of the southern counties. Families will be encouraged to state their preferences for placement for their loved ones, enabling patients to receive treatment closer to home. Administrative Order 1:90 would not need to be changed: the Commissioner's designation of Ann Klein Forensic Center would stand as the most appropriate setting for legally-involved mental health consumers, including those with the most violent charges.

By eliminating Trenton Psychiatric Hospital beds totally and under the same timetable put forward by the existing plan to close Hagedorn, by virtue of patient numbers alone (450 at Trenton versus 300 at Hagedorn) cost savings to the State would be substantially greater under this proposal, as shown in the table below.

Plan	FY 2012 Savings Projections [†]	Annualized Savings Projections
Close Hagedorn Hospital	\$11,001,000	\$57,646,000
Close Trenton Psychiatric	\$15,781,000	\$82,325,000

Using the Department's own method of financial analysis as applied to both the Hagedorn and Trenton closure plans, it is easy to understand why this proposal, for financial reasons alone is regarded so highly by its advocates on the Task Force. Consistent with Olmstead and with consumer testimony at Task Force Public Hearings, the substantially greater savings associated with closing Trenton Psychiatric Hospital should be dedicated primarily to community-based services and placement.

But, cost-savings are only part of the benefit. Value to the taxpayer will be augmented further by introducing clinical and administrative benefits. In a four-hospital vision of the future, two hospitals would be regional catchment facilities providing general psychiatric beds for either the NJ northern tier (Greystone) or the southern tier (Ancora). The Department would be able to

[†] Savings projections for Trenton were calculated by applying exactly the same formula utilized in the DHS calculations for Hagedorn, applying corrections to account for the differential in average patient census, 450 for Trenton versus the 300 for Hagedorn. The relevant spread sheets detailing were kindly provided to the Task Force via email from the DHS Commissioner on January 4, 2011.

triage and refer patients as appropriate to Ann Klein or Hagedorn for specialty care. This would allow the maximum number of patients to receive more appropriate and cheaper care at the two specialty facilities while retaining regional catchment areas for general psychiatric admissions.

Concerning 'specialty care' for the medically vulnerable, the presence of Freedom House at Hagedorn has provided unique programs for the substance-abusing patient. The consumers who are served there reside in a community-like setting and the comprehensive nature of their programs means that a substantial number of MICA patients could be successfully managed without hospital admission, a boon to the patient and the taxpayer both[‡].

Because co-occurring mental health and substance abuse disorders are so common[§], Freedom House should be allowed to continue to operate at Hagedorn as established in current policy. Indeed, the Department should be encouraging them to expand services. In testimony to this Task Force on December 15, 2010, Fred Riehl, Executive Director, testified that Freedom House saves the State approximately \$70,000 for every person who stays clean and sober upon graduation from their program.

Finally, in comparing the two plans now before the Task Force, *i.e.*, Close Trenton Psychiatric Hospital versus Close Hagedorn Hospital, there is the issue of the residual value of each property after all patients have left. The commercial development value of Hagedorn's land, located on a mountaintop preservation area in the Highlands of rural Hunterdon County and accessed only by one steep, narrow and winding road, is essentially nil, while the ultimate market value of Trenton Psychiatric Hospital's former site -- many acres of level land in metropolitan Trenton accessible by public transportation along two major roads-- would be in the tens of millions of dollars.

In overview, this draft proposal builds on the excellent conceptual thinking first laid out by the Department of Human Services, but takes it further by more aggressively and more appropriately targeting to close Trenton Psychiatric Hospital, a facility with buildings that are decaying beyond repair and operating at substantially higher per diem net costs than Hagedorn Hospital.

A regional approach in a state as small as New Jersey can be easily attained with northern and southern general-purpose psychiatric hospital beds. In the process, the downsized overall state configuration of two specialty care facilities (Ann Klein and Hagedorn) plus the two regional general admission hospitals (Greystone and Ancora) would constitute a more streamlined statewide system that builds on current strengths and cost-efficiencies, while addressing the need for increased community placements consistent with Olmstead.

[‡] On December 17, 2010, Task Force member Karen Kubert, and Ed Smith, legislative aide to Senator Doherty, had a personal conversation with Commissioner Velez and Deputy Commissioner Martone about other potential uses for Hagedorn buildings. They were charged with talking to community partners, whose services would make sense to have on the grounds of Hagedorn. That conversation has taken place, and Fred Riehl, Executive Director of Freedom House, has expressed a real interest in working with the Division of Mental Health and Substance Abuse to develop such MICA-related services as a modified supportive housing program, a diagnostic and treatment center, and an expansion of the women's program that has successfully reunited mothers with their children.

[§] The National Mental Health Association reported in a recent survey that more than half of the people who had ever been diagnosed with alcohol or drug abuse or dependence had also experienced a mental disorder at some time.

ATTACHMENT 5

Further Considerations on the “The Plan to Close Senator Garret W. Hagedorn Psychiatric Hospital”

*We have reviewed the “The Plan to Close Senator Garret W. Hagedorn Psychiatric Hospital”. Philosophically, we support the closure of a state psychiatric hospital when it has been determined that significant funds are reallocated within the mental health system to truly benefit those with serious mental illness. Therefore, we believe the plan is feasible only with the re-investment of savings in community-based alternatives and long-term supports which could be financed through the Community Mental Health Developmental Disabilities Investment Act and other mechanisms. Regardless of the ultimate action of the administration and Department of Human Services, an analysis of the long-term required state hospital and community capacities over the next several years is desirable. If the consent agreement under the Olmstead (Disability Rights NJ vs. Velez) settlement continues to be implemented as planned and the CEPP issue is addressed long-term, significantly less state hospital capacity and more community-based services will be required. **That planning should begin now.** We have also reviewed an initial effort put forth by other task force members to begin planning for the closure of more than half of Trenton Psychiatric Hospital. At this time, the Trenton proposal is less developed and has not been the focus of attention and study. Many issues remain troublesome, such as, where would individuals who are civilly committed in the Central part of the state will be hospitalized without a Trenton Psychiatric Hospital or with it functioning only as a specialty hospital? Our belief is that persons with serious and persistent mental illness who need commitment should be hospitalized as close to their home and community as possible to facilitate contact with family and friends and to foster easier re-integration back to the community. As already noted, the closure of a state psychiatric hospital is not feasible without significant redirection of resources to alternative, more cost-effective, community-based services. This document discusses what the role of the mental health system should be in the lives of people recovering from serious mental illness and what will be required for a successful closure of any state facility.*

The Ideal Role of the Mental Health System in the lives of Persons with Serious Mental Illness

Persons in recovery from serious mental illnesses would benefit from services that are geared to their current stage of recovery. Regardless of the setting of care, being treated with respect, and having meaningful choices are important for both immediate therapeutic reasons and long-term independence. Therefore while safe, controlled settings are often needed for the resolution of many acute phases of these illnesses, when these settings create learned helplessness or reduce self-initiative, they are undesirable. Preferable to inpatient care is the prevention of the aggravation of symptoms by early intervention teams that address incipient crises before screening and commitment services. Preferable to any hospitalization, early intervention alternatives are needed to prevent hospitalization, including mobile early intervention teams. Thus, mobile emotional support, crisis housing, intensive outpatient, and time unlimited care coordination through Programs in Assertive Community Treatment (PACT), Residential Intensive Services Team (RIST) or other approaches are essential to the prevention of hospitalization.

Hospital Care

When inpatient care is necessary, current services have to be modernized to include the integration of physical and mental health care due to the high incidence of hepatitis, diabetes, and other disorders among persons with serious mental illness, especially those served in state institutions. Services delivered must be “trauma-informed”, with staff educated in this model. This includes the elimination of both physical and chemical restraints. Our state hospitals in their present condition need to improve in this area. There is strong evidence from statewide patient focus groups that many NJ state hospital patients feel unsafe, fearing bullying by other patients and staff; patient-on-patient violence is very common. The hospitals vary significantly over time in their use of seclusion and restraints which need to be eliminated. Making hospitals safe for patients and staff will improve both their efficacy and everyone’s morale.

Preferable to extended state hospital stays, “extended acute” services must be allowed and reimbursed in local hospitals, closer to home, beyond the length of stay currently offered in short-term care facilities. These stays could be 30-45 days. This length of time would allow resolution of the great majority of acute episodes and for stabilization not currently possible in the current short stay units. Often several weeks are necessary to determine whether psychotropic medications are working and to allow optimal, lower dosing. It would also reduce the necessity of transfer to longer stay institutions. In all cases, lengths of stay should be as brief as possible so as not to disrupt the person’s integration in the community unnecessarily. Good communications between hospital staff and with community treatment team & family is necessary and indeed, needs significant attention in all our state’s facilities today.

Throughout our hospital systems, access to specialty services is needed: including: truly voluntary unlocked units; units with modern integration of medical and psychiatric disorders (given the epidemics of diabetes, hepatitis, and other disorders), staff trained to deal with serious anxiety disorders and Axis II problems, psychotropic-free treatment options, and mother/child living arrangements and gero-psychiatric care. Additional short stay forensic units are needed as well. All hospital stays, but especially extended ones, must include access to fresh air, exercise, and computers with Internet access. Brief breaks in small fenced-in areas or on patios do not constitute true access to fresh air or exercise.

All hospitalizations should include “housing preservation” vouchers so individuals can retain their established homes.

Long-Term Community care

For adults of all ages, additional service and resources not traditionally offered need to be explored to promote successful community living opportunities and challenges. Services have to be tailored to a person’s specialized needs, such as parenting skills, bilingual services, and complementary and alternative therapies that reduce or eliminate the need for psychotropic medication. Also, more support for the pursuit and maintenance of employment for working age adults is necessary for economic independence. For persons who are elderly and frail, existing, comprehensive, home-based approaches, such as the Program of All Inclusive Care (PACE) can

be adapted for persons with psychiatric disorders.

The state should look at models developed elsewhere that help ensure resources are made accountable to the person receiving service. This begins with person-centered planning in both hospital and community settings, but should also include use of voucher systems and “the money follows the person initiatives” tried in other states and in our state for persons in other disability groups.

What would have to exist for us to have a comfort level with closure?

There must be a commitment to reinvest savings into community based and state hospital alternatives that eliminate the need for long-term hospitalization and support community integration. This is consistent with the *Community Mental Health Developmental Disabilities Investment Act*.

Many of the services offered today and those planned in the community will effectively serve those unnecessarily institutionalized under CEPP status who are being released from state hospitals under the Olmstead consent order. These services need to continue and expand. Therefore, Integrated Case Management Services (ICMS) have to be more accountable and less time limited. At a minimum, length of stay in that service should be tied to achieving a level of independent functioning, not a finite number of months. Furthermore, it would be good to see some adapted PACT model, more health promotion services, more vocational support for working age adults, and alternatives to medication available statewide. The introduction and adaptation of PACE for gero-psychiatric patients, as well as the adaptation of PACT and RIST care to older adults are all needed.

In addition, sound gero-psychiatric and integrated medical services have to be established at the Ancora, Trenton & Greystone campuses. Integrated medical services are needed for patients of all ages at each of these hospitals. Furthermore, a culture of accountability, which does not exist today, has to be established in these settings. Steps in the right direction of by the measurement of fidelity to best practices, such as Illness Management and Recovery (IMR), dialectical behavior therapy (DBT) and restraint reduction initiatives are all underway and should be broadened.

Other Thoughts on Closure

An alternative to closure of Hagedorn would be to convert it to a private non-profit specialty hospital-overseen by a state authority. It could be more efficiently operated under these auspices, especially eliminating unnecessary overtime and inflated pension liability. It could provide a good opportunity for the state to test out privatizing state mental health services and to establish contractual relationships with organizations that could be held accountable for results and replaced with alternate organizations if needed.

Accountability within the hospital and community systems

Discussions of the task force and our study of the issues have all highlighted the need for accountability both with the hospital system and community services. Ongoing data collection and outcomes assessment are necessary and are insufficiently in place today. A special evaluation effort to study the impact of any facility closure should be part of any plan.

Mental Health Facilities Task Force Members

Carolyn Beauchamp

Kenneth J. Gill

Margaret (Peggy) Swarbrick, Vice Chair

Wayne Vivian

NEW JERSEY ADMINISTRATIVE CODE
TITLE 10. DEPARTMENT OF HUMAN SERVICES
CHAPTER 10. COMMUNITY MENTAL HEALTH AND DEVELOPMENTAL DISABILITY
SERVICES INVESTMENT

Subchapter 1. General Provisions

10:10-1.1 Purpose

The purpose of this chapter is to provide for a process by which the resources which result from the sale of residential facilities and/or the reduction of expenditures for State inpatient resources shall be invested in community-based services for persons with developmental disabilities and community-based mental health services for persons with serious mental illness, including children and adolescents with serious emotional disturbances.

10:10-1.2 Scope

This chapter applies to the Division of Mental Health Services and the Division of Developmental Disabilities.

10:10-1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Children and adolescents with serious emotional disturbances" means individuals under 18 years of age who are in psychiatric crisis or have a designated diagnosis of mental illness under the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, fourth edition, incorporated herein by reference, as amended and supplemented, published by the American Psychiatric Association, 1400 K Street, Washington, DC 20005, and whose severity and duration of mental illness result in substantial functional disability.

"Commissioner" means the Commissioner of the Department of Human Services.

"Community mental health and developmental disability services" means the following services for persons with serious mental illness, or for persons with developmental disabilities, as appropriate:

1. Emergency and crisis services provided in programs licensed or approved by the Commissioner;
2. Case management services;
3. Outpatient services which provide treatment and rehabilitation to persons with serious mental illness in accordance with N.J.A.C. 10:37E and 10:37F, and those with developmental disabilities, in accordance with [N.J.A.C. 10:46-2.3](#);
4. Residential services, other than inpatient services, provided in programs licensed or approved by the Commissioner and in long-term health care facilities licensed by the Department of Health and Senior Services, including, but not limited to, assisted living residences, comprehensive personal care homes and residential health care facilities;

5. Psychiatric rehabilitation services, including, but not limited to, supported employment, supported living, psychosocial clubhouse and other partial care modalities;
6. Other community support services, including, but not limited to, consumer advocacy, consumer operated self-help activities, drop-in centers, and family education and supports services; and
7. Services which are directed toward the alleviation of a developmental disability or mental illness, or toward the social, personal, physical or economic habitation or rehabilitation of a person with a developmental disability or mental illness, and provided by an agency or program licensed or approved by the Commissioner; and
8. Other services for which the Department has regulatory standards.

"Department" means the Department of Human Services.

"Developmental disability" means a developmental disability as defined in the "Developmentally Disabled Rights Act," P.L. 1977, c.82 ([N.J.S.A. 30:6D-1](#) et seq.).

"Facility" means a State psychiatric hospital or developmental center operated by the Department.

"Persons with serious mental illness" means individuals who are in psychiatric crisis, or have a designated diagnosis of mental illness under the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, fourth edition, incorporated herein by reference, as amended and supplemented, published by the American Psychiatric Association, 1400 K Street, Washington, DC 20005, and whose severity and duration of mental illness result in substantial functional disability. Persons with serious mental illness shall include children and adolescents with serious emotional disturbances.

Subchapter 2. Policies and Procedures

10:10-2.1 Redeployment of proceeds

(a) All proceeds, net the costs of marketing and disposal of the property, from the sale of Department facility property shall be held in a separate account established by the Office of Management and Budget, within the Department of the Treasury.

(b) All such funds shall be used for the establishing or funding of community mental health and developmental disability services. Approval of the use of funds shall be in accordance with procedures established in the Capital Funding Program at N.J.A.C. 10:3-2.

(c) On an annual basis, or more frequently if necessary, the Department will forward to the Office of Management and Budget, within the Department of the Treasury, a plan for expenditure of these funds, outlining general subject areas and anticipated amounts.

(d) When a facility's residential capacity is reduced by 50 percent or more, the funds realized by such a reduction in capacity shall be used to support the individuals who formerly resided at the facility and have been moved to community mental health and developmental disability services.

1. When the amount of funds realized by such a reduction is not required for community

developmental disability services, the funds shall be used to provide for services for those individuals on the Division of Developmental Disabilities waiting list for services.

2. When the amount of funds realized by such a reduction is not required for individuals formerly residing at the psychiatric hospital, the funds shall be used by the Division of Mental Health Services to improve and enhance community mental health services.

(e) The Division of Mental Health Services and Division of Developmental Disabilities shall prepare a report, within 90 calendar days of the end of any fiscal year in which there is a 50 percent or greater reduction in residential capacity of any facility, which certifies to the Commissioner that funds realized by such a reduction have been utilized in a manner consistent with these rules.

ATTACHMENT 7

State Mental Health Facilities Evaluation Task Force

Summary of Meeting of November 18, 2010

In Attendance:

Task Force Members:

Jennifer Velez, Chair, Commissioner of DHS
Margaret Swarbrick, Vice Chair, Ph.D., OTR, CPRP, Director, Institute for Wellness & Recovery Initiatives, CSP
Dawn Apgar, Deputy Commissioner, DHS
Sylvia Axelrod, Executive Director, NAMI NJ
Robert Bollaro, DMAHS
Carolyn Beauchamp, President, Mental Health Association in New Jersey
The Honorable Patrick Diegnan, Assembly, 27th Legislative District (represented by Candice Howard, Chief of Staff)
The Honorable John DiMaio, Assembly, 23rd Legislative District (represented by Kelly Comerford)
The Honorable Michael Doherty, Senate, 23rd Legislative District
Kenneth J. Gill, Ph.D., CPRP, Chair, Dept. of Psychiatric Rehabilitation & Counseling Professions, UMDNJ
Gilbert Honigfeld, Ph.D., General Public Member
Barry Johnson, Director, Monmouth County Division of Mental Health and Addiction Services
Karen Kubert, Director, Warren County Department of Human Services
Valerie Larosiliere, Acting Asst Commissioner, DMHAS
Judith A. Lucas, Ed.D., APN-BC, Institute for Health, Health Care Policy and Aging Research
Gail Masson-Romano, M.A., Board of Trustees, Hagedorn Psychiatric Hospital
Rosalyn Metzger, General Public Member
Joseph A. Miller, Ph.D., L.C.S.W., Dir, Neurosciences & Behavioral Health, Meridian Health
Wayne Vivian, President, Coalition of Mental Health Consumer Organizations of NJ
Debra Wentz, Ph.D., CEO, New Jersey Association of Mental Health Agencies.

Other:

Ed Smith, The Honorable Michael Doherty's Chief of Staff
Brett Tanzman, Office of the Governor's Counsel

Staff:

Kevin Martone, Deputy Commissioner, Department of Human Services
Paula Hayes, Task Force Secretary
Gayle Riesser, Task Force Secretary
Beth Connolly, DHS, Commissioner's Office
Mary Jo Kurtiak, Acting CEO, Hagedorn Psychiatric Hospital
Ellen Lovejoy, DHS, Office of Public Affairs

Unable to attend:

The Honorable Richard Codey, Senate, 27th Legislative District

Summary

1. Welcome and Introductions
2. Business
 - Attendance: **Members are expected to attend all scheduled Task Force meetings**
 - Confidentiality: **Commissioner emphasized that meetings are part of a deliberative process. Task force members should feel free to have open discussion of the issues, while respecting the integrity of the Task Force process.**
 - Dates of meetings
 - Public Hearings **All Task Force (TF) members are expected to attend. Members are asked to email the Chair if they are unable to attend any of the public hearings.**
 - Report Preparation **Gayle Riesser and Paula Hayes will assist with preparation of the report for the TF.**
 - Vice Chairperson **Vote was delayed until the end of the meeting.**
3. Review of A2866/Scope of Task Force Work
 - The Commissioner went over issues one through six which the Task Force (at a minimum) is to discuss. Points one and two were on the agenda for this meeting.
 - **A point was made that it would be more appropriate to start with issue 6. The Commissioner mentioned that to have a meaningful discussion of issue 6, TF would need to have additional information and data available prior to that discussion and may want additional staff resource people present for the discussion.**
 - Financial information for other state hospitals including OT, infrastructure, etc. was requested.
4. Overview of “*Plan for the Closure of the Senator Garrett W. Hagedorn Psychiatric Hospital*” Power point presented by Deputy Commissioner Martone. **There was extensive discussion among Task Force members following Deputy Commissioner Martone’s presentation. Task Force members felt that, in some cases, certain topics had not been sufficiently addressed by the plan; requests were made for additional information or clarification. These questions and data requests fell into the following four general categories:**
 - Comparisons of State Psychiatric Hospitals (cost of care, staffing, overtime, capital costs, compliance costs for Ancora, internal or other measures of quality such as incident reports)
 - Care of the geropsychiatric population (levels of care, quality, standards, programs, staffing and training at the state hospitals; characteristics of those served at Hagedorn, including needs and discharge placement)
 - Property and shared infrastructure (ease of separation of campus utilities; cost if Hagedorn remains vacant; plans to maintain community resources such as Freedom House now at Hagedorn)

- Systemic impact (jails, STCFS, EDs, nursing homes)

Some requests or questions were addressed during the meeting:

- Incident reports (Data available on the Division of Mental Health Services data dashboard)
- Source of funding for new programs proposed for older adults (Olmstead)
- Consideration of closing units and maintaining specialized units at existing facilities (accessibility and desirability of serving consumers closer to home community)

Assurances were requested in the following areas:

- Forensic and geriatric populations will not be mixed
- Everything in the plan will be implemented; ombudsperson for the elderly

5. Question 1 Discussion: The plan's consistency with the United States Supreme Court Olmstead decision and the department's July 2009 Olmstead settlement agreement.

Discussion of this issue was delayed.

6. Question 2 Discussion: Whether sufficient capacity and appropriate staff expertise will be made available in the remaining State psychiatric facilities to accommodate the current and future needs of patients requiring that level of care, including, but not limited to, an evaluation of geriatric care. **Discussion of this issue was delayed.**

Nominations were taken and paper ballots were collected and counted. Peggy Swarbrick was elected Vice-chair of the Task Force

At the next meeting TF will start with issue 6 and then issue 5.

There was interest in having a clinician or clinicians—possibly Dr. Eilers or a representative from the hospital or hospitals attend the next meeting and discuss levels of care at the hospitals.

The report presented at today's meeting is a launching point for the TF discussion regarding the Department's plan for closure.

State Mental Health Facilities Evaluation Task Force

Summary of Meeting of December 3, 2010

In Attendance:

Task Force Members:

Jennifer Velez, Chair, Commissioner of DHS

Margaret Swarbrick, Vice Chair, Ph.D., OTR, CPRP, Director, Institute for Wellness & Recovery Initiatives, CSP

Dawn Apgar, Deputy Commissioner, DHS

Sylvia Axelrod, Executive Director, NAMI NJ

Robert Bollaro, DMAHS

Carolyn Beauchamp, President, Mental Health Association in New Jersey

The Honorable Richard Codey, Senate, 27th Legislative District

The Honorable Patrick Diegnan, Assembly, 27th Legislative District (represented by Candice Howard, Chief of Staff)

The Honorable John DiMaio, Assembly, 23rd Legislative District

The Honorable Michael Doherty, Senate, 23rd Legislative District

Kenneth J. Gill, Ph.D., CPRP, Chair, Department of Psychiatric Rehabilitation & Counseling Professions, UMDNJ

Barry Johnson, Director, Monmouth County Division of Mental Health and Addiction Services

Karen Kubert, Director, Warren County Department of Human Services

Valerie Larosiliere, Acting Asst Commissioner, DMHAS

Judith A. Lucas, Ed.D., APN-BC, Institute for Health, Health Care Policy and Aging Research

Gail Masson-Romano, M.A., Board of Trustees, Hagedorn Psychiatric Hospital

Joseph A. Miller, Ph.D., LC.S.W., Director, Neurosciences and Behavioral Health, Meridian Health

Wayne Vivian, President, Coalition of Mental Health Consumer Organizations of NJ

Debra Wentz, Ph.D., CEO, New Jersey Association of Mental Health Agencies.

Other:

Ed Smith, The Honorable Michael Doherty's Chief of Staff

Brett Tanzman, Governor's Counsel

John Hulick, Governor's Office of Policy

Staff:

Kevin Martone, Deputy Commissioner, Department of Human Services

Paula Hayes, Task Force Secretary

Gayle Riesser, Task Force Secretary

Mary Jo Kurtiak, Acting CEO, Hagedorn Psychiatric Hospital

Ellen Lovejoy, DHS, Office of Public Affairs

Vicki Fresolone, Office of Deputy Commissioner

Robert Eilers, MD, MPH, Medical Director, DMHS

Roger Borichewski, MSW, LCSW Acting Assistant Director, Community Services, DMHS

Unable to attend:

Task Force Member:

Gilbert Honigfeld, Ph.D., General Public Member

Rosalyn Metzger, General Public Member

Summary

1. Welcome and Introductions

2. Business

- Distribution of November 18th meeting summary
- Information Requests – Commissioner indicated that various requests for information have been made. The Department compiled information for presentation at the meeting today to the extent possible and given the condensed time frame. The Commissioner also referred TF members to the written plan for other information that is contained in the plan.
- Confidentiality: Commissioner emphasized that meetings are part of a deliberative process. Task force members should feel free to have open discussion within the TF of the issues, while respecting the integrity of the Task Force process.

3. Greystone Tour/December 1st Public Meeting

- There were 20 speakers and 40 people in attendance; most speakers were opposed to the closure. One TF member indicated that MH consumers are reluctant to testify, fearing retaliation from staff should they need to become a patient there at some point. Another TF member stated that if another hospital was proposed for closure, employees there would oppose it as strongly.
- Several TF members toured Greystone including Assemblyman DiMaio, Gilbert Honigfeld, Barry Johnson, Roslyn Metzger, Judy Lucas, Barry Johnson and Bob Bollaro. Ed Smith, representing Senator Doherty toured as well. The tour included the lobby with a donated player grand piano used during music therapy, the auditorium where ceremonies, talent shows and other presentations are conducted; the extensive treatment mall, the classroom for the hearing impaired, the art room, the music room, the medical clinic where medical staff and consultants provide a variety of services, the music room, the courtroom where civil commitment hearings take place, Park Place, the pool, the gym, the exercise room, the beauty salon, art rooms, the falls clinic, GPA store, and creative employment center.

4. S2069/A2866 Task 2: “Whether sufficient capacity and appropriate staff expertise will be made available in the remaining State psychiatric facilities to accommodate the current and future needs of patients requiring that level of care, including, but not limited to, an evaluation of geriatric care.”

As a result of questions about the quality of care provided at Hagedorn as compared to the other hospitals, there was a presentation by Kevin Martone to present various quality measures. This was followed by a presentation and dialogue with Dr. Robert Eilers, DMHS Medical Director with input from Roger Borichewski, Acting Assistant Director of Community Services at DMHS regarding the capabilities of other hospitals in meeting the needs of older adults, after a closure. Among the key points from the presentations:

- In deciding which hospital to close, the Department asserted that it considered quality in the process and presented quality indicators that suggest variability and comparability among the four state psychiatric hospitals with no state hospital consistently appearing the best or the worst. Each has its strengths and weaknesses. Indicators presented included CMS findings, assaults, falls, polypharmacy, restraints and recidivism. Each of the hospitals has failed at some point to meet standards established by the Center for Medicare and Medicaid Services (CMS); all currently meet CMS standards and also are accredited by the Joint Commission.
- Data show that Olmstead is being implemented successfully with relatively small percentages of discharges, from any of the hospitals, returning within 30 days. This has contributed to the significant reduction in patient census statewide. There was consensus from the TF members that Olmstead placements with community providers are largely successful with little recidivism. A question was raised regarding the growth of the older adult population; reference was made to the written plan which addresses that issue.
- Dr. Eilers discussed the following in his presentation: Programs and staff expertise currently exist at all of the hospitals that meet the needs of older adult consumers and consumers with medically complex conditions. Medically complex conditions are not restricted to the elderly. Trenton and Ancora have capability to address the needs of these populations without mixing them on units with younger, more active consumers. Services provided at Hagedorn can be replicated elsewhere in the system. There was agreement that the way the system is currently configured, the other hospitals periodically send patients to Hagedorn for treatment. However, other factors are involved in those decisions as well. Department staff provided examples of services provided at the other facilities that are identical to those at Hagedorn.

Discussion among Task Force members was wide-ranging. Listed below are the general categories into which their comments and questions fell:

- Consumers by and large support closure of state psychiatric hospitals and prefer and succeed in community living.
- TF members felt strongly that any plan should incorporate the redirection of funds from the savings of closure into community services.
- Consensus that Olmstead placements have been successful, especially RIST, leading to successful reduction in the state hospital census and successful community tenure.
- Merits of dedicated geriatric hospital and segregating forensic patients from others at all of the hospitals. Some TF members felt that the State should continue to operate five hospitals and specialize in care. Others felt that the state should operate a smaller state hospital infrastructure spread geographically throughout the state and re-direct funds to community services. Some members felt that despite the decision factors in the plan, Hagedorn should continue to remain open and specialize in older adults. TF members agreed that older adults should not be mixed on units with younger adults,

especially those with forensic backgrounds. Note: Discussion of Consumers with Legal Involvement is found on pages 10 and 11 of the Plan for Closure.

- Need for more intermediate hospital beds in the community to bridge the LOS gap between the STCFs and the state psychiatric hospitals.
- Cost, space, and relative merits of equipment for the elderly such as oxygen (wall vs. portable), and lifts. Some TF members expressed concern that the other hospitals could not provide this equipment. However, the Department indicated it does provide this equipment now in other hospitals and on an as needed basis according to consumers' needs.
- Unique features of Hagedorn (scenic view, staff culture) should not be lost. Several TF members noted the positive culture that staff at Hagedorn has developed. Another TF member suggested that a scenic view does not equal quality care.
- Need to determine best practices for providing services to the older consumer.

5. Next meetings

- Public Hearing on December 8, 2010 at DDD
- TF meeting on December 17, 2010 at Hagedorn
- Tour to be arranged in conjunction with the TF meeting

12/14/10

State Mental Health Facilities Evaluation Task Force

Summary of Meeting of December 17, 2010

In Attendance:

Task Force Members:

Jennifer Velez, Chair, Commissioner of DHS

Margaret Swarbrick, Vice Chair, Ph.D., OTR, CPRP, Director, Institute for Wellness & Recovery Initiatives, CSP

Dawn Apgar, Deputy Commissioner, DHS

Sylvia Axelrod, Executive Director, NAMI NJ

Robert Bollaro, DMAHS

Carolyn Beauchamp, President, Mental Health Association in New Jersey

The Honorable Richard Codey, Senate, 27th Legislative District (Participated by phone)

The Honorable Patrick Diegnan, Assembly, 27th Legislative District

The Honorable John DiMaio, Assembly, 23rd Legislative District

The Honorable Michael Doherty, Senate, 23rd Legislative District

Kenneth J. Gill, Ph.D., CPRP, Chair, Department of Psychiatric Rehabilitation & Counseling Professions, UMDNJ

Gilbert Honigfeld, Ph.D., General Public Member

Barry Johnson, Director, Monmouth County Division of Mental Health and Addiction Services

Karen Kubert, Director, Warren County Department of Human Services

Valerie Larosiliere, Acting Asst Commissioner, DMHAS

Judith A. Lucas, Ed.D., APN-BC, Institute for Health, Health Care Policy and Aging Research

Gail Masson-Romano, M.A., Board of Trustees, Hagedorn Psychiatric Hospital

Rosalyn Metzger, General Public Member

Joseph A. Miller, Ph.D., LC.S.W., Director, Neurosciences and Behavioral Health, Meridian Health

Wayne Vivian, President, Coalition of Mental Health Consumer Organizations of NJ

Debra Wentz, Ph.D., CEO, New Jersey Association of Mental Health Agencies.

Other:

Ed Smith, The Honorable Michael Doherty's Chief of Staff

John Hulick, Governor's Office of Policy

Staff:

Kevin Martone, Deputy Commissioner, Department of Human Services

Paula Hayes, Task Force Secretary

Gayle Riesser, Task Force Secretary

Mary Jo Kurtiak, Acting CEO, Hagedorn Psychiatric Hospital

Roger Borichewski, MSW, LCSW Acting Assistant Director, Community Services, DMHS

Beth Connolly, Special Assistant to the Commissioner

Summary

1. Welcome and Introductions
2. Business
 - Distribution of December 3 meeting summary and hand-outs
 - Hagedorn tours to be given following the meeting
3. Task Force Process
 - Respecting each others comments
 - Need to focus on tasks in legislation
 - Format of report

Discussion provided diverse views regarding the Task Force process:

- Some TF members wished to focus on the questions posed in the legislation regarding the State's Plan for closing Hagedorn in order to capture multiple viewpoints. Some Task Force members, particularly the legislators, felt the legislation establishing the TF was being viewed narrowly. They viewed the questions as being the minimum, but that it should not be the only, or necessarily, the main consideration. The Commissioner stated that additional discussion regarding the plan and other options could occur, but that the task force needs to examine the plan using the questions in the legislation. Other TF members questioned whether the allotted timeframe was sufficient given the intervening holidays and could be extended past the February 1st deadline if necessary. The Commissioner suggested that the Task Force allow the process to proceed and then see where matters stand.
- Other TF members also did not want to examine the questions, but instead focus on alternative uses for the hospital in the context of the entire system, including revenue sources that would allow Hagedorn to remain open. The examples included the following:
 - Finding an additional \$9 million to continue operations
 - Use of the facility by DDD or some other purpose for older adults
- Several TF members wondered whether there is still a need for Hagedorn in five years given the increase in older adults. Reference was made to the Plan that addressed the issue, but some members questioned the accuracy of the projections.
- Another issue raised is how the findings of the report would be developed. The Commissioner expressed that there may not be consensus regarding whether the hospital should remain open, and that the task force, at minimum, needs to respond to the issues detailed in the law.

4. Review of Public Hearings (on the agenda but not discussed)
5. Finish Discussion of S2069/A2866 Task 2: “Whether sufficient capacity and appropriate staff expertise will be made available in the remaining State psychiatric facilities to accommodate the current and future needs of patients requiring that level of care, including, but not limited to, an evaluation of geriatric care.” (This occurred following discussion of Task #1)

One individual attending the meeting stated that the answer to #2 should be “No.” However, there did not appear to be agreement. Several TF members wanted additional discussion on this item before they could reach a conclusion regarding this item.

In addition to questions, the quantity and quality of care was discussed. Some TF members felt that there were insufficient hospital beds given the growing number of elderly. One TF member indicated that it is too costly to institutionalize all of the older adults with dementia in the state, not all of whom need hospital care. Other TF members explained that the Olmstead decision revolved around the human and civil rights of individuals to be treated in the least restrictive setting.

Several TF members felt that there was a need for a consumer perspective, particularly patients. They referenced patient surveys that were done previously. (Note: All patients receive a Housing Preferences Interview (discussed in the written plan) to elicit patient preferences regarding discharge options. This is a new process as part of the Olmstead settlement and was not in place during the Marlboro closure.)

Other TF members mentioned a need to understand what housing and services are available for the older adult population served by the hospital. One TF member mentioned that PACT could be adapted to serve the elderly and that RIST is a good model adapted for the needs of individuals with medical needs. Another TF member asked for information about PACT, including the number served by PACT and also asked more generally about slots and wait times for services, access to medical care, and funding for services.

Some TF members mentioned that Hagedorn had the best quality care in the system and they would not want to see HPH patients going to these other facilities. The issue of quality of care was discussed comparing different state facilities and community placements. It was noted that these topics were addressed during the December 3, 2010 presentation by Dr. Eilers. Questions were raised by one TF member regarding training and they were referred to pages 29 and 35 of the Plan.

A request for information on reviews conducted by the Federal Centers for Medicare and Medicaid (CMS) was raised. DHS staff explained that they were advised by CMS that only finalized reports could be shared publicly. Members of the TF expressed concern over the restriction on public access to such reports. Another member of the TF explained that this is the Federal requirement since these documents are viewed as legal findings and could be used in future litigation, hence only finalized reports are permitted

for review outside the receiving department. The Commissioner indicated that finalized reports will be made available at the next meeting.

6. Task #1: “The Plan’s consistency with the United States Supreme Court Olmstead decision and the Department’s July 2009 Olmstead settlement agreement.”

Several Task Force members indicated that the answer to whether the plan is consistent with Olmstead was “Yes.” However, one TF member said that agreeing that the Plan was consistent with Olmstead was not synonymous with agreeing that Hagedorn needed to be closed. Another TF member indicated that consistency with Olmstead was tied to dates in the Settlement Agreement and asked about the current status. A DHS staff member responded that the Department is meeting its Olmstead timeframes and successfully discharging a range of consumers into the community. A question was also asked about placements for individuals who were not CEPP and the Department mentioned the community diversion beds that are being created under Olmstead for individuals who are not hospitalized but at risk.

7. Several budget issues were discussed during the meeting. Among the discussion points:

- Why money was spent on building a larger Greystone hospital if the trend was toward a smaller census
- Bridge funding similar to what occurred during the 450 project. One TF member mentioned that Olmstead and other funding for housing and services over the past five years have constituted a bridge and resulted in the reduced census. Another TF member said that a plan for services expansion and bed reduction was not the same as a hospital closure.
- The importance that savings from the Hagedorn closure be redirected to the community
- Cost to maintain the campus at HPH following closure
- The formulas and assumptions used to arrive at the cost savings from closing Hagedorn
- Cost of upgrading the physical plants at Ancora and Trenton to serve Hagedorn’s population.

DHS staff noted that the CFO for the Division of Mental Health and Addiction Services would present at the January 7th meeting in order to discuss the budget questions raised by TF members. A request was made to review information prior to the next meeting.

8. Hagedorn Tour

Three TF members toured Hagedorn: Judith Lucas, Wayne Vivian, and Valerie Larosiliere. They were accompanied by the two TF secretaries, the Acting CEO for the hospital and the Acting Assistant Director for Community Services at DMHS. The tour included units on East and West Hall, as well as the portion of North Hall that serves higher functioning older adults. The tour included group activities occurring in all three Halls, the dental and hairdressing facilities, “comfort” rooms, consumer hospital rooms in East and West Halls, and the gymnasium and other large public areas. Staff guiding the tour included the Acting Section Chief, Acting Medical Director, and the Director of Rehabilitation Services.

State Mental Health Facilities Evaluation Task Force

Summary of Meeting of January 7, 2010

In Attendance:

Task Force Members:

Jennifer Velez, Chair, Commissioner of DHS

Margaret Swarbrick, Vice Chair, Ph.D., OTR, CPRP, Director, Inst.for Wellness & Recovery Initiatives, CSP

Sylvia Axelrod , Executive Director, NAMI NJ (participated by phone)

Robert Bollaro, DMAHS

The Honorable Richard Codey, Senate, 27th Legislative District (participated by phone)

The Honorable Patrick Diegnan, Assembly, 27th Legislative District (represented by Candice Howard, Chief of Staff)

The Honorable John DiMaio, Assembly, 23rd Legislative District (participated by phone)

The Honorable Michael Doherty, Senate, 23rd Legislative District (represented by Ed Smith, Chief of Staff)

Kenneth J. Gill, Ph.D., CPRP, Chair, Dept.of Psychiatric Rehabilitation & Counseling Professions, UMDNJ

Gilbert Honigfeld, Ph.D., General Public Member

Barry Johnson, Director, Monmouth County Division of Mental Health and Addiction Services

Karen Kubert, Director, Warren County Department of Human Services

Valerie Larosiliere, Acting Asst Commissioner, DMHAS

Judith A. Lucas, Ed.D., APN-BC, Institute for Health, Health Care Policy and Aging Research (participated by phone)

Gail Masson-Romano, M.A., Board of Trustees, Hagedorn Psychiatric Hospital (participated by phone)

Rosalyn Metzger, General Public Member

Joseph A. Miller, Ph.D., L.C.S.W., Director, Neurosciences and Behavioral Health, Meridian Health

Wayne Vivian, President, Coalition of Mental Health Consumer Organizations of NJ

Debra Wentz, Ph.D., CEO, New Jersey Association of Mental Health Agencies (participated by phone)

Other:

John Hulick, Governor's Office of Policy

Staff:

Kevin Martone, Deputy Commissioner, Department of Human Services

Paula Hayes, Task Force Secretary

Gayle Riesser, Task Force Secretary

Mary Jo Kurtiak, Acting CEO, Hagedorn Psychiatric Hospital

John Whitenack, Acting Assistant Director, State Hospital Management, DMHS

Roger Borichewski, Acting Assistant Director, Community Services, DMHS

Diane Zompa, Chief of Staff, DHS

Beth Connolly, Special Assistant to the Commissioner

Steve Adams, Director, Fiscal Management Operations, DMHS

Lou Nyktas, Manager, Office of Workforce Utilization, DMHS

Katherine Fling, Director, Property Management and Construction, DHS

Ellen Lovejoy, Office of Public Affairs, DHS

Vicki Fresolone, Deputy Commissioner's Office, DHS

Task Force Members Unable to Attend:

Dawn Apgar, Deputy Commissioner, DHS

Carolyn Beauchamp, President, Mental Health Association in New Jersey

Summary

1. Welcome and Introductions
2. Business
 - Distribution of December 17 meeting summary and hand-outs
3. Task Force Process
 - Answering remaining questions:
Commissioner indicated that the TF had an obligation to answer the questions even in the absence of consensus. Per the legislation, the report is due February 1, 2011.
 - Report format:
Will present questions outlined in legislation with answers that reflect the views presented in TF process. Append the alternate proposal to the report. Will acknowledge that TF's views are mixed.
 - Additional meeting scheduled for January 14, 1-4 pm:
Every effort will be made to allow people to participate by phone.
 - Final Report review January 28, 2011
 - Discussion about need for state hospitals:
One TF member contended that DHS was trying to close HPH now by reducing admissions. DHS responded with data that demonstrated that each hospital in the system is experiencing reduced admissions and census as a result of Olmstead activity. Another TF member mentioned that the consumer perspective was that it is desirable if people can be stabilized in the community and do not enter the involuntary system, and that boarding homes and RHCfs are not filled with recent hospital discharges.
4. Budget Presentation by Steve Adams, CFO, DMHS
 - Budget spreadsheet was sent to TF members for review prior to the meeting.
 - Numbers in the budget book only capture state expenditures for hospitals, and do not reflect the actual costs of operating the hospitals. This explains why some TF members were confused about what HPH's budget is in the state appropriations book versus the savings suggested by the HPH closure plan.
 - Presented summary as well as details of summary figures for FY 12 and 13.
 - Numbers are projections based on certain assumptions; can fluctuate with potential for both increased costs and savings (e.g., DSH or disproportionate share)
 - Some of savings in FY 12 are overtime savings; based on 1-year closure timeframe; as wards close, can fill vacancies at other hospitals. The salary expense would come out of Hagedorn's budget, but not reflected at other hospitals which are already funded during the phase-down period. One TF member asked about alternative savings projections for different timeframes, such as 18 or 24 months.
 - Cost savings in FY 13 are basically the total hospital operating costs reduced by some ongoing expenses and decreased revenue due to lower system census.
 - No capital or depreciation costs included.
 - Per diem patient costs will increase at all of the hospitals if nothing is done about staffing as census comes down.
 - A TF member indicated that the ideal, personnel-wise, was to transplant entire teams from Hagedorn to Trenton or Ancora with patients in order to minimize impact on consumers.
 - Several TF members suggested that a main recommendation in the report should be that savings from a closure should be re-allocated to community services. Staff indicated that DHS supported that this is important to the success of a closure. Those dollars could also leverage Medicaid funding in the community, which as a hospital/Institution for Mental Disease (IMD) they currently cannot do for under 65 year old patients.

- Another TF member suggested that Freedom House be offered a one-year extension; continue power plant operations and water/heat at Freedom House.
 - Questions were raised regarding the value of vacant property at Marlboro and Brisbane, as well as value of Hagedorn and Trenton. Questions also raised about the continuation costs at Marlboro. Staff indicated that when property is declared surplus it is turned over to Treasury for disposition. Katherine Fling, DHS, spoke about the property, indicating that TPH property may have wetlands restrictions and environmental problems. She indicated that Brisbane was deed-restricted for children's services when that facility closed. TF members asked about the possibility of carving out buildings that had been recently renovated prior to closure of Marlboro for community use and K. Fling indicated that there had been deterioration that would entail repairs before buildings could be used.
5. Submission of alternate proposal to close Trenton Psychiatric Hospital by Karen Kubert
- Alternate plan was crafted by Karen Kubert, Gil Honigfeld, Gail Masson-Romano, and Rosalyn Metzger, and supported by Senator Doherty, and Assemblymen Diegnan and DiMaio.
 - Plan concurs with the need to close a hospital given overall census reductions and need for cost efficiencies, but contends the State should close TPH instead.
 - Primary focus was to achieve the most savings that can be re-directed into the community
 - Alternate proposal suggests closing TPH over the same timetable (one year)
 - Alternate proposal suggests that:
 - Ann Klein Forensic Center handle the State's forensic population
 - Hagedorn handle the older adult population. Older patients from all counties would go to HPH instead of TPH and APH.
 - Ancora and Greystone handle general civil commitment hospital beds in north and south. The younger population that currently goes to TPH would be diverted to GPPH and APH.
 - Have 2 specialty hospitals and 2 general hospitals. If AKFC cannot handle the capacity, the plan suggests keeping additional TPH building operating for forensic patients.
 - Task Force members raised a number of issues and questions:
 - One TF member noted that Freedom House did not accept people on medication and questioned whether this was in the best interests of consumers with a co-occurring mental illness and substance use disorder. Presenter noted that they understand that they need to change and are open to expanding operations at Hagedorn.
 - Several TF members expressed concerns about the greater number of hospital beds that would be closed and that this proposal causes disruption at all of the hospitals. One TF member noted that we need hospitals, that there would be more political pressure to not close Trenton, and that we would have the same reaction from TPH employees. Several TF members noted that Trenton is a larger facility and the alternate proposal is short about 150 beds.
 - Several TF members raised questions about reported cost savings. One TF member noted that reported savings did not include increasing costs at both Ancora and Greystone. Another participant noted that moving beds under AKFC would cause a decrease in operating revenue for the TPH beds under AKFC since AKFC is not CMS certified and cannot receive Medicaid or DSH funds.
 - A participant noted that the alternate proposal also needed to be considered in light of the six questions.
 - There was some discussion about the value and re-development of both campuses. DHS staff indicated that the TPH campus could not fully be re-developed because of

the continued use of several buildings and that costs to demolish others would be high, largely due to environmental reasons. There are also buildings of historical significance. HPH faces similar issues, but may have better re-use potential.

- TF member made a recommendation of benchmarks for reinvestment linked to downsizing of the hospital; increase confidence in any plan.

6. Summary of expectations (working backwards)

- Final report due 2/1/11
- At 1/28/11 meeting will focus on finalizing report
- At 1/21/11 meeting, the TF should begin review of draft report
- TF member asked about questions. Discussion indicated that responses would reflect variety of opinions expressed.
- Additional next steps:
 - TF members were encouraged to forward suggested answers to the six questions for both Close Hagedorn Plan and the alternative, Close Trenton Plan that can be incorporated into the final report. Ken Gill to send his answers for others to examine.
 - Steve Adams will attempt to work up numbers for Close Trenton plan by next meeting

State Mental Health Facilities Evaluation Task Force

Summary of Meeting of January 14, 2011

In Attendance:

Task Force Members:

Jennifer Velez, Chair, Commissioner of DHS
Margaret Swarbrick, Vice Chair, Ph.D., OTR, CPRP, Dir., Inst. for Wellness & Recovery Initiatives, CSP
Sylvia Axelrod, Executive Director, NAMI NJ
Carolyn Beauchamp, Pres., Mental Health Association in New Jersey (participated by phone)
Robert Bollaro, DMAHS
The Honorable Richard Codey, Senate, 27th Legislative District
The Honorable Patrick Diegnan, Assembly, 27th Legislative District (represented by Candice Howard)
The Honorable John DiMaio, Assembly, 23rd Legislative District (participated by phone)
The Honorable Michael Doherty, Senate, 23rd Legislative District
Kenneth J. Gill, Ph.D., CPRP, Chair, Dept. of Psychiatric Rehab. & Counseling Professions, UMDNJ
Gilbert Honigfeld, Ph.D., General Public Member
Barry Johnson, Director, Monmouth County Division of Mental Health and Addiction Services
Karen Kubert, Director, Warren County Department of Human Services (participated by phone)
Valerie Larosiliere, Acting Asst Commissioner, DMHAS
Judith A. Lucas, Ed.D., APN-BC, IHHCPAR, Rutgers University
Gail Masson-Romano, M.A., Board of Trustees, Hagedorn Psychiatric Hospital
Rosalyn Metzger, General Public Member
Joseph A. Miller, Ph.D., L.C.S.W., Director, Neurosciences & Behavioral Health, Meridian Health
Wayne Vivian, President, Coalition of Mental Health Consumer Organizations of NJ
Debra Wentz, Ph.D., CEO, New Jersey Association of Mental Health Agencies

Other:

Ed Smith, The Honorable Michael Doherty's Chief of Staff
John Hulick, Governor's Office of Policy

Staff:

Kevin Martone, Deputy Commissioner, Department of Human Services
Paula Hayes, Task Force Secretary
Gayle Riesser, Task Force Secretary
Mary Jo Kurtiak, Acting CEO, Hagedorn Psychiatric Hospital
John Whitenack, Acting Assistant Director, State Hospital Management, DMHS
Roger Borichewski, Acting Assistant Director, Community Services, DMHS
Beth Connolly, Special Assistant to the Commissioner
Steve Adams, Director, Fiscal Management Operations, DMHS
Katherine Fling, Director, Property Management and Construction, DHS
Joe Tebeest, Director, Office of Finance, DHS
Ray Fusco, Office of Finance

Task Force Members Unable to Attend:

Dawn Apgar, Deputy Commissioner, DHS

Summary

1. Welcome (Kevin Martone on behalf of Commissioner Velez)
2. Business
 - Distribution of January 7th meeting summary and hand-outs (corrections noted to attendance)
 - Next meeting January 21, 2011 at DHS
3. Task Force Process
 - Written responses to questions
 - Report review January 28, 2011
4. Review of Trenton Psychiatric Hospital Budget (presentation by Steve Adams, CFO, DMHS)
 - Steve Adams presented preliminary budget estimates for Trenton psychiatric Hospital closure scenarios for discussion purposes.
 - Budget scenarios based upon a statewide census of 1550 (or 1350 excluding Ann Klein Forensic Center) in June 2012.
 - Consider two options A & B:
 - A: Hagedorn at 275
Greystone at 500
Ancora at 575
AKFC at 200
 - B: Hagedorn at 275
Greystone at 500
AKFC at 200 + 150 in TPH buildings = 350
Ancora at 425
 - Preliminary/Incomplete annualized savings of closing TPH
 - Total Closure: \$58.950 million savings
 - Partial Closure: \$50.608(does not include 1-time cost of security enhancements at TPH to handle 150 forensic)
5. TPH Closure Proposal in context of 6 questions
Discussion focused on a variety of topics including the proposal to close TPH, the Hagedorn Closure Plan and system's issues:
 - Trenton Closure Proposal:
 - One TF member asked about the cost of retrofitting TPH to serve the forensic population. Staff indicated that two buildings (Drake and Raycroft) at TPH are easier to secure and already have some safety features (e.g., card access reader).
 - Discussion of neighborhood reaction. Some TF members felt that it should not be a concern because the campus already has forensic consumers and a DOC facility. Other TF members suggested there could be a negative reaction.

- Concern that the potential use of Trenton for forensic now treated elsewhere may be stigmatizing people with mental illness with legal charges. Another member felt that mixing patients with patients with legal charges stigmatized mental illness. A TF member mentioned that specialty hospitals are more cost effective. In terms of specialty facilities, one TF member mentioned the needs of returning vets but staff indicated that vets are the responsibility of the VA system.
 - Staff indicated that system might save more money by closing Trenton, but that was not the only consideration. Closing Hagedorn would affect one state hospital whereas the realignment called for under the Trenton Closure proposal would result in more substantial system changes both in terms of aligning counties (to determine which clients go where in light of available beds) and moving existing patients. Another participant mentioned that not all forensic need to go to AKFC/TPH. Ancora could continue to serve forensics, but that negates the idea of specialty care suggested by some TF members.
 - Concern about hospital capacity (Ancora/Greystone) to absorb general patients if Trenton were to close. One TF member indicated that most would not like to see a high Ancora census.
 - Debate occurred around the significance of geography for families, including transportation since many families using state hospitals are low-income. Legislators felt that geography was not an issue given the compact, dense population in the state. One TF member mentioned that Greystone and Ancora are both about 40 miles from Trenton. When asked for the family perspective, some TF members indicated that what's best for their loved one matters more than geography, and another TF member felt that family members should have the opportunity to weigh in on geography.
 - Discussion also occurred around the potential loss of 12 transitional cottages at Trenton, with capacity for 8 consumers each or about 100 beds.
 - Some discussion about whether if TPH closed would Hagedorn operate at capacity and serve the same population. There was discussion regarding whether Hagedorn could fill 270+ beds. Since so many patients have a co-morbid medical diagnosis, it is likely that each hospital will need to serve this population and there may not be enough older adults needing state hospital care; some TF members felt there is a greater need for beds due to census. Some TF members suggested that families get to pick the hospital where their relative receives treatment; this wasn't suggested for consumers.
 - Some TF members indicated belief that TPH has greater re-use and resale value for property, but most agreed that there are too many variables to make an informed decision with out an appraisal and assessment of both campuses.
 - Most agreed that that closure of Trenton would take longer than Hagedorn, because of the scope of the system change required, complexity and numbers.
- Hagedorn Closure Plan:
 - One TF member expressed concern about dramatic decrease in Hagedorn admissions and whether it was deliberate. Staff mentioned that this is due

Olmstead implementation and centralized admissions and is being seen at all of the hospitals.

- Another TF member mentioned that continuing compliance with Olmstead is not addressed in the Plan.
- A TF member was concerned about the emphasis in the closure plan solely on “beds”, indicating that a specialty population needs the culture and expertise, hence the importance of specialization.
- System Issues:
 - Several TF members expressed concern about the impact of any closure on the acute care system. They mentioned that consumers in STCFs are staying longer; more apt to transition directly to the community. TF members also mentioned the back up in emergency departments (ED). One asked about long term care and STCF beds.
 - Agreement that the goal is to move people into the community and concentrate more of the treatment in the community
 - TF members also expressed concern about needs in the community should a hospital close. They stressed that savings from a closure need to be earmarked for the community. However, some TF members are concerned that there is no guarantee from the State that funds saved through closure will go back into the community.
 - There was debate over the impact of closure on the counties; Staff indicated that county governments save if a hospital closes since they pay 15% of the costs now, but pay nothing once a consumer is served in the community. One TF member asserted that costs to the counties continue to increase, however.

6. Community System Program Development

- Task Force members indicated that it was important to be as specific as possible about the community services that are needed and where the dollars saved are needed. Among the suggestions made by TF members:
 - Use resources that are in place the way they are intended to be used. Take pressure off the acute care system; consumers in STCF beds staying 30, 60, 90 days.
 - Think about how best to achieve diversion from screening; expand development of intermediate beds.
 - Several TF members agreed that the recommendations of the Acute Care Task Force and Governor Codey’s MH Task Force Report offer sound recommendations for system improvement. Both reports available on DHS website.

7. Task Force Report

- Some TF members wanted the Trenton closure proposal to be viewed as parallel and equal in the final report to the Hagedorn closure plan indicating that closure of TPH potentially yields more savings and would be in greater compliance with Olmstead. Others expressed a concern about whether the savings would go to community treatment absent commitment by the State.

- It was suggested by those who developed the Trenton closure proposal that an Executive Summary indicate that closure of TPH yields more savings and would be in greater compliance with Olmstead. Others expressed a concern about whether the savings would go to community treatment absent commitment by the State.
8. Re-use/Redevelopment Considerations for Hagedorn and Trenton Psychiatric Hospital campuses (presentation by Katherine Fling, Director, Property Management and Construction, DHS with maps of both facilities).

Generally, the highest and best use is for single family homes. Appraisal would be conducted and if not suitable, then go to next best use, i.e., commercial. Maps handed out of Hagedorn and Trenton:

- Trenton
 - No code related changes needed or Joint Commission to serve older adults
 - Drake and Raycroft are the 2 most secure buildings
 - \$22 million in capital improvements represent a “wish list”; larger infrastructure is fundamentally sound.
 - Historical significance: 1st hospital in state; created by Dorothea Dix. Main building designed by Thomas Kirkbride, historic architect of early state psychiatric hospitals. TF member mentioned on-grounds museum of Dix memorabilia. Staff indicated that TPH buildings have more historic preservation significance than Hagedorn.
 - Property falls within two municipalities: Trenton and Ewing; complicate redevelopment process
 - Land is mostly flat, but stream, some wetlands
 - \$7.5 million demolition; issues include asbestos, lead-based paint
 - Groundwater contamination at powerhouse restricts sale of property because DEP variance would not apply if sold; demolition would require remediation.
 - Public transportation and utilities
 - public water and sewer exist on campus
 - Perception is that TPH is potentially more of a Marlboro; very complicated; Many buildings are not reusable.
- Hagedorn
 - Mountainous, secluded; part of NJ lands trust and Highlands Preservation Council District.
 - Lots of impervious surface at Hagedorn but not in surrounding area that may permit re-development
 - Spanish mission style architecture; consistency
 - Topography – picturesque, deer population, stream (wetlands).
 - Wastewater goes into stream (concern)
 - Landfill and potential groundwater contamination
 - Cemetery
 - \$1.5 million demolition, 2 buildings on property are unreclaimable
 - Better reuse potential as most buildings are reusable and property is attractive, but no public sewer or water currently exist; the campus operates these.

The TF generally agreed that absent more detailed information, including full appraisals, that informed decisions on the future use of the campuses could not be made. Discussion among TF members resulted in a general recommendation that the State consider and propose concrete uses for any property that closes to avoid another Marlboro. Among the recommendations that could be considered regarding Hagedorn and/or Trenton:

- Explore public/private partnerships to yield savings and ensure the State continues to meet the needs of severely mentally ill individuals.
- Privatize Hagedorn and convert to nursing home type facility
- Restrict Hagedorn's re-use to older adults
- Use of TPH property by other state entities
- Preserve/carve out Travers – either for residential housing or require developers to preserve the roughly 100 community beds or pay for their relocation elsewhere.

State Mental Health Facilities Evaluation Task Force

Summary of Meeting of January 21, 2011

In Attendance via Conference Call:

Task Force Members:

Jennifer Velez, Chair, Commissioner of DHS

Margaret Swarbrick, Vice Chair, Ph.D., OTR, CPRP, Director, Inst.for Wellness & Recovery Initiatives, CSP

Sylvia Axelrod , Executive Director, NAMI NJ

Carolyn Beauchamp, President, Mental Health Association in New Jersey (participated by phone)

Robert Bollaro, DMAHS

The Honorable Richard Codey, Senate, 27th Legislative District

The Honorable Patrick Diegnan, Assembly, 27th Legislative District represented by Candice Howard and Tom Lynch

The Honorable John DiMaio, Assembly, 23rd Legislative District

The Honorable Michael Doherty, Senate, 23rd Legislative District represented by Ed Smith

Gilbert Honigfeld, Ph.D., General Public Member

Barry Johnson, Director, Monmouth County Division of Mental Health and Addiction Services

Karen Kubert, Director, Warren County Department of Human Services

Valerie Larosiliere, Acting Asst Commissioner, DMHAS

Judith A. Lucas, Ed.D., APN-BC, IHHCPAR, Rutgers University

Gail Masson-Romano, M.A., Board of Trustees, Hagedorn Psychiatric Hospital

Rosalyn Metzger, General Public Member

Joseph A. Miller, Ph.D., L.C.S.W., Director, Neurosciences and Behavioral Health, Meridian Health

Wayne Vivian, President, Coalition of Mental Health Consumer Organizations of NJ

Debra Wentz, Ph.D., CEO, New Jersey Association of Mental Health Agencies

Staff:

Kevin Martone, Deputy Commissioner, Department of Human Services

Paula Hayes, Task Force Secretary

Gayle Riesser, Task Force Secretary

Mary Jo Kurtiak, Acting CEO, Hagedorn Psychiatric Hospital

John Whitenack, Acting Assistant Director, State Hospital Management, DMHS

Roger Borichewski, Acting Assistant Director, Community Services, DMHS

Beth Connolly, Special Assistant to the Commissioner

Steve Adams, Director, Fiscal Management Operations, DMHS

Ellen Lovejoy, Office of Public Affairs

Task Force Members Unable to Attend:

Dawn Apgar, Deputy Commissioner, DHS

Kenneth J. Gill, Ph.D., CPRP, Chair, Dept.of Psychiatric Rehab. & Counseling Professions, UMDNJ

Summary

This Task Force Meeting was conducted by Conference Call.

1. Welcome and Roll Call conducted by the Task Force Chair, Commissioner Jennifer Velez.
2. Presentation of Consumer Perspective/Further Considerations

Task Force member Carolyn Beauchamp presented a paper prepared by her and Task Force members Dr. Ken Gill, Dr. Margaret Swarbrick and Wayne Vivian called “Further Considerations on the Plan to Close Senator Garret W. Hagedorn Psychiatric Hospital”.

The paper had been sent to all Task Force members to review in advance of the meeting. Carolyn, Wayne and Dr. Swarbrick discussed the following:

- Impact of The Community Mental Health Developmental Disabilities Investment Act on the closing of the hospital. This law was passed in the 90’s. Carolyn reviewed the provisions of the law with the TF members calling particular attention to the section below:
 - (d) When a facility's residential capacity is reduced by 50 percent or more, the funds realized by such a reduction in capacity shall be used to support the individuals who formerly resided at the facility and have been moved to community mental health and developmental disability services.
- TF members asserted this law should ensure that the money saved from closing a hospital should go into the community system. DHS staff stated that the law is still on the books but can be overridden by the Appropriations Act.
- Carolyn indicated the paper is in support of closure. It is preferable to have people be served in the community. However, closure is supported only if the funding stays in the mental health system.
- She recommended that an ongoing planning body be established that looks at the whole mental health system—County hospital, State hospital, and the community.
- They do not see the proposal to close Trenton Psychiatric Hospital as being developed enough.
- Ideal role of the Mental Health System
 - Concern about “learned helplessness” that occurs with long term institutionalization.
 - Importance of prevention and early intervention to address incipient crisis.
- Institutionalization should be used judiciously.
 - Safety is significant issue at each of the state hospitals.

Seclusion and restraint should be eliminated.

- Move away from state hospitalization to extended STCF stays of up to 30 to 45 days. (Extended acute care at Trinitas is an example.)
- Long term community care could be provided to the frail elderly through home based approaches such as Program of All Inclusive Care (PACE) whenever possible.
- All state psychiatric hospitals should offer a high level of care and staff should have high level of training.
- Consider utilizing Hagedorn as a private, non profit geriatric hospital with some state oversight.

Task Force members had questions and comments regarding the presentation.

- A TF member asked if the money from the Marlboro closure was reinvested in the community. DHS staff reported that it was. Marlboro's operational dollars went into the community grants in aid budget.)
- There was a discussion of STCF's, their role, location, funding and the negative experience of one TF member with one STCF.
- Regarding privatization, it was suggested that indigent patients must continue to be served. DHS staff indicated that privatization would take over a year due to the time it takes to plan for, go through the procurement process and transition to a new operator. Some TF member felt privatization was a viable alternative, though DHS staff indicated that savings are less significant than a full facility closure.
- Regarding planning body: Carolyn envisioned long range planning that would use local and national experts; in her opinion the TF represents too many vested interests. TF member suggested State Mental Health Board and Planning Council would have a role in long range planning. This idea could be posed to the Planning Council. Concern was expressed that the Planning Council deals with the community, not the hospitals. One TF member expressed concern that the Division and stakeholders are aware of needed system improvements but that there is just insufficient funds
- TF member indicated support for serving gero-psychiatric individuals in or closer to community but resources are needed such as gero-psychiatrists. PACE is also a wonderful system for aging in place but it is a capitated system.

Other issues mentioned:

- Geographic issues: One participant wondered if one unit could be kept open at Trenton to provide geographic accessibility.
- Projections needed of people who will need geriatric care in the future. DMHS projects average older adult admissions to be 13 per month and they would have capacity for that but several TF members continue to dispute that.

- TF member stressed the benefits of specialization—that it is important to have a skill base of specialized staff. TF members were asked to suggest training/skills needed.
- Some TF members continue to express concern about closing any hospital.

3. Hospital Budget Update

Updated budget information that Steve Adams, CFO for DMHS had prepared was emailed to TF members in advance of the meeting. Savings estimates for a Trenton closure were revised down based on additional considerations not previously factored in due to the brief turnaround time to prepare savings estimates. Revised savings estimates approximate Hagedorn's but are still incomplete.

Driving factor related to number of patients/ward, number of wards and number of buildings. The Division revised the assumptions used in the original projections which were 4 wards at 38 patients to 6 wards at 25 patients each. This is consistent with other units throughout the system and ensures safety, particularly with a forensic population. This level requires 2 buildings and the change caused the total FTEs to increase from 289 to 350 and the staff: patient ratio to increase from 1.93:1 to 2.33:1. This is the significant reason for reduced savings.

4. Final Report Review/Process

- An initial Draft report will be emailed to TF members this afternoon. Request that comments in response be provided by COB Monday, January 24. Revisions will be made based on comments and final draft will be sent out via email COB Wednesday or Thursday so members will have it in advance of Friday's Task Force meeting. The report will be provided to the Governor and Legislature by February 1st.
- The report will attempt to capture all viewpoints. Report will respond to what is required in the law. TF members wanted assurances that the report would show that there is not clear consensus, that there is different thinking.
- Supporters of the Trenton closure proposal wanted to ensure that it was part of the report and discussion about it reflected in the narrative.
- Concern was expressed about Freedom House still not having a lease. Staff agreed to look into this.

TF member thanked the staff for all their work supporting the Task Force.

NEXT MEETING: Friday, January 28, 2011 at DHS

State Mental Health Facilities Evaluation Task Force

Summary of Meeting of January 28, 2011

In Attendance:

Task Force Members:

Jennifer Velez, Chair, Commissioner of DHS
Margaret Swarbrick, Vice Chair, Ph.D., OTR, CPRP, Director, Inst.for Wellness & Recovery Initiatives, CSP
Dawn Apgar, Deputy Commissioner, DHS
Sylvia Axelrod , Executive Director, NAMI NJ
Carolyn Beauchamp, President, Mental Health Association in New Jersey
Robert Bollaro, DMAHS
The Honorable Richard Codey, Senate, 27th Legislative District
The Honorable Patrick Diegnan, Assembly, 27th Legislative District
The Honorable John DiMaio, Assembly, 23rd Legislative District
The Honorable Michael Doherty, Senate, 23rd Legislative District
Kenneth J. Gill, Ph.D., CPRP, Chair, Dept.of Psychiatric Rehab. & Counseling Professions, UMDNJ
Gilbert Honigfeld, Ph.D., General Public Member
Barry Johnson, Director, Monmouth County Division of Mental Health and Addiction Services
Karen Kubert, Director, Warren County Department of Human Services
Valerie Larosiliere, Acting Asst Commissioner, DMHAS
Judith A. Lucas, Ed.D., APN-BC, IHHCPAR, Rutgers University
Gail Masson-Romano, M.A., Board of Trustees, Hagedorn Psychiatric Hospital
Rosalyn Metzger, General Public Member
Joseph A. Miller, Ph.D., L.C.S.W., Director, Neurosciences and Behavioral Health, Meridian Health
Wayne Vivian, President, Coalition of Mental Health Consumer Organizations of NJ
Debra Wentz, Ph.D., CEO, New Jersey Association of Mental Health Agencies

Other:

John Hulick, Governor's Office of Policy
Tom Lynch, The Honorable Patrick Diegnan's Office
Ed Smith, The Honorable Michael Doherty's Chief of Staff

Staff:

Kevin Martone, Deputy Commissioner, Department of Human Services
Paula Hayes, Task Force Secretary
Gayle Riesser, Task Force Secretary
Mary Jo Kurtiak, Acting CEO, Hagedorn Psychiatric Hospital
John Whitenack, Acting Assistant Director, State Hospital Management, DMHS
Roger Borichewski, Acting Assistant Director, Community Services, DMHS

Summary

Commissioner Velez opened the meeting and thanked Task Force members for their commitment and passion for serving on the Task Force. The Department was made aware that a draft copy of the final report was shared with the press and requested members to respect the integrity of the deliberative process until the report was finalized and submitted to the Governor and Legislature. She added that the Department will not be commenting to the press until the report is official.

A final draft report had been emailed on Thursday to the Task Force members for their review. The main agenda item for the meeting was a discussion of the draft report in order for the Task Force members to suggest any final edits to the report.

Some Task Force members felt strongly that the report should make a recommendation regarding whether or not to close Hagedorn. Other Task Force members disagreed; they asserted the role of the Task Force was to review the Department's plan to close Hagedorn and make recommendations regarding the plan according to the issues detailed in the law establishing the Task Force that the Legislature passed.

While several Task Force members felt the draft report did a good job of reflecting the differing points of view among Task Force members, they did not feel the draft report gave the Governor enough guidance. Another Task Force member disagreed stating that early on it was obvious that the Task Force could not reach consensus and the report would reflect different perspectives.

A motion to vote on whether or not to approve the Department's plan to close Hagedorn was tabled. A vote was taken on the following motion: "The Task Force recommends that Hagedorn should not be closed". Ten Task Force members voted yes, seven Task Force members voted no and there were four abstentions.

Many Task Force members felt there were items in the draft report on which there was consensus and that the report accurately reflected the content of deliberations. There was also concern that a vote would only demonstrate lack of consensus and that it is important for the final report to reflect the fullness of deliberations, particularly where there was consensus. They felt these items should be listed up front so they were not lost in the body of the report. These were the three key themes that appeared in the introduction. In addition, there was agreement among Task Force members of a fourth theme that they would want assurance that the failure to close Hagedorn would not cause other cuts in the mental health system.

A lengthy discussion of the draft report followed which again reflected the differing views among Task Force members:

- Some Task Force members stated the draft Task Force report needs more information and outside analysis beyond what the Task Force could even do. There was a perception that the Task Force had missed an opportunity to use the process to make a more informed decision about state hospitals and the community system. Some Task Force members felt they could be open to a Hagedorn closure if more information was available.
- Supporters of a closure reiterated the need to strengthen community systems as opposed to investing resources into five hospitals, and felt that several comments during the process have been stigmatizing to people with mental illness.
- Some Task Force members suggested that the work of the Task Force be extended and they be given more time.
- Another Task Force member stated that the philosophical differences among members were so great it was unlikely that agreement would ever be reached.

- Some felt strongly that the Governor needs to be shown different options.
- Viewpoints from earlier meetings on both sides of the issue were reiterated.

PH 1/30/11